

**GENDER MOTIVATIONAL FACTORS OF HUMAN
RESOURCES FOR HEALTH: THE STUDY OF
BONDO AND VIHIGA DISTRICTS**

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2009

DECLARATION

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This is my original research project and has not been presented elsewhere for approval

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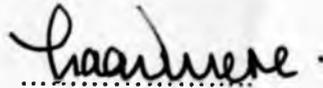
Supervisor

This project has been submitted to the University with my approval

Name

Signature

Isaac Amboseli Were

 12.11.09.

I hereby declare that I have no financial or other interests that may be affected by the outcome of this research.

DEDICATION

To
my beloved niece, Ciira
your candle blew out too soon
yet your lessons to us
of love, servitude and
living life to the full
will linger on
always.

I am grateful to my family for their support and prayers.

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TABLE OF CONTENTS

Declaration	i
Dedication	ii
Acknowledgements.....	iii
List of Figures.....	vii
List of Tables.....	viii
List of Acronyms.....	x
Abstract.....	xi
CHAPTER ONE	1
1.0 Introduction.....	1
1.1 Background Information	2
1.2 Statement of the Problem.....	2
1.3 Research Questions.....	3
1.4 General Objective.....	3
1.5 Specific Objectives	3
1.6 Justification of the Study	4
1.7 Scope of the Study	5
1.8 Limitations of the study.....	5
1.9 Definition of Terms	5
CHAPTER TWO.....	7
LITERATURE REVIEW.....	7
2.1 Introduction.....	7
2.2 Health Sector.....	7
2.3 Theoretical Framework: The ERG theory.....	10
2.4 Research Hypotheses	11
CHAPTER THREE.....	12
RESEARCH DESIGN AND METHODOLOGY	12
3.2 Study Area.....	12
3.3 Study Population	13
3.4 Sample Size Determination.....	13
3.5 Sampling	14

3.6 Data Collection	14
3.7 Data Analysis	15
CHAPTER FOUR: RESULTS AND FINDINGS	17
4.1: Introduction.....	17
4.2 Respondents Socio demographic information	17
4.3. Number of children	20
4.4. Experience	22
4.5 Career Advancement	25
4.6 Training	28
4.7 Perception Motivational tools.....	30
4.8 Comparison between female and male motivation and demotivational factors ..	36
4.9 Hypothesis Test.....	39
4.10 Key Informants Interviews	41
4.11 Motivation	42
4.12 Health workers' motivators	43
4.13 Human resource tools applied to motivate the workers	45
4.14 Response to measures and human resource management tools	46
4.15 Female and male motivators	47
4.16 Opinion on whether in putting measures, the organization took into consideration male and female motivators.	49
4.17 Opinion on importance of consideration on what motivates and demotivates females and males	50
4.18 Focus group discussions	51
CHAPTER FIVE:.....	55
SUMMARY, CONCLUSION AND RECOMMENDATIONS	55
5.1 Introduction.....	55
5.2 Summary of the Findings	55
5.3 Conclusions.....	63
5.4. Recommendations	67
ACTIVITY PLAN AND BUDGET	70

4.1 Activity Plan	70
4.2 Budget	1
REFERENCES	72
Annexes	76
Annex 1. Self Introduction and Consent	76
Annex 2: Key Informants Interview Guide	77
Annex 3: Self-Administered Questionnaire.....	79
Annex 4: Focus Group Discussions Guide.....	85

LIST OF FIGURES

Figure 1: Gender	18
Figure 2: Opinion on quality of services provided	42
Figure 3: Motivation of health workers in the facility	43
Figure 4: Health workers' motivators	43
Figure 5: Health workers' De-motivators	44
Figure 6: Measures to motivate health workers	45
Figure 7: Opinion on whether there are factors that motivate female workers more than male workers and the various factors.	47
Figure 8: Female motivational factors	48
Figure 9: Opinion on factors that de-motivate female workers	48
Figure 10: Female de-motivational factors	49
Figure 11: Consideration on what motivates and demotivates females and males ..	50

LIST OF TABLES

Table 1: Age * Gender Crosstabulation.....	18
Table 2: Designation * Gender Crosstabulation	19
Table 3: Marital status * Gender Crosstabulation.....	20
Table 4: Number of children * Gender Crosstabulation	20
Table 5: Age of children * Gender Crosstabulation	21
Table 6: How long did you begin your career * Gender Crosstabulation.....	22
Table 7: How long have you worked in this facility * Gender Crosstabulation	23
Table 8: Times you changed job grade to higher grade * Gender Crosstabulation ..	24
Table 9: Reasons for change of job grade to the next level * Gender Crosstabulation	25
Table 10: Plans of advancing career in the next 2 years * Gender Crosstabulation.	26
Table 11: If yes, how? Rate them if more than one choice * Gender Crosstabulation	26
Table 12: Reasons against career advancement * Gender Crosstabulation	27
Table 13: Training undergone (sponsored or self sponsored) in the last one year * Gender Crosstabulation.....	28
Table 14: Duration of training * Gender Crosstabulation	29
Table 15: Training Sponsors * Gender Crosstabulation	30
Table 16: Motivational factors by Gender.....	30
Table 17: Demotivating factor and Gender.....	31
Table 18: Level of motivation at work	32
Table 19: Perception of existing human resource management tools.....	33
Table 20: Gender perception comparison on existing Human Management Tools .	34
Table 21: What is your opinion of these efforts * Gender Crosstabulation	35
Table 22: Most appropriate motivators Gender Cross tabulation	36
Table 23: Worst demotivators Gender Cross tabulation.....	37
Table 24: A cross tabulation and Forms of motivation Gender.....	38
Table 25: A cross tabulation of what people value most about their job and Gender	40

Table 26: Designation	41
Table 27: Human resource tools applied to motivate the workers	45
Table 28: Response to measures and human resource management tools	46
Table 29: Opinion on putting measures.....	50

LIST OF ACRONYMS

CBHC:	Communities Based Health Care
DFID:	Department for International Development
ECOSOC:	United Nations Social and Economic Council
ERG:	Existence, Relatedness and Growth Theory
FBOs:	Faith Based Organization
FGDs:	Focus Group Discussions
GoK:	Government of Kenya
HLSP:	Health and Life Sciences Partnership
HRH:	Human Resources for Health
JLI:	Joint Learning Initiative
MCH:	Mother and Child Health
MDGs:	Millennium Development Goals
MO:	Medical Officer
MoH:	Ministry of Health
NGO:	Non Governmental Organizations
NHSSP II:	National Health Sector Strategic Plan II

ABSTRACT

Introduction

Human Resources for Health are the most critical factor in driving health system performance. However, motivation of health workforce has been very low in almost all developing countries including Kenya. Majority of the health workforce is female who mostly occur the junior positions while majority of policy and decision making positions are occupied by the their male counterparts. There is a need for motivators of the health workforce to be segregated by gender in order to ensure an adequately performing workforce.

Objective

The objective of this study was to determine the factors that female and male employees find motivational or demotivating and to determine the perception of male and female health employees of the existing human resources management tools in order improve on motivational incentives for health employees.

Methodology

This is cross sectional comparative study whose data was collected through qualitative methods using Key Informants Interviews and Focus Group Discussions and through quantitative methods using semi structured self administered questionnaires. Data analysis consisted of descriptive and inferential statistics

Findings

The female and male health workers had several and different motivational factors. Majority of the females, were motivated by their passion for work, while the male respondents' key motivation was appreciation by the employer. For the demotivators, both genders shared similar attributes at the workplace. There existed some efforts of motivating employees among the health human resource that were encouraging.

The study revealed that majority of the females viewed career development and increase in payment as the most appropriate motivator, whereas for the males, it was frequent meetings and increase in payment.

CHAPTER ONE

This section introduces the study topic, background and problem statement, justification, study area, scope and the objectives of the study. Definitions of the technical terms are also done in this section.

1.0 Introduction

Many countries including Kenya are attempting to tackle human resource issues in the health sector as part of Health Sector Reform. The reforms are aiming at having policies in place to ensure adequate numbers of equitably distributed and appropriately skilled and motivated health workers. (NHSSP II: 12-13). However on the whole, little attention has been paid to gender. The unequal social relations between women and men may produce inequalities in health outcomes and access to or utilization of health services. Moreover, women carry a disproportionate burden of informal health care provision in households and communities. They are also the main front line health providers in many health service settings (HSR, 2000: 1).

The Ministry of Health of Kenya 2003 public expenditure review identified human resource development as the greatest challenge to health service development, and to achieving the Millennium Development Goals (MoH, HLSP, 2006:1-2) Restructuring the workforce provides opportunities to address issues of quality of service delivery and equal opportunities for women and men. A gender perspective for Human Resources for Health acknowledges the importance of both sexes in contributing to development and promotes the equitable distribution of resources, opportunities and benefits (Standing, 2000: 32-33). In terms of quality of care, both women and men need access to services where health workers can respond appropriately to their needs. To achieve this, the health workers need to be adequately skilled to cope with changing disease patterns and be motivated to cope with the emerging challenges.

1.1 Background Information

According to the 2006 Human Resources Mapping of the Health Sector in Kenya, Ministry of Health employees had 35,643, 18 802 females and 16 841 males provide care from 2,158 health facilities, which included 1,536 dispensaries, 440 health centres, 132 district hospitals and 7 provincial hospitals⁴ (MoH, HSLP, 2006: 2). Overall, medical staff made up two thirds of the workforce (doctors 3.4% clinical officers 6.1%; public health officers 11.9%); enrolled and registered nurses 45.3%.

As at 2006, the Faith Based Organizations (FBOs) were operating a total of 816 health facilities in the country comprising of large (secondary) and medium (primary) referral hospitals, health centres and dispensaries (MoH, HSLP, 2006: 2). In addition, FBOs also had 104 communities based health care (CBHC) programs. However, the private sector is much more amorphous and there was no data available to indicate their number. The female employees in all types of facilities are mainly in nursing and low cadre jobs, while there are more men than women in senior and decision-making positions.

1.2 Statement of the Problem

The 2007 MoH Health Worker Satisfaction Survey (2007) conducted to analyze the employee and work environment satisfaction among the staff of the Ministry of Health deployed in health facilities showed that the male employees were more satisfied with their jobs (59%) compared to the female employees (48%)(NHSSP II-MTR, 2007: 33). In the second National Health Sector Strategic Plan II (NHSSP II), one of the major goals is to contribute to the reduction of health inequalities, which exist between urban and rural populations, between districts and provinces and are related to gender, education and disability (NHSSP II, 2005: 3). One of the expected outputs for Human Resource Management are policies to enhance staff motivation and welfare and improve staff retention; the introduction of annual staff performance appraisals; and suggestions for the introduction of a functional performance-based

remuneration system with incentives and/or promotion (NHSSP II, 2005: 33). However, the factors that motivate the female employees and the male employees in the public, private and FBO health facilities are not known. In addition it is not known whether the female and the male workforce are motivated by the same factors.

Questions then arise: what are the motivating factors for health workers in public, private and FBO health facilities? Are female and male employees motivated by the same factors? Could the incentives applied to motivate health employees be from a male perspective therefore not adequately motivating the female employees? How do the female and male employees respond to the Human Resources Management tools for example, continuing education and career development, performance management, supervision and staff appraisal, transfer, working conditions and other activities to retain staff (e.g. schemes aimed at provision of land at a subsidized cost, mortgages, car loan etc)?

1.3 Research Questions

- What factors do the female and male health employees consider motivational and what do they consider demotivating (discouraging)?
- Are these factors the same for female and male employees?
- What is the perception of the female and male health employees on the existing human resources management tools?

1.4 General Objective

To determine the motivational factors for female and male health employees

1.5 Specific Objectives

- To determine the factors that female and male health employees consider motivational and those they consider demotivating (discouraging)
- To determine how the female and male health employees perceive the existing human resources management tools.

- To compare the female and male motivating and demotivating factors
- To compare the perception of male and female employees to existing human resources management tools.

1.6 Justification of the Study

Human resources for health restructuring may reinforce gender inequities if reforms are not sensitive to the gender composition of the health sector workforce. Opportunities to motivate health workers may be missed if the gender issues are not addressed. With disparities in job satisfaction among the female employees, who are the majority, and male employees, the application of performance-based remunerations and promotions may only enhance inequalities, if the female employees are less satisfied with their jobs than their male counterparts. Their performance may then be less than their male counterparts therefore scoring less on performance based remuneration and incentives, leading to more dissatisfaction and less performance. Poorly motivated and remunerated health workers are rarely likely to provide adequate, “user-friendly” services (Standing, 2000: 30).

In addition, most of the primary health care services e.g. Mother and Child Health (MCH), Family Planning; Antenatal clinics are mainly run by female health employees. Women and children are major users of primary health care facilities. This means that the health service needs of women and children are actually substantially met by other women, particularly midwives and community health nurses. The maternal and child indicators in Kenya have over the last years been performing poorly (NHSSP II, 2005: 19). Therefore to improve these indicators, there is need to address the motivating factors of the providers who play a great role influencing the outcomes of these indicators and therefore to address the motivating factors of female employees.

1.7 Scope of the Study

The study will focus on Medical Personnel working in Bondo and Vihiga districts of Nyanza and Western Provinces respectively in Kenya. These are two of the districts supported by German Development Cooperation in the area of health with special emphasis in Reproductive Health. The study respondents will include Medical Officers, Clinical Officers and Nurses –Enrolled and Registered working in the public, private and faith based facilities.

1.8 Limitations of the study

Bondo and Vihiga Districts were some of the districts that experienced post election violence with some of the health workers fleeing from the districts. The perspectives of those who may have fled and may not have returned will not be captured. Residual effects of post election violence may also influence the respondents' perspectives.

In conclusion, it is hoped that this study will shed more light on the motivation of the female and male health employees therefore enabling development of innovative ideas to address the motivating and demotivating factors. Motivated health workforce is key to improvement of health of communities and the nation and achieving Millennium Development Goals (JLI, 2004: 2).

1.9 Definition of Terms

1.10.1 Gender

The concept of gender is rooted in societal beliefs about the appropriate roles and activities of men and women and in the behaviors and status that result from those beliefs (WHO, 2003: 1).

