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Understanding Intrinsic Motivation and Performance Factors for Public Sector and Faith-based Facility Health Workers in Uganda

BACKGROUND

At the core of every health system are the health workers who care for patients, provide essential services, and translate health knowledge into action. While changing demographics, emerging epidemics, and the rising burden of disease drive the need for motivated and appropriately skilled personnel, there continues to be a persistent global health worker shortage (Africa Working Group 2006). In 2006, the World Health Organization (WHO) announced that 57 countries had a critical deficit of health professionals and that there was a global shortage of 2.4 million doctors, nurses, and midwives (WHO 2006). Of the 57 countries identified, 36 were located in Africa (WHO 2006) where the shortage is so severe that the workforce in many countries must be tripled to achieve the Millennium Development Goals (Dubois and Singh 2009). Compounding the issue are inappropriate skill mixes within facilities, unequal distribution of workers between and within countries, and poor working conditions that create additional health system bottlenecks (Dambisya 2007).

The Role of Nonfinancial Incentives to Motivate Health Workers

A growing body of evidence shows that to address health worker constraints, health care organizations should move beyond traditional human resource management approaches that use financial incentives to motivate and retain workers (Dubois and Singh 2009). Instead, organizations should also take into account organizational conditions that influence health worker motivation and nonfinancial incentives (Dubois and Singh 2009, Mathauer and Imhoff 2007). This study takes the latter approach to examine the role that faith plays in motivating and retaining existing health workers in Uganda. More specifically, the study aims to answer the following research questions:

- Are rates of retention, levels of intrinsic motivation, and degrees of job satisfaction

Brief

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different for faith-based health workers as compared with public sector health workers?

- How important is faith as a predictor of intrinsic motivation for health workers in Uganda?

Faith-based Health Care in Uganda

Conventional wisdom in the region is that faith-based health facilities are one of the most efficient mechanisms for service delivery in sub-Saharan Africa and are better able to attract, retain, and motivate staff as compared with the public sector. Faith-based health facilities play a major role in service delivery throughout the region. These facilities provide 30 to 70 percent of all health care services (WHO 2007) and more than one fifth of all HIV services (Global Health Council 2005), and serve patients in rural areas where governments have difficulty attracting and retaining workers (Capacity*Plus* 2011). The presence of faith-based health facilities is even greater in Uganda, where 84 percent of the population of 31 million identifies as Christian and 12 percent as Muslim (Thurston and de la Mata 2009). Since faith-based health facilities have such a strong presence within Uganda, there is reason to examine whether the conventional wisdom is supported by evidence.

In addition to service delivery, faith-based health facilities in sub-Saharan Africa have a reputation for enhancing community cohesion, social support, and solidarity during times of personal and health challenges (WHO 2007). The workplace environment is proven to influence job satisfaction and retention (Dambisya 2007); hence, faith-based organizations may create an environment that better attracts and retains health workers as compared with the public sector. Overall, this study also aims to identify unique attributes of faith-based health facilities that attract, retain, and motivate staff and that can be "exported" for use in the public and private sectors.

METHODS

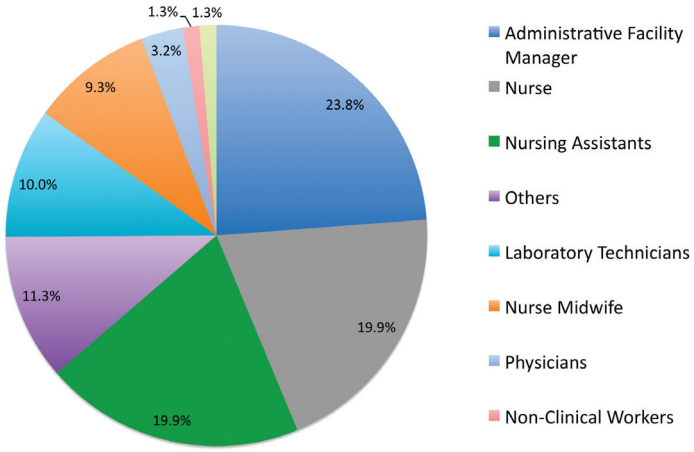
This study examines the differences between morale and satisfaction, performance support factors, intrinsic motivation, faith and religion and compensation and retention of health workers in public (Government of Uganda) and private not-for-profit (PNFP) sectors in Uganda. Table 1 lists the indicators that were selected to evaluate each measure. These indicators were chosen based on a review of international and domestic human resource literature to identify variations and best practices among survey instruments and to determine idicators relevant to this study.

