

**Exploring Factors Affecting Health Extension Workers Motivation in Selected Urban,
Rural and Pastoralist Districts of Ethiopia**

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**A research report submitted to the School of Public Health, University of the
Witwatersrand in partial fulfilment of the requirements of a Master of Public Health.**

Date of Submission: September 20, 2013

Declaration

I, the undersigned Sisay Abebe Shega student number 511039, declare under oath that this master thesis is the product of my own independent work. All content and ideas drawn directly or indirectly from external sources are indicated as such. The thesis has not been submitted to any other examining body and has not been published.

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Date: September 20, 2013

Signature: _____

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Acknowledgements

Foremost, I would like to express my sincere gratitude to my supervisors Sara Nieuwoudt and Bunmi Makinwa for the continuous support of my MPH study and research, for your patience, motivation, enthusiasm, and immense knowledge. Your guidance helped me in all the time of research and writing of this thesis. I could not have imagined having better supervisors and mentors for my MPH study.

Besides my supervisors, I would like to thank Dr. Nicola Christofides and her team for their unreserved support all the way through my study at Wits. I will never forget your encouragement, dedication and sincere support to all MPH cohorts.

My sincere thanks also goes to my brother Bete Lewi for your unconditional love and support during my study.

I thank TafachBekele and families: Terefe Bekele, Addisalem Bekele, Filiklik Bekele, Mintesnot Desta as well as Fikadu and his family for the emotional support and all the fun that we have had in the past three years.

Last but not the least, I would like to thank Ministry of Health and my family: my mother, Zenebech Sahile, who is a single constant in my all up and downs. My daughter Abyssinia Sisay and my son Noah Sisay, my brothers Yihun and Daniel also deserve my appreciation for their understanding throughout the course of my study.

Acronyms

CBN	Community Based Nutrition
COC	Center of Competency
CSA	Central Statistical Agency
EDHS	Ethiopian Demography and Health Survey
HEP	Health Extension Program
FMOH	Federal Ministry of Health
HEWs	Health Extension Workers
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HREC	Human Research Ethics Committee
ICCM	Integrated Child Care Management
KIs	Key Informants
LCHWs	Lay Community Health Workers
MDGs	Millennium Development Goals
MAX QDA	Maximum Qualitative Data Analysis
NGOs	Non-Governmental Organizations
PHC	Primary Health Care
PHCU	Primary Health Care Units
RHBs	Regional Health Bureaus
TB	Tuberculosis
TV	Television
TVET	Technical Vocational Education and Training

USD United States Dollar

WHO World Health Organization

Abstract

Introduction: Ethiopia launched a nationwide Health Extension Program (HEP) in 2003 with a view to addressing major health problems of the country by mainly focusing on essential promotion, preventive and selected high impact curative services that target households. The country's health care service depends on close to 39,000 Health Extension Workers (HEWs). Deployment of HEWs alone was reported to be was not enough to achieve better health outcome. Motivating such a workforce is an important element that deserves attention of all stakeholders. This study explored factors affecting HEWs motivation in rural, urban and pastoralist districts of Ethiopia in 2012.

Methods: In this qualitative study, 19 people were interviewed: 12 HEWs and seven key informants from rural, urban and pastoralist districts of Ethiopia. Data on factors motivating and de-motivating HEWs as well as government HEP coordinators' perceived support to HEWs motivation were gathered and analyzed.

Results: Supportive supervision, continuing education, career structure and salary have been identified by rural HEWs as major motivating factors while they found competing interests such as marriage and family issues, absence of housing, and unrealistic performance expectation as factors inhibiting their motivation. The major factors found to be de-motivating for pastoralist HEWs were absence of transportation, poor supervision, insufficient training and lack of capacity among others. Absence of career development and limited recognition were also mentioned as de-motivating for urban HEWs.

Conclusion: HEWs play a pivotal role in Ethiopia's HEP. As such, their motivations require special consideration to support them to continue doing their health care activities in a productive way.