1.10.2 Gender Mainstreaming

The United Nations Social and Economic Council (ECOSOC) defined Gender mainstreaming as: "the process of assessing the implications for women and men of any planned action, including legislation, policies or programmes, in any area and at

all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring, and evaluation of policies in all political, economic, and societal spheres so that women and men benefit equally, and inequality is not perpetuated”(ECOSOC, 1997: 28).

1.10.3 Gender Equality

This refers to absence of discrimination on the basis of a person's sex in opportunities and the allocation of resources or benefits or in access to services (WHO, 2001: 1).

1.10.4 Gender Equity

Fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes (WHO, 2001: 1).

1.10.5 Motivation

This is defined as an individual's degree of willingness to exert and maintain an effort towards organizational goals (Franco et al, 2002: 1255-1266)

1.10.6 Human Resources Management Tools

These are a variety of tools and instruments to help managers tackle the challenges associated with human resources for health and human resources management (MSH, 2006: 1). These may include continuing education and career development, communication and relationship among colleagues, salaries and allowances, performance management, supervision and staff appraisal, transfer working conditions, such as equipment and transportation and other activities to retain staff.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This section discusses the review of literature and the theoretical framework together with the research hypotheses to be examined in this study. The chapter presents a review of literature of the study done on the aspect of the motivational factors for female and male health employees

2.2 Health Sector

The health sector in sub-Saharan Africa employs significant numbers of women and is one of the only parts of the formal sector where women have established a major presence. At the same time, women tend to be concentrated in certain occupations and to be poorly represented in management positions and at senior levels in the professions (Standing, 2000: 36). Gender, among other power relations, plays a critical role in determining the structural location of women and men in the health labour force and their subjective experience of that location. The resulting gender biases influence how work is recognized, valued and supported with differential consequences at the professional level (career trajectories, pay, training and other technical resources, professional networks) and at the personal level (personal safety, stress, autonomy, self-esteem, family and other social relationships) (George, 2007: 7). A retrospective study in the USA found that 85% of female physicians made career changes for the benefit of their children and family, while only 35% of male physicians did so (Warde et al. 1996: 729-735).

There is now evidence to show the hazards of what are seen as traditionally female jobs, e.g. nursing (Barnett and Marshall, 1991: 111-136). These areas of work frequently pose psychological as well as physical risks, with these risks being directly related both to the gendered definitions of the jobs themselves and to the

gendered identities that women bring to their work. Women are expected to care for others and about others. When they are unable to achieve this, female workers are especially likely to blame themselves and may suffer a range of psychological symptoms as a consequence.

In Canada, a study exploring the characteristics of, and challenges faced by women in nursing, medicine, physiotherapy and social work, who also care for elderly relatives at home found that the boundaries between their professional and personal lives were frequently blurred and eroded beyond their coping strategies, resulting in feelings of isolation, tension, extreme physical and mental exhaustion (Ward-Griffen et al. 2005: 379-394).

Women and men express differences in what constitutes a positive work environment. For example, women express security concerns when deployed in remote areas or when their job requires outreach services into the community. Women also tend to request better transportation, access to bathrooms, and respect from superiors. (Brown et al, 2004: 3). Female auxiliary health staff in India reported being afraid to walk on their own in between villages, coping with remotely located housing with inadequate lighting and harassment from villagers (George, 2007: 38). In a study conducted in Sudan, it was noted that the primary concern for women doctors in moving to rural areas was adequate housing and security, not with salary compensation (Salim, 1991: 37-57).

A commitment to addressing gender inequities in the deployment and utilization of Human Resources for Health (HRH) will illuminate policy mechanisms that seek to minimize productivity losses and improve the capacity of HRH to work more effectively and efficiently (Brown et al: 1). Men and women express differences around desired terms and conditions of employment. Due to differential home/work responsibilities that are often culturally bound, women tend to value flexible working hours and also tend to place greater value on the status gained from employment in the health sector and report higher job satisfaction whereas men tend to express concerns of salary as paramount. (Brown et al, 2004: 5). In the Sudan study, nearly

half of the female medical graduates sampled were not undertaking postgraduate citing the pressures of family responsibilities (Salim, 1991: 37-57).

One policy strategy to meet the current demand for health care workers would be to minimize migration from south to north, rural to urban and from the public to private sectors. If policy makers were to address the differential in how men and women react to the 'push/pull' factors, which propel people to migrate, they would have the information to develop innovative incentive structures to retain existing health workers. Evidence from Kenya and Nigeria suggests that an increasing number of men are entering the nursing profession and public health respectively. This trend is money driven: Kenyan men who are looking for an opportunity to leave the country and in the case of Nigeria, men who are looking for higher paid employment within their own country which may require internal migration. (Brown et al, 2004: 5) Attention to policy aimed at developing a positive work environment would be expected to increase job satisfaction, which is associated with increased motivation and effectiveness, and ultimately performance of the health system. Acknowledging the differential needs of male and female health workers will introduce contextual factors into macro-level management policies.

Gender blindness may occur when an assumption is made that all health workers are formally substitutable, regardless of gender and also when there is also an unrecognized bias that these individuals are "male."(DFID, 1999: 1) Thus, working hours, conditions of service and career structures may be predicated on what are really typically male patterns of employment. Women then become seen as a "problem" when they cannot or do not accommodate to these patterns (Standing, 2000: 34). Strategic management of the health workforce should aim to achieve positive health outcomes for the population from a more productive health workforce by setting goals of equitable access, efficiency, effectiveness, quality and responsiveness. This will depend on numerically sufficient and appropriately skilled and motivated health workforce. Motivation is promoted by a satisfactory

remuneration, positive work environment and systems that support the employee (JLI, 2004:70-71)

2.3 Theoretical Framework: The ERG theory

Clayton Alderfer exemplified a set of three needs: Existence, Relatedness and Growth (hence 'ERG') which is a continuum (Alderfer, 1972: 2). After the original formulation of Maslow's Hierarchy of Needs, which studies showed that the middle levels of Maslow's hierarchy overlap; Alderfer addressed this issue by reducing the number of levels to three;

Clayton Alderfer's ERG Theory



Source: ERG Theory of Motivation - Clayton P. Alderfer

Existence: At the lowest level is the need to stay alive and safe, now and in the foreseeable future. When we have satisfied existence needs, we feel safe and physically comfortable.

Relatedness: At the next level, once we are safe and secure, we consider our social needs. We are now interested in relationships with other people and what they think of us. When we are related, we feel a sense of identity and position within our immediate society.

Growth: At the highest level, we seek to grow, be creative for ourselves and for our environment. When we are successfully growing, we feel a sense of wholeness, achievement and fulfillment.

This theory helps the policy makers to understand that each employee operates with the need to satisfy several motivators simultaneously. Based upon the ERG theory, leadership which focuses on exclusively on one need at a time will not motivate their people effectively. Furthermore, the frustration-regression principle has additional impact on motivation in the workplace. As an example, if employees are not provided opportunities to grow or have circumstances hindering their growth, an employee might regress to fulfilling relatedness needs, socializing with co-workers more. Alternatively, the inability of the environment or situation to satisfy a need for social interaction might increase the desire for more money or better working conditions. If leadership recognizes these conditions soon enough in the process, they can take steps to satisfy those needs which are frustrated until such time that the worker can again pursue growth.

2.4 Research Hypotheses

- Female and male health employees are motivated by the different factors
- Female and male employees perceive the existing human resources management tools differently
- Health managers perceive motivating factors from a male health employees' point of view.

In conclusion, having knowledge on the extent the needs of female and male health employees are met, and what threatens or improves them would enhance sensitivity to the gender specific motivational factors.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

This section outlines the area studied, the research design and methodology employed in conducting this study.

3.2 Study Area

3.2.1 Bondo

Bondo District is an administrative district in the Nyanza Province of Kenya. The district is relatively new; it was created in 1998 from southern parts of the Siaya District. It borders Busia district to the West, Kisumu to the East, Siaya to the North, Rachuonyo to the South East, Suba to the South West and Uganda to the West (DHP, 2008: 2). It covers an area of 1987 km² of which 987 km² is land surface and 1000 km² is covered by water. It is dotted with 72 beaches and several islands. The district has a total population of 280,321 (DHP, 2008: 2). It has five administrative divisions: Nyang'oma, Maranda, Usigu, Rarieda and Madiany. The economic activities carried out in this district are fishing and family farming. The district has 2 District and sub district hospitals, 7 health centres, 24 dispensaries, and 1 maternity home and 26 clinics. This includes GoK, Faith based and private facilities. The Medical/Technical Health workers are 169, 162 and 187, in GoK, Faith Based and private health facilities respectively (DHP, 2008: 8-11).

3.2.2 Vihiga

Vihiga District is an administrative district in the Western Province of Kenya. Its capital town is Mbale, which is located in Vihiga Division. It has total area of 563 km². Vihiga District was split from Kakamega District in 1990 and is among the smallest districts in Kenya. It is sub-divided into six administrative divisions: Luanda, Emuhaya, Sabatia, Tiriki East, Tiriki West and Vihiga (FSDP, 2007: 2). The district has a health facilities catchment population of 621,399 people of which 3.5% are under 1 years, 15.0% are under 5 years, 43.7% is the under 15 year population,

24% - women of child bearing age and 3.8% is the estimated number of pregnant women. It has 4 hospitals – 1 GOK and 4 FBO among them a specialized eye care hospital, 20 health centers – 17 GOK among them a Provincial Rural Health Training Center and 3 FBO, and 7 GOK dispensaries (DHP, 2007: 8). It has a total of 512 technical health workers (DHP, 2008: 21)

3.3 Study Population

The study population was the health workers who included doctors, nurses, clinical officers, laboratory technologists and technicians, pharmacists working in Bondo and Vihiga districts. It targeted both female and male health workers.

3.4 Sample Size Determination

To obtain the sample size, the formula below was applied (Mugenda & Mugenda, 2003: 41-52)

$$n = \frac{z^2(pq)}{d}$$

Where n =the desired sample size when the population is greater 10 000 therefore greater than 10 000

z= the standard normal deviate- 1.96

p= Proportion of the population who are female-0.5

q= Proportion of the population who are male-0.5

d=level of statistical significance- 0.05

$$(1.96)^2 (0.5) (0.5)$$

Therefore n = $\frac{\quad}{(0.05)^2}$

$$(0.05)^2$$

$$= 384$$

However, in this case the total population was less than 10 000

Therefore the formula below was further applied

$$nf = \frac{n}{1+n/N}$$

Where:

nf = the desired sample size (when the population is less than 10, 000).

n = the desired sample size when the population is more than 10,000 therefore 384

N = the estimate of the population size = 1029

$$\begin{aligned} \text{Therefore } nf &= \frac{384}{1 + (384/1029)} \\ &= 279 \end{aligned}$$

3.5 Sampling

Purposive sampling was done so as to include all the different types of the facilities in the two districts. The facilities included public, faith based facilities, private and NGO facilities. The total number of Medical Officers, Clinical Officers and Nurses constituted the sampling frame. The sample for each facility was proportional to the total number of employees in the particular facility. Systematic sampling of female and male employees was done using the employees register in the facility. However, a number of employees were on leave, night duty or away on assignments and therefore the ones available were sampled. If the sampled employee declined participation in the study, the researcher moved on to the next employee.

3.6 Data Collection

Data collection took place between April and May 2009. Data collectors were recruited and trained on the data collection. They participated in the pretesting of the

tools which will be conducted in New Nyanza Provincial Hospital and adjusted to the data collection tools was made accordingly.

Data collection was triangulated with key informants interviews conducted with employers, hospital administrators, registration boards and councils and associations heads. Data from the health workers was collected through self administered close and open-ended questionnaires to obtain both qualitative and quantitative data. Two Focus Group Discussions (FGDs) was held with female and male employees separately for each district. An assistant recorded all the proceedings of the focus group discussion using a tape recorder and also in writing. The data collectors were supervised with random counter checking to ensure data validity. All the data collected was sorted at the end of day to ensure completeness and edited to eliminate mistakes that would have made data entry difficult.

3.7 Data Analysis

A total of 167 self administered questionnaires were collected from the respondents, three were spoilt so were discarded and 164 were entered for analysis. 7 interview guides from the key informants were also obtained as well as information from a total of 4 focus groups discussions, two for each district with each gender.

Coding frame was developed and questionnaires and the interview guides were analyzed with respect to the coding frame. Information from the Focus Group Discussions and the key informant interviews was also analysed. The dependent variables were motivation and demotivation and the independent variables were the motivating and demotivating factors.

The descriptive statistics for each district were calculated which included means, frequencies and standard deviations and also inferential statistics including differences between means and proportions, correlation coefficient and chi-square at 95% confidence interval. The findings were computed in form of tables, graphs and

pie charts. The testing of the hypothesis was done through calculations of the difference between the means and proportions.

3.8 Inclusion Criteria

Focus was on Medical officers, Clinical officers and Nurses –Enrolled and Registered. This included those working in the public, private and FBO facilities including hospitals, nursing homes and health centres.

3.9 Exclusion Criteria

Due to logistical reasons and to minimize bias, private clinics were excluded from the study. All employees who had worked in these districts for less than 1 month were also excluded. All the other employees not in the inclusion criteria were also excluded including those who declined to participate in the study.

3.10 Ethical Considerations

The proposal was presented to the Kenyatta National Hospital/University of Nairobi Ethics and Research committee for review and was approved. A written authorization letter was also obtained from the Director of Medical Services. Permission from the relevant District Medical Officers of Health and facility in charges was obtained. The consent of each of the respondents was sought and they were assured of confidentiality. All the raw data collected was kept in a lockable place in the custody of the principal researcher and will be destroyed once the study is over.

In conclusion, the study design and methodology employed was aimed at obtaining quality data in the most ethical manner in order to get an in-depth perspective of the factors that motivate female and those that motivate male health employees.

CHAPTER FOUR: RESULTS AND FINDINGS

4.1: Introduction

This chapter provides statistical presentation and analysis of the data collected. The data was presented in tables and figures with summaries being given for each table and figure. The objective of this chapter was to explain the data rather than draw conclusions and interpretations. Retrieved questionnaires were coded, entered and analyzed guided by the study objectives. Both bivariate and univariate analysis were used.