TABLE 1: HUMAN RESOURCE INDICATORS

Measure	Indicator
Morale and satisfaction	• Satisfaction with job • Professional development opportunities • Opportunities for promotion and career advancement • Flexibility to balance personal life with job
Performance support factors	• Adequacy of equipment and supplies • Manageability of workload
Intrinsic motivation	• Proud of job and position • Feel good at job • Ability to successfully complete tasks
Faith and religion	• Religion is discussed at work • Importance of working in a religious environment • Religion enhances ability to serve clients • Religion influence commitment to work • View work as a mission
Compensation and retention	• Adequacy of pay • Adequacy of benefits • Fairness of pay • Intention to remain at job

Data collection from a nationally representative sample of 22 districts took place during April 2010. A total of 311 health workers from 91 health facilities were interviewed using quantitative and qualitative data collection methods. Of the sample, 165 (53.05 percent) worked in government-owned health facilities and 146 (46.95 percent) worked in a PNFP facility. In each district, an equal probability systematic sample was selected; hence, Ugandan Christian Medical Bureaus, Ugandan Presbyterian Medical Bureaus, and other PNFP facilities were selected in proportion to their distribution in the district. As Figure 1 illustrates, the majority of the respondents were administrative facility managers (23.8 percent), followed closely by nurses (19.9 percent) and nurse assistants (19.9 percent). Only 3.2 percent of the respondents were physicians.

FIGURE 1: SAMPLE CADRE DISTRIBUTION



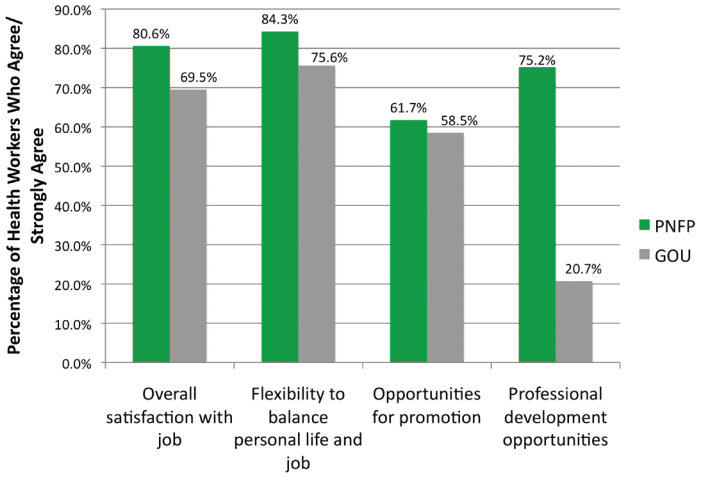
The study had three main limitations. First, the sample size in each cadre is too small to present results for each individual subcadre; hence, results are presented as a profile for the cadre overall. Second, the PNFP sector represented in the sample includes only Christian facilities and not Muslim ones. As a result, the sample is not representative of all faith-based health care facilities in the country. Finally, the link between intrinsic motivation and job satisfaction is not matched with health outcomes. While it is uncertain whether health worker motivation translates into enhanced performance, the study assumes that it does.

