IMPLEMENTATION OF THE INCENTIVE SCHEME FOR HUMAN RESOURCE FOR HEALTH IN THE PUBLIC HEALTH FACILITIES IN NEWALA DISTRICT

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IMPLEMENTATION OF THE INCENTIVE SCHEME FOR HUMAN RESOURCE FOR HEALTH IN THE PUBLIC HEALTH FACILITIES IN NEWALA DISTRICT

By

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A Dissertation submitted in (partial) Fulfillment of the Requirements for the Degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled; **Implementation of the incentive scheme for human resource for health in the public health facilities in Newala district, Tanzania,** in (partial) fulfillment of the requirements for the degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences.



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DEDICATION

This work is dedicated to parents, my father Hussein Mpuya and my mother Salima Swaibu, for bringing me into this world, supporting and always praying for my success.

ABSTRACT

Background: Availability of human resource for health and its distribution to required areas is vital in delivering health care services, especially in rural areas. Deployment, attraction and retention of health workers in rural districts/areas have been a problem for a long period. Various incentives and benefits have been set by the government of Tanzania whereby employers are directed to provide those incentives to improve attraction and retention of health workers. However, its implementation and outcomes is not well explored.

Objectives: The study aimed at assessing the implementation of the public health sector incentive scheme for attraction, deployment and retention of human resource for health in Newala district.

Materials and methods: A cross sectional descriptive study was conducted in Newala district between March and May, 2010 using both quantitative and qualitative data collection methods. A total of 120 health workers were interviewed using semi-structured questionnaires, and an interview guide was used for key informants (4 district officials and three heads of facilities) in their respective workplaces.

Results: Majority of health workers interviewed were not aware of their stipulated benefits and rights. Health workers who had heard about the government documents stipulating health workers rights and benefits were 63.3%, while only 14.5% of those who had heard about the documents reported to had ever read such government documents. Both financial and non financial incentives were implemented but the overtime allowances were less implemented in rural health facilities as compared to urban health facilities. It was also found that majority of health workers had attended seminars (81.7%), while less than fifty percent had been promoted (33.3%), and went for leave (24.2%). Nurses were more likely to have had attended seminars than other cadres. Furthermore, district/health facility official reported that some of the incentives were specific to a certain cadres while some were for all health workers (e.g. overtime allowances). Majority of health workers who reported to had received non financial incentives were satisfied with those incentives which also was reported to create job satisfaction, however, those who reported to had received financial incentives were not satisfied with leave allowances hence created job dissatisfaction. Incentives preferred by health workers were overtime allowances,

improved working conditions and tools, while their leaders preferred to provide hardship allowances and housing. This study also revealed the factors affecting effective implementation of incentive scheme were shortage of funds and district lack authoritative power to implement.

Conclusion and Recommendations: Majority of health workers interviewed were not aware of their benefits and rights. Both financial and non financial incentives were implemented but overtime allowances were less implemented in rural facilities. Health workers who reported to receive non financial incentives were satisfied with those incentives which also were reported to create job satisfaction. District and facilities leaders should give education to all health workers concerning their benefits and rights. Implementation of non financial incentives (e.g. recognition) should be emphasized. Further research should be conducted to assess the relationship between different types of incentives and improved work performance in hard to reach districts.

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ACRONYMS/ ABBREVIATIONS

CHMT=Council Health Management Team

DED= District Executive Director

DHRO= District Human Resource Officer

DMO= District Medical Officer

HRH= Human Resource for Health

HSSP=Health Sector Strategic Plan

HW = Health Workers

MDG= Millenium Development Goals

MoEVT=Ministry of Education and Vocation Training

MoFE= Ministry of Finance and Economy

MoHSW = Ministry of Health and Social Welfare

MUHAS=Muhimbili University of Health and Allied Sciences

PMORALG= Prime Ministers' Office, Regional Administrative and Local Government

POPSM= President's Office Public Service Management

TNC= Tanzania National Census

UiB=University of Bergen

URT=United Republic of Tanzania

WHO= World Health Organization

DEFINITION OF TERMS

Incentives –An activity to motivate people to achieve pre-determined health objectives or **incentives** is defined as "all rewards and punishments that providers face as a consequence of organisations in which they work, institution under which they operate and the specific interventions they provide"(WHO,2000)

Motivation- An individual's degree of willingness to exert and maintain an effort towards organisational goals

Standing Orders –Orders issued under the authority of the government pursuant to S.24 (5) of Act 16of 1989, stipulating the general condition of service of public officers and the procedure of handling personnel matters.

Perception -A conscious understanding of something

Awareness –A state or level of consciousness where data can be confirmed by an observer. OR it is the knowledge or understanding of a subject, issue or situation

Attraction – A quality of arousing interest or being attractive.

Coverage – The extent or amount to which something is observed, analyzed, and reported.

Deployment –The distribution of health workers at health facilities and use them effectively.

Retention - The action of keeping something rather than losing it.

Motivators- An incentive with positive motivational influences

Satisfiers – Any agent capable of producing satisfaction

CHAPTER ONE

1. INTRODUCTION

1.1 Background

In Tanzania like many other developing countries, the scarcity of skilled human resources for health is a major problem. The total staffing in the health sector in Tanzania stands at 35% of the actual needs. According to the defined norms, the available number of professional health workers in the public sectors by 2009 is 35,202 with a deficit of 90,722 health workers (MoHSW, 2009).

The retrenchment policy coupled with freezing of employment implemented from 1993 until 1999 led to a sharp decline in health work force in advent of increasing burden of diseases and consequently, present human resource crisis in the health sector (MoHSW, 2008a). The Health Sector is also facing the problem of weak human resources planning and forecasting requirement (Kiwara et al, 2010). The problem is mainly affecting health facilities situated in rural areas. The shortage of health workers is felt more in rural areas due to geographical imbalance in distribution of health workers (Mæstad, 2006).

Brain drain within and outside the country and ineffective implementation of recruitment, deployment and retention process are also contributing to human resource crisis (Kiwara et al, 2010). Brain drain within the country is also reported, whereby human resources for health migrate from rural to urban areas and from NGO facilities to government facilities (MoHSW, 2008a).

According to Decentralization by Devolution policy, recruitment, deployment and retention of human resource for health under current decentralised system, regions and districts have the mandate to identify and fill the existing staff vacancies (MoHSW, 2009), but practically, human resource management is the joint responsibility of various ministries such as Ministry of Health and Social Welfare (MoHSW), Prime Minister's Office Regional and Local Government (PMORALG), President Office Public Service

Management(POPSM), Ministry of Finance and Economy (MoFE), and Ministry of Education and Vocational Training (MoEVT) (MoHSW, 2008a).

Districts and regions face many challenges in human resource management such as low human resource management capacity and multiple coordination which has contributed to slow recruitment process, delay in staff placement and slow promotion process (MoHSW, 2008b).

Provision of financial and non financial incentives to health workers is stipulated in the United Republic of Tanzania (URT) Standing Orders (URT, 1994). A responsibility of the government involves provision of housing, promotion, leave, appreciation of good performance, salary (URT, 1994). Implementation of financial and non financial incentives is reported to help in attracting, deploying and retaining health workers in rural areas (Zurn et al, 2004; Mangham, 2007). Implementation of these incentives is accomplished by districts in collaboration with above mentioned ministries (POPSM, MoHSW and PMORALG). At district level implementation process is done by District Executive Director (DED), District Human Resource Officer (DHRO) and District Medical Officer (DMO) together with heads of health facilities (MoHSW, 2008a).

Ineffective implementation of available government incentive schemes for attracting, deploying and retaining health workers in rural areas usually results in poor attraction, poor deployment, and poor retention of health workers hence shortage of staff. Implementation of incentive schemes are affected by various barriers, some of these barriers are not well known.

Since the effective implementation of government incentives for retention, deployment and recruitment process is necessary to curb human resources crisis in Tanzania, understanding the factors contributing to poor implementation of the laid down incentives for attracting, deployment and retention and process for human resource for health will enable health sector to deal with the problem of poor attraction, poor deployment and poor retention.

The chapters in this study are organized chronologically as follows: the study background, problem statement, and rationale of the study, literature review, objectives, methodology, results, discussion, conclusion and recommendation.

1.2 Statement of the Problem

In Tanzania the total staffing in the health sector stands at 35% of the actual needs. According to defined norms and available number of professional health workers by the end of 2009 in the public sectors, the total staff stands at 35,202, and the deficit is 90,722 (MoHSW, 2009). Shortage of health workers is across all cadres, affecting more in rural areas than urban because health staffs are not attracted to work in those areas. The deficit of human resource for health in regional hospitals is 66%, districts hospitals 67%, health centres and dispensaries is 74% (MOHSW, 2006).

Shortage of health workers due to poor deployment and poor retention scheme is more felt in rural districts than urban districts. A report by Ministry of Health and Social Welfare (2008b) shows Tabora, Kigoma and Mara have fewer medical doctors compared to Arusha and Dar es Salaam (MoHSW, 2008b). But regions with shortage of health workers in general regardless of their cadres are Mtwara, Lindi, and Kigoma (Nswila, 2009). Study done in Northern Tanzania showed most of qualified staff is concentrated in few centralized locations, while those remaining are inequitably distributed in rural areas (Øystein et al, 2005).

The health sector in Tanzania is experiencing severe shortage of human resource for health especially in regions with hard-to-reach rural districts. This has been contributed by a number of factors including poor implementation of recruitment, deployment, and retention strategies for human resources for health, poor working conditions, geographical barriers, low income, poor managerial/supervision and low enrolment and low output of graduates. These factors have also contributed to having few health workers attracted to the sector; and working for a longer period in rural areas. Furthermore, human resource crisis was aggravated by the freezing of employment and retrenchment of health workers since 1993 to 1999(MoHSW, 2008a).

Incentive scheme stipulated in government documents in Tanzania includes financial and non financial incentives. Deployment and retention of health workers in Tanzania as per standing orders in the public sector (published by the United Republic of Tanzania authority Pursuant to S.24 (5) of Act No.16 of 1989), there are benefits/incentives in which

workers are supposed to get from his/her employer so as to motivate and remain at the duty station for longer periods. This benefit include financial incentives (salary, on call allowances, part time duty allowances ,uniform allowances for nurses, overtime allowances, responsibility allowances),and non financial are promotion, leave including study leave, training, housing and recognition/appraisals,(URT Standing Order,1994 p L).

Apart from the government incentives stipulated in Standing Orders, some non governmental organisations introduced top-up allowances and other incentives as the means of attracting health workers to work in rural district with high prevalence of HIV and AIDS (Dambisya, 2007). These programmes of non governmental organisations managed to attract and deploy health workers in those rural districts.

These government incentive packages may be known to most public servants, implying that if they are not given to them, it may result into low attraction, poor deployment and poor retention of human resource for health hence creating a shortage of staff in some parts of the country.

Shortage of health workers coupled with poor motivated staff in those districts would lead to poor health service delivery hence increasing morbidity and mortality in population. A study done in some of the districts of Tanzania (Bariadi, Meatu, Iringa Municipal and Mbeya Municipal) have identified shortage of funds, and staff to implement, weak management capacity and practice and districts lacking authoritative power to implement strategies as factors which hinder implementation of non financial incentives (Munga and Mbilinyi, 2008).

But, in spite the incentives stipulated by the government, attraction, deployment, motivation and retention of health workers in the rural districts remained low. The government incentives to facilitate deployment and retention (financial and non financial incentives) are supposed to be implemented in districts. However, it is not well known whether these incentives are well implemented, and, if implemented, act as motivators or satisfiers to facilitate deployment and retention of health workers in hard-to-reach areas and what factors hinder their implementation.