The specific objectives of the study were:

- 1) To determine factors that female and male health employees consider motivational and those they consider demotivating
- 2) To determine how the female and male employees perceive the existing human resource management tools.
- 3) To compare the female and male motivating and demotivating factors.

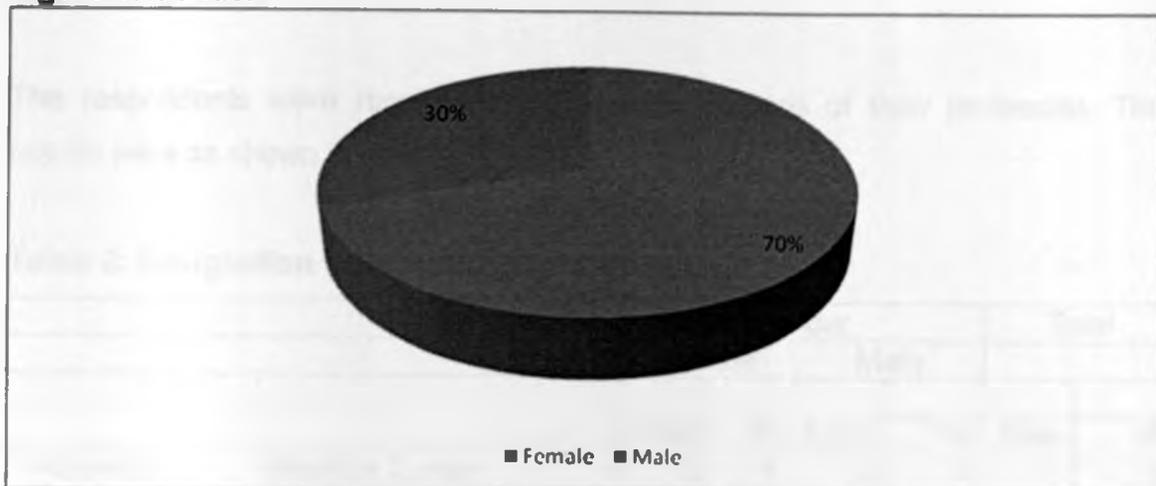
4.2 Respondents Socio Demographic Information

This section of the study sought to capture respondent's socio demographic information. Respondents were asked to answer a set of questions detailing on socio demographic information. Results are presented under the following sub sections.

4.2.1 Gender

Study findings revealed that majority of the study respondents, 70% were female, whereas minorities of respondents, 30% were males. Figure 1 below shows the results.

Figure 1: Gender



4.2.2 Age

This section of study sought to establish the age of respondents, given their gender. Respondents indicated their ages as follows.

Table 1: Age * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Age	20-29 yrs	16	14	13	26	29	18
	30-39 yrs	84	74	24	48	108	66
	40-49 yrs	9	8	10	20	19	11
	50-59 yrs	5	4	3	6	8	5
Total		114	100	50	100	164	100

The cross tabulation revealed that majority of the females, 74% were aged between 30-39 years. This was followed by 14% of the females who constituted the youthful respondents, aged between 20-29 years. This was the same trend amongst the males, whereby majority, 48% were aged between 30-39 years, then 26% representing the youthful respondents aged between 20-29 years. The elderly respondents, aged between 50-59 years constituted 4% and 6% for females and males respectively. It can generally be concluded that most of health human resource within the two districts under study were mid adults.

4.2.3 Designation

The respondents were required to indicate descriptions of their profession. The results were as shown in table 2.

Table 2: Designation * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Designation	Medical Doctor	1	1	2	4	3	2
	Nursing Officer-Cadre	79	70	16	32	95	58
	Clinical Officer	7	6	7	14	14	9
	Laboratory Technology/Technician	5	4	16	32	21	13
	Pharmaceutical Technologist/Technician	8	7	3	6	11	7
	Other Specify	14	12	6	12	20	
Total		114	100	50	100	164	

The cross tabulation above shows that majority of the female respondents, 70% were Nursing Officer-Cadre, followed by a proportion of 12% who were other staff personnel. Meanwhile, among the males, a proportion of 32% each represented Nursing Officer-Cadre and Laboratory Technology/Technician. However in both genders, only 1% of females and 4 % of males constituted medical doctors

4.2.4 Marital status

This section of the study was directed into establishing the marital status of the respondents

Table 3: Marital status * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Marital status	Single	14	12	5	10	19	12
	Married	91	80	42	84	133	82
	Widowed	9	8	1	2	10	7
	Divorced	0	0	2	4	2	1
Total		114	100	50	100	164	100

According to the study, an overwhelming majority of the females, 80% and males, 84% were married, followed by 12% of the females and 10% of the males who were single. Eight percent of the females were widowed, while only 2% of the males were widowed. Still, 4% of the males were divorced and none of the females was divorced.

4.3. Number of children

Children in family institutions comes with lot of responsibility where all the parties contributes to successful up bring of the children. The respondents were asked to indicate the number of children they had. The results were as shown in table 4.

Table 4: Number of children * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Number of children	None	9	8	12	24	21	13
	1-2	69	61	16	32	85	52
	3-4	30	26	17	34	47	28
	Over 4	5	4	5	10	10	6
	No response	1	1	0	0	1	1
Total		114	100	50	50	164	100

The cross tabulation shows that majority of the female respondents, 61% had either one child or two children in their household, followed by 26% who had between 3 and 4 children. However, 8% of the females had no children. Meanwhile, most of the males 32% and 34% constituted those who had either between one and two children or between 3 and 4 children in their household. Also, 24% of the males had no children.

A proportion of 6% in both genders comprised of those who had many children; being over 4 children. In short respondents in the study had relatively small families.

4.3.2 Age of children

The age of the children is very important as it spells the degree of dependency to the respondents. Low age calls for attention and tender care as opposed to high children age. This part of the study sought to establish the age of respondents' children. Respondents indicated these ages as follows.

Table 5: Age of children * Gender Cross tabulation

		Gender				Total	
		Female		Male		Freq	%
		Freq	%	Freq	%		
Age of children	Non applicable	9	8	12	24	21	13
	At least one below 5 years	38	35	18	36	56	35
	At least one between 6-10 yrs	41	38	8	16	49	31
	At least one between 11-20 yrs	20	19	11	22	31	20
	All above 20 yrs	0	0	1	2	1	1
Total		108	100	50	100	158	100

A cross tabulation of age of children and gender shows that majority of the females, 41% had at least one child aged between 6 and 10 years. This was closely followed by 38% who indicated that at least one child in their household was below 5 years. Still, at least one child was aged between 11 and 20 years, as indicated by 20% of the females. None of the females had an elderly child aged above 20 years.

Meanwhile, most males, 36%, had at least one child in their household being below 5 years. Also, 22% of the males had at least one child aged between 11 and 20 years. A section of male respondents, 16% each stated that they had at least one child aged between 6 and 10 years or the age of the children was not applicable.

4.4. Experience

Respondents work experience was probed were the researcher asked them on number of years they have worked since the start of their career. The response was as indicated.

Table 6: How long did you begin your career * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
How long did you begin your career	Less than 2 yrs	7	6	9	18	16	10
	2 yrs-5 yrs	24	21	8	16	32	20
	6yrs-10 yrs	29	25	9	18	38	23
	11 yrs-20 yrs	44	39	18	36	62	38
	Over 20 yrs	4	4	6	12	10	6
	No response	6	5	0	0	6	3
Total		114	100	50	100	164	100

A cross tabulation of the duration the respondents began their career and gender shows that majority of the females, 39% began their career between 11 and 20 years ago. Further, 25% indicated that they began their career between 6 and 10 years ago. Only 6% of the females had taken the shortest duration of less than 2 years in their career. Meanwhile, majority of the males, 36% began their career between 11 and 20 years ago. A proportion of 18% each stated that they began their career between 6 and 10 years ago and also had taken the shortest duration of less than 2 years in their career. The males had been in their careers for the longest time of over twenty years as compared to their female counterparts, represented by 12% and 5% correspondingly. Of great significance to this research is the fact that majority of study population had over 2 years working experience and therefore were able to give concrete experience on research questions.

4.4.2 Duration worked in the current facility

Further, the respondents were asked to indicate how long they had worked in their current facility. The results were as shown in table 7.

Table 7: How long have you worked in this facility * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
How long have you worked in this facility	Less than 2 yrs	16	14	18	36	34	21
	2 yrs-5 yrs	50	44	16	32	66	40
	6yrs-10 yrs	33	29	13	26	46	28
	11 yrs-20 yrs	7	6	1	2	8	5
	Over 20 yrs	2	2	2	4	4	2
	No response	6	5	0	0	6	4
Total		114	100	50	100	164	100

Majority of the females, 44% had worked in the facility for a period between 2 and 5 years. Twenty nine percent indicated that they had worked in the facility for a period between 6 and 10 years. Only a proportion of 14% and 6% of the females had worked in the facility for the shortest period of less than two years and the longest period of over 20years. For the males, most of them, 36% had worked in the facility for the shortest period of less than two years. This was closely followed by 32% who had worked in the facility for a period between 2 and 5 years. Still, 26% of the males had worked in the facility for a period between 6 and 10 years and a minority of 4% had worked in the facility for a longer period of over 10years. This results show that male could more easily transfer from one health facility to another.

4.4.3 Frequency of changing job grade to higher grade

The study section was carried out to establish the frequency in which the respondents changed job grade to a higher grade; for instance from Nursing Officer III to II. Respondents indicated the frequency as follows.

Table 8: Times you changed job grade to higher grade * Gender Cross Tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Times you changed job grade to higher grade?(E.g. from Nursing officer III to II etc)	None	47	41	18	36	65	40
	Once	23	20	16	32	39	24
	Twice	34	30	13	26	47	29
	Thrice	11	10	2	4	12	6
	No response	0	0	1	2	1	1
Total		114		50		164	100

A cross tabulation of the frequency of changing job grade to higher grade and gender shows that majority of the females, 41% and males, 36% had never changed their jobs to a higher grade. However, a proportion of 30%, 20% and 10% of the females had changed job to higher grade twice, once and thrice in that order. Moreover, for the males, 32%, 26% and 4% had changed their jobs to higher grade once, twice, and thrice correspondingly. The results shows that although females tended to change to higher grade after changing the first time, more females than males stagnated in their first grade of employment.

4.4.4 Reasons for the changed job grade

The respondents, who admitted that they had changed their job grades to a higher grade, were further asked to state the reasons for the change of the job grade; whether it came as a result of training or it was a natural progression to the next level.

Table 9: Reasons for change of job grade to the next level * Gender Cross Tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
If yes in no- 9,when you changed your job grade didi it come as a result of training or it as a natural progression to the next level	As a nature of training	12	17	14	40	26	25
	natural progression	57	82	21	60	78	75
Total		69	100	35	100	104	100

There were two reasons for the change of the job grade; of which most females, 82% and males, 60% stated that the change of job came as natural progression to the next level. 40% of the males changed job grade as a result of training as compared to only 17% of the females.

4.5 Career Advancement

4.5.1 Plans of advancing career in the next 2 years

On the aspect of career growth, the respondents were asked to state whether they had any plans of advancing career in the next 2 years they had in mind.

Table 10: Plans of advancing career in the next 2 years * Gender Cross Tabulation

		Gender				Total	
		Female		Male		Freq	%
		Freq	%	Freq	%		
Do you have any plans of advancing your career in the next 2 years?	Yes	101	89	38	76	139	85
	No	6	5	8	16	14	9
	Do not know	4	4	2	4	6	4
	No response	3	2	2	4	5	3
Total		114	100	50	100	164	101

On the aspect of career growth, majority of the females, 89% and males, 76% admitted that they had any plans of advancing career in the next 2 years. However, 5% and 16% of the females and males respectively were contented with their current career status and so had no intention of career advancement.

4.5.2 Modes of career advancement

The respondents, who confirmed that they had plans of advancing their career in the next 2 years, were further asked to state the means through which they would achieve this. The responses were as presented in the table 11.

Table 11: If yes, how? Rate them if more than one choice * Gender Cross Tabulation

		Gender				Total	
		Female		Male		Freq	%
		Freq	%	Freq	%		
If yes, How? rate them if more than one choice	By going into training	94	89	33	75	127	85
	By working hard to ensure i get promoted	4	4	5	11	9	6
	By looking for another job	7	7	6	14	13	9
	Any other-Explain	1	1	0	0	1	1
Total		106	101	44	100	150	100

The cross tabulation revealed that majority of the females, 89% and males, 75% had plans to advance their career by going into training. Another mode of career advancement was looking for another job, which was subscribed to by 7% of the

females and 14% of the males. Still a proportion of females, 4% and males, 11% stated that they would advance their career by working hard to ensure promotion.

4.5.3 Reasons against career advancement

The respondents, who admitted that they had no plans of advancing their career in the next 2 years, were further asked to state the reasons for their stake. The responses were as presented in table 12.

Table 12: Reasons against career advancement * Gender Cross tabulation

		Gender				Total	
		Female		Male		Freq	%
		Freq	%	Freq	%		
Reasons against career advancement	I don't think they are any prospects	1	1	4	8	5	3
	I'm satisfied where i am	2	2	2	4	4	2
	I have reached the highest, cant go any further	1	1	0	0	1	1
	I have tried before and it didn't work	4	4	4	8	8	5
	I don't think I shall manage as I have other commitments.	3	3	0	0	3	2
	No comment	104	91	40	80	144	87
Total		114	100	50	100	164	101

Majority of the respondents, 87% did not react to this section of the study. Nevertheless, a proportion of 5% of both genders who were against career advancement, stated that they had tried before and it never worked. One percent of the females and 8% of the males were of the opinion that career advancement had no prospects of. Still, 2% of both genders confirmed that they are satisfied with their current career position. Only the females, 3% declined career advancement as they thought that cannot manage as they have other commitments.

4.6 Training

4.6.1 Training undergone (sponsored or self sponsored) in the last one year

The study sought to find out whether the respondents had undergone any training, be it a sponsored or self sponsored one in the last one year.