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1-Introduction

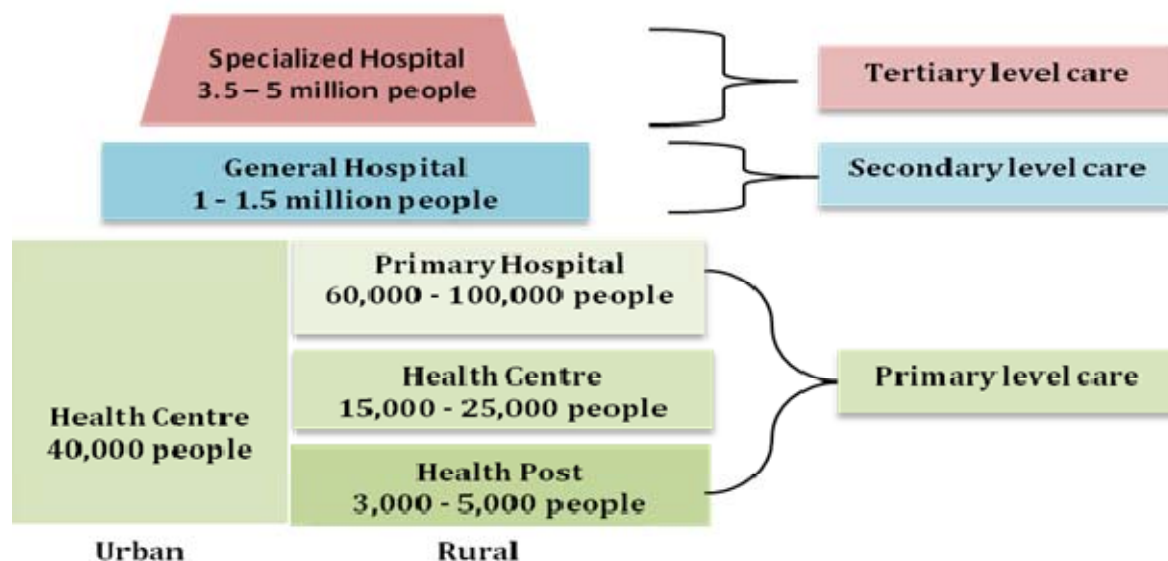
1.1-Background

Ethiopia is an Eastern African country with a federal government with nine regional states and two city administrations. The total population is more than 84 million, of which 83 percent live in rural areas.¹ The country is divided into 624 districts and more than 15,000 Kebeles.¹

According to the Federal Ministry of Health (FMOH), 60 to 80 percent of the country's health problems are caused by communicable diseases such as malaria, diarrhoea, pneumonia, TB and HIV/AIDS.² Although these diseases are easily preventable, maternal, infant and under five mortality in the country, is one of the highest in the world. Every year 676 out of 100,000 mothers die due to pregnancy or child birth complications.³ Infant and under five mortalities are 59 and 88 per 1,000 live births respectively.⁴

Research indicates that there is a direct relationship between rising death rates and the weakening of health systems in sub Saharan African countries.⁵ The Ethiopian health system, which is organized into a three tier structure, includes specialized hospitals, general hospitals and Primary Health Care Units (PHCUs). The PHCUs are comprised of health posts, health centres and primary hospitals, and have been a top priority for the government of Ethiopia to help provide health care services to the disadvantaged many in rural, pastoralists and urban settings of the country.⁶ The health post is expected to serve 3,000-5000 people while a health center is envisaged to provide health care services to 15,000-25,000 people and a primary hospital is meant to cater to between 60,000-100,000 people. General hospitals are intended to support up to 1.5 million people while specialized hospitals are expected to serve up to 5 million people.⁶

The following diagram clearly shows how the health system is organized and the number of people expected to be served under the various health facilities.



Source: FMOH

As in many developing countries, the ratio of health workers to population is low; Ethiopia is one of the 57 countries with a critical shortage of health workers. There is only one doctor for 42,706 citizens and many of them are working in urban areas.^{7, 8} Many of the past efforts made by Ethiopian governments to serve the marginalized poor through Primary Health Care (PHC) services were not a success.⁹ Civil war, natural disaster and HIV/AIDS have also affected the proper delivery of PHC in many sub-Saharan African countries, including Ethiopia.^{9, 10}

Drawing on the 1978 Alma Ata Declaration of Primary Health Care (PHC), the government of Ethiopia launched a nationwide Health Extension Program (HEP) in 2003 to address major health problems of the country by mainly focusing on essential promotion, preventive and selected high impact curative services that target households.¹¹ Accordingly, the country trained and deployed 33,755 Health Extension Workers (HEWs) in all rural areas and more than 5,726 Health Extension Workers in 90 percent of urban settings.¹²

Most HEWs are females aged 18 years old and above, the majority with a minimum of grade 10 education. These women are selected by local committees comprised of community members

and representatives from local government offices. Following their selection, the majority of the HEWs attend a one year course at Technical Vocational and Education Training (TVET) institutes with a focus on 16 packages organized under four major streams such as Disease control, Family Health, Hygiene and Environmental Sanitation as well as Health Education and Communication. The HEWs operate from health posts built in each Kebele (smallest administrative unit) to serve a population of approximately 5,000 people under the supervision of Woreda health office and Kebele administration with technical and referral support from the nearest health center.¹¹