FINDINGS

Morale and Satisfaction

Overall, most health workers within the study are content with their work, as 80.6 percent of PNFP health workers and 69.5 percent of public sector health workers agree or strongly agree that they are satisfied with their job. As Figure 2 illustrates, both sectors had similar perspectives in terms of flexibility to balance personal life with work, feeling that their opinion is valued at work, and having opportunities for promotion. The main difference between the PNFP and public sectors are in terms of professional development opportunities, where 75.2 percent of PFNP health workers agree/ strongly agree that they have adequate professional development opportunities as compared with only 20.7 percent of workers in the public sector. Professional development opportunities, such as training, attendance at international conferences or activities, or funding for continuing education were commonly cited by workers in the PNFP sector as contributing factors to feeling valued at work.

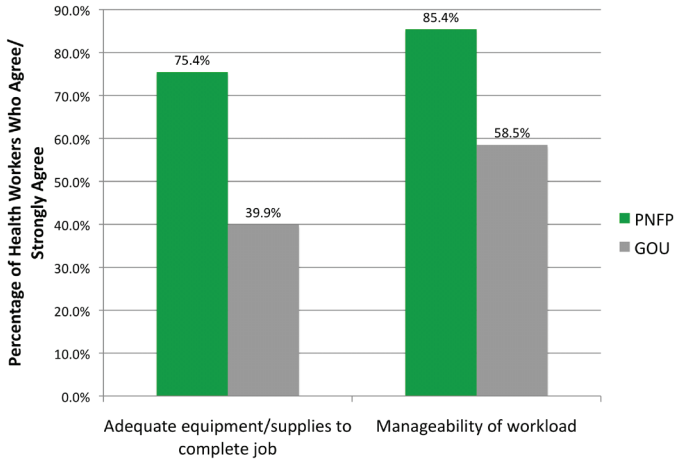
FIGURE 2: MORALE AND SATISFACTION FACTORS



Performance Support Factors

A significantly higher proportion of PNFP health workers (74.5 percent) agree/strongly agree that they have adequate equipment to complete their job whereas only 39.9 percent of workers in the public sector agree/strongly agree with this statement (Figure 3). Nonetheless, workers in the PNFP sector still cited a lack of uniforms, office supplies, equipment, drugs, or nice working space as reasons that contribute to dissatisfaction. In terms of the manageability of workload, a higher proportion of PNFP health workers (85.4 percent) agree/strongly agree that their workload is manageable as compared with the public sector (58.5 percent). Of the health workers who strongly disagree that their workload is manageable, 88 percent are in the public sector. Overall, the PNFP health workers are significantly more satisfied with their performance support factors, but this does not seem to be associated with overall levels of job satisfaction where the two sectors are comparable.

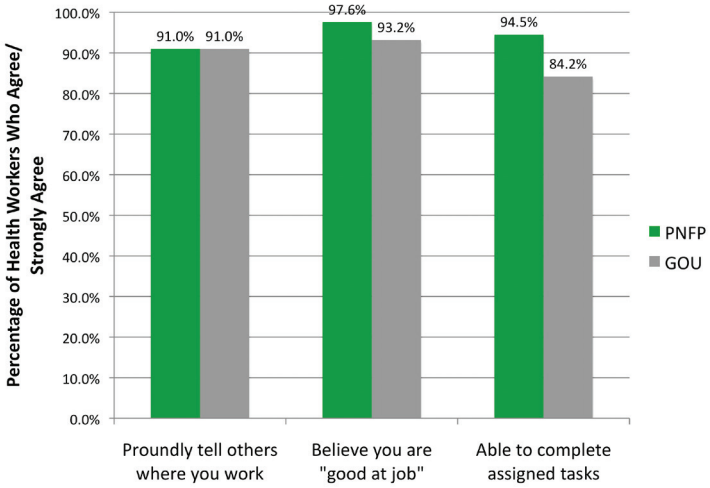
FIGURE 3: PERFORMANCE SUPPORT FACTORS



Intrinsic Motivation

The differences in intrinsic motivation between the two sectors were limited overall, with high levels of self-reported intrinsic motivation for all health workers (Figure 4). For example, over 91 percent of health workers in both sectors feel that they would proudly tell others where they work and what they do professionally and the overwhelming majority – 97.6 percent in the PNFP sector and 93.2 percent in the public sector – feels that they are good at their jobs. Most health workers in both sectors think that they can complete all assigned tasks, particularly in the PNFP sector (94.5 percent) as compared with the public sector (84.2 percent).