Table 13: Training undergone (sponsored or self sponsored) in the last one year * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Have you undergone any training(sponsored or self sponsored)in the last one year	Yes	75	66	32	64	107	65
	No	35	31	18	36	53	32
	Not sure	1	1	0	0	1	1
	No response	3	3	0	0	3	2
Total		114	101	50	100	164	100

The cross tabulation showed that majority of the females, 66% and males, 64% had undergone some training in the last one year. Meanwhile, 31% of the females, and 36% of the males had not undergone some training in the last one year.

4.6.2 Duration of training.

Duration of training was probed in order to assess the quality of training by virtue of time factor. Results of the findings are as shown in table 14.

Table 14: Duration of training * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Duration of training	Less than 1 week	15	13	4	8	19	11
	1-2 weeks	48	42	19	38	67	41
	Over 2 weeks to 6 months	6	5	1	2	7	5
	Over 6 months to 1 year	6	5	5	10	11	7
	Over 1 year	12	11	5	10	17	10
No comment		27	24	16	32	44	26
Total		114	100	50	100	164	100

The results of the cross tabulations between duration of training and gender showed that more female staff, 42% and male staff, 38% had undergone through training which took between one and two weeks. Meanwhile, the shortest duration of less than one week was represented with 13% of the female staff and 8% of the male staff. It was noted that twice as many males than females had training that took over six months to 1 year represented by 10 % for males and 5% for females. However, the longest duration of time of more than one year was represented by 11% of the females and 10% of the males. It was also noted that 26% of the respondents gave no comment on the duration of training.

4.6.3 Sponsors of the training

The study aimed at finding out who met the cost of training. It is important to identify who paid for the training because it has implications on the applicability of the same. People were likely to implement what they learnt in the training if they paid for it as compared to when another entity paid, Lawson and Luks. (2004). It also helps to determine the level of commitments and affordability to training by the recipients. The responses to the sponsors of training are presented in table 15.

Table 15: Training Sponsors * Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Who is sponsoring you for the training	Employer	21	18	4	8	25	15
	Self sponsored	10	9	18	36	28	19
	Donor /NGO	50	44	20	40	70	42
	Other-Explain...	4	4	0	0	4	2
No comment		30	26	8	16	38	23
Total		114	100	50	100	164	100

Majority of the females, 44% and males, 20% indicated that it was the donors/ NGO who met the cost of training. Further, 18%, 9% and a minority of 4% of the females indicated that the employer, themselves, and other stakeholders financed the training in that orders. For the males, four as many were able to sponsor themselves, 36% as compared to 9% of the females.

4.7 Perception Motivational tools

4.7.1 Factors those female and male health employees considered motivational

Table 16: Motivational factors by Gender

What factors make you willing to do your job everyday?	Gender				Total
	Female		Male		
	F	%	F	%	
New challenges	5	4	0	0	5
Working without pressure	3	3	2	4	5
Passion for the job	27	24	8	16	35
Personal duty and experience	9	8	3	6	12
Motivation from other staff	6	5	3	6	9
Professional ethics	10	9	9	18	19
Earns me a living	15	13	5	10	20
Appreciation by employer	11	10	10	20	21
Conducive environment	18	16	3	6	21

Other factors	10	9	7	14	17
Total	114	101	50	100	164

Majority of the females were motivated due to their passion for work, 24 %, followed by 18 percent who were motivated by the conducive environment. In addition, 13 percent were motivated by work since it earned them a living, while 10 percent were motivated by appreciation from their employers. On the other hand males respondents' key motivation was appreciation by the employer as confirmed by 20 percent of entire male respondents, professional ethics was second motivator with a total percentage of 18. As observed by the study both male and female are motivated by different factors.

4.7.2 Demotivating Factors by Gender

Respondents were asked to highlight some of demotivating factors within their work environment. Results are as tabulated in table 17.

Table 17: Demotivating factor and Gender

Demotivating factors	Gender				Total	%
	Female		Male			
	F	%	M			
Overworking	0	0	3	6	3	2
Discrimination	1	1	0	0	1	1
Shortage of staff	5	4	0	0	5	3
Lack of appreciation	6	5	6	12	12	7
Poor pay	30	26	14	28	44	27
Lack of equipment and drugs	26	23	11	22	37	23
Lack of incentives	21	18	10	20	31	19
Inflation	22	19	3	6	25	15
Others	3	3	3	6	6	3
Total	114	100	50	100	164	100

Results indicated that majority of both males (26%) and females (28%) identified poor pay as a demotivating factor this was followed by lack of equipments and drugs

Table 19: Perception of existing human resource management tools

		Gender				Total	%
		Female		Male			
		F	%	F	%		
If so which	Supervision	1	1	0	0	1	1
	Transfers	7	6	0	0	7	4
	Staff appraisal	14	12	11	22	25	15
	Career development	47	41	21	42	68	41
	Continuing in education	24	18	10	20	34	21
	Others	21	18	8	16	29	17
Total		114	100	50	100	164	100

Majority of the females perceived career development as a major tool (47%) followed by 18 who perceived continuing in education as a tool. However, among the males, 42% perceived career development followed by staff appraisal with 22 percent.

4.7.5 Gender perception comparison on existing human management tools.

The respondents were asked to state the various reasons which made them dislike their current jobs. Majority of (26%) the females did not like the risks of getting infected that they encountered in the workplace (safety), in addition 23 percent disliked harassment by the employers or other male staff. On the other hand, 28% majority of the male counterparts cited lack of appreciation at their workplace, as well as 18 percent who disliked lack of equipment and staff. In conclusion dislike of work motivation elements varied substantially across gender divide.

Table 20: Gender Perception of what the Health Workers do not like about their Job.

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	
What do you NOT like about your job	Uncooperative staff	0	0	1	2	1	1
	Loosing patients through death	1	1	6	12	7	4
	Lack of career development	1	1	0	0	1	1
	Low pay	11	9	1	2	12	7
	Overworking	9	8	3	6	12	7
	Lack of equipment and staff	5	4	9	18	14	8
	Lack of appreciation	15	13	14	28	29	18
	Harassment	26	23	6	12	32	11
	Risks of getting infected (safety)	30	26	2	4	32	19
	Others	16	14	8	16	24	15
Total		114	100	50	100	164	100

4.7.6 Efforts of motivating employees

The researcher aimed to achieve the existence of efforts in motivating employees among the health human resource. The study appreciates some degree of effort measures put in place in motivating employees at work place. Opinion on these efforts was sought. The findings were as indicated in table 21.

Table 21: What is your opinion of these efforts * Gender Cross tabulation

		Gender				Total	
		Female		Male		Freq	%
		Freq	%	Freq	%		
What is your opinion of these efforts	education should be constant	24	21	16	32	40	25
	encouraging	41	36	12	24	53	32
	not adequate	12	10	7	14	19	11
	requires positive change	1	1	1	2	2	1
	increases productivity	8	7	2	4	10	6
No comment		28	25	12	24	41	25
Total		114	100	50	100	164	100

Majority of the females, 36% were of the opinion that the efforts aimed at motivating the employees were encouraging. Twenty-one percent further stated that education as motivation tool should be constant. For the males, majority, 32%, shared the opinion that education as motivation tool should be constant, while 24% were of the opinion that the effort aimed at motivating the employees were encouraging. Only a minority, 1% within both genders admitted that the motivating efforts required positive change in order to succeed.

4.8 Comparison between female and male motivation and demotivational factors

4.8.1 What in your opinion do you think would be most appropriate motivator

Table 22: Most appropriate motivators Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Most appropriate motivators	improved work conditions	2	2	0	0	2	1
	reward and recognition	0	0	2	4	2	1
	seminars and upgrading	4	3	4	8	8	5
	promotions	5	4	2	4	7	4
	career development	31	27	2	4	33	20
	frequent meetings	12	10	17	34	29	17
	Employing more staff	16	14	3	6	19	11
	increase in payment	23	20	11	22	34	21
	Payment of overtime hours	9	8	2	4	11	7
	Others	12	10	7	14	19	11
Total		114	100	50	100	164	100

According to the study, majority of the females, 27% viewed career development as the most appropriate motivator, followed by 20%, who were of the opinion that increase in payment was the most appropriate motivator. On the side of the males, frequent meetings were seen as the most appropriate motivator, constituting 34%. This was followed by 22% who were of the opinion that increase in payment was the most appropriate motivator. However, none of the females was of the opinion that reward and recognition was the most appropriate motivator. In addition, none of the males was of the opinion that improved work conditions were the most appropriate motivator.

4.8.2 Demotivators

Table 23: Worst demotivators Gender Cross tabulation

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
What do you think are the worst demotivators in your job	delay of salaries	0	0	1	2	1	
	lack of appreciation and recognition	10	9	6	12	16	
	long working hours	11	9	10	20	21	
	poor supervision and harassment	4	3	1	2	5	
	Poor communication	7	6	10	20	17	
	Poor working conditions	14	12	3	6	17	
	poor pay and lack of risk allowance	37	32	11	22	48	
	lack of equip and staff	16	14	5	10	21	
	Others	15	13	3	6	18	
Total		114	100	50	100	164	

The cross tabulation revealed that majority of the females, 32% were of the opinion that poor pay and lack of risk allowance was the worst demotivators. This was followed by 14% of the females who stated that lack of equip and staff was the worst demotivators. Meanwhile, amongst the males, poor pay and lack of risk allowance was seen as the worst demotivators. Poor communication and long working hours, each constituting 20%, showed the opinion of the males on the worst demotivators. Delay of salaries and poor supervision and harassment were seen as the least bad demotivators for both the females and males.

4.8.3 A cross tabulation of forms of motivation and Gender

Table 24: A cross tabulation and Forms of motivation Gender

		Gender				Total	
		Female		Male			
		Freq	%	Freq	%	Freq	%
Forms of motivation	supervision	1	1	0	0	1	
	transfers	7	6	0	0	7	
	staff appraisal	14	12	11	22	25	
	career development	47	41	21	42	68	
	continuing in education	24	21	10	20	34	
	Others	21	18	8	16		
Total		114	100	42	100	164	

Majority of the females, 47% and males, 24% were motivated through career development at work place. Still females, 21% and males, 20% stated that continuing in education was the form of motivation available at the work place. However, only one percent of the females admitted that supervision was the form of motivation available at the work place. Meanwhile, none of the males was of the view that supervision was the form of motivation available at the work place

4.9 Hypothesis Test

4.9.1 Female and Male Health Employees are Motivated by Different Factors

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	6.441(a)	4	.169
Likelihood Ratio	6.756	4	.149
Linear-by-Linear Association	.006	1	.936
N of Valid Cases	161		

A High significance value (typically above 0.05) indicates that there may be no relationship between the two variables.

Hypothesis 2

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.027(b)	1	.869
Continuity Correction(a)	.000	1	1.000
Likelihood Ratio	.027	1	.868
Linear-by-Linear Association	.027	1	.869
N of Valid Cases	154		

A High significance value (typically above 0.05) indicates that there may be no relationship between the two variables.

4.9.2 Most valued in job setting

Table 25: A Cross Tabulation of What People Value Most About their Job and Gender

		Gender				Total	
		Female		Male		Total	
		Freq	%	Freq	%		
What do you value most about your job	job security	6	5	3	6	9	6
	professionalism	8	7	4	8	24	10
	code of conduct and ethics	11	9	1	2	24	10
	patients recovery	18	16	13	26	38	19
	improvement	14	12	10	20	32	15
	satisfaction	18	16	11	22	35	18
	servicing patients passionately	33	28	7	14	43	24
	Others	6	5	0	0		
Total		114	100	50	100	164	100

The results of the cross tabulations between what respondents valued most about their job and gender showed that more female staff, 28% mostly valued serving patients passionately. Patients' recovery and work satisfaction were also considered as the most valued thing in job place among the females, each constituting 16%. Among the males, 26% of the respondents mostly valued Patients' recovery, followed by satisfaction at work place, represented by 22%. Job security was least valued for both the females and males, comprising of 5% and 6% respectively.

4.10 Key Informants Interviews

4.10.1 Respondents Socio Demographic Information

This section of the study sought to capture respondent's socio demographic information. The respondents (Key Informants) were asked to answer a set of questions detailing on socio demographic information. Results are presented under the following sub sections.

4.10.2 Designation

The respondents were required to indicate their positions in the organization. The results are as shown in table 26.

Table 26: Designation

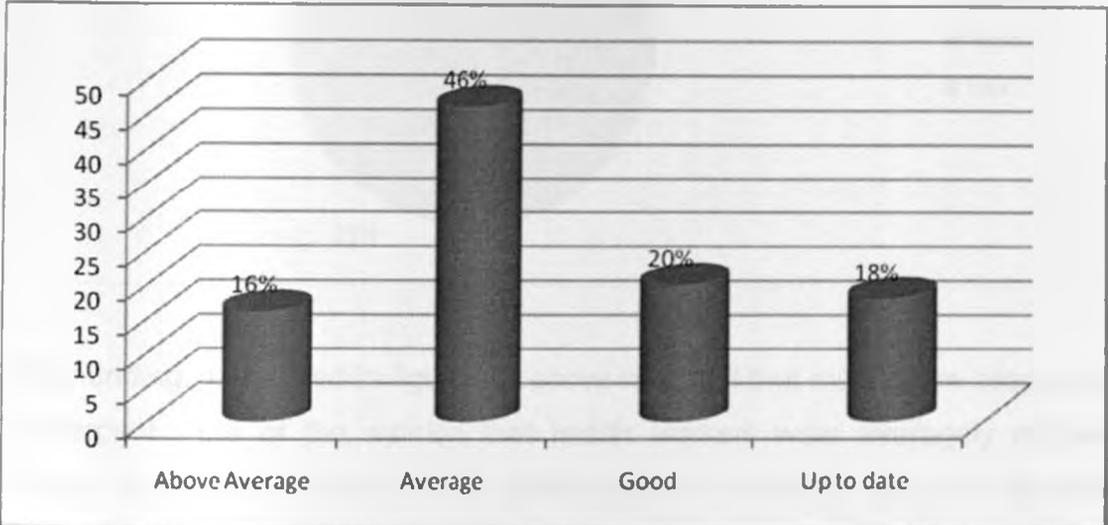
Designation	Frequency	Percent
Accountant	1	14
District Clinical Officer	1	14
DPHN	1	14
HRM	1	14
Medical Superintendent/ Facility manager	2	29
No response	1	14
Total	7	100

The study revealed that most of the respondents, 29% were /medical superintendents/ facility manager. Fourteen percent of the respondents each constituted the accountants, district clinical officers and Human resource managers. However, 14 percent of the respondents gave no response.