The HEP fully integrated into the health system delivers 16 defined packages of preventive, promotive and selective curative services. The 16 areas of intervention are indicated below.¹³

Disease Prevention and Control • HIV/AIDS and other sexually transmitted infections prevention and control • Tuberculosis prevention and control • Malaria prevention and control • First-aid emergency measures • Family health	Hygiene and Environmental Sanitation • Excreta disposal • Solid and liquid waste disposal • Water supply and safety measures • Food hygiene and safety measures • Healthy home environment • Personal hygiene • Rodent control
Maternal and Child Health • Family planning • Immunization • Nutrition • Adolescent reproductive health	Health Education and Communication

Source: FMOH 2009

The huge number of health workforce deployed all over the country from Kebele to the federal level requires substantial funding to satisfy the health care need of the population.

The overall national health expenditure accounted in 2008 showed that Ethiopia spent some 1.2 billion USD or 1609 USD per capita per annum.¹⁴ The overall financing of the health sector mainly originated from development partners (40%), households (37%) and the government itself (21 %) ¹⁴. All other sources, such as the private sector, contributed the remaining two percent of the national health expenditure.¹⁴

According to a study conducted by health system 20/20 , the health care service in Ethiopia is underfinanced in actual terms and by any standards, even in the sub-Saharan African countries.¹⁵

With a view to address the financial gaps, the government of Ethiopia has been working on health care financing since 1998 and put in place strategies including revenue retention and use at the facility level, systematizing a fee waiver system for the poor, standardizing exemption services, setting and revising user fees, outsourcing non clinical services, introducing private wing in public hospitals and promoting health facility autonomy through the introduction of a governance system.¹⁵

So far, in order to provide quality and sustainable health care services to the majority of people in Ethiopia, the government has introduced a community based and social health insurance scheme for both informal and formal sectors.¹⁶

According to FMOH's 2012 annual report, as a result of efforts in dealing with the financial gaps, so far health care financing reform began in 2,241 health facilities, 90 hospitals, and 2151 health centers in all regions except Afar and Somalia regions.¹⁷

In terms of health infrastructure the country has managed to construct 15,668 health posts, 2,999 health centers and 125 hospitals and a lot more are under construction.¹⁷

Drug supply is also an important area of health delivery system that requires adequate attention for its procurement and distribution. Eighty seven percent of the pharmaceuticals in the country are imported through commercial purchase and donations.⁶

The country has also re-designed its Health Management Information System (HMIS) to acquire important data for proper planning and decision making. HMIS is now being implemented in 116 hospitals and in 2402 health centers.¹³ A community health information system that was meant to support the HEP is also being implemented at health posts and so far 3.9 million households have family folders that they can keep major health records.¹³

The governance structure of the health sector presents the responsibility of policy and standard development to the FMOH, while the implementation of policies standards and protocols as well as the responsibilities of service delivery is mandated to regional health bureaus(RHBs).RHBs are also responsible for owning, financing and supervising the service delivery of regional hospitals whereas the Woredas Health Offices manage and coordinate the operation of the PHCUs, i.e. health centers and health posts.¹⁴

The health care financing system, the drug supply, the health management information system, the governance structures as well as the overall health care service delivery have their own impacts in the ever increasing health workforce in Ethiopia.¹⁴

1.2-Justification for the Study

Although much emphasis has been given to the deployment of HEWs to ensure PHC in Ethiopia, an intensive study to explore the particular experiences of HEWs, both personal and professional, and how this affects their motivation has not been conducted. Only a few studies have been undertaken on motivation of HEWs which are limited in scope and focus mainly on the quality of training, access to information, working conditions and assess the implementation of the Health Extension Program (HEP)¹⁸⁻²²Most of these studies were published in 2007/08 and the HEP has now progressed. The research will provide valuable insight in to how Ethiopian government can use both financial and non-financial incentives to improve health workers motivation. This exploratory research is also unique in it provides scope on a broader range of motivational factors at individual, interpersonal, organizational and societal levels with a particular focus on urban, rural and pastoralist settings to explore the various challenges in diversified areas of the country. This study has the potential to contribute to policy makers' decisions particularly in relation to the retention and performance of HEWs as well as the overall success of the health extension program. Furthermore, the themes emerging qualitatively from this study can be used to develop or adapt existing quantitative tools, typically used to measure healthcare worker motivation, to develop a more nuanced and representative picture of HEW motivation in Ethiopia.

1.3-Aim/Objectives

Aim: The aim of this study was to explore factors affecting HEW motivation in rural, urban and pastoralist districts of Ethiopia in 2012.