FIGURE 4: INTRINSIC MOTIVATION FACTORS

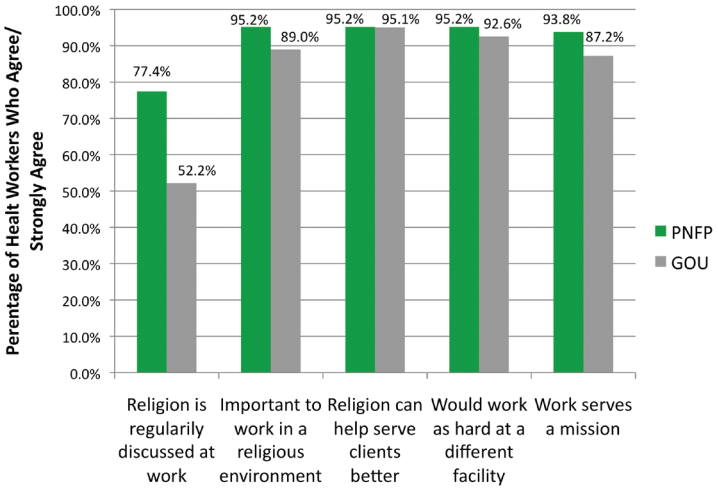


Religion

A statistically significant difference exists between the PNFP and public sectors concerning the discussions of religion at work. Within the PNFP sector, 77.4 percent of health workers reported that they regularly discuss religion at work as compared with 52.2 percent in the public sector (Figure 5). Several respondents in the PNFP sector expressed that they feel open to discussing religion because they work in a faith-based facility.

While this variable differed between sectors, almost all health workers in both the PNFP and public sectors agreed/strongly agreed that it is important to work in a religious environment, that religion can help them to provide better service to clients, that they would work as hard at a different facility, and that they view their work as serving a mission. Nearly all health workers in faith-based facilities felt that working in a religious institution provides them with an outlet to practice their faith, and that religion plays a role in how they interact with patients. For example, several participants from the PNFP sector stated that faith makes them a better health worker because it motivates them to be more caring, reach out to people unselfishly, and serve God's will by serving others. Nonetheless, the majority of health workers in faith-based facilities were not at their specific facility by choice, but rather because of open placements or transfer. Respondents within the PNFP sector who chose to work at a faith-based facility reported that they did so strictly because it was religious, or because they perceived a faith-based organization would pay their wages on time.

FIGURE 5: RELIGION IN THE WORKPLACE

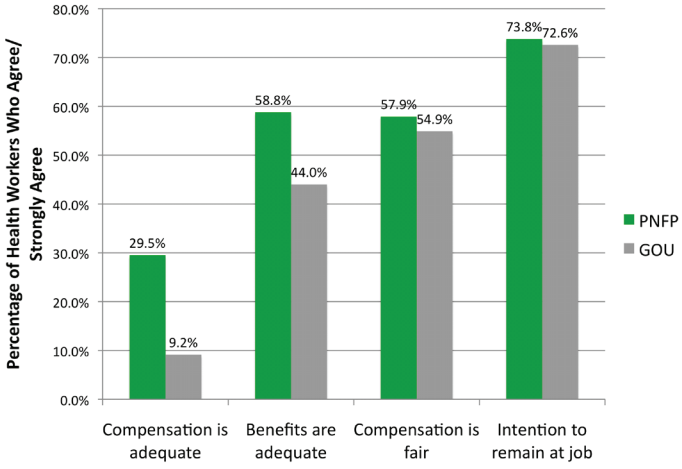


Compensation and Retention

The majority of health workers disagree/strongly disagree that their pay is sufficient considering their family's needs; however, there were discrepancies between the two sectors. Approximately 25 percent more government-employed health workers (89.0 percent) are dissatisfied with their rate of pay as compared with the PNFP sector health workers (65.7 percent); hence there is a statistically significant difference between the sectors in terms of their satisfaction with overall compensation. Despite this difference, low level or tardiness of pay was still the main contributor to dissatisfaction in the workplace for PNFP participants. Level of pay was rated above lack of equipment or poor administration as a main driver of job dissatisfaction.