4.10.3 Opinion on quality of services provided

This section of the study was directed into establishing the opinion on quality of services that were being provided. The results are as indicated in figure 2.

Figure 2: Opinion on quality of services provided



The study revealed that majority of the respondents, 46 percent considered the services as average, while 20 percent considered the services as being good. 18 percent of the respondents considered them up to date, while 16% of the respondents considering them as above average.

4.11 Motivation

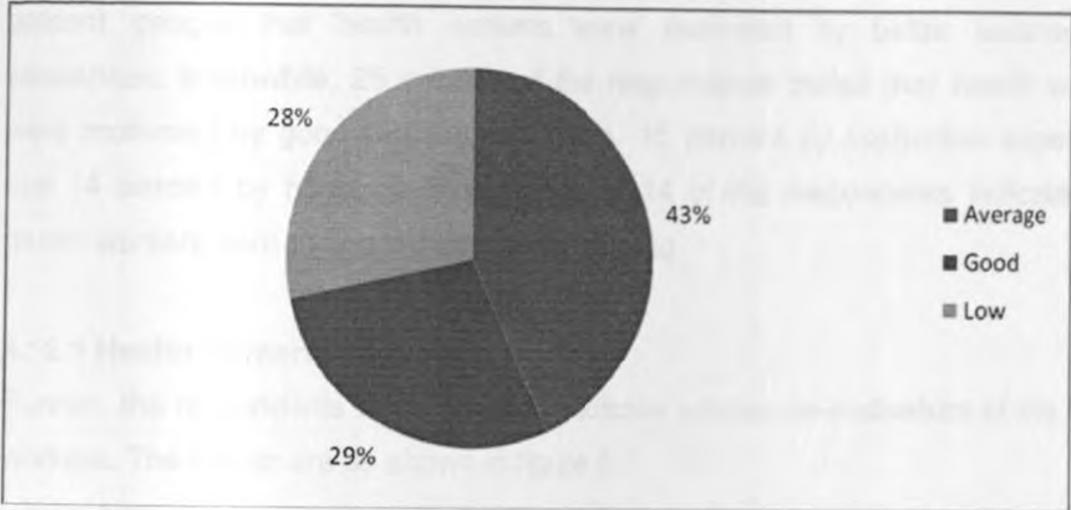
4.11.1 Influence of motivation on health workers on quality of services

The respondents were asked to whether motivation influenced the quality of services. Surprisingly, all the respondents' agreed that motivation of health workers influenced quality of services.

4.11.2 Motivation of health workers in the facility

This section of study sought to establish the gauging of motivation of health workers in the facility by the respondents. Results are as shown in figure 3.

Figure 3: Motivation of health workers in the facility

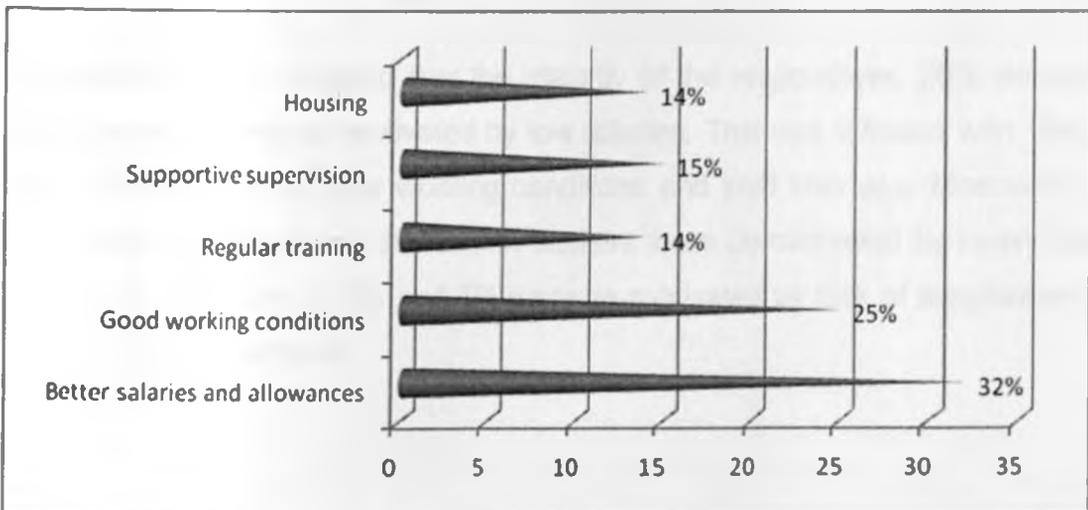


Study findings presented in figure 4.2 above revealed that most of the respondents, 43 percent were of the opinion that health workers were averagely motivated. Twenty eight percent admitted that health workers' motivation was low. Meanwhile, 29% of the respondents termed health workers' motivation as being good.

4.12 Health workers' motivators

This section of study sought to establish the various health workers motivators.

Figure 4: Health workers' motivators

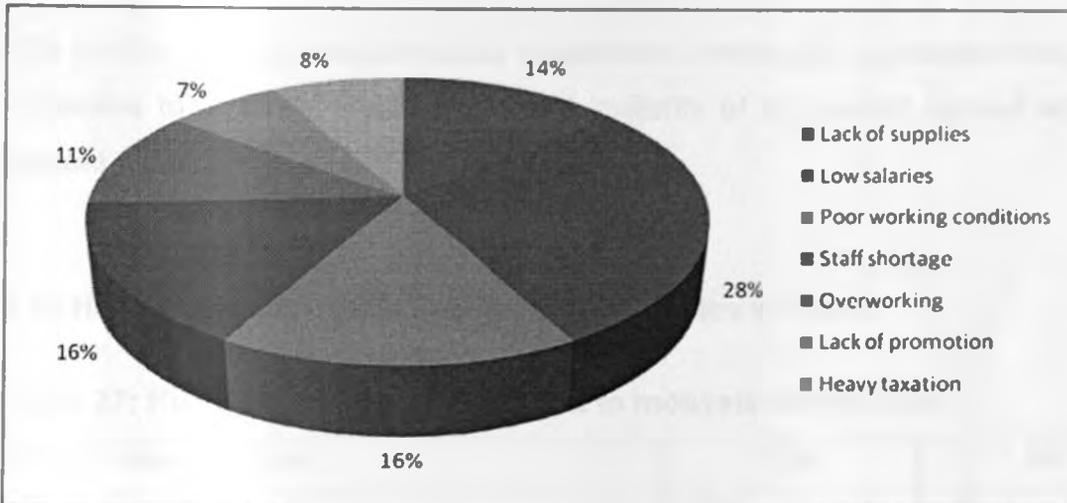


The study findings presented in figure revealed that most of the respondents, 32 percent gauged that health workers were motivated by better salaries and allowances. Meanwhile, 25 percent of the respondents stated that health workers were motivated by good working conditions, 15 percent by supportive supervision and 14 percent by housing. A proportion of 14 of the respondents indicated that health workers were motivated by regular training.

4.12.1 Health workers' De-motivators

Further, the respondents were asked to indicate various de-motivators of the health workers. The results are as shown in figure 5.

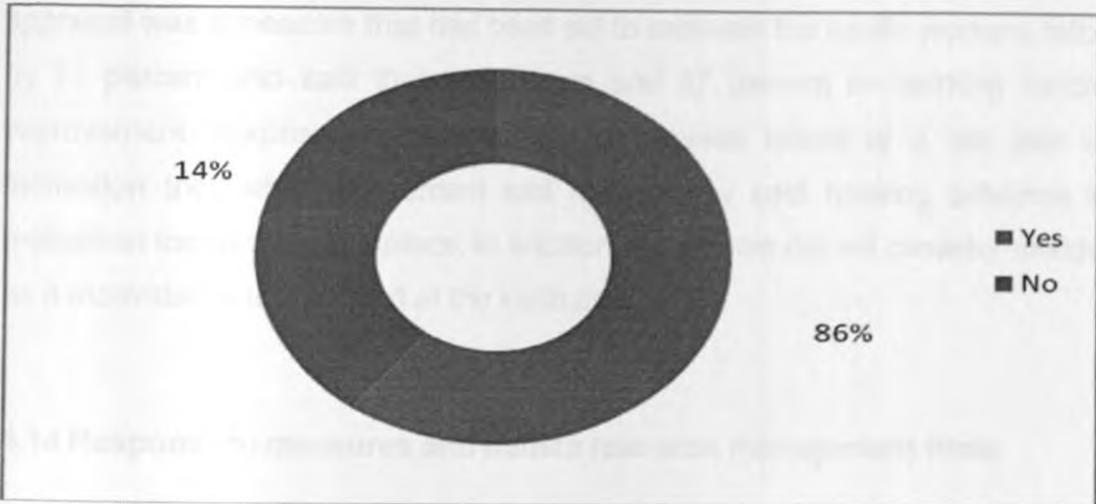
Figure 5: Health workers' De-motivators



The study findings revealed that the majority of the respondents, 28% indicted that health workers were de-motivated by low salaries. This was followed with 16%, who were de-motivated by poor working conditions and staff shortage. Meanwhile, 14% of the respondents stated that health workers were de-motivated by heavy taxation burden. A proportion of 8% and 7% were de-motivated by lack of supplies and lack of promotion respectively.

4.12.2 Has your organization put in measures to motivate health workers?

Figure 6: Measures to motivate health workers



This section of study was carried out to establish whether the organization had put in measures to motivate health workers. A majority of 86 percent agreed while 14 percent did not.

4.13 Human resource tools applied to motivate the workers

Table 27: Human resource tools applied to motivate the workers

Human resource tool	Yes		No	
	Freq	%	Freq	%
Car loan			7	100
Low cost housing Schemes	1	14	6	86
Mortgages	2	29	5	71
Career development	3	43	4	57
Performance management	3	43	4	57
Working conditions improvement	4	57	3	43
Supervision	5	71	2	29
Staff appraisal	6	86	1	14
Continuing education	7	100	0	

The study sought to find out the various human resource tools measures applied to motivate the workers. Majority of the respondents, 86 percent, said that staff appraisal was a measure that had been put to motivate the health workers, followed by 71 percent who said that supervision and 57 percent on working conditions improvement. Surprisingly, none of the employees talked of a car loan as a motivation tool, while 86 percent had not put low cost housing schemes as a motivation tool in their workplace. In addition, 71 percent did not consider mortgages as a motivational tool applied at the institution.

4.14 Response to measures and human resource management tools

This section of study sought to find out the manner of response in which female and male health employees responded to measures and human resource management tools. The results are as shown below.

Table 28: Response to measures and human resource management tools

Sex	Frequency	Percentage
Female	3	43
Male	0	0
No difference	4	57
Total	7	100

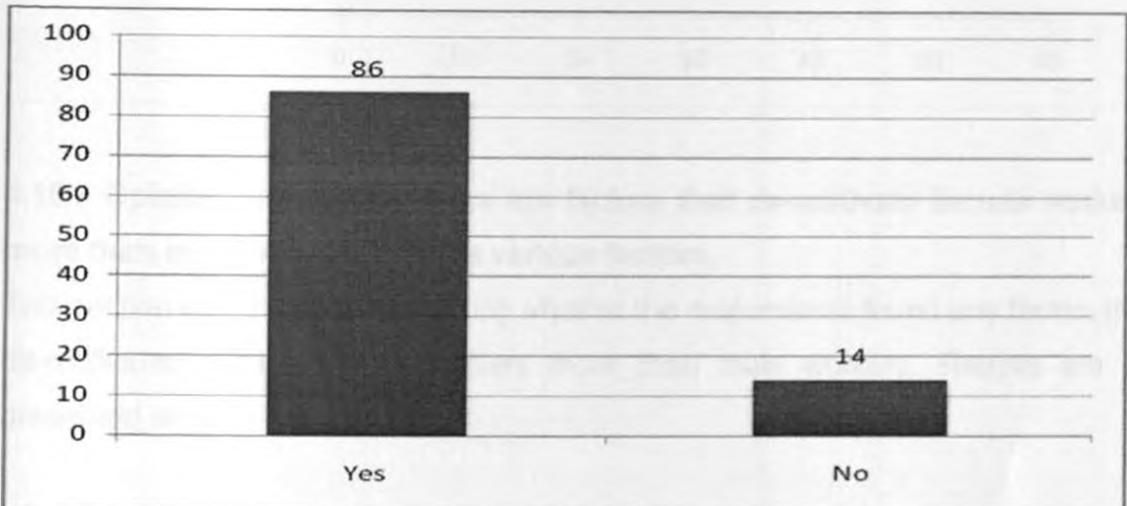
The study revealed that the highest proportion, 57 percent did not find any difference among response among the different sexes. Meanwhile 43 percent of the respondents agreed that female employees responded better to human resource management tools than male employees. Surprisingly, none of the respondents agreed that male employees responded better to human resource management tools.

4.15 Female and male motivators

4.15.1 Opinion on whether there are factors that motivate female workers more than male workers and the various factors.

This section was aimed at identifying whether the respondents found any factors that motivated female health workers more than male workers. Results are as presented in figure 7.

Figure 7: Opinion on whether there are factors that motivate female workers more than male workers and the various factors.