This study therefore looked at the coverage of implemented incentives and factors hindering effective implementation of incentives as in Standing Order/Circulars, thus aiming at improving attraction, deployment, and retention of health workers in rural areas. Therefore, the purpose of this study was to assess the incentive scheme/packages; whether they are implemented, factors affecting implementation, and to assess if these incentives are enough motivators or satisfiers if well implemented or if they do not meet the health workers needs.

1.3 Research questions

To what extent are incentives (as per standing order/circulars) for attraction, deployment and retention health workers implemented?

What are the factors affecting effective implementation of incentives (as per standing orders) for attracting, deploying and retention of health workers in rural areas?

Are incentives perceived by health workers as enough/meeting their needs to attract and retain them in hard-to-reach areas?

1.4 Rationale of the study

The government of Tanzania has set its vision "the Tanzania Development Vision 2025" which identifies health and social welfare as priority. The Vision 2025 is also reflected in the National Health Policy (2007); whereby the mission of National Health Policy is to facilitate provision of basic health services, which are proportional, equitable, quality, affordable, sustainable and gender sensitive. Human resources for health is considered to be the major issues in National Health Policy whereby the Human Resource policy guideline has been formulated with the aim to have a well-planned, trained, deployed, and motivated workforce (MoHSW, 2008). Another programme/strategy called National Strategy for Growth and Reduction of Poverty (NSGRP) also known as MKUKUTA which it advocates for improvement in the quality of life and wellbeing of all Tanzanians by ensuring availability of skilled workforce to provide quality services. All the above mentioned policies will reach their target if various incentives are implemented to various health facilities so as to attract, motivate, deploy and retain health workers.

This study has generated information that may be used to: increase knowledge on the usefulness of incentives, help on the improvement of incentives, give knowledge on the role of incentives, help decision makers to understand the usefulness of incentives and influence policy makers to improve upon the incentive policy for attracting, deploying, and retaining health workers. The findings will also help the government of Tanzania to reach the targets of National Vision 2025, MKUKUTA and Millennium Development Goals which then will improve the health of Tanzanians.

1.5 Objectives

1.5.1 Broad objective

To assess the implementation of the public health sector incentive scheme for attraction, deployment, and retention of human resources for health in Newala district.

1.5.2 Specific objectives

1. To assess the level of awareness of health workers on their rights and benefits as stipulated in the government document (Standing Order and Circulars) governing their services.
2. To identify incentives implemented for attracting and retaining human resource for health in Newala district.
3. To assess the number of the health workers who benefited from the implemented incentives for attraction, deploying, and retaining health workers in Newala district.
4. To determine the incentive received by health workers that satisfies their needs in Newala district.
5. To determine factors affecting effective implementation of incentives (as in standing orders) for attraction, deployment and retention of health workers in Newala District.
6. To solicit health worker's views on the best way of implementing incentives for attracting, deployment and retaining of human resources for health in Newala district.

CHAPTER TWO

2. LITERATURE REVIEW

Assessment of the incentive scheme/packages and factors hindering its implementation is paramount important towards achievement of deployment and retention of human resource for health, especially in ill served rural areas. A proper implementation of the financial incentives and non financial incentives usually helps in attracting, motivating and retaining health workers.

Contents of the Government Standing Order and Circulars

The Government Standing Order is the government documents published by the United Republic of Tanzania authority Pursuant to S.24 (5) of Act No.16 of 1989), which consists benefits/incentives in which workers are supposed to get from his/her employer so as to motivate and remain at the duty station for a longer period. These benefits include financial benefits and non financial benefits (URT, 1994). The benefits and rights are listed below as follows as stipulated in Tanzania government Standing Orders ad Circulars (URT, 1994):-

1 Salary/salary increase
2 Subsistence allowances
3 On-call allowances
4 Overtime allowances
5 Uniform allowances
6 Leave allowances
7 Medical benefits
8 Promotion
9 Good working conditions and tools
10 Opportunity for training/study
11 Leave
12 Seminar/workshop
13 Flexible working hours
14 Recognition/ appraisal
15 Houses
16 Confirmation at workplace

Motivation theory

According to Herzberg's Motivation –Hygiene theory explains the two factors which can cause the satisfaction or dissatisfaction to perform among health workers at workplace. These factors are termed as motivators or satisfiers and hygiene factors or dissatisfiers. Satisfiers (intrinsic factors) include; achievement, recognition, the work itself, responsibility, and advancement (growth) while the dissatisfiers (extrinsic factors) include: company policy and administration, supervision, salary, interpersonal relations and working conditions. The satisfiers lead people to feel good about their jobs and motivate effectively. Hygiene factors (dissatisfiers) causes people to feel unhappy, or dissatisfied with jobs due to its association with the physical characteristics of the environment in which people work (D'Souza, 2008). Results from a study done by Maidani (1991) showed that employees' motive to work in both (public and private) sectors tends to emphasize intrinsic or motivator factors of employment, also shows that the satisfaction of employees were not attributable to hygiene factors. Another study showed that intrinsic factors were served as a source of job satisfaction, while extrinsic factors were the primary source of job dissatisfaction (Koelbel et al, 1991; Paul, 1966). All the above studies support Herzberg's theory; therefore if it is to be applied at work place on the process of providing various incentives it may motivate health workers.

Awareness of health workers on their benefits/incentives

A study done in Zimbabwe on retention of health workers, reported that health workers were not aware of retention packages offered by the government of Zimbabwe (Chimbari et al, 2008). The possible reason of health workers not been aware could be due to lack of sensitization programme on their incentives. Another study done in Kilimanjaro, Tanzania showed that health workers know their right to be promoted every three years and according to MoHSW regulation; promotion is accompanied by a salary increment (Manongi et al, 2006). Awareness of health workers on their benefits or incentives they are supposed to receive from their employer is one step towards demanding those benefits from the employer. Once a health worker knows his/her rights it is possible to request the employer to implement it.

Incentives implemented for attracting and retaining human resource for health in rural district/areas

The World Health Organisation (WHO) defines incentives as "all rewards and punishments that providers face as a consequence of organisations in which they work institution under which they operate and the specific interventions they provide" (WHO, 2000 p61) (quoted in Iipinge et al, 2009). In Tanzania, health workers have their incentives/benefits stated in the Standing Order of 1994, including financial and non financial incentives (involve provision of allowances such as on call, part time and overtime allowance, leave, housing, appreciation of good performance and improvement of communication between different levels of health systems) (URT, 1994). Several studies have been conducted to explore incentives implemented for attracting, deploying and retaining health workers. For example wage increases, additional benefits and working hours flexibility are examples of commonly used incentives to attract or retain the health workforce (Zurn et al, 2004). A study done in Malawi identified net monthly pay, availability of material resources, opportunities to upgrade qualifications, provision of government housing, opportunities to attend in-service training, promotion prospects and grade structure, and transport as incentives to attract and retain health workers (Mangham, 2007).

The study conducted in Kenya by Ndetei (2008) has identified that "facilities offered a number of financial incentives to their staff, such as paid leave and overtime pay, access to house or car loans at lower negotiated market rates (for highly skilled public sector workers) and numerous allowances, such as transport, entertainment, hardship, responsibility, special duty and uniform allowances" (Ndetei et al, 2008). Other studies recommended; increasing salaries and rural allowances; improving rural hospital accommodation (houses); ensuring career progression; providing continuing medical education; increasing support by specialist consultants; improving the physical hospital infrastructure (Kotzee et al, 2006). Another study on assessment of the challenges for retaining nurses in Lebanese hospitals revealed that incentive implemented were monetary rewards and benefit, salary scale, staff development, praise and improving work environment as retention strategies for human resource for health (El Jadarli et al, 2009). Most of the above studies showed that health workers were motivated and retained by

using the mentioned incentives, hence implementing the incentive scheme as sipulated in the Standing Ordes/circulars in our country (Tanzania) may help to attract, motivate and retain health workers in rural district/ areas.

Open Performance Review and Appraisal System (OPRAS) is the process/tool designed by the government of Tanzania to be used by employer to assess the performance of staff. According to Tanzania Public Service Management and Employment Policy (PSM&EP) of 1999 states that "Every organisation within the Public Service shall be required to operate a performance appraisal system for all its employees. Performance appraisal systems may vary from organisation to organisation, and from level to level, but shall have the following common elements: a written performance assessment shall be completed each year, and its contents discussed between the employee and his or her reporting officer". The assessment interview provide the opportunity to discuss the employee's training and career development needs, as well as to recognise good performance and to examine the reasons and agree on remedial action where performance has not matched the required standard(URT-PSM&EP, 1999). OPRAS process usually enable employer to recognise, promote and increase payment those health workers who performed well. Therefore OPRAS if is to be used by all employer/heads of facility to assess their employees, it can be an important tool on provision of incentives like recognition, promotion and increase payment openly and fairly to every health workers.

A health worker's performance depends on a combination of skills, knowledge, and level of effort; the later is largely driven by incentives and the degree of accountability in the system. Another way of provision of incentive in Tanzania which is recently introduced is through Performance based funding which also called Pay for Performance (P4P). Pay for performance has been proposed to speed up the implementation of intervention for reduced maternal and newborn mortality. Health workers are rewarded according to number of deliveries, hence making it in their interest to improve the quality of the services at health facility (Mæstad, 2007). This rewarding system (Pay for Performance) was also used in Burundi as the means addressing extremely low and demoralizing salaries as well as improving the performance of staff leading hopefully to increased utilization rates and better quality health services; including maternity services (Cowley, 2009).

Performance based funding can be distinguished from other form of incentives because the rewards for high performance is granted to institutions (i.e. health facilities) rather than individuals. Despite of Pay for Performance (P4P) having effect in improving performance of health workers towards reducing maternal and newborn mortality but this system faces many challenges like lack appropriate measure to assess provider performances, also it may induce physicians to choose not to treat risky patients within the payment category or avoid treatments that do not receive bonuses (Ellis and McKinnon Miller 2007).

Health workers who benefited from the implemented incentives

It is necessary to ensure that all health workers benefit from the implemented incentives according to cadre's status. The incentives introduced to retain health workers often depend on effective implementation in the facility, with better organised facilities; often in higher-income areas are more successful in providing incentives (Ndetei et al, 2008). The study done in Mali showed that less than fifty percents of health workers interviewed were covered by incentives given to them (Dieleman et al, 2006). Understanding the extent to which the incentives implemented among health workers would help leaders to monitor and evaluate the implementation of various incentives hence increase motivation and retention of health workers.

Incentives and health worker's satisfaction of needs

According to Iipinge et al, 2009; Incentives are generally designed to accomplish enhancement of productivity and quality of services, to support staff recruitment and retention. A study done in Tanzania recently has shown that health workers perceived non financial incentives as a motivating agent to remain in rural areas (Munga and Mbilinyi, 2008). Study done in Vietnam identified that graded appreciation by managers, colleague health worker and community, a stable job and income, and training as the strong motivators (Dieleman et al, 2003). Another study done in Mali also showed that health workers were satisfied with recognition, responsibility, training opportunity and promotion (Dieleman et al, 2006). Once the health workers are satisfied with incentives they received, it would results into job satisfaction.

Locke (1976) states that job satisfaction is a collection of attitudes about specific facets of the job. Employees can be satisfied with some elements of the job while being simultaneously dissatisfied with others. Overall job satisfaction is a combination of the person's feeling towards the different facets of job satisfaction. He argues that the more important factors conducive to job satisfaction are mentally challenging work, equitable rewards, supportive working conditions, and supportive colleagues (quoted in Srivastava, 2004). Usually employees want a fair unambiguous provision of incentives (e.g. pay system and promotion policies). It is also said that satisfaction is not linked to the absolute amount one is paid; rather, it is the perception of fairness. For example individuals who perceive that promotion decisions are made in a fair and just manner are likely to experience satisfaction from their jobs (Witt and Nye, 1992) (quoted in Srivastava, 2004). Therefore proper implementation of the incentive packages that satisfies the need of health workers as stipulated in Standing order and circulars may lead to motivation, job satisfaction and improve retention of health workers at their work station.