Similar to satisfaction with adequacy of pay, there was also a statistically significant difference between the sectors in terms of adequacy of benefits. More PNFP health workers (58.8 percent) stated that the additional benefits that they receive are adequate compared with 44.0 percent of public sector health workers (Figure 6). PNFP sector workers cited financial extras, like the provision of free health care for themselves or family members, allowances, pay raises, provision of emergency funds, Christmas bonuses, small gifts or tokens, soap, sugar, uniforms, or free residence as reasons to feel valued at work.

FIGURE 6: COMPENSATION AND RETENTION FACTORS



The difference between PNFP and public sector health workers were not statistically significant in terms of fairness in compensation and retention. The majority of health workers in both sectors – 57.9 percent of the public sector and 54.9 percent of the PNFP health workers – feel that their compensation is fair in comparison to peers doing similar work. Overall, less than 3 percent of all health workers strongly agree that their compensation is fair. Despite this finding, over 70 percent of all health workers agree/strongly agree with the statement, "If it was my decision, I would remain in my current job for at least 12 months."

DISCUSSION

Based on the study findings, the strongest predictors of health worker satisfaction and motivation were adequate equipment and supplies in the workplace, professional development opportunities, feelings of being "good at their job," and fair pay as compared with others doing similar work. While some faith-based health facilities were strong in these support factors, others were weak; hence, predictors varied among institutions. The only predictor of satisfaction and motivation that was related to faith was the feeling that religion can help a health worker to serve his or her clients better.

Several unique attributes were identified among health workers from PNFP facilities. The data suggest that PNFP health workers feel as though they have more manageable workloads, better supplies, and substantially more professional development opportunities despite their widespread dissatisfaction with their level of compensation. Triangulated qualitative data reveal that health workers within each sector are individually religious and that outside factors, like geographic proximity to a facility and job openings, play a large role in determining the sector in which an individual works.

The statistically significant predictors revealed in this study suggest that some interventions can be used to motivate and retain health workers. Professional development opportunities, small rewards, and measures that recognized employees to help them feel successful at their jobs – like appreciation boards, certificates, and awards ceremonies – can all be used to motivate and retain existing health workers.

CONCLUSION

Faith and religiosity are present and influence health workers at an individual level for both faith-based and public sector facilities. High levels of faith are associated with greater compassion, empathy, and patience for health facility patients, which may lead to higher levels of client satisfaction but not necessarily translate into higher levels of service delivery quality.

The strongest predictors of motivation and job satisfaction are not related to faith. While there was a statistically significant difference between faith-based and public sector workers in terms of their view toward the adequacy of compensation, the strongest predictors of motivation and job satisfaction were professional development opportunities and a sense of being valued within the organization.

Several findings are contradictory to common beliefs and conventional wisdom concerning health workers. First, dissatisfaction with compensation does not seem to be associated with a health worker's intention to leave a facility. Second, high levels of job satisfaction can co-exist with high levels of dissatisfaction with compensation. Finally, faith and religiosity do not need to be "exported" as a means to motivate and satisfy health workers; however, certain organizational attributes of PNFP facilities can be modeled in other health facilities to achieve higher levels of intrinsic motivation and satisfaction. For example, developing a sense of community within the organization, recognizing high performers, ensuring that staff members have professional development opportunities, and providing adequate supplies can be implemented throughout the health system.

As the international community searches for effective nonfinancial incentives to address the global shortage of health workers and the associated health system bottlenecks, systems level interventions need to be better aligned with religious organizations. More specifically, variables that religious health workers may value, like patience and empathy, should be taken into account when designing human resource initiatives.

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June 2011