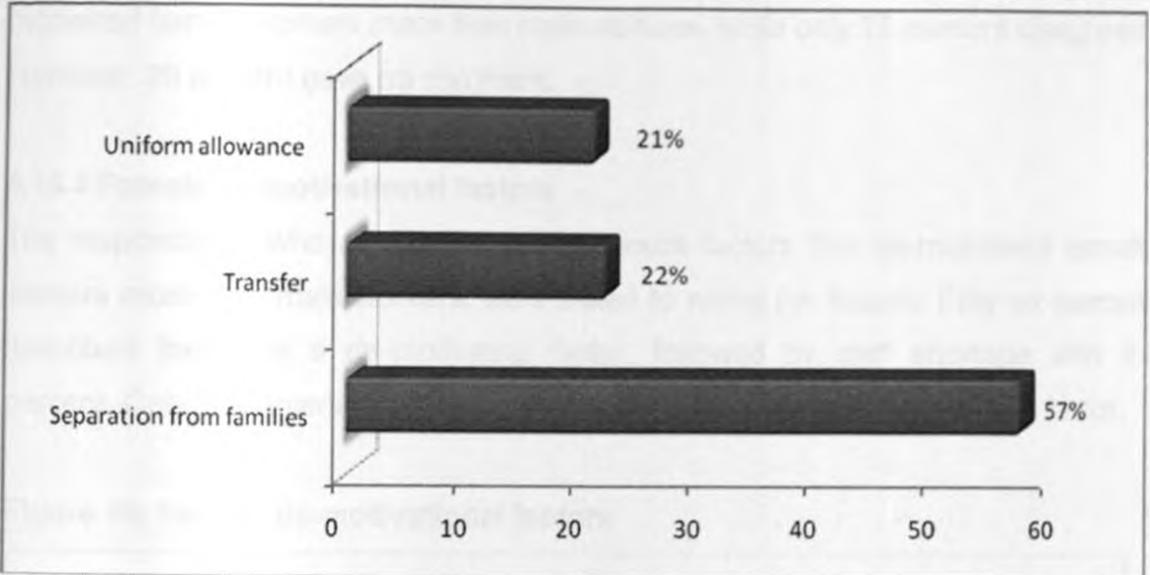


Majority of the respondents, 86 percent, agreed that there were factors that motivated female workers more than male workers, while only 14 percent disagreed.

4.15.2 Female motivational factors

The respondents, who admitted that there were factors that demotivated female workers more than male workers, were asked to name the factors. Fifty seven percent described separation from families as a factor, followed by transfers with 22 percent. Only 21 percent described uniform allowance, allocated to females as a motivational factor. Figure 8 shows the results.

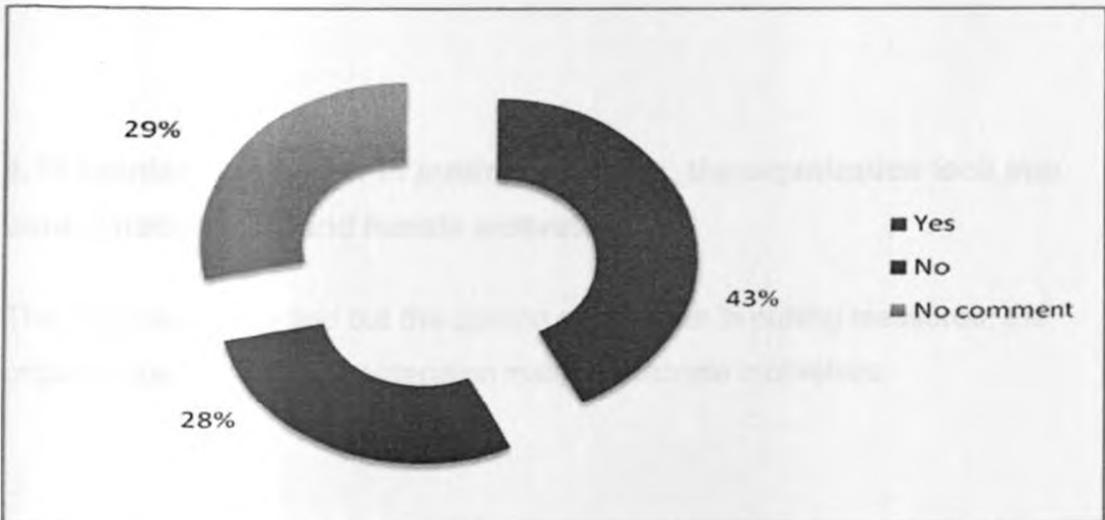
Figure 8: Female motivational factors



4.15.3 Opinion on whether there are factors that de-motivate female workers more than male workers and the various factors.

This section was aimed at identifying whether the respondents found any factors that de-motivated female health workers more than male workers. Results are as presented in figure 9.

Figure 9: Opinion on factors that de-motivate female workers

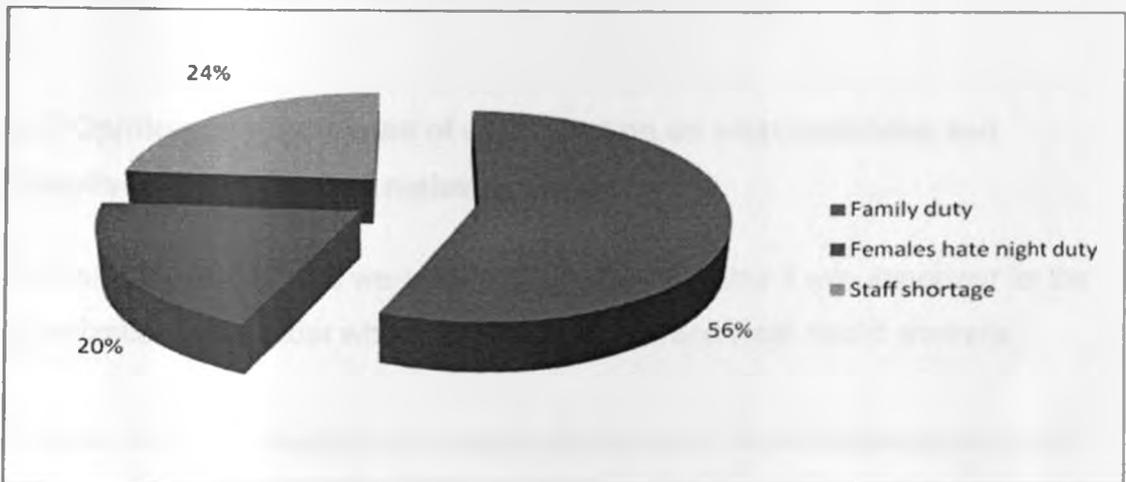


Majority of the respondents, 43 percent, agreed that there were factors that de-motivated female workers more than male workers, while only 28 percent disagreed. However, 29 percent gave no comment.

4.15.4 Female de-motivational factors

The respondents, who admitted that there were factors that de-motivated female workers more than male workers, were asked to name the factors. Fifty six percent described family as a de-motivating factor, followed by staff shortage with 22 percent. Only 20 percent described dislike of night duty as a de-motivational factor.

Figure 10: Female de-motivational factors



4.16 Opinion on whether in putting measures, the organization took into consideration male and female motivators.

The study sought to find out the opinion on whether in putting measures; the organization took into consideration male and female motivators.

Table 29: Opinion on putting measures

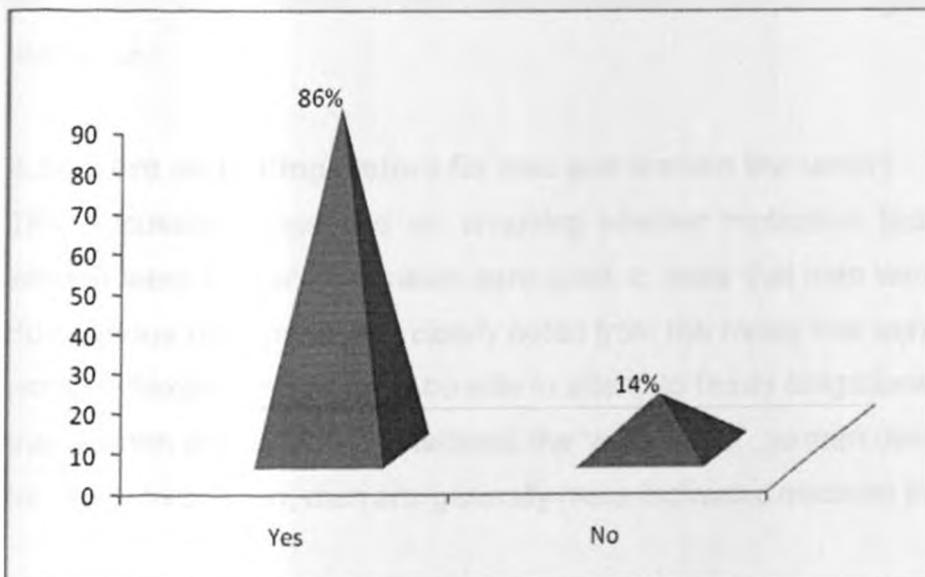
Opinion	Frequency	Percentage
Yes	3	43
No	2	30
No comment	2	27
Total	7	100

Majority of the respondents, 43 percent, agreed that the organization took into consideration male and female motivators. Thirty Percent disagreed while 27 percent gave no comment.

4.17 Opinion on importance of consideration on what motivates and demotivates females and males

Further, the respondents were asked to indicate whether it was important for the organization to consider what motivated females and male health workers.

Figure 11: Consideration on what motivates and demotivates females and males



The study revealed that the highest proportion, 86 percent agreed that it was important for the health organization to consider what motivated females and male health workers, while 14 percent disagreed.

4.18 Focus Group Discussions

4.18.1 Focus group discussions on males

Men defined Motivation as something Intrinsic- the energy that pushes somebody forward to perform something. Various factors that they found motivational were given. Most of the males considered the work itself as motivational. This included a good and suitable working environmental, cooperative staff and the availability of resources and equipment .A better salary was also seen as a motivator amongst the males with other being motivated by ability to progress, good supervision and frequent promotions

Meanwhile, various factors were also found as de-motivating amongst the males. Majority of them cited poor pay and overworking as the key de-motivators. Stagnated promotion and lack of supervision were also seen as factors inhibiting motivation. Nevertheless a few males considered lack of recognition also as a de-motivator.

4.18.2 Are motivating factors for men and women the same?

The discussion proceeded on enquiring whether motivation factors for men and women were similar. The males were quick to state that men were more motivated due various reasons. It was clearly noted from the males that women needed more working flexible time so as to be able to attend to family obligations and also the fact that women are generally considered the 'weaker sex', so men usually covered more for them. In addition, men are generally more motivated because the society expects

them to be harder working to provide for their families hence the vigor that men work with is different from the women.

On a light note, the males described women as being happy with just 'having tea at work' while men wanted more so they would put more effort. In conclusion, it was also found out that women sometimes did not attend duty because of family obligations e.g. when a child is sick or no house help.

4.18.3 Factors That Could Make Women More Motivated

The males were then asked to state factors that could make women more motivated. One of the major suggestions given was to give more flexible working hours to women and allow more maternity leaves. In addition, the males suggested that women terms could also be improved.

In addition, having specialized facilities so that women can bring their children to work could also contribute to women motivation and more team work where men could be sensitized to understand the special needs of women better. In conclusion, employing more people to ease work load and availing family planning should be availed to the women to enable them plan children better were also seen as effective women motivators.

In addition the males were asked to state their opinion on whether men and women took human resource tools in the same way. The males disagreed saying that males were able to make decisions faster without consulting anyone and therefore can take loans, promotions, transfers etc and also it was common to women that they had to consult before up taking these incentives and if their husbands refuse, they could not take them.

4.18.4 Solution

The discussion then aimed at identifying the various measures that could be put in order to motivate women. Educating the girl child so that she was more empowered to make decisions and introducing more incentives for women was a major

suggestion. In addition, breakdown of incentives into those targeting women was also suggested. *"In Africa for a woman to grow up from a child to an adult with a career is not a joke"* said one doctor in Vihiga".

4.18.5 Focus group discussions on females

Women defined Motivation as something extrinsic- A gesture put in place to boost the morale of the health worker. Various factors that they found motivational were given. Most of the females considered continuous education as motivational. Upgrade in the job scale was also seen as a motivator amongst the males with others being motivated by seminars and frequent promotions. Meanwhile, various factors were also found as de-motivating amongst the females. Majority of them cited shortage of staff and lack of equipment as the key de-motivators. At one instance a nurse said *"I'm still on probation though I have worked for 15 years"*. Stagnated promotion and too much workload were also seen as factors inhibiting motivation.

4.18.6 Is the Motivation of Men And Women the Same?

The discussion proceeded on enquiring whether motivation factors for men and women were similar, among the females. The females were quick to state that women were less motivated due to family obligations which the supervisors did not take in consideration. It was clearly noted from the females that social beliefs played a role as no matter how junior males are they were always addressed as *"Doctor"* by patients and relatives while women were addressed as *"Sister"* or *"Nurse"*. This boosted the morale of men as they feel appreciated by the society and dampened the morale of women. Lack of bathrooms and sanitary facilities also de-motivated women. *"When we have menses we have to go our houses to change and if you don't live in the hospital compound you have to carry the pad in your pocket till you can find a place to throw it"* said some females from Vihiga.

4.18.7 Opinion on whether women and men took Human resource tools in the same way

This section aimed to assess the opinion from women on uptake of Human resource tools. The females agreed that men took human resource tools better than women. This was as a result of men easily accepting transfer even to the most remote part of the country as the obligations of taking care of the family were with their wives. In addition, women could not just accept a transfer even with a promotion as they would have to think about moving the family and whether the family would have the required amenities e.g. school.

Promotions were also advantageous on men since to pursue the promotion the headquarters took lot of time and men could afford to go and camp in Nairobi with relatives or in cheap hotels to pursue their promotions but this is very difficult for women due to insecurity in those cheap hotels, or they cannot leave their families for long. Therefore men attained promotion faster than the women.

4.18.8 Solution

The females suggested that there should be a consideration of the factors that motivate women and those that motivate men independently. In addition, the existing tools were mainly made for men and it was assumed that women would fit in; therefore the special factors that affected women should also be given recognition.