Incentives preferred by health workers

Knowing the incentives preferred by health workers and their leaders helps the government of Tanzania to design and implement those incentive packages which could be able to attract, motivate and retain health workers especially in rural areas. Several studies done in Tanzania and elsewhere revealed that health workers preferred financial and non financial incentives (Kolstad, 2008; Serneels et al, 2005; Mireille et al, 2003; Stringhin et al, 2009). Also various studies done in Tanzania and elsewhere (Gauri, 2001; Dussault et al, 2006; Kolstad, 2008) showed that health workers preferred overtime allowances, hardship and risk allowances. It seems health workers preferred risk allowances due to occupational hazards that they are facing at their workplaces. Hardship allowances were preferred due to poor infrastructures and poor living condition. This reflects that human resources planning should consider not only health workers performance and equipment but also the environment that surrounds them.

Factors affecting implementation of incentives for deployment and retention of health workers in rural areas

A study done by Munga and Mbilinyi (2008) identified factors which hinder the implementation of non financial incentives in some districts of Tanzania. It included factor like lack of the capacity to implement, shortage of funds and lack of the authoritative power to implement incentives like promotions. In some district of Tanzania they lack capacity to implement incentives due to shortage of skilled labours especially in human resource management, also for a certain incentive to be implemented the district has to seek for permission from higher authority (Ministry). Also, some districts are faced with shortage of funds which jeopardize the implementation of incentives. But, incentive like recognition of health worker who performed well her/his job does neither require permission from high authority to implement nor financial muscle, so it is easier to implement it at facility level. Mangham (2007) also reported weak administration as a factor hindering effective implementation of incentives for retention of human resource for health in rural areas (Mangham, 2007). Another study mentioned factors that contribute to failure of human resource strategies/incentives; these include donor funds piece of the solution, unrealistic time frame, no grounding in management systems (Human resources) and key stakeholders outside the health sector are not involved (O'Neil, 2008). The above factors, if reversed and implemented well, could result into improved attraction; deployment and retention of health workers hence reducing the effect of the shortage of staff in rural areas

Effect of Institutional factors on incentives for human resource for health

Institution can be defined as rule, norm, or strategy that creates incentives for behaviour in repetitive situations (Crawford and Ostrom, 1995). Also institutions may be formally described in the form of a law, policy, or procedure, or they emerge informally as norms, standard operating procedures, or habits (Polski and Ostrom, 1999). Institutional factors are therefore the factor that affect or influence the implementation or provision of various incentives. Institutional factors include management style, career structure, salary scales, and recruitment, posting and retention practices (Dovlo, 2005). Also in other way, factors

influencing retention or provision of incentives can be divided into macro-health system and micro-health facility. Macro-health system factor include reforms, roles, reforms, resource allocation, and regulatory framework. Micro-health facility includes leadership, work-policies implementation, and teamwork, availability of resources, continuous education and career opportunity (Dieleman and Willem, 2006), good governance of health system (JLI, 2004), and multi-sectoral collaboration involving all the key decision-makers (Lehman, 2008). These factors if are to be implemented as required it will provide conducive room for the success of the provision of incentives and its effects can be felt by health workers hence they become attracted, motivated and retained them at their work places.

Furthermore, provision of incentives and its effect to health workers can be affected by institutional factors at workplace, for example local supervisor who do not appreciate health workers but look for mistakes leading to tensions between colleagues, lack of fairness in ensuring equal access to opportunities such as training and seminar, lack of communication, and commitment of managers to improve staff conditions and poor scheme of services (Mbindyo, 2009). These negative factors could be counteracted by ensuring effective management from facility level to national level, for example practice fairness, appreciate those health workers who perform well, and improve communication.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study site

The study was conducted from March to May 2010 in Newala district. Newala district is among the five districts of Mtwara. Mtwara region consists of five districts, namely, Masasi, Tandahimba, Mtwara rural, Mtwara urban and Newala. This region according to recent data from Ministry of Health and Social Welfare, ranked as the first region with high percent of deficit of health workers (62.6%) followed by Lindi and Kigoma region (Nswila, 2009). Newala district was chosen by using simple random sampling method from the list of four districts of Mtwara region (Mtwara region was chosen because has few health workers).

Newala District is bordered in the west by Masasi district, in the east by Tandahimba district, in the south by Mozambique, and in the north by Tandahimba and Masasi. Administratively, the district is divided into twenty wards. According to 2002 Tanzania Census, population of Newala is 183,930 (TNC, 2002).

3.2 Study design

A cross sectional descriptive study was conducted in Newala district. Both quantitative and qualitative data collection methods using semi structured questionnaires with open and close ended questions and in-depth interview guides were used to collect data in the field.

3.3 Study population

The study population included health care workers of different cadres: health workers working at district hospitals; health centres; and dispensaries. District Medical Officer (DMO), and District Health Secretary, and District Human Resource Officer (DHRO), District Executive Director (DED), and some of heads of health facilities were included in this study as key informants.

3.4 Sample size and Sampling procedures

Newala district has a total 225 health workers. A total of 120 (53.3%) health workers out of 225 health workers were chosen conveniently and were interviewed in this study. District hospital was selected purposively because there was only one hospital in the district. Two health centres were also chosen purposively because in the district there were only two health centres; and fourteen dispensaries were randomly selected from the list of 24 dispensaries. All health workers who were present at the time of the study and willing to participate in the study in the selected health facilities were interviewed. In case of a health facility with many staff, simple random sampling were conducted by taking a list of names of health workers and then select them by simple random procedure to get the required number of health workers to be interviewed.

For the qualitative data collection method, key informants, who, in one way or another, deal with human resources, were chosen purposively to be involved in the study. These are DED, DHRO, DMO and heads of health facilities. All key informants (7) were consulted in their offices and health facilities.

3.5 Inclusion and exclusion criteria

Health workers working at district hospital, health centres and dispensaries (Public Health Facilities) were included in the study. This is because the questionnaire was designed to capture information even from those who are newly employed. Health workers working in private health facilities were excluded from the study because the assessed incentives were concerned with only public servants (Standing orders and circulars apply only to public health facilities). All mentioned key informants were included in the study.

3.6 Data collection instruments

The study used both quantitative and qualitative methods in data collection. For the quantitative data collection method; data were collected by using the semi- structured questionnaires (with close ended and open ended questions). The questionnaires were designed in English and then translated into Kiswahili. The Kiswahili questionnaires were used for data collection.

For the qualitative data collection method, interview guides for in-depth interviews were developed in English and then translated in Kiswahili. Interview guides with list of

questions was used in this study by interviewer to interview participants. All in-depth interviews were tape recorded by using a tape recorder.

Contents of instruments contained background data, demographic information and the questions covering the specific objectives of the study. The questionnaires covered awareness of health workers on their benefits/rights, types of incentives implemented, coverage of implemented incentives, satisfaction of health workers on the government stipulated incentives, factors affecting effective implementation of the government incentives, and aimed also to solicit health workers' views on the best ways of implementing incentives for attracting, deploying and retaining health workers in Newala district.

Study variables

Dependent variable

Level of incentives implemented

Independent variables

1. Age of respondent
2. Sex of respondent
3. Marital status of the respondent
4. Education level of respondent
5. Type of health facility workers is placed
6. Cadre/Profession (type)
7. Placement (rural, urban, or semi urban, remote rural)
8. Number of dependents
9. Family size
10. Number of children

11. Ambition for further education

12. Ever sent for upgrading

13. Ever went for a workshop/seminar

More variables are elaborated according to specific objectives, see the table below

Specific objectives	**Independent Variables**	**INSTRUMENTS**		
		Questionnaires	Interview guides	
To assess level of awareness of health workers on their benefit and rights	Level of awareness of health workers on benefits and rights	Was used to interview Health Workers	Was used to interview Key informants	
To identify incentives implemented for attracting, deploying and retaining HRH in Newala Districts	Availability of incentives -house -allowances paid -recognition of good performance	Was used to interview Health Workers	Was used to interview Key informants	

Specific objectives	Independent Variables	Questionnaires	Interview guides	
To assess the number health workers who benefited from incentive implemented for attracting ,deploying, and retaining HRH in Newala District	Number of Health worker given incentives -number of H/W paid on call allowances -number of H/W paid Overtime allowances -Number of H/W promoted -number of H/W recognised for good performance	Was used to interview Health Workers	Was used to interview Key informants	
To determine incentives received by health worker that satisfies their needs in Newala district.	-Number of health workers satisfied with the incentives received. -Number of health workers not satisfied the incentive received.	Was used to interview Health Workers	Was used to interview Key informants	
To determine factors affecting effective implementation of incentive scheme for attraction , deployment, and retention of health workers in Newala district	-fund availability -Guideline available -Availability people with managerial skills -Reported community involvement -reported intersectoral collaboration	Was used to interview Health Workers	Was used to interview Key informants	

Selection and training of research assistants

Two research assistants with previous experience in data collection were employed after being interviewed for the task. They were trained for two days to understand the study objectives, questions, and record responses and develop interviewing skills. Research assistants were trained on how to ask questions consistently and record the answers correctly. The research assistants were supervised in the field and checked at the end of each day to ensure accuracy and completeness of questionnaires. When we found a questionnaire which is not properly filled, we usually returned to the field on next day to find the respondent who is his/her questionnaire was not filled properly.

Pre-testing

Before starting the study, the questionnaires and interview guides were pre-tested for validity, coherence and consistency of the questions in one of the districts of Dar es Salaam. Correction and rephrasing the questions was done after pre-test.

3.7 Data collection procedure

Permission was obtained from Regional Administrative Secretary, DED and DMO, and Heads of Facilities before starting collecting data. Eligible health workers were interviewed and before starting the interviews individuals were asked for their consent to participate in the study. Face to face interviews were conducted privately between the interviewer and the interviewee using semi structured questionnaires with both open ended and close ended questions. Permission to interview people in their respective workplaces was obtained from the Regional Administrative Secretary, District Executive Director and District Medical Officer. All mentioned key informants in this study were asked their consent to be interviewed and tape recorded. The interview guide for the DED, DHRO, and DMO were different from that of heads of facilities. Interview of key informant were conducted by principal researcher while in interview of health workers were done by both the Principal researcher and research assistants.

3.8 Data management and analysis

In the field, research assistants were supervised by the Principal researcher by inspecting the collection of data; questionnaires were collected in the same day immediately after data were collected/questionnaires filled. The questionnaires were given serial numbers before data entry. Data were entered and analysed in the computer using EPI Info Version 3.5.1 software. Frequency distribution tables and figures were run followed cross tabulation and analysis of different variables.

For the qualitative data, all interviews and field notes were transcribed manually by the Principal researcher. The transcribed information from in-depth interviews were read several times in order to identify the family codes and codes which facilitated the organizing of data and picking up meaningful data or phrases or quotations in analysis. We used an approach according to Miles and Huberman (1994), to facilitate the production of core constructs from textual data through a systematic methods of coding, data reduction, display and interpretation. The reduction of the data was done by putting together related concepts after sorting out the information in order to focus on the necessary concepts. The data collected from key informants were coded and then responses were grouped into similar ideas as explained by the respondents for in-depth interview. The information collected were systematically categorised into nine themes. Themes of this study include awareness of the health workers on their benefits and rights; the employment, deployment and retaining procedures/strategies; availability of health workers; incentives implemented; coverage of the incentives implemented; incentives preferred by health workers and leaders; health workers' satisfaction on the incentives implemented; factors affecting the implementation of the incentive packages; and the solution/ best way of implementing incentive packages. These codes were identified from the respondent's concepts adapted to the use of ATLAS.ti version (6.1) computer software.