Specific objectives:

To describe how HEWs experience their work under Ethiopia's Health Extension Program in selected urban, rural and pastoralist districts.

To explore factors that HEWs perceive to support or inhibit their ability to do their job in selected, urban, rural and pastoralist districts of Ethiopia.

To explore how federal, regional, and district governments' health extension program coordinators believe they support HEWs.

To compare the factors motivating HEWs to do their jobs with government perceptions of HEW support priorities.

1.4-Statement of the Problem

Providing training and deploying this cadre of HEWs both in rural and urban villages is a crucial step by the government of Ethiopia for meeting the health Millennium Development Goals (MDGs).^{5, 23} The deployment of frontline health workers by low income countries is commended by WHO reports.²⁴ However, deployment alone is not enough to achieve a desired health outcome in the community. Retention and ensuring performance of HEWs is important to provide quality health services.²⁵ Motivation of healthcare workers is believed to be a major concern as it is a key determinant for improving health workers' performance.²⁴

1.5-Literature Review

The shortage of skilled health workers continues to be major human resource crisis, particularly for developing countries.²⁶ Countries are taking multiple measures to address the crisis, mainly through task shifting and deployment of community workers in underserved areas.²⁶

Task shifting is a subsequent delegation of tasks to the lowest categories that can perform them successfully.²⁷ In areas where there are critical shortage of motivated and skilled health professionals, it is evident that deployment of community health workers in primary health care can add an important contribution to improving the health of the population.²⁶ In the past 50 years, China had been using the concept of deploying community health workers to serve the health needs of its community through its barefoot doctors.²⁸ Similar initiatives were utilized by Thailand in the early 1950s under the name of village health volunteers and communicators.²⁸

The term community health work is used under various names such as lay community health workers, village volunteers, and barefoot doctors. However, it is very difficult to generalize the profile of CHWs. Rather it is important to focus on common broad trends that CHWs share. The definition of CHWs must respond to local, societal and cultural norms and customs to ensure community acceptance and ownership.²⁸

According to the WHO, CHWs are defined as 17 “members of communities where they work, should be selected by communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily apart from its organization and have shorter training than professional workers.”²⁹

A review conducted on 82 interventions on Lay Community Health Workers (LCHW) revealed that LCHWs provide promising benefits in promoting immunization uptake and breastfeeding, improving TB treatment outcomes and reducing child mortality when compared to usual care.³⁰ A recent Lancet report also suggested the need for training and deployment of one million CHWs in sub Saharan African countries for the health goals of MDGs to be achieved.³¹ Though its quality is poor, CHWs brought about positive health outcomes in child health.²⁸

Ethiopia, like Brazil, Pakistan, and India, considers CHWs as cornerstones of the scaling up of community health care delivery.³¹ Sharing the experiences of CHW initiatives and learning from best practices of other countries, such as India, and to face the current human resource challenges in the health sector, the government of Ethiopia has initiated the HEP program with strong will and political commitment.²⁷

In Ethiopia, HEWs are the key driver of the HEP and their recruitment is normally based on their willingness to stay in the community, their knowledge of the local language, graduation from 10th grade and their residence in the village, among others.²⁶ Their selection is done through a committee comprised of members nominated by the community and representative from local administration and other sectoral offices, such as education and health. Before their deployment, a year-long training is provided to all the selected HEWs at Technical Vocational and Educational Centers in collaboration with the Ministry of Education. Apart from the normal training packages, training is organized by NGOs and government of Ethiopia on clean and safe delivery and case management of selected child diseases.²⁶

A supervisory team with various technical experts was also established at the federal regional and Woreda level to oversee the activities of HEWs and support them to effectively perform their duties. The team is equipped with program management components including planning, implementation and monitoring and evaluation skills to help them discharge their supervisory role in a supportive way.²⁶

If CHWs are carefully selected, properly trained and continuously and adequately supported they can make important contribution for the effective and efficient delivery of health care.²⁸ However such programs are neither the panacea for weak health systems nor a cheap option to provide health care to disadvantaged communities.²⁸

Despite some challenges in terms of quality of care and in sustaining the HEP with career structure, substantial results have been registered, especially in the areas of disease prevention, family planning, hygiene and environmental sanitation.²⁸ Though not completely attributable to the HEP program, under five mortality has decreased from 123 to 88 per 1000 live births the

contraceptive prevalence rate increased from 15 percent to 29 percent, stunting in under-five children declined from 52 percent to 44 percent the total fertility rate decreased from 5.4 to 4.8 and use of insecticide treated nets increased from 1.3 percent to 42 percent.⁴