CHAPTER FIVE: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter is a presentation of the summary of the findings, conclusion and recommendations. The analysis was based on the general objective of the study which was to determine the motivational factors for female and male health employees

5.2 Summary of the Findings

5.2.1 Socio-demographic characteristics (age, marital status and gender)

The gender distribution of the respondents was 70 % female and 30 % males as there was gender disparity in the workforce of the two districts. The age of the respondents was that most of human resources for health within the two districts under study, females, 84% and males, 74% were mid adults, of between 30-39 years. Most of the respondents, the female, 79% and males, 70% were Nursing Officer-Cadre and Laboratory Technician, males, 16% and females, 4%. Still, a proportion of 14% constituted female other staff personnel. The study revealed that majority of the females, 91% and males, 84% were married of which the families were relatively small, whereby majority of the respondents, females ,69% and males, 61% had either one child or two children in their household, followed by female respondents,26% and males, 34% who had between 3 and 4 children. On the aspect of the age of the respondents' children, majority of the females, 38% had at least one child aged between 6 and 10 years, and closely followed by 35% who indicated that at least one child in their household was below 5 years, while for males, 36% had at least one child in their household being below 5 year. Meanwhile, none of the females had an elderly child aged above 20 years.

Of great significance to this research was the fact that majority of study population had over 2 years working experience and therefore were able to give concrete information on research study, of which majority of the females, 39% and males, 36% begun their career between 11 and 20 years ago. Further, most females, 44% had worked in the facility for a period between 2 and 5 years, followed with females, 29% who had worked in the facilities for 6-10 yrs. However, 36% of the males had worked in the facility for the shortest period of less than two years showing they were able to transfer from one facility to another more easily than females.

The frequency in which the respondents changed job grade to a higher grade was low as revealed by majority of the females, 41% and males, 36% had never changed their jobs to a higher grade. However, a proportion of 30%, 20% of the females and males, 26% 32%, had changed job to higher grade twice, and once in that order. There were two main reasons for the change of the job grade; training or natural progression, where by most females, 82% and males, 60% stated that the change of job came as natural progression to the next level and 17% of the females, 40% of the males admitted that it was as a result of training, showing that more males than females were able to influence their own progression through the career ladder through training.

Despite the fact that training was not common, majority of the females, 89% and males, 76% admitted that they had any plans of advancing career in the next 2 years. However, 5% and 16% of the females and males respectively were contented with their current career status and so had no intention of career advancement. The means through which career advancement would be achieved was majorly training, females, 89% and males, 75%. This was followed by twice as many males, 14%, intending to look for better jobs as compared to 7% of the females who wanted to look for better jobs. Those who intended to work hard to ensure promotion were 4% females and 11% males. On the other hand, there were some reasons against career advancement; 5% of both genders had tried it before but failed, 1% of the females and 8% of the males saw no prospects of career

advancement, 2% of both genders confirmed that they are satisfied with their current career position. Only the females, 3% declined career advancement as they thought that cannot manage as they had other commitments.

5.2.2 Training

The study finding on training indicated that most respondents, females, 66% and males, 64% had undergone through some training in the last one year, unlike 31% of the females, and 36% of the males who had not gone through any training. Generally, the duration of training was found to be short; as shown by female staff, 42% and male staff, 38% who indicated that training took between one and two weeks, followed by 15% of the female staff and 8% of the male staff who took less than one week. However, the longest duration of training was more than one year, as represented with 11% of the females and 10% of the males. The highest proportion, females, 44% and males, 40% indicated that it was donors/ NGO who met the cost of training while females, while four times as many males 36% compared to 9% females were able to sponsor themselves for training. The employer financed the training of 18% of the females and 8% of the males.

5.2.3 Perception Motivational tools

There were several factors that motivated both the female and male health employees, of which the study found that both male and female were motivated by different factors. Majority of the females, 24% were motivated by their passion for work, followed by 16% who were motivated by the conducive environment and 13% who were motivated by the earning a living. On the other hand, the male respondents' key motivation was appreciation by the employer as confirmed by 20 percent of the males, followed by professional ethics, 18%.

The study found out that the respondents shared similar demotivators attributable to the workplace. The majority of males, 28% and females, 26% identified poor pay as a demotivating factor. This was followed by lack of equipments and drugs in

executing their duties, males, 22% and females, 23%, then lack of incentives males, 20% and females, 18%.

On the level of motivation at work, majority of the females, 31% were moderately motivated as compared to 36% of the males. Twice as many females felt very lowly motivated, 24% as compared to 12% males who felt very lowly motivated. Only 6 percent of the males were highly motivated as compared to 12 percent of the females who were highly motivated and so the level of motivation among respondents was an issue of concern and generally females felt less motivated than the males.

The perception of health employees on the existing human resource management tools, showed that most females, 41% perceived career development as a major tool, followed by 18% who perceived continuing in education and 12% who viewed staff appraisal as a management tool,. Among the males, 42% perceived career development followed by staff appraisal with 22% and continuing in education, 20% as management tools.

The study revealed that there were various reasons which made the hospital employees dislike their current jobs. Majority of the females, 26% did not like the risks of getting infected that they encountered in the workplace (safety). In addition, 23% disliked harassment by the employers or other male staff. On the other hand, majority of the male, 28% cited lack of appreciation at workplace, as well as 18% who disliked lack of equipment and staff. Therefore, dislike of work motivation elements varied substantially across gender divide.

There existed some efforts of motivating employees among the health human resource; the majority of the respondents, females, 36% and males, 24% stated the opinion that the efforts aimed at motivating the employees were encouraging, females, 21% and males, 32% were of the opinion that education as a motivation

tool should be constant. However, only a minority, 1% of both genders admitted that the motivating efforts required positive change in order to succeed.

5.2.4 Comparison between female and male motivation and demotivational factors

The study revealed that majority of the females, 27% viewed career development as the most appropriate motivator, followed by 20%, who were of the opinion that increase in payment was the most appropriate motivator. On the side of the males, frequent meetings were seen as the most appropriate motivator, 34%, followed by increase in payment, 22%. However, none of the females was of the opinion that reward and recognition was the most appropriate motivator. In addition, none of the males was of the opinion that improved work conditions were the most appropriate motivator. On the aspect of demotivators, majority of the females, 32% were of the opinion that poor pay and lack of risk allowance was the worst demotivators, followed by lack of equipment and staff, 16%. Meanwhile, amongst the males, poor pay and lack of risk allowance, 22% was the worst demotivators. Poor communication and long working hours, each constituting 20%, showed the opinion of the males on the worst demotivators. Delay of salaries and poor supervision and harassment were seen as the least bad demotivators for both the females and males; in which case no female admitted that delay of salaries was demotivating.

The study found out that majority of the females, 41% and males, 42% were motivated through career development at work place. Still females, 21% and males, 20% stated that continuing in education was the form of motivation at the work place.

5.2.5 Employers and Incharges Respondents Socio Demographic Information

The study revealed that most of the respondents, 29% were medical superintendents, and 14% each constituted the accountants, district clinical officers and Human resource managers. On the quality of services provided, the study found

out that majority of the respondents, 46% considered the services as average, 20% as being good 18% as up to date, while 16% as above average.

All the respondents admitted that motivation of health workers influenced quality of services. Study findings revealed that most of the respondents, 43% were averagely motivated, 28% lowly motivated, and 29% termed their motivation as being good. It was further noted that most of the respondents, 32% were motivated by better salaries and allowances, 25% by good working conditions, 15% by supportive supervision and 14%, each by housing and by regular training. Consequently, 28% were de-motivated by low salaries, followed by poor working conditions and staff shortage, 16%. Meanwhile, 14% of the respondents were de-motivated by heavy taxation burden. A proportion of 8% and 7% were de-motivated by lack of supplies and lack of promotion respectively.

The study disclosed that majority of the respondents; 86% stated the organization had measures of motivating health workers. There were various human resource tools measures applied to motivate the workers; the main tool being, staff appraisal 86%, and followed by supervision, 71% and also working conditions improvement 57%. Surprisingly, none of the employees regarded car loan as a motivation tool, while 86 percent disagreed on low cost housing schemes as a motivation tool in their workplace. In addition, 71 percent did not consider mortgages as a motivational tool applied at the institution.

The study revealed that the highest proportion, 57% did not find any difference on the response among the different sexes. Meanwhile 43 percent of the respondents agreed that female employees responded better to human resource management tools than male employees, who did not respond at all. Majority of the respondents, 86 percent, stated that there were factors that motivated female workers more than male workers, such as; separation from families 57%, transfers 22%, and uniform allowance 21%. Similarly, 43% stated that there were factors that de-motivated female workers more than male workers, although 28% opposed. Fifty six percent

described family as a de-motivating factor, followed by staff shortage, 24% and night duty, 20%.

Majority of the respondents, 43% agreed that the organization took into consideration both the male and female motivators though, 30% disagreed. Moreover, 86 percent agreed that it was important, for the organization to consider what motivated females and male health workers.

5.2.6 Focus group discussions

The focus group discussions on males revealed that men defined Motivation as something intrinsic- the energy that pushes somebody forward to perform something. Most of the males considered the work itself as motivational. This included a good and suitable working environmental, cooperative staff and the availability of resources and equipment. A better salary was also seen as a motivator amongst the males as well as the ability to progress, good supervision and frequent promotions. Meanwhile, various factors were also found as de-motivating amongst the males, such as; poor pay and overworking, stagnated promotion and lack of supervision. Nevertheless a few males considered lack of recognition also as a de-motivator.

The males stated that men were more motivated due various reasons. Further, the males stated that women needed more working flexible time so as to be able to attend to family obligations and also due to being a weaker sex. Men were generally motivated because the society expects them to be harder workers so as to provide for their families. Therefore flexible working hours to women and room for maternity leaves were good motivators. In addition, having specialized facilities so that women could bring their children to work was seen to be a good women motivation. Further, more team work where men could be sensitized to understand the special needs of women better motivated women. Thus the need to employ more people to ease work load and availing family planning to the women to enable them plan children.

The males stated that they were able to make decisions faster without consulting anyone and therefore can take loans, promotions, transfers and also it was common for women that they had to consult before up taking any incentives. Educating the girl child so that she was more empowered to make decisions and introducing more incentives for women was a major suggestion. In addition, breakdown of incentives into those targeting women is vital. *"In Africa for a woman to grow up from a child to an adult with a career is not a joke"* said one doctor in Vihiga".

The focus group discussions on females revealed that women defined motivation as something extrinsic- the energy; a gesture put in place to boost the morale of the health worker. Most of the females considered continuous education as motivational, upgrade in the job scale, seminars and frequent promotions. Meanwhile, various factors were also found as de-motivating amongst the females, such as; shortage of staff and lack of equipment, stagnated promotion and too much workload.

The females stated that women were less motivated due to family obligations which the supervisors did not take into consideration. The females stated that social beliefs played a role on how males, even the juniors were addressed as "Doctor" by patients and relatives while women were addressed as "Sister" or "nurse". This boosted the morale of men as they feel appreciated by the society and dampened the morale of women. Lack of bathrooms and sanitary facilities also de-motivated women.

The females disagreed that men took human resource tools better than women. This was as a result of men easily accepting transfer even to the most remote part of the country as the obligations of taking care of the family were with their wives. In addition, women could not just accept a transfer even with a promotion as they would have to think about moving the family and whether the family would have the required amenities such as school. Promotions were also advantageous on men since to pursue the promotion the headquarters took lot of time and men could afford to go and camp in Nairobi with relatives or in cheap hotels to pursue their

promotions but this is very difficult for women due to insecurity in those cheap hotels, or they cannot leave their families for long. Therefore men attained promotion faster than the women.

The females suggested that there should be a consideration of the factors that motivate women and those that motivate men independently. In addition, the existing tools were mainly made for men and it was assumed that women would fit in; therefore the special factors that affected women should also be given recognition.

5.3 Conclusions

The respondents occasionally changed their job grade to a higher grade as facilitated by two main reasons; training or natural progression. More females relied on natural progression as compared to their male counterparts who went into training to enhance career progression. Despite the fact that training was not common, almost an equal proportion of the both female and males had plans of advancing their careers through training. A few respondents were contented with their current career status and on the other hand, there were some who had no plans of career advancement; some of the respondents had tried it before but failed and further saw no prospects of career advancement.

5.3.2 Training

The study concludes that most respondents had undertaken some training in the last one year, although the duration of training was found to be short, lasting for even just a few weeks. Meanwhile the cost of training was majorly met by the donors/ NGO and employer as well as other partners. However the males were four times more likely to sponsor themselves for training than the females. People were likely to implement what they learnt in the training if they paid for it as compared to when

another entity paid, (Lawson and Luks, 2004). It also helps to determine the level of commitments and affordability to training by the recipients.

5.2.3 Perception Motivational tools

Females were generally less motivated than their male counterparts and this compares well with the MoH Health Worker Satisfaction Survey (2007) that showed that the male employees were more satisfied with their jobs than the females.

There were several factors that motivated both the female and male health employees, of which the study found that both male and female were motivated by different factors. The females were mainly motivated by their passion for work, conducive environment and the rewards. On the other hand, the male key motivation was appreciation by the employer and professional ethics. The study concludes that both the males and females shared similar demotivators attributable to the workplace. These include; poor pay, lack of equipments and drugs, lack of incentives. However among the factors that the females don't like about their jobs were the risks of getting infected at workplace (safety), and harassment by the employers or other male staff. On the other hand, the males, cited lack of appreciation at workplace, lack of equipment and staff.

The perception of health employees on the existing human resource management tools showed that the females perceived career development as a most appropriate tool, as well as continuing in education and staff appraisal as a management tool. Among the males, career development, staff appraisal and continuing in education were the most appropriate management tools.

There existed some efforts of motivating employees among the health human resource; of which the study concludes that the efforts aimed at motivating the employees were encouraging, and that education as a motivation tool should be constant. However, some of the respondents felt that the efforts were not adequate, thus required positive change in order to succeed.

5.3.4 Comparison between female and male motivation and demotivational factors

The study concludes that the female staff mostly valued serving patients passionately, as well as patients' recovery and work satisfaction, while the males mostly valued Patients' recovery and satisfaction at work place. Job security was least valued by both genders

5.3.5 Key informants' Socio demographic information

The study concludes that most of the employed respondents (key informants) were medical superintendents, and accountants, as well as district clinical officers and Human resource managers. On the quality of services provided, the key informants noted that the services were mainly average, or rather good and a small portion above average. Moreover, motivation of health workers influenced quality of services; of which most of the respondents were averagely motivated. These conclusions were similar to those made by Standing (2000) who asserted that poorly motivated and remunerated health workers are rarely likely to provide quality health services.