3.9 Measurements of awareness

Awareness of health workers on their benefits and rights was explored by asking health worker to mention his/her benefits which they are supposed to get from his/her employer/government. A health worker was asked to respond to "yes" if he/she knew their benefits and rights and "no" if he/she did not know. Then health workers, who responded

"yes", were regarded to know their benefits and rights; they were further asked to mention their benefits and rights spontaneously as stipulated in the government documents. The responses to these questions were given scores: those who were able to mention at least one benefits scored one and those who did not know their benefits scored zero. The sum of scale was ranging from zero to sixteen and it was divided into five categories; those who were totally not aware, those who were slightly aware, those who were somehow aware, those who were aware, and those with high awareness. A health worker who spontaneously mentioned nine to twelve benefits and rights was taken to be aware on benefits and rights on health workers and those who mentioned thirteen and above were considered to have high awareness. A health worker who spontaneously mentioned one to four benefits was taken as slightly aware; those who mentioned five to eight benefits and rights was taken as somehow aware; and those who scored zero, was taken as they were totally not aware on their benefits and rights of employments. The cut off point for health workers to be considered as were aware in this study were those health workers who were able to mention nine and above benefits and rights; while those health workers who mentioned benefits and rights below nine benefits and rights were considered as not aware.

3.10 Ethical issues

Ethical clearance was secured from Muhimbili University of Health and Allied Sciences (MUHAS) Research and Publication Committee. Permission to conduct research was obtained from the Regional Administrative Secretary [RAS] and Regional Medical Officer [RMO] of Mtwara region; also permission was obtained from District Executive Director [DED] and District Medical Officer [DMO] of Newala district. Written individual informed consent to participate in the study was sought after explaining to participant the aim of study, methods and benefit. The participants was asked to sign a written consent form (see appendix 1) before starting to participate in the study and would be assured that identification number were used instead of their names; also data collected would be used for the purpose of the study.

3.11 Study Limitations

This study faced several limitation; because the study response relied on the reported information; hence there was a possibility that response were not reflecting the true picture due to recall bias, but to minimize it, we asked the interviewee extra questions. They were also asked to provide information not only from workplaces but also from other facilities. Furthermore, the result obtained in this study can not be generalised because the sample were not randomly selected and the factors affecting implementation of incentives, sometimes are regional/area specific. But it may help to design incentive policies for retention of health workers in rural areas and how to implement it.

Finding interviewees for the interview in hospital setting was difficult. Some health workers were busy due to shortage of health workers; some were missing due to the shift system. These problems were minimized by returning back to the facility or finding an appropriate time for interviewing, such as lunch time or evening. However, not all required health workers were available for the interview. Some of respondent hesitated to participate in this study. To minimize this we assured them that the data we are collecting will be used for purpose of this study only.

CHAPTER FOUR

4.0 RESULTS

4.1 Socio-demographic characteristics of the study population

A total of 120 health workers from 17 health facilities (1 hospital, 2 health centres, and 14 dispensaries) were interviewed. Out of the 120 health workers interviewed, 88 (73.3%) were female. The age of the respondents ranged between 26 to 59 years with mean of 45.3 years, and most of them were aged between 41 and 50 years. In each age group females (over 70%) were more than males. Most of respondents (77.5%) were married and the majority of them had primary education 70 (58.3%). Among 18 clinicians, males were about 72.2%. Data in table 1 summarize the socio-demographic characteristics of the study population.

Table 1: Socio-demographic characteristics of the study population (health workers) by sex

Characteristics	Respondents' sex		Total N=120(%)
	Male n=32 (%)	Female n=88 (%)	
Age groups in years			
21 – 30	2 (28.6)	5 (71.4)	7 (5.8)
31 – 40	5 (26.3)	14 (73.7)	19 (15.8)
41 – 50	19 (29.7)	45 (70.3)	64 (53.3)
51 – 60	6 (20.0)	24 (80.0)	30 (25.0)
Marital status			
Married	25 (26.9)	68 (73.1)	93 (77.5)
Single	7 (35.0)	13 (65.0)	20 (16.7)
Separated/divorced/widowed	0 (0)	7 (100)	7 (5.8)
Educational level			
Primary	10 (14.3)	60 (85.7)	70 (58.3)
Secondary	1 (11.1)	8 (88.9)	9 (7.5)
Diploma	17 (45.9)	20 (54.1)	37 (30.8)
Advanced diploma	4 (100)	0 (0)	4 (3.3)
Professional category			
Clinicians/ Prescribers	13 (72.2)	5 (27.8)	18 (15.0)
Nursing staff	3 (6.3)	45 (93.8)	48 (40.0)
Medical attendants	8 (17.4)	38 (82.6)	46 (38.3)
Others*	8 (100)	0 (0.0)	8 (6.7)

***Others category** comprises of laboratory personnel, radiographer, health officers, and pharmaceutical technician

Data in Table 2 indicates that the majority of respondents (65%) interviewed were from the district hospital and most of them (85.0%) had worked at the health facility for more than three years. About 65.8% of all respondents were from urban, 20.8% from rural and 10.0% from remote rural.

Table 2: Distribution of study population (health workers) in health facilities and location by sex

Variable	Respondents' sex		Total N=120 (%)
	Male n=32(%)	Female n=88(%)	
Type of facility			
Dispensary	7 (21.9)	25 (78.1)	32 (26.7)
Health centre	4 (40.0)	6 (60.0)	10 (8.3)
Hospital	21 (26.9)	57 (73.1)	78 (65.0)
Location			
Urban	21 (26.6)	58 (73.4)	79 (65.8)
Semi urban	2 (50.0)	2 (50.0)	4 (3.3)
Rural	6 (24.0)	19 (76.0)	25 (20.8)
Remote rural	3 (25.0)	9 (75.0)	12 (10.0)
Years of being at the health facility			
More than three years	24 (23.5)	76 (76.5)	102(85.0)
One to two but less than three years	7 (46.7)	9 (53.3)	16(13.3)
Less than one years	1 (50.0)	1 (50.0)	2(1.7)

4.2 Awareness of health workers on their rights and benefits from the employer

Awareness of health workers on their benefits and rights were explored. Data in Table 3 show that 76 (63.3%) of the health workers had heard about government documents (Standing order and circulars) that stipulate their employment benefits and rights. Among clinicians 15 (83.3%) had heard of the documents while among medical attendants were less than fifty percent who had heard about the government documents. However, only 11(14.5%) out of 76 of health workers who had heard about the government document (Standing Orders/circulars) reported to have ever read the documents. None among medical attendants interviewed reported to had ever read those government documents. Among health workers interviewed, about 44.7% of them got the information from district leaders while 18.4% got the information from the facility leader (Figure 1).

Table 3: Health workers who had heard of or read the government documents stipulating their benefits and rights

Health workers who:	Clinicians n=18(%)	Nursing staff n=48(%)	Medical attendants n=46(%)	Other HW n=8(%)	Total n=120(%)
Had heard about the government documents concerning with their rights(n=120)					
	15 (83.3)	33 (68.8)	22(47.8)	6 (75.0)	**76 (63.3)**
Had Read the government documents(n=76)*					
	n=15(%)	**n=33(%)**	**n=22(%)**	**n=6(%)**	**n=76(%)**
	3 (20.0)	4 (12.1)	0 (0)	4 (66.7)	**11 (14.5)**

**Question was asked to only respondents who had heard about the government documents stipulating their rights and benefits; that is why is not adding up to 120*

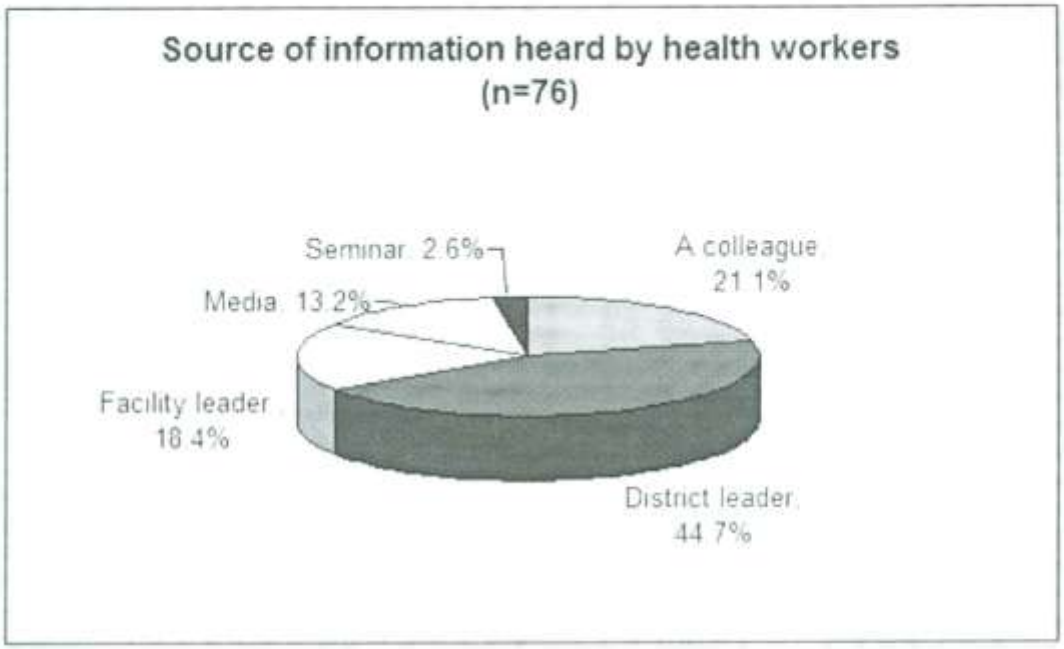


Figure 1: Source of information heard by health workers

Data in Table 4 show that 15 (12.5%) of all health workers interviewed were totally not aware of any benefits and rights stipulated by the government on their employment and also medical attendants were ranked high (23.9%) among categories of health workers who were totally not aware. Health workers who managed to mention 1 – 4 types of incentives (slightly aware) were 56.6% while among health workers categories, other health workers category were 87.5% (this mean that the many health workers in other health worker category were slight aware of the stipulated government benefits and rights). It was also observed that health workers who were aware of the stipulated benefits and rights were very few 2 (1.7%) (This means that health workers who managed to mention more than 8 of the benefits out of 16 benefits stipulated in the government documents were regarded being aware of their benefits in the government documents).

Table 4 Number of benefits and rights as mentioned by health workers by professional categories

Number of benefits mentioned by health workers	Professional categories				*Total*
	Clinicians	*Nursing staff*	*Medical attendants*	*Other HW*	*N=120(%)*
	n=18(%)	*n=48(%)*	*n=46(%)*	*n=8(%)*	
Don't know(0)	1(5.5)	3(6.3)	11(23.9)	0 (0)	**15(12.5)**
1 – 4	10(55.5)	25(52.1)	26 (56.5)	7 (87.5)	**68(56.6)**
5 – 8	7(38.9)	18 (37.5)	9 (19.5)	1 (12.5)	**35 (29.2)**
9 – 12	0(0)	2(11.1)	0 (0)	0 (0)	**2(1.7)**

Key: Don't know (0) means totally not aware
1 – 4 means slightly aware of the stipulated rights and benefits
5 – 8 means somehow aware of the stipulated rights and benefits
9 – 12 means health workers were aware of the stipulated rights and benefits
NB: Respondents were asked to respond spontaneously (multiple responses)

Data in Table 5 show the type of benefits and rights as mentioned by health workers who reported to know their benefits and rights. The benefits and rights mentioned by most of the health workers were the salary/salary increase (86.6%), seminars/workshops (39.1%), houses (38.1%), overtime allowances (37.1%), leave days (35.2%), promotion (35.2%), and opportunity for further studies (32.4%). Also more benefits and rights were mentioned by health workers working in rural health facilities than those who were working in urban health facilities. For example salary/ salary increase were mentioned more in rural location 96.8% while in urban was 85.1%; overtime allowances were mentioned 45.1% in rural while in urban was 33.8% (Table 5).