To sustain the results achieved and for the health related MDGs to be met, healthcare workers need to be skilled, motivated and supported.⁵ However, in spite of remarkable efforts of deploying health workers in large numbers, governments in developing countries give little thought to follow up supervision and motivation of their workers, which may ultimately lead to the failure of the health system.¹⁹ Low motivation of health workers has a negative impact on the performance of individual health workers, facilities and the health system as a whole.³²

According to a study conducted in 2010 by Lewin and others, health workers need to be motivated to be more productive and provide the kind of health care services in an effective way.³⁰ Health worker motivation is not a function of single determinant, but is the result of a complex interplay of factors that operate between individual workers, their interpersonal relationships as well as organizational and societal factors.³³ Health worker motivation can be influenced at an individual level by various demographic and psychological factors that include age, sex, marital status, origin and education level as well as health knowledge and attitudes.³⁴³⁵For instance, a study conducted in Australia indicated that older female health workers with more education were likely to be less motivated than younger females.³⁶ The motivation of women health workers is also related to marriage or family considerations. In the same study, married women with families were more likely to stay longer in their area of deployment than those who were single with no families.³⁶ In the Pacific and Asian context that health workers recruited from their areas of origin, such as rural places, are most likely to stay in rural settings³⁵ and that motivates them to perform well in their duty stations. In the Ethiopian context, HEWs' insufficient health knowledge has also de-motivated them from properly performing their job.²⁰

Workers motivation can also be affected at the interpersonal level by peer pressure³³ and the lack of recognition and appreciation by colleagues, supervisors and the community at large.³²

³⁷A meta analysis of 20 papers conducted by Willis-Shattuck et al. indicated that workers who

received more recognition had higher motivation than those who reported that they never received recognition³⁸.

There are factors that affect HEWs motivation at organizational level as well. Organizational factors that define the work environment include availability of resources and human resource management practices, among others³³ For instance, financial incentives have been shown to be an important motivating factor for health workers, especially in countries where government salaries and wages are inadequate to meet the basic needs of health workers and their families.³⁵ However, another study by Willis-Shattuck et al. showed that financial incentives alone were not sufficient for the motivation of workers in the health sector. They argued that a range of other non-financial incentives, such as improved living and working conditions, continuing education, career development, supportive supervision and management are needed to attract and retain a workforce, especially in remote areas.³⁸

A study in Ethiopia conducted in 2007 revealed that HEWs were generally content with their work and motivated by adequate salaries, housing and the availability of safe water and toilet facilities.²¹ However, the same study confirmed that only few HEWs wanted to stay in their deployment areas for more than three years and this needed to be further explored²¹ The assignment of HEWs to communities with which they share a common tradition and language, and their appointment into Kebele cabinets as well as their close collaborations with the local administration and community members were reported to be factors that positively affected their performance.²⁵

Several societal factors are also known to affect the motivation of community health workers. Health policy, such as decentralization of health system at district level, can affect motivation positively or negatively depending on the context²⁵ Gender issues that involve perception of community about the acceptability of female health workers are also among societal factors that affect health workers motivation. For instance, in Afar, women are more reluctant to be examined by male health workers.^{33, 38, 39}

While there are many motivating factors that keep health extension workers in their duty areas, the literature has also identified immense challenges that contribute to the dissatisfaction of health workers that can possibly lead them to leave their job or perform at less than their capacity. Factors identified for female HEWs include lack of personal safety, widespread violence and sexual harassment³⁹, poor management in relation to absence of guideline for transfer and promotion of HEWs¹⁸, lack of support and poor supervision^{32, 40} and homesickness of those workers assigned to different health posts other than their area of recruitment.²⁵ Poor infrastructure³², unsatisfied patients^{24, 25}, and lack of training^{20, 32} have also been reported as common de-motivators for health workers in Ethiopia. Harsh climatic conditions, weak referral system and static health facilities are also found to be challenging factors and often result in high turnover of staff, particularly in pastoralists areas.⁴¹ Finally, the low utilization of health facilities in pastoralist areas due to the mobile nature of the community and cultural perceptions, such as religious beliefs and traditional attitudes, are particularly challenging HEWs in Ethiopia²²

2-Study Method

2.1-Study Design

A descriptive cross-sectional study design was used to explore factors affecting HEWs motivation in three, urban, rural and pastoral districts of Ethiopia.

2.2-Study Sites

This study was carried out between 1st January 2012 and 31st May 2012 in three districts of Afar (pastoralist) and Amhara (rural) regional states and Addis Ababa city administration (urban). The selected Woredas were East Este from Amhara, Mille Woreda from Afar regional state, and Yeka sub-city from Addis Ababa city administration. The study is conducted in three different settings with a view to understand motivational factors that affect health workers in rural, urban and pastoralist districts of Ethiopia. In order to obtain a fair representation of views two kebeles, one very far from the main town and another relatively nearer were purposively selected.