According to the key informants, most health staff was motivated by better salaries and allowances, good working conditions, supportive supervision housing and regular training. Consequently, de-motivators included; low salaries, poor working conditions and staff shortage, heavy taxation burden, lack of supplies and lack of promotion.

The study concludes that most health institutions had measures of motivating health workers. This was through staff appraisal and improving working conditions. Surprisingly, none of the employers had put in place car loan, low cost housing schemes, and mortgages as a motivational tool to the health workers.

There were factors that demotivated female workers more than male workers, such as; separation from families, transfers and lack of uniform allowance. Similarly, family obligations, staff shortage and night duty were also quite demotivating for female health workers. The study therefore concludes that it is important for the organization to consider what motivates females and male health workers.

5.3.6 Focus group discussions

Most of the males considered the work itself as motivational. This included a good and suitable working environmental, cooperative staff and the availability of resources and equipment, better salary, ability to progress, good supervision and frequent promotions. The de-motivators amongst the males were; poor pay and overworking, stagnated promotion and lack of supervision and lack of recognition.

The study concludes that the males proposes that women need more working flexible time; for instance room for maternity leaves, provision of facilities that enables women to bring their children to work; so as to be able to attend to family obligations and also due to being a weaker sex. Further, more team work where men could be sensitized to understand the special needs of women better motivated women. Thus the need to employ more people to ease work load and availing family planning to the women to enable them plan children.

The study concludes that males were able to take up the human resource management tools than the females since they could make decisions faster without consulting anyone unlike the women, therefore could take loans, promotions, transfers.

Women defined motivation as extrinsic- the energy; a gesture put in place to boost the morale of the health worker. Most of the females considered continuous education as motivational, upgrade in the job scale, seminars and frequent promotions. De-motivating factors amongst the females, were; shortage of staff and lack of equipment, stagnated promotion and too much workload. The study

concludes that the females were less motivated due to family obligations, social beliefs, lack of bathrooms and sanitary facilities. This conclusion is similar to those made by Brown et al (2004) who postulates that women tend to request better transportation, access to bathrooms, and respect from superiors.

The females agreed that men took human resource tools better than women. This was due to the fact that obligations of taking care of the family are with the wives, therefore men can accept transfers, training easily without thinking about the family. In addition, women could not just accept a transfer even with a promotion as they would have to think about moving the family and whether the family would have the required amenities such as school. Therefore men attained promotion faster than the women by default. Most female physicians made career changes for the benefit of their children and family (Warde et al. 1996).

5.4. Recommendations

5.5.1: Recommendations for Improvement

The following recommendations were made based on findings and conclusions of the study.

5.4.1.1 Training

Affordable flexible training should be availed to the health workers to enable more females access it as means of advancing their careers. Knowledge in health care is constantly changing and therefore the health sector should ensure that health workers are constantly trained to ensure provision of quality health services.

5.4.1.2 Perception Motivational tools

The hospital should improvise more and new strategies of motivation since the employees were moderately motivated. Safety measures that reduce the risks of getting infected at workplace and elimination of harassment by the employers or other male staff should be enhanced to motivate the female staff. Moreover,

appreciation at workplace, and provision of equipment should be beefed up, to motivate the staff, especially the males. Further, there is need to employ strategies such as; reward and recognition was and improved work conditions to enhance service delivery. These will eliminate demotivators that thwart the performance of the health staff.

Improvement of bathrooms and sanitary facilities will help reduce man hours being lost in search of these amenities, increase a sense of dignity among female employees and decrease absenteeism.

5. 4.1.3 Comparison between female and male motivation and demotivational factors

Both the male and female staff mostly valued serving patients passionately, patients' recovery and work satisfaction. This should be coupled with adequate compensation for the health workers, with improved safety measures, conducive environment, and adequate equipment. The health sector need to check on the job security which was least valued by the employees as the sector risk losing competent staff to other greener pastures

5.3.1.4 Employers and Incharges

The employers and Incharges to large extent were familiar with the motivation status of their employees though the measures they had put in place to motivate employees had not adequately met the motivational needs of the employees. In addition, the existing tools were mainly made for male employees and it was assumed that women would fit in and therefore there is need to take into consideration the factors that motivate or demotivated each of the genders.

5.4.1.5 Focus group discussions

Generally, males considered work itself to be motivational; however, the health sector should improve their payment schemes and working schedule, prompt promotion and effective supervision and timely recognition. The women need more

working flexible time that provides for maternity leaves, facilities and humble time for their children, and attending to family obligations. Further, more team work should be adopted as it eases the work load on the females. Educating the girl child so that she becomes more empowered to make decisions and introducing more incentives for women is very essential.

Since only the males were able to utilize the existing human resources tools for instance taking loans, promotions, transfers, the health sector need to tailor the tools to suit the females as well considering her gender roles and position in the society. Empowerment of the female health workers should be enhanced to improve their decision making and hence their motivation resulting in improved quality of health services.

5.4.2 Recommendations for further research

This study only focused on two districts which are not representative of the whole country; a country wide study should be done to determine the factors that motivate the female and male employees. Disaggregated data for public, faith based private and NGO facilities should be obtained to determine whether there are any major differences.

Operations research should be done to test different motivational models and how the different genders respond to them. Further research should be done to assess how the motivational factors influence the quality of health services in the country.

ACTIVITY PLAN AND BUDGET

This section details the activity plan and the budget

4.1 Activity Plan

Activity 2009	April		May				June				July	
	3 rd Wk	4 th Wk	1 st Wk	2 nd Wk	3 rd Wk	4 th Wk	1 st Wk	2 nd Wk	3 rd Wk	4 th Wk	1 st Wk	
Inform all sampled facilities												
Recruit/train data collectors												
Pre-testing Questionnaires												
Hold Key informants interviews at the central level												
Data collection Bondo and Vihiga												
Data collection Vihiga												
Data analysis												
Report writing												
Submit Report												

4.2 Budget

Task 1: Prepare for data collection			
Activities	Time framework	Resources	Budget in Kshs
Activity 1: Flight to Kisumu	4 th week April 2009	1 Return air ticket	10 000
Activity 2: Recruit data collectors	4 th week April	Stationery- Kshs 100	100
Activity 3: Train Data collectors	4 th week April	2 data collectors Per diems- 1000x 2 Stationery-200	2 000 200
Activity 4 Pre-test the questionnaires and interview guides	4 th week April	Transport- Taxi-2000, perdiems, 1000 x2 stationery, 200	4 000 2 000 200
Activity 5: Print out all the data collection tools/ get tape recorder/ pens/books	4 th week April	Photocopies-10 000 Tape recorder batteries 200x4 Stationery-1000	10 000 800 500
Task 2: Data Collections-Bondo/ Vihiga			
Activity 1: Hold key informants Interviews	4 th week April	Principal researcher per diems- 3500 x 2 days	7 000
Activity 2: Data collection in health facilities	1 st -3 rd week May	Per diems 2 500x 4 data collectors x 5 days Transport 400x4 data collectors x5 days	50 000 8 000
Activity 3: Supervision of data collectors.	1 st -3 rd week May	Principal researcher per diems – 3500x 5 days Vehicle hire 3000 x5 days	17 500 15 000
Activity 4: Organise and inform the participants of FGDs	1 st -3 rd week May	Airtime -3000	3 000
Activity 5: Hold Focus groups discussions	1 st -3 rd week May	Refreshments- 1000x4	4 000
Task 3: Data Analysis			
Activity 1: Key in the coded data in SPSS	2nd Week June	Data entry -2 clerks 1500x3days	9 000
Activity 2: Analyse the data	2 nd Week June	Biostastician X 1day-5000	5 000
Totals			148 300 Kshs

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Annexes

Annex 1. Self Introduction and Consent

Hello. My name is Salome Ngata/..... We are conducting study on behalf of Dr. Salome Ngata in partial fulfillment for a master thesis at the University of Nairobi. The purpose of this study is to help improve the motivational incentives for Health workers.

Objectives

The objective of this study is to determine the factors that motivate female employees and compare them with those that motivate male employees. We will carry out the study on health workers in Bondo and Vihiga districts and also with facility incharges, district incharges and at the headquarters.

Benefits and Risks

The benefits of this study are to enable the policy makers tailor the motivational factors to suit both female and male employees. The study will not present any risks to you and any information that you share will be kept completely confidential. You may also choose to stop participating in the study at any time. Do you have questions for me? Please allow me to give you the questionnaire now.

Interviewers'/data collector' signature

Date and location

.....

.....

.....

Annex 2: Key Informants Interview Guide

- What is your position in the organization?
- What is your opinion on the quality of services provided by our/your health facilities?
- Do you think the motivation of the health workers influence the quality of services provided?
- How would you gauge the motivation of the health workers in this facility/ organization?
- What do you think motivates/would motivate the health workers?
- What do you think demotivates/ would demotivate the health workers?
- Has your facility/organization put in measures to motivate health workers?
- Are there human resources management tools applied to motivate the workers, Tick if present

Continuing education		Performance management	
Career development		Supervision	
Staff appraisal		Transfer	
Working conditions improvement		Schemes aimed at provision of land/houses at a subsidized cost	
Mortgages		Car loan	
Others, list:			

- How has the female and male health workers responded to the measures and HRM tools put in place?
- In your opinion is the motivation of the female health workers different from the male health workers?
- Are there factors you can say motivate the female more than male health workers and vice versa? If yes which?

- Are there factors you can say demotivate the female more than male health workers and vice versa? If yes which?
- In putting the measures to motivate health workers does your facility/organization take into consideration what motivates female and male health workers and try to accommodate both?
- Do you think it is important to consider what motivates and demotivates female health workers and male health workers?

Thank you very much

Annex 3: Self-Administered Questionnaire

1. Age:

- 1. 20-29yrs
- 2. 30-39yrs
- 3. 40-49yrs
- 4. 50-59yrs

2. Gender

- 1. Female
- 2. Male

3. Designation

- 1. Medical Doctor
- 2. Nursing Officer -Cadre (specify).....
- 3. Clinical Officer (specify).....
- 4. Other Specify.....

4. Marital status

- 1. Single
- 2. Married
- 3. Widowed
- 4. Divorced
- 5. Other (specify).....

5. Number of Children

- 1. None
- 2. 1-2
- 3. 3-4

4. Over 4

6. Age of children

1. Non applicable
2. At least one below 5yrs.
3. At least one between 6-10 yrs.
4. At least one between 11-20yrs
5. All above 20yrs.

7. How long ago did you begin your career?

1. Less than 2yrs
2. 2yrs-5yrs
3. Over 5yrs-10yrs
4. Over 10yrs-20yrs
5. Over 20yrs.

8. How long have you worked in this facility?

1. Less than 2yrs
2. 2yrs-5yrs
3. Over 6yrs-10yrs
4. Over 11yrs-20yrs
5. Over 20yrs.

9. How many times have you changed job grade to higher grade? (E.g. From Nursing Officer III to II or MO III to II etc)

1. None
2. Once
3. Twice
4. Thrice
5. Over 3 times.

10. If yes in No.9, when you changed your job grade did it come as a result of training or it was a natural progression to the next level.

- 1. As a result of training
- 2. Natural progression
- 3. Other: Explain.....

10. Do you have any plans of advancing your career in the next 2yrs?

- 1. Yes
- 2. No
- 3. Other – Explain.....

12. If yes, How? *(If more than one choice rate them in order of priority in the box provided).*

- 1. By going into training.
- 2. By working hard to ensure I get promoted.
- 3. By looking for another job.
- 4. By migrating.
- 5. Any other means. – Explain.....

13. If No, why?

- 1. I don't think they are any prospects.
- 2. I'm satisfied where I am.
- 3. I have reached the highest, can't go any further.
- 4. I have tried before and it didn't work.
- 5. I don't think I shall manage as I have other commitments. Explain.....

.....

.....

- 6. Other – Explain.....

15. Have you undergone any training (sponsored or self sponsored) in the last one year?

1. Yes
2. No
3. Had begun but discontinued.
4. Not sure

16. How long is/was it?

1. Less than 1 week
2. 1-2 weeks
3. Over 2 weeks to 6 months
4. Over 6 months to 1 year
5. Over 1 year

17. Who is sponsoring you for the training?

1. Employer
2. Self sponsored
3. Donor/ NGO
4. Family Member sponsored, if yes who
5. Other- Explain.....

18. What factors make you willing to do your job everyday?.....

.....

19. Are there some factors that make you feel unwilling to work?

If so, what are those factors?

.....

20. What do you like most about your job?.....

.....

21. What do you NOT like about your job?.....

.....
.....

22. How would you define the word motivation in one sentence?

.....
.....

23. How would you rate your level of motivation to work?

- 1. Highly motivated
- 2. Very motivated
- 3. Moderately motivated
- 4. Lowly motivated
- 5. Very lowly motivated

24. Are there efforts to motivate employees in your work place?

(e.g. continuing education, career development, performance management, supervision, and staff appraisal, transfers, working conditions, loans etc)

Yes, No

If so which?.....

.....
.....

25. What is your opinion of these efforts?.....

.....
.....

26. Have these efforts been able to improve your motivation to work?

.....
.....

27. What do you think would be the most appropriate motivators?.....

.....
.....

28. What demotivators do you think should be addressed?

.....
.....

29. What do you value most about your job?.....

.....
.....

THANK YOU VERY MUCH

Annex 4: Focus Group Discussions Guide

- How would you define the word 'motivation'?
- What factors would you consider motivating in your work?
- What factors would you consider demotivating in your work?
- Do you think what you consider motivating is different from female (male) employees, if so how?
- Do you think what you consider demotivating is different from female (male) employees, if so how?
- How can the factors that demotivate female (male) employees be addressed? And for the other gender?
- How can the factors that motivate female (male) employees be improved? And for the other gender?
- Do you think males and females are able to utilize/access factors like training, promotion the same way?
- If there are differences what do you think causes the differences?

Thank you very much