Table 5: Financial and Non financial rights and benefits as mentioned by health workers of Newala by location

Benefits or rights	*Place /location*		*Total n=105(%)*
	Rural n= 31 (%)	**Urban n=74(%)**	
Salary/salary increase	30 (96.8)	63 (85.1)	**93 (88.6)**
Seminar	15 (48.4)	26 (35.1)	**41 (39.1)**
Overtime allowances	14 (45.1)	25 (33.8)	**39 (37.1)**
Promotion	11 (35.5)	26 (35.1)	**37 (35.2)**
Houses for health workers	15 (48.4)	25 (33.8)	**40 (38.1)**
Opportunity for further studies	11 (35.5)	23 (31.1)	**34 (32.4)**
Leave	10 (32.3)	27 (36.5)	**37 (35.2)**
Treatment	2 (6.4)	14 (18.9)	**16 (15.2)**
On call allowances	3 (9.7)	9 (12.2)	**12 (11.4)**
Other financial benefits*	7 (22.5)	14 (18.9)	**21 (20.0)**
Other non financial benefits**	1(3.2)	25 (33.8)	**26 (24.7)**

Key: *Multiple responses (rural n=31, urban n=74, total n=105 is equal to number of health workers who reported to know their benefits and rights)*
***Other financial incentives** include subsistence and leave allowances. ****Other non financial incentives** include recognition/appraisal for good performance, uniforms for nurses, good working conditions, flexible working hours and confirmation at the work as employee.*

Participants of in-depth interviews (district and health facility leaders) were asked to give their views on how they assess the awareness of health workers on their benefits and rights. Most of respondents (district and health facility leaders) reported that some of health workers were not aware. One of the respondents reported that, *"Health workers being aware depends on his/her level of education and the attitude" (R1).*

Other respondent mentioned that:

> *"Lower health worker cadres are the ones who are not aware of their benefits and rights as compared to other cadres" (R4).*

Another respondent said:

> *"Health workers have no enough knowledge on their benefits and rights so we requested Tanzania Union of Government and Health Employee (TUGHE) to start giving them education on their benefits and rights" (R6).*

Generally health workers were not aware of their benefits and rights as stipulated in the government documents as reported by key informants.

4.3 Incentive implemented by employers in Newala district

This study found that different types of incentives were implemented by employers in Newala district as shown in Table 6. Type of incentives implemented by employers as spontaneous reported by health workers were seminar/workshop (69.0%), houses for health workers (51.7%), promotion (35.8%), and overtime allowance (31.7%) and leave (30.8%). Information in Table 6 also show that overtime and on call allowances in rural health facilities were not implemented in most of facilities (13.5%) and 2.7% respectively, as compared to urban health facilities. Seminars/workshops were perceived as incentives by health workers because they were paid allowances to attend, skills and knowledge acquired in the process (but the main reason was due to skills and knowledge acquired).

Table 6: Incentive implemented for attracting and retaining human resource as reported by health workers

Type of incentives implemented	Number of respondents		Total
	Rural n %	Urban n %	n=120
Financial incentives			
Overtime allowances	5 (13.5)	33 (39.8)	**38 (31.5)**
On call allowances	1 (2.7)	20 (24.1)	**21 (17.5)**
Other financial incentives	3 (8.1)	9 (10.8)	**12(10.0)**
Non financial incentives			
Leave	14 (37.8)	23 (27.7)	**37 (30.8)**
Opportunity for further studies	7 (18.9)	27 (32.5)	**34 (28.3)**
Recognition /appraisal	4 (10.8)	8 (9.6)	**12 (10.0)**
Seminar	26(70.3)	57 (68.7)	**83 (69.0)**
House for health workers	21 (56.8)	41 (49.4)	**62 (51.7)**
Promotion	14(37.8)	29 (34.9)	**43 (35.8)**
Other non financial incentives	1(2.7)	10 (12.1)	**11 (9.2)**

Key: *Spontaneous multiple responses accepted [respondents were allowed to mention what they knew] (rural n=37, urban n=83, total n=120)*

This study also found that incentive implemented in this district as reported by district and facilities leaders for attracting, motivating, and retaining health workers were leave, sponsorship for studies, on call allowances, subsistence allowances, extra- duty allowances and Pay for Performance (P4P) and many more as mentioned by district and facility officials during the in-depth interview conducted.

One of the respondents reported that:

> *"We normally provide some privilege like leave, medical benefit, and sponsorship for those who need further studies, paying those who have transfer, paying extra duty and on-call allowances" (R1).*

One participant (District Official) argued that in health sector, there are a lot of seminars and training which help to motivate health workers. Promotion and salary adjustment has been done, he further gave evidence by giving real examples, and he said that,

Table 6: Incentive implemented for attracting and retaining human resource as reported by health workers

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	Rural n %	Urban n %	n=120
Financial incentives			
Overtime allowances	5 (13.5)	33 (39.8)	**38 (31.5)**
On call allowances	1 (2.7)	20 (24.1)	**21 (17.5)**
Other financial incentives	3 (8.1)	9 (10.8)	**12(10.0)**
Non financial incentives			
Leave	14 (37.8)	23 (27.7)	**37 (30.8)**
Opportunity for further studies	7 (18.9)	27 (32.5)	**34 (28.3)**
Recognition /appraisal	4 (10.8)	8 (9.6)	**12 (10.0)**
Seminar	26(70.3)	57 (68.7)	**83 (69.0)**
House for health workers	21 (56.8)	41 (49.4)	**62 (51.7)**
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> *"We normally provide some privilege like leave, medical benefit, and sponsorship for those who need further studies, paying those who have transfer, paying extra duty and on-call allowances" (R1).*

One participant (District Official) argued that in health sector, there are a lot of seminars and training which help to motivate health workers. Promotion and salary adjustment has been done, he further gave evidence by giving real examples, and he said that,

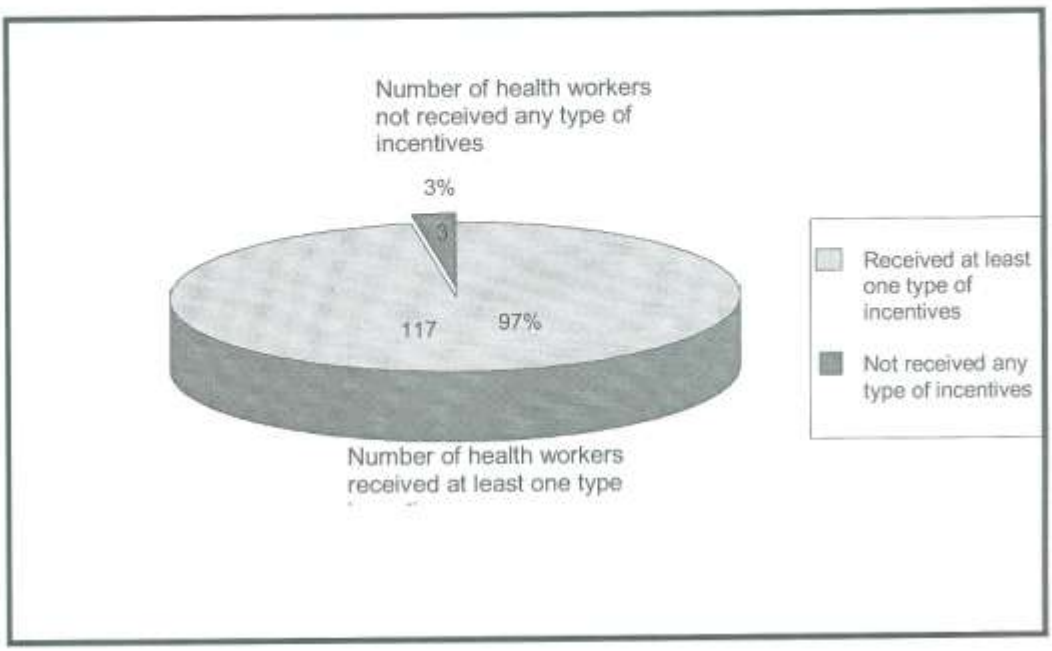


Figure 2: Health workers who had received incentives

Data in Table 7 indicate the type of incentives received by health workers or shows how many health workers had received by a certain type of incentives implemented by the employer. We found that the incentives benefited by majority of respondents (health workers) were seminars (81.7%), promotion (33.3%), and leave (24.2%). On call allowances and recognition/appraisal for good performance were received by few health workers (5.8%). Nurses were more likely to have been chosen to attend seminar/workshops (91.7%), opportunity for studies (20.8%) and promotion compared to other cadres while housing were more benefited by other health workers categories (25%) and clinicians (22%). On other hand, clinicians were more likely to get recognitions/appraisals (16.7%) and on call allowance (16.7%) as compared to other cadres. Findings also shows that overtime allowances were most received by nurses (25%) and other health workers [laboratory personnel, radiographer, and health officer] (50%).

Table 7: Type of incentives received by health workers (coverage)

Type of incentive received	Number of health workers received incentives				Total
	Clinicians	Nursing staff	Medical attendants	Other HW	N=117(%)
	n=17(%)	n=48(%)	n=44 (%)	n=8(%)	
Non financial incentives					
Seminar/workshop	13 (72.2)	44 (91.7)	36 (78.3)	5 (62.5)	**98 (81.7)**
Promotion	6 (33.3)	18 (37.5)	14 (30.4)	1 (12.5)	**39 (33.3)**
Houses for HW	4 (22.2)	8 (16.7)	2 (4.3)	2 (25.0)	**16 (13.3)**
Leave*	6 (33.3)	12 (25.0)	10 (21.7)	1 (12.5)	**29 (24.2)**
Opportunity for further studies	2 (11.1)	10 (20.8)	1 (2.2)	0 (0)	**13 (10.8)**
Recognition/appraisal	3 (16.7)	3 (6.3)	1 (2.2)	0 (0)	**7 (5.8)**
Financial incentives					
Overtime allowances	0 (0)	12 (25.0)	2 (4.3)	4 (50.0)	**18 (15.3)**
Outreach allowances	0 (0)	3 (6.3)	5 (10.9)	1 (12.5)	**9 (7.5)**
On call allowances	3 (16.7)	2 (4.2)	0 (0)	2 (4.2)	**7 (5.8)**
Leave allowances*	4 (22.2)	2 (4.2)	5 (10.9)	0 (0)	**11 (9.2)**

Key: *Multiple responses and the questions were spontaneous asked. Total number is 117 due to three respondents reported to have not received any types of incentives.*

**Leave represents just time out as reward while leave allowance represents the money paid before or after leave.*

In the in-depth interview all respondents were asked to explain the extent to which the incentives package was implemented among health workers. All respondents reported that some of the incentives provided to only specific group of health workers due to shortage of its availability or guideline directives, but there are also some of the incentives provided to

all health workers, depending on its availability, however this study found that some of incentives were provided to only specific cadres, these includes incentives like houses and on-call allowances.