With a population of 17.2 million people, Amhara Region is the second most populous region in Ethiopia next to Oromia, with about 88% of the population living in rural areas.¹ East Este is one of the rural districts of Amhara region with a total population of 226,469 people.¹² The Afar population is estimated to be 1.5 million with 90 percent of them adhering to a pastoral lifestyle. Mille is one of the most populous areas in Afar with a total population of 102,410 people.¹ Addis Ababa is the capital city of Ethiopia with a total population of close to 3 million people.¹² Yeka sub city is one of the ten sub cities of Addis Ababa with a population of 376,512 people.¹² All the districts have several Kebeles under them. The Government of Ethiopia assigned two Health Extension Workers for each Kebele¹

2.3-Study Population

The study population was all HEWs in selected regions of Ethiopia where Amharic is used as a working language and all health extension program coordinators working for the Ministry of Health at the federal, and selected regional and Woreda levels.

2.4-Study Sample

Sampling for this study was conducted for both HEWs and key informants, who included health extension program coordinators at the federal, regional and Woreda levels in Ethiopia.

The sampling for HEWs for the study occurred at three levels. First, the researcher purposively selected three regions of Ethiopia namely Afar, Amhara and Addis Ababa, where Amharic is spoken. Secondly, three Woredas (districts) were purposively selected from each region to achieve maximum variability in terms of the types of areas served by HEWs (pastoralist, rural and urban). Finally, having selected the Woredas, the researcher purposively selected two Kebeles from each Woreda where both HEWs in the Kebele met eligibility criteria. This was established in consultation with Woreda health offices. Both HEWs from the Kebele were recruited to participate.

For the health extension program coordinators, one at the federal level and three from regional health bureaus of each region and another three from Woreda health offices were purposively recruited as key informants of the study.

To obtain focused and in-depth views of the target population, the researcher conducted only 12 in-depth interviews (IDIs) with HEWs and 7 key informant (KI) interviews with the health extension program coordinators.

	Urban	Rural	Pastoralist	National	TOTAL
IDIs (HEWs)	4 (2/Kebele)	4 (2/Kebele)	4 HEWs (2/Kebele)		12
KIs	2 (1 RHB & 1 Woreda)	2 (1 RHB & 1 Woreda)	2 (1 RHB & 1 Woreda)	1	7

For HEWs to be eligible in the study, they must have been staying in their deployment area for at least one year. The reason for this is participants of the study needed to have been working long enough to have interacted with the community and programme to reflect on both positive and

negative experiences. The participants also had to speak Amharic and consent to participate in the study.

2.5-Data Collection and Management

Participants of the study were approached by the researcher, who is a 35 year old man, with a letter of permission written by FMOH, Regional health Bureau and Woreda health offices. After explaining the overall purpose of the study, participants went through an informed consent process. Written informed consent was obtained from each participant before proceeding.

To address the mismatched age, sex, and education between the HEWs, who were majorly females above the age of 18 years with little academic trainings, and the researcher, who is older, more experienced and well educated, a female note-taker was employed. Also, the researcher had previous experience of handling interviews with both males and females of different cultural backgrounds.

An IDI guide and a semi- structured KI guide were used during the interviews of HEWs and key informants respectively. The interview guides were originally developed in English and then translated by the researcher into the local language of Amharic. The researcher conducted the interviews in Amharic with all of the 19 interviewees (12 HEWs and 7 KIs) with the support of female note-taker. The English interview guides, information sheets and consent forms are in Appendix A&B and the Amharic versions are available upon request. Each interview took a maximum of 50 minutes. The interviews were audio taped, supplemented by note-taker's notes.

Before the actual data collection, the researcher pre-tested the interview guides. The pre-test for the HEWs interview was conducted with four HEWs in two randomly selected neighbouring Kebeles next to the study sites in Addis Ababa, for convenience. The pre-test for the key informants was conducted with three officers who are working at the federal, at Addis Ababa Health Bureau and Arada Sub City Health Office levels and who were not participating in the study.

The data collected were the note-taker's notes and verbatim transcripts of the audio recordings. The audio tapes were transcribed immediately after the interviews in Amharic by the researcher and an experienced and qualified transcriber, who was also the note-taker. All of the transcriptions conducted by the hired transcriber were checked and corrected by the researcher. The data collected in Amharic was translated into English by the researcher in Microsoft Word and then imported into the Max QDA software version 2 to support qualitative analysis. Field notes were also used to support the analysis.

Semi- structured In-depth Interview

The researcher conducted all of the IDIs with the 12 HEWs in culturally appropriate spaces chosen by the study participants, including health posts, tea rooms and in the field.

The IDIs sought to explore and analyse the motivational factors of HEWs and encourage them to freely describe the various challenges that they face while performing their duties in their deployment areas. Interview guide questions were guided by the literature and encouraged HEWs to discuss their personal motives, relationships with their colleagues, supervisors and community members, their living and working conditions as well as financial incentives and opportunities for training and further education. The interviewer explored personal and environmental challenges that were potential barriers for HEW performance.

Key informant semi structured interviews

The interview guide encouraged exploration of the HEW motivation strategy of the government of Ethiopia, including financial and non-financial incentives. The future strategy of the government to address any possible challenges was also explored.

Data Management and Storage

The English transcripts were de-identified by the researcher in Microsoft Word using key settings, sex, age and type of respondents such as (Pastoralist Female 18, HEW), (Pastoralist

Male 26,KI), (Rural Female, 27, HEW), (Rural Male 39,KI), (Urban Female 28, HEW), (Urban Male 48, KI) etc) before uploading into MaxQDA 2. The digital audio recordings have been saved on a computer with a secure password and will be destroyed two years after the completion of the study.

2.6-Data Analysis

The transcripts from the in-depth and key informants' interviews were analysed using both inductive and deductive methods in MaxQDA software version 2. Codes were developed after reading and re-reading the raw data to identify important and common themes related to the main aim of the study. Deductive codes were used based on the study objectives mentioned in the first chapter. However, the researcher also coded inductively, based on what emerged from the data. A colleague, who is Masters Graduate in public health, independently coded a sample of interviews using the codes developed by the researcher. Similarities or differences in the codes were used to assess inter-coder reliability. The researcher decided on the final set of codes.

The researcher started with descriptive analysis of the findings followed by comparison and theoretical analysis. Findings from HEWs and key informants were compared. Analytical discussion was made by the researcher with his supervisors about different factors affecting HEW motivation in rural, urban, and pastoralist settings as well as whether the motivational interest of HEWs were in line with the government plans and current motivational packages. Both the findings and discussion are presented in accordance with the study aim and objectives.

2.7-Ethical Considerations

Ethical approval for this study was obtained from the Human Research Ethics Committee (HREC) of the University of Witwatersrand (certificate number M110949), Johannesburg, South Africa and from the Ministry of Ethiopian Science and Technology. Permission to undertake the survey was obtained from the federal, regional, *Woreda and Kebele* administrative authorities. Official letters from the FMOH, Regional Health Bureaus were secured for the study Woredas

and Kebeles. Two informed written consents, one for the interview and the other for audio recordings were obtained from each study participants after explaining the purpose of the study. Participation of all interviews was strictly voluntary. Measures were taken to assure the respect, dignity and freedom of each participating individual in the study. The researcher did not pay any money to the study participants for their contribution.

All the information collected was strictly confidential. Participants of the study were de-identified as described earlier and the specific Kebeles where the study was undertaken are not mentioned in this report. All audio materials will be kept in a secure location for two years and destroyed afterwards.

3-Findings

This chapter reports on the findings from nineteen interviewees drawn from three districts representing rural, urban and pastoralist. The HEWs and KIs ranged in age range from 17-48 years. It is organised into three sections, beginning with HEWs job experience, factors that support or inhibit HEWs motivation, and government perception of support provided for HEWs.

Table 1.HEW study participant demographics

	Number	Age (mean, range)	% Female
Setting			
Rural	4	24.5 (21-28)	100%
Urban	4	27.0 (24-29)	100%
Pastoralist	4	18.0 (17-20)	50%

This section explores how HEWs experience their major and daily activities with a particular focus on their recruitment, training, and major activities and gender related issues. This addresses the first study objective.

3.1.Recruitment, Trainings, Major Activities and Gender

3.1.1-Recruitment

Different educational attainment criteria were reportedly applied for the recruitment of HEWs in Ethiopia in the different settings. For instance, a minimum of 10th grade completion is required to be qualified for rural HEWs, while holding a diploma in health sciences is mandatory to be eligible as an urban HEW. For pastoralist HEWs, having a grade five education was considered adequate. The process of selection was reported by key informants to have important implications for the motivation of HEWs in this study.

Rural HEWs were selected by local administrators and from communities in which they will work according to certain criteria: they all are female, at least 18 years old and have at least a

10th grade education, as set in the federal recruitment guideline. In contrast, most HEWs in Afar were selected by district officials without the active involvement of community members and other pertinent bodies in the area. Almost all of the HEWs in Afar were regular students in town and some of them never showed up in their duty stations. As one pastoralist HEW described his work experience:

Now we are playing hide and seek with district officials. They do not want to see us in towns. Frankly speaking we cannot stop our education for extension job. There has to be some other solution. (Pastoralist Male 17, HEW)

Many HEWs and key informants in the pastoral area believe that the HEP in Afar is on the verge of collapse partly due to the contestable recruitment practice including hiring males and less educated HEWs. According to some key informants, Afar region recruited students from lower grades due to the absence of an educated population base in the region. But one key informant did not agree with the above assertion. He said that although female health workers were appropriate and available, male HEWs were hired and deployed in several health posts. According to this study participant, the recruitment process has resulted in of male HEWs who do not feel ownership over their jobs.

The health extension program usually fails in Afar region because of misguided recruitment procedure ... Those who are currently selected as HEWs do not take the job as their own. (Pastoralist Male 28, KI)

The recruitment criteria for urban settings such as Addis Ababa were completely different. Due to the nature of urban settings and availability of educated manpower, the Addis Ababa health bureau recruited diploma holders trained in nursing and other health fields to serve as urban HEWs. Recruiting a higher educated work force may have contributed to misunderstandings early on. For instance the below quote suggests that during recruitment, this HEW misunderstood the job of a HEW as being more clinical than preventative.

When I first get recruited as a nurse I thought that I could be able to do treatment stuff. But now we are doing only health education by moving from door to door.(Urban, Female 24,HEW)

3.1.2-Trainings

Regarding training, almost all HEWs were expected to take pre service training before they embark on any health extension activities. However the study found that the duration and types of the trainings were different in urban as well as pastoralist and rural settings. Rural and pastoralist HEWs described completing a year-long training, while urban HEWs who are nurses by training only completed three month training before their deployment.

According to HEWs participated in the study a wide range of on-job trainings that include among others family planning issues, HIV/AIDs, TB, malaria and maternal and child health are also offered by governmental and non-governmental actors.

Rural HEWs who said they are a 10th grade complete with only one year basic health training, faced multiple problems ranging from assisting delivery to report writing. Even though delivery was part of their training curriculum, most HEWs found it difficult to assist delivery. They complained that there were no women delivering during their internship period and most of them had not practically experienced a woman delivering with the help of skilled birth attendant in the health center they were assigned to practice.

I really did regret that I was not trained enough to help mothers and children who dies everyday with simple preventable causes. Even now I wish I could be trained as skilled birth attendant, because I hate seeing mothers in labour, in pain. I would love it to be on their side with God and help them. (Rural Female 27, HEW)

Pastoralist HEWs in Afar reported that they could not help their community due to their lack of knowledge in various aspects of health. Their limited knowledge on assisting delivery, as a result of the absence of additional training opportunities, was discouraging. For instance one pastoralist HEW said:

When we see people suffering with some preventable diseases, we really take it to the heart and regretted our limited knowledge. As you might know in Afar we did not receive additional trainings to assist a mother to deliver. Sometimes you can see mothers dying before your eyes and there are times that we are really discouraged and hate the job. (Pastoralist Female 17, HEW)

In addition to pre-service training, HEWs described For example, in rural Amhara, most HEWs noted that government introduced curative services such as Integrated Child Care Management (ICCM) and Community Based Nutrition (CBN) to their training program. For urban HEWs apart from the normal three months training ,on job trainings on counselling, implanon insertion etc are organized but respondents said that it is difficult to apply them in their day today activities. Rather urban HEWs consider the training as an opportunity to find a better job.

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3.1.3. Major Activities of HEWs

HEWs described the overall and day to day job experiences of HEWs' in relation to their motivation. Most HEWs noted that their major focus was helping family members with 16 health packages that fall under four components: sanitation and hygiene, disease prevention, family health and health education. They also said they were expected to help graduate model families from the programme so that they can maintain their own health. This was done through continuous dialogue and engagement with the community members. One HEW said:

Normally we are implementing the 16 health packages that focus on hygiene and sanitation, family planning and disease prevention with a particular focus on mother and children in consultation with the community... So far we have managed to graduate almost all family heads as model family. (Rural Female 21, HEW)

One HEW also emphasized that she spent her time in building the capacity of community role models, because she said they are more accepted by the community.

Of the sixteen packages, the content areas mentioned most frequently by the majority of HEWs include sanitation and hygiene, malaria prevention, family planning, maternal and child health as well as diarrhoea and trachoma. HIV and TB were also mentioned, but not as frequently as other areas of intervention. Some HEWs reported that maternal health, particularly delivery care, received little attention due to poor training and delivery equipment. One rural HEW illustrated her point as follows:

Knowing that