One of the respondents reported that:

> *"House for health workers in rural facilities are built to accommodate two health workers, so if health workers are two, all of them will live in that house but at district hospital all doctors, anaesthetist, District Nursing Officer, and District Medical Officer are provided with house. For the on-call allowances only doctors, laboratory personnel, X-ray personnel, drivers, and anaesthetist get such allowances. When other health personnel perform extra duty/overtime we usually pay them" (R1).*

However, to eliminate that "inequality", the facility management have prepared incentives covers other cadres like nurses and medical attendants; this was confirmed by one of the facility in-charge:

> *"For nurses and medical attendants who work extra time, we have prepared their allowances through basket funds" (R2).*

This study also found that incentives provided to almost all health workers were seminars and opportunity for further studies (training) overtime allowances depending on its availability. Two respondents (district and health facility officials) reported that:

> *"Overtime allowances is for everyone who perform their work beyond time scheduled but on-call allowance is for doctors and some of health workers who are in roster"(R5).*

Another respondent reported that:

> *"In our district seminar covers almost all health workers especially in rural setting, everybody has a chance to attend different seminars and training" (R4).*

The findings from key informants shows that health workers receives both financial and non financial incentives in which some of them covers few health workers while some of them covers all health workers.

4.5 Types of incentives received by health workers that satisfy their needs

Types of incentives received by health workers that satisfy health workers needs was assessed to only health workers who reported to had personally received a specific type of incentives as shown in table 7. Then health workers were asked to say if they were satisfied or not satisfied with the incentive personally received as they reported in Table 7. When the incentives received by health workers satisfy the need of health workers, it therefore makes them to be satisfied with their jobs (job satisfaction). Job satisfaction is a collection of attitudes about specific facets of the job. Employees can be satisfied with some elements of the job while being simultaneously dissatisfied with others. Data in Table 8a shows that 83(84.7%) out of 98 health workers who reported to attend seminars were satisfied with seminars, 12 (92.3%) out of 13 health workers who reported to had had got opportunity for further studies were satisfied with it, 13 (81.3%) out of 16 health workers reported to receive/live in houses were satisfied with it, and 6 (85.7%) out of 7 health workers who were recognized for good performance were satisfied with that incentives.

Also health workers (all different categories of health workers) who reported personally to receive seminar offers, houses, leave, recognitions/appraisal, opportunity for further studies were satisfied with them. However medical attendants were not satisfied with promotion (64.3%) while other cadres including clinicians, nursing staff, and other health workers were satisfied with promotion.

Administrators interviewed were asked to give views to say whether health workers were satisfied or not satisfied with incentives received. Most of them thought that health workers were satisfied with incentives they provided. One of the respondents (district officials) confirmed by saying:

> *"Health workers are generally satisfied with the houses because they are not so bad" (R1).*

Other respondent gave his views when he was asked to comment if health workers are satisfied with incentives implemented by saying:

> *"Yes, health workers are satisfied because even if, when they get little amount of money helps to boost their life and sometimes refresh their minds when they attend seminars" (R4).*

Generally we found that non financial incentives received by health workers satisfy their needs which in turn results into job satisfaction. Therefore implementation of above mention incentives fairly it would satisfies the needs of health workers hence creates the conducive environment for job satisfaction and retention of health workers in rural districts.

Table 8a: Type of non financial incentives received by health workers that satisfy their needs by professional categories

Type of incentive received (Non financial)	Professional categories				
	Clinicians n %	Nursing staff n %	Medical attendants n %	Other HW n %	Total n %
Seminar					
Satisfied	11 (84.6)	40 (90.9)	28 (77.7)	4 (80.0)	83 (84.7)
Not satisfied	2 (15.4)	4 (9.1)	8 (22.3)	1 (20.0)	15 (15.3)
Total	**13 (13.3)**	**44 (44.9)**	**36 (36.7)**	**5 (5.1)**	**98 (100)**
Houses for Health Workers					
Satisfied	4 (100)	6 (75.0)	2 (100)	1 (50.0)	13 (81.3)
Not satisfied	0 (0)	2(25.0)	0 (0)	1 (50.0)	3 (8.7)
Total	**4 (25.0)**	**8 (50.0)**	**2 (12.5)**	**2 (12.5)**	**16 (100)**
Leave					
Satisfied	4 (66.6)	12(100)	9 (90.0)	1 (100)	26 (89.7)
Not satisfied	2 (33.3)	0 (0)	1 (10.0)	0 (0)	3 (10.3)
Total	**6 (20.6)**	**12 (41.3)**	**10 (34.5)**	**1 (3.4)**	**29 (100)**
Promotion					
Satisfied	5 (83.3)	14 (77.7)	5 (35.7)	1 (100)	25 (64.1)
Not satisfied	1(16.7)	4 (22.3)	9 (64.3)	0 (0)	14 (35.9)
Total	**6 (15.4)**	**18 (46.1)**	**14 (35.8)**	**1 (2.5)**	**39 (100)**
Opportunity for studies					
Satisfied	2 (100)	9 (90.0)	1 (100)	0 (0)	12 (92.3)
Not satisfied	0 (0)	1 (10.0)	0 (0)	0 (0)	1 (7.7)
Total	**2 (100)**	**10 (76.9)**	**1 (7.6)**	**0 (0)**	**13 (100)**
Recognition /appraisal					
Satisfied	3 100)	2 (66.6)	1 (100)	0 (0)	6 (85.7)
Not satisfied	0 (0)	1 (33.3)	0 (0)	0 (0)	1 (14.3)
Total	**3 (42.9)**	**3 (42.9)**	**1 (14.2)**	**0 (0)**	**7 (100)**

Key: Total of each incentive does not add up to 120 because it depends on the incentives received by individual health workers in Table 7 and it were multiple response. Satisfaction was assessed to only health workers who reported to had received a certain incentives.

Data in Table 8b show that the 7 (63.6) out of 11 health workers who reported to receive leave allowances were not satisfied with that incentive. Almost all nurses and 60% of medical attendants who reported to receive leave allowances were not satisfied with it. Health workers were not satisfied with leave allowances. They reported that: *"Leave allowances are not paid in time"*.

Table 8b: Type of financial incentives received by health workers that satisfy their needs by professional categories

	Professional categories				
Type of incentives received (Financial)	**Clinicians**	**Nursing staff**	**Medical attendants**	**Others**	**Total**
On call allowances					
Satisfied	3 (100)	1 (50.0)	0 (0)	0 (0)	4 (57.1)
Not satisfied	0 (0)	1(50.0)	0 (0)	2 (100)	3 (42.9)
Total	**3 (42.8)**	**2 (28.5)**	**0 (0)**	**2 (28.5)**	**7 (100)**
Overtime allowances					
Satisfied	0 (0)	6 (50.0)	1 (100)	2(40.0)	9 (50.0)
Not satisfied	0 (0)	6 (50.0)	0 (0)	3 (60.0)	9 (50.0)
Total	**0 (0)**	**12 (66.7)**	**1 (5.5)**	**5 (2.8)**	**18 (100)**
Outreach allowances					
Satisfied	0 (0)	2 (66.7)	3 (60.0)	0 (0)	5 (55.6)
Not satisfied	0 (0)	1 (33.3)	2 (40.0)	1 (100)	4 (44.4)
Total	**0 (0)**	**3 (33.3)**	**5 (55.6)**	**1 (100)**	**9 (100)**
Leave allowances					
Satisfied	2 (50.0)	0 (0)	2 (40.0)	0 (0)	4 (36.4)
Not satisfied	2 (50.0)	2 (100)	3 (60.0)	0 (0)	7 (63.6)
Total	**4 (36.4)**	**2 (18.2)**	**5 (45.5)**	**0 (0)**	**11 (100)**

Key: Total of each incentives do not add to 120 because it depends on the incentives received by individual health workers in Table 7 ad it was multiple responses

Some of the respondents (key informants) reported that health workers were not satisfied with the incentives implemented because life is very expensive and some of the allowances did not match with the work load. For example one participant argued that:

> *"Health workers are not satisfied with on call allowances because most of time is not enough to cover all days they have worked for" (R2).*

Table 8b also shows that all other health workers category who reported to receive on call allowances was not satisfied with it. Furthermore, one respondent continued to comment that:

> *"health workers are not satisfied with the incentives because usually they do heavy tasks which do not match with the incentives given to them, for example even the salary itself is not satisfying our needs" (R7).*

To conclude this section, provision of the incentives which do not satisfy the needs of health workers leads to dissatisfaction of health workers towards their job (that it means it result into job dissatisfaction). Therefore unfair implementation of incentives creates poor conducive environment for job satisfaction hence health workers become dissatisfied with their job.

4.5.1 Can the incentives attract, motivate, and retain health workers if well implemented?

About 80% of the health workers interviewed reported that the incentives they had received from their employer can attract, motivate and retain health workers if those incentives are well implemented. Nurses and other health workers (e.g. laboratory personnel, pharmaceutical technician, radiographer) reported that the incentives provided to them may possibly attract, motivate and retain health workers if are well implemented as shown in Table 9.

Table 9 Number of health workers who agreed that incentives provided to them can motivate, attract, and retain health workers if are well implemented

Ability of incentives to:	Clinicians	Nursing staff	Medical attendants	Other HW	Total
	n=17(%)	n=48 (%)	n=44 (%)	n=8 (%)	n=120 (%)
Motivate	12 (70.6)	43 (89.6)	31 (70.5)	8 (100)	94 (80.3)
Attract	12 (70.6)	43 (89.6)	30 (68.2)	8 (100)	93 (79.5)
Retain	12 (70.6)	42 (87.5)	30 (68.2)	8 (100)	92 (80.5)

4.5.2 Incentives preferred by health workers

4.5.2.1: Health workers' incentives preferences

Health workers were asked to mention the incentives which they would prefer to be provided to them which could motivate to work hard and increase performance and productivity; and retain them. Most of health workers mentioned/preferred overtime allowances (43.3%), improved working condition and tools (40.8%), salary increase (30.8%), transport facilities (26.7%), houses for health workers (22.3%) and risk and hardship allowances (20.8%). Overtime allowances were preferred more by large number of medical attendants (52.2%), followed by group of clinicians (50.0) while improving working condition and tools were preferred more by clinicians (61.1%) and nurses (43.8%) (Table 10).

Table 10: Motivating incentives mentioned by health workers

Type of incentives preferred by health workers	Professional categories				Total N=120(%)
	Clinicians n=18(%)	Nursing staff n=48(%)	Medical attendants n=46(%)	Other health workers n=8(%)	
Overtime allowances	9 (50.0)	17 (35.4)	24 (52.2)	2 (25.0)	**52 (43.3)**
Improve working condition and tools	11 (61.1)	21 (43.8)	14 (30.4)	3 (37.5)	**49 (40.8)**
Salary increase	7 (38.9)	13 (27.1)	12 (26.1)	4 (50.0)	**36 (30.8)**
Transport facilities	6 (33.3)	15 (31.3)	9 (19.5)	2 (25.0)	**32 (26.7)**
Houses for health workers	4 (22.2)	18 (37.5)	4 (8.6)	2 (25.0)	**28 (22.3)**
Risk and hardship allowances	2 (11.1)	15 (31.3)	6 (13.0)	2 (25.0)	**25 (20.8)**
Opportunity for further studies/training	1 (5.5)	5 (10.4)	2 (4.3)	2 (25.0)	**17 (14.2)**
On call allowances	2 (11.1)	9 (18.8)	5 (10.8)	3 (37.5)	**19 (15.8)**
Increase number of health workers	3 (16.7)	6 (12.5)	2 (4.3)	0 (0)	**11 (9.2)**
Promotion and Recognition/appraisal for good performance	2 (11.1)	8 (16.6)	2 (4.3)	1 (12.5)	**13 (10.8)**
Education on their rights and benefits	0 (0)	5 (10.4)	3 (6.5)	0	**8 (6.7)**
Leave allowances be paid in time	0 (0)	2 (4.1)	2 (4.3)	1	**5 (4.2)**

Multiple responses were allowed, n=120.

4.5.2.2: Incentives preferred by district and facility leaders that they would wish to give to their health workers

The district officials and heads of facilities were asked of which type of incentives they would prefer to give their health workers inorder to improve attraction, motivation and retention in the district. They mentioned hardship allowances; houses; provision of tea to health workers; improving working condition and tools.

One respondent mentioned hardship allowances for hard-to-reach areas. He gave an example, *"Those health workers who live in Dar es Salaam they have opportunity to work as part time or opportunity for studies but these is not possible to happen in Newala district"*. He further said that, *"by giving a health worker hardship allowances it may compensate those things which are missing in this hard-to-reach districts"*. Furthermore he continued to explain, *"In order to motivate and retain health workers, the government has to design a special incentive for rural districts like sponsorship for further studies especially first degree and masters. By providing sponsorship to health workers working in hard to reach areas, I think more workers will be attracted" (R1).*

Other respondent mentioned houses for health workers as an important incentive, he said;

> *"Do you know, the very important incentives are houses for health workers, DED has to design a loan system to their health workers which would help to build their own houses" (R2).*

Another respondent reported that;

> *"I like an incentive which is able to make health workers survive, to give thanks/appreciation to those who performed well. Also paying various allowances" (R3).*

One of the district official mentioned incentives which are possible and he said: *"To provide an opportunity for further studies to health workers, houses and solar power (electricity), convincing telephone companies to reach most of our village to make the communication easier, ensuring the length of stay on one facility should not exceed three years so that to give chances of changing environments/working condition and making sure promotions goes as required" (R5).*

Therefore generally incentives preferred by district and facility leaders that they would wish to give their health workers in this study were opportunity for studies, hardship allowances, and houses for health workers, appreciation to those who performed well, paying allowances, and promotions.

4.6 Factors affecting implementation of incentive packages

4.6.1 Factors affecting implementation of the incentive packages: Health workers' perspectives

Health workers were asked to mention barriers that hinder implementation of incentives packages in the district. Table 11 shows major barriers mentioned by health workers were shortage of funds (48.3%), negligence (23.5%), selfishness of leaders (22.5%), and weak management capacity (8.3%). Other barriers hindering the implementation of incentive packages mentioned were district lack authoritative power to implement, leaders do not read health workers' files, and they are not cooperative to health workers (Table 11).

Table 11: Barriers of implementation of incentives as reported by health workers

Type of barriers hindering implementation of incentives	Number of responses* N (%)
Shortage of funds	58 (48.3)
Selfishness of leaders	27 (22.5)
Negligence	28 (23.3)
Leaders are not cooperative to us and they read our files	11(9.1)
Weak management capacity	10 (8.3)
District lack authoritative power to implement	9 (7.5)
Not budgeting properly	6 (5.0)
Favouritism	5 (4.2)

Key:

*Multiple responses (A total of 120 health workers interviewed)

4.6.2 Factors affecting implementation of the incentive packages: Leaders' perspectives

Almost all respondents from the key informants mentioned shortage of funds and bureaucracy as barriers toward implementation of the incentive packages in Newala district. One participant argued that barriers hindering implementation of incentives were: *"Shortage of funds (the budget is not enough or due to ceiling), and lack aggressive policy guiding the implementation of incentives as barriers" (R1).*

4.6.3: Problems encountered by health workers on accessing benefits and rights

About 58.5% of health workers reported to have had encountered problems in accessing their rights/benefit (Figure 3). The following are the problems that were mentioned by health workers: too much bureaucracy, promotion process is not clear to most of health workers, response from the leader was not satisfactory and some of health workers were not paid yet their first salary/arrears (Table 12). Among other health workers categories (*radiographer, laboratory personnel, pharmaceutical technician and health officer*) and medical attendants, 50% and 43.5% of them respectively reported to encounter bureaucracy when they were accessing their rights (Table 12).

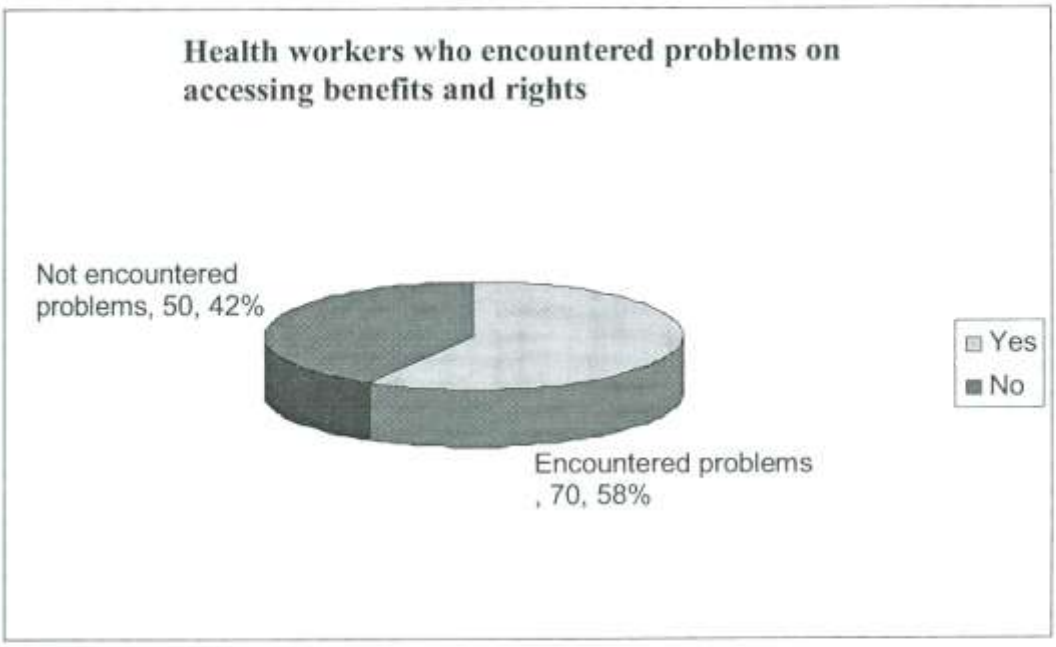


Figure 3: Health workers who encountered problems on accessing their rights and benefits

Table 12: RSeported problems encountered by health workers on accessing/receiving by professional categories

Type of problems encountered by health workers	Professional categories				Total
	Clinicians	Nursing staff	Medical attendants	Other Health workers	
	n (%)	n (%)	n (%)	n (%)	n (%)
Bureaucracy on accessing their rights	7 (38.9)	14 (29.2)	20 (43.5)	4 (50.0)	**45 (37.5)**
Promotion process is not clear	1 (5.5)	5 (10.4)	3 (6.5)	0 (0)	**9 (7.5)**
Response from leaders are not satisfactory	0 (0)	3 (6.3)	3 (6.5)	0 (0)	**6 (5.0)**
Not paid arrears/transfer allowances	1 (5.5)	5 (10.4)	4 (8.6)	0 (0)	**10 (8.3)**
Not encountered any problems	9 (50.0)	21(43.8)	16 (34.8)	4 (50.0)	**5 (4.1)**
Total	**18 (15.0)**	**48 (40.0)**	**46 (38.3)**	**8 (6.7)**	**120(100)**

4.7: Suggestions by health workers on how to improve incentive packages implementation

The following are the views given by health workers on the best ways of implementing incentives in Newala district and other places in Tanzania. During on

- Leaders should be fair in providing incentives to health workers and not practice favouritism (47.5%).
- Leaders are supposed to visit to our facilities in order to see our problem (32.5%).
- Government should involve us in setting /preparing incentives and government document should be open to health workers (22.5%).

- Government should gives us education concerning our benefits/rights and conduct meeting with health workers (19.2%).
- Government should pay allowances [outreach, risk, hardship] (15.0%).
- Incentives should be incorporated in the salary and increase the amount of salary (11.0%).
- Government is supposed to set incentive for hard to reach areas different from other places (7.5%).
- Government should provide transport facility to all health facilities (7.5%)

All these suggestion generally based on monetary and non monetary incentives.

Another solution to effective implementation incentives suggested by key informants was that, cost sharing and basket funds should be flexible in its use so that sometimes may be used to motivate health workers. The suggested solutions were reported by one of the health facility in-charge:

> *"Leaders should make arrangement to visit health facilities and conduct meeting with health workers to educate them concerning their benefits and rights by showing different government documents" (R3).*

Furthermore, one respondent (district official) emphasized the provision of opportunity for further studies to health workers, he said that:

> *"Opportunity for further studies (education) is the best incentive because every level of education has the limit of salary and rank. Education will solve all problems concerning promotion and salaries" (R5).*

Another interviewee suggested that the government has to design special incentives for hard-to reach districts, and increase the number of health workers at district hospital because it receives patients from Newala, Tandahimba, Mtwara rural, Masasi and Mozambique. One of the interviewee reported that:

> *"What I see, there is a need to health workers be trained and given job description of their work early when he/she is still at college and also the government has to*

design special incentive for hard to reach areas i.e. health workers working Newala has to get large salary than those working in Dar es Salaam" (R1).

Other respondent said that:

"All the time patients are so many here; therefore the government has to send many health workers to our district" (R6).

Generally health workers suggested that provision of incentives should be in fairly manner, involving them in setting/preparing of incentives, incentives be incorporated in salary and provision of transport facilities as the best way of implementing incentives while leaders (key informants) suggested provision for opportunity for studies, visiting health facilities and conducting meeting with health workers, design special incentives for hard to reach areas, and increase of health workers as the best way of implementing incentive package.

In conclusion, this chapter shows that majority of health workers were not aware of their benefits and rights as stipulated in the government documents. It is also found that only 14.5% of health workers who had heard about the government documents had ever read it. Both financial and non financial incentives were implemented; however, overtime allowances were less implemented in rural facilities as compared to urban facilities. The study also found that majority of health workers who reported to had received non financial incentives was satisfied with those incentives which also created job satisfaction. But health workers who reported to receive financial incentives were not satisfied with leave allowances as a result health workers were dissatified with their job. Health workers preferred overtime allowances and improved working condition and tools. The most factors affecting implementation of incentives was shortage of funds.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Health workers' awareness on their rights and benefits

Awareness of health workers on their benefits/rights or incentives which they are supposed to receive from their employer is one of the step towards demanding those benefits. Once a health worker knows his/her rights it is possible to request the employer to implement it. Findings from this study revealed that majority of health workers were not aware of their benefits and rights. This has also been found to be common in other African countries. The study done in Zimbabwe on retention of health workers, revealed that health workers were not aware of retention packages offered by the government of Zimbabwe (Chimbari et al, 2008). There is a possibility that district management were not taking responsibility of educating their health workers which in turn would result into health workers not demanding their benefits and rights. Another reason of health worker been not aware it could be due to the data collection technique used in this study whereby health worker were asked to mention their benefits spontaneously. This probably caused health workers to mention few benefits and rights despite of the effort made by interviewer to stimulate them to mention more and more benefits.

It was also observed that lower cadres (Medical attendants) constituted large number of health workers who do not know their benefits as compared to other cadres. This finding was also supported by response from key informants. Less involvement of lower cadres in various activities could be the possible explanation for this cadre not knowing their benefits.

The government of United Republic of Tanzania usually provides government documents (Standing Orders and circulars) to the region and district officials and heads of health facility so that they could be used as guide in performing their daily activities. Moreover, leaders are supposed to make sure the government documents are easily accessed by every health worker who need to know his/her benefits. Results from this study revealed that among health workers who had heard about government documents only few of them had ever read those documents at least once. This shows that supervisors and other managers

may be they are not giving these documents to the health workers or those documents were not available at facilities; and sometimes treated as confidential matters.

5.2 Incentive implemented for attraction and retaining human resources

Incentive packages are well stated in Standing Order of 1994, which include both financial and non financial incentives (involve provision of allowances such as on call, part time and overtime allowance, leave, housing, appreciation of good performance and improvement of communication between different levels of health systems) (URT, 1994). Findings from this study revealed that both financial and non financial incentives were implemented in this district. Similar situations are observed in other studies conducted in other countries, whereby financial and non financial incentives were reported to be implemented (Mangham, 2007; Kotzee et al, 2006; Ndetei et al, 2006; El Jadarli et al, 2009). It has also been agued that "implementing both financial and non financial incentives usually aid in recruitment and retention in underserved areas and mitigate the adverse conditions in areas that have difficult in maintaining sufficient number of personnel and the right mix of skills in the health workforce" (Orvill and Hick, 2000), so it is very important for the Government of Tanzania to make sure these incentives are implemented effectively specially in peripheral districts and rural areas.

In this study we also found that there is difference in implementation of overtime allowances between urban and rural facilities whereby overtime allowances were provided more in urban than rural facilities. Rural areas is understaffed as we observed during the field work, most of health facilities had two health staff while attendance of patients was high. This overworking may involve and demand health workers to work beyond the normal schedules. Sneels et al (2002) states that "working in rural areas is associated with heavy responsibility and workload". By allowing this situation to happen in rural settings which have less human resources and increased workload, would result in pushing health workers away from such duties or moving to other areas of less work burden.

5.3 Extent to which health workers benefited from the implemented incentives

Ensuring every health workers benefits from the implemented incentives is necessary in the whole process of attracting, retaining, and motivating health workers. In this study we found that most of each type of the incentive implemented in this district covered less than fifty percent of health workers interviewed. These findings correspond to findings of the study done in Mali which revealed that some of incentives implemented covered less than fifty percent of health workers involved (Dieleman et al, 2006). By having few health workers covered by incentives (i.e. promotion and overtime allowances) has implication on the performance of health workers because they need to be motivated through those incentives. This suggests that may be the district and facility management are failing to implement it, may be due to lack of funds and sometime they lack power to implement it.

According to the guidelines, on call allowances are enjoyed by only health workers who are in on call roster, leaving aside nurses and medical attendants who work in shift system. This has been seen as a kind of "inequality", because those health workers who are called to perform medical emergence are assisted by nurses and medical attendants who in return do not enjoy the on call allowances hence, it is likely to acts as de-motivator among them in performing their work. To minimize this kind of "inequalities" in providing incentive packages, considering that doctors who receive call allowances, in performing their work are assisted by nurses who do not get anything, hence, the incentive packages should be designed in such that be enjoyed by all cadres, even if they are not in the same salary scale.

5.4 Incentives received by health workers that satisfy their needs

Incentives are generally designed to accomplish enhancement of productivity and quality of services, and to support staff recruitment and retention (Iipinge et al, 2009). Incentive packages implemented have to satisfy health workers, motivate them to work hard and increase job satisfaction. According to Locke (1976) states that job satisfaction is a collection of attitudes about specific facets of the job. Employees can be satisfied with some elements of the job while being simultaneously dissatisfied with others. Overall job satisfaction is a combination of the person's feeling towards the different facets of job

satisfaction. He argues that the more important factors conducive to job satisfaction are mentally challenging work, equitable rewards, supportive working conditions, and supportive colleagues (quoted in Srivastava, 2004). In this study, we found that health workers who had reported to receive incentives were satisfied with non financial incentives which also created job satisfaction. Other studies done in other part of Tanzania and Vietnam (Munga and Mbilinyi, 2008; Dieleman et al, 2003) also showed that health workers perceived non financial incentives as a motivating agent to remain in rural areas. Another study done in Mali also showed that health workers were satisfied with non financial incentives [training opportunity and promotion] (Dieleman et al, 2006). Health workers were satisfied with the non financial incentives because it satisfies their needs and hence increased job satisfaction. Proper implementation of the incentive packages that satisfies the need of health workers as stipulated in Standing order and circulars may lead to motivation, job satisfaction and improve retention of health workers at their duty station.

In this study Medical attendants were mostly not satisfied with promotion process. The results implies that medical attendant were not promoted as other cadres and most of them complained that the process itself were not clear. Possible reason for medical attendant to be dissatisfied with promotion could be due to fact that promotion go hand in hand with level of education of the health worker, however, most of medical attendants were primary school holder, so it is difficult for them to be promoted, and this would result into less satisfaction with job. Usually employees want a fair unambiguous provision of incentives (e.g. pay system and promotion policies). It is also said that satisfaction is not linked to the absolute amount one is paid; rather, it is the perception of fairness. For example individuals who perceive that promotion decisions are made in a fair and just manner are likely to experience satisfaction from their jobs (Witt and Nye, 1992) (quoted in Srivastava, 2004).

Financial incentives have been reported to have a positive effect on the willingness to work in rural areas (Serneels et al, 2005). Therefore proper implementation of financial incentives may result into attraction, motivation, and retention of health workers in rural areas. In this study health workers who reported to receive leave allowances were not satisfied with that incentive which also resulted into job dissatisfaction. Leave allowances were reported not to be paid in time and the amount paid was regarded as not enough.

According to policy guiding provision of leave allowances, health workers will be paid leave allowances in reference to mileage travelled from the place of their domicile (URT, 1994). But many health workers in this study are residents of Newala or nearby districts; hence they cannot enjoy this particular benefit. It is therefore a demotivator and job dissatisfiers to health workers who work in their motherlands districts.

Furthermore this study found that most of respondent interviewed agreed that the incentives they had received from their employer can attract, motivate, and retain health workers if are properly implemented. Findings from other studies also show that financial and non financial incentives were able to attract and retain health workers where they have been well implemented (Willis-Shattuck et al, 2008; Dieleman et al, 2003). Proper implementation of incentives of the incentive packages is very necessary toward achieving provision of good quality of health service delivery, hence reaching the target of Millennium Development Goals.

Other findings show that leaders and health workers preferred both financial and non financial incentives which can attract motivate and retain health workers especially in rural areas. Several studies done in Tanzania and elsewhere revealed that health workers preferred financial and non financial incentives (Kolstad, 2008; Serneels et al, 2005; Mireille et al, 2003; Stringhin et al, 2009). Like in other places, the increased workload, and poor working condition and tools in Newala district, showed that most respondents preferred overtime allowances, hardship and risk allowances. Similar findings were revealed in various studies done in Tanzania and elsewhere (Gauri, 2001; Dussault et al, 2006; Kolstad, 2008). They prefer risk allowances due to occupational hazards that they are facing at their workplaces. Hardship allowances were preferred due to the fact that Newala district is situated at the periphery and their infrastructures are very poor compared to other places. This reflects that human resources planning should consider not only health workers performance and equipment but also the environment that surrounds them by involving various sectors to construct roads, railways and airport, improving telecommunication system, electricity and water supply.

According to Herzberg's Motivation–Hygiene theory explains the two factors which can cause the satisfaction or dissatisfaction to perform among health workers at workplace. These factors are termed as motivators or satisfiers and hygiene factors or dissatisfiers. Satisfiers (intrinsic factors) include; achievement, recognition, the work itself, responsibility, and advancement (growth) while the dissatisfiers (extrinsic factors) include: company policy and administration, supervision, salary, interpersonal relations and working conditions. The satisfiers lead people to feel good about their jobs and motivate effectively. Hygiene factors (dissatisfiers) causes people to feel unhappy, or dissatisfied with jobs due to its association with the physical characteristics of the environment in which people work (D'Souza, 2008). Therefore, implementation of incentives as stated in the Herzberg's Motivation- Hygiene theory may help to motivate and retain health workers at their working station.

In this study incentives preferred by health workers were recognition for good performance, opportunity for studies and promotions which resemble to satisfiers (intrinsic factors) and they also preferred improving working conditions, salary increases, hardship and risk allowances which resemble dissatisfiers (extrinsic factors) as mentioned in Herzberg's Motivation and Hygiene theory. District and facility leaders are supposed to implement those incentives preferred by health workers; for example recognizing or appreciation of workers who performed well their duties could make health workers feel good about their jobs and hence become motivated. Recognition of the health worker who performed well his/her duty does not require any fund to implement it; therefore it is very easy to implement it especially in rural district like Newala district. Opportunity for studies and promotion to health workers if are to be implemented it can lead to motivation of workers to perform their work effectively and sometime attract and retain workers.

For the case of extrinsic factors as preferred by health workers (salary increase, hardship allowances and improving working condition) if are well implemented would avoid health workers become dissatisfied with the job. District leaders and the government itself should make sure that they implement the above mentioned extrinsic factors so as to make working environment conducive to their workers. Several studies have been done to support Herzberg's theory; one of the study done by Maidani (1991) showed that

employees' motive to work in both private and public health sectors tended to emphasize intrinsic or motivator factors of employment, also shows that the satisfaction of employees were not attributable to hygiene factors. Another studies showed that intrinsic factors were served as a source of job satisfaction, while extrinsic factors were the primary source of job dissatisfaction (Koelbel et al, 1991; Paul, 1966). Therefore implementing of the incentives according to Herzberg's theory may help to motivate health workers, increase job satisfaction and improve retention.

5.5 Factors affecting implementation of incentive packages

Implementation of incentive packages as per Standing order and circulars sometimes faces many challenges which lead to poor implementation which results into demotivating health workers, which would result into poor delivery of health services. In this study, there are number of factors which hinder the implementation of incentives. These include shortage of funds, and the leaders lack commitment to perform their duties. Studies done by Munga and Mbilinyi (2008) and Mangham (2007) reported similar factors hindering implementation of incentive package. Shortage of funds was most prominent barriers because at district level there is too much restriction on the use or allocation of funds, especially Basket funds. Committed leaders are also required and they are necessary toward success of implementation of incentive packages; since without their efforts little could move well. Leaders are the one who are supposed to solicit funds, plan, and budget and then implement incentive packages. Leaders are also supposed to have leadership skills and know their functions like the ability to get others to work enthusiastically and competently toward accepted objectives.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

This study shows that the majority of health workers were not aware of their benefits and were not able to give details on their benefits and rights because most of them had no access to the government Standing orders and circulars which stipulates benefits and rights of employees.

The study also found that both financial and non financial incentive packages were implemented in Newala district. But overtime allowances were less implemented in rural facilities as compared to urban health facilities.

The study also revealed that almost all health workers interviewed had received some incentives from their employers; however, most of each type of the incentive implemented covered only few health workers. Also some incentives were specifically given to certain cadre.

Almost all cadres of health workers who had reported to receive a specific type of non financial incentives were satisfied with the incentive which also was reported to create job satisfaction; however, they were not satisfied with financial incentives like leave allowances which may result into job dissatisfaction. Incentive received by health workers were reported to attract, retain and motivate health workers if are well implemented.

Incentives preferred by both health workers and leaders were overtime allowances, improved working condition, opportunity for further studies, salary increase, houses and risk and hardship allowances.

Furthermore, the study also found that among factors which hinder the implementation of incentive packages were shortage of funds, followed by negligence, weak management, and district lack authoritative power to implement and leaders do not educate health workers on benefits and rights of employments.

1.2 Recommendation

District and facilities leaders should give education to all health workers concerning their benefits and rights and make sure all necessary documents including Standing orders/circulars are accessible to all health workers.

Policymakers (MoHSW, POPSM and PMORALG officials) in collaboration with district officials (DED, DMO, DHRO) should review the human resource for health policy and design incentive packages which covers all health workers and across all cadres.

District and facilities leaders should be encouraged to implement incentives which do not require money like a written or verbal recognition/appraisal of health workers for well performance and other non financial incentives in large scale so as to satisfy health workers needs which also create job satisfaction.

The district (local government) should make sure that funds are available for implementation of various incentives and also make sure managers perform their duties as per job description.

Further research should be conducted to assess the relationship between different types of incentives and improved work performance in hard to reach districts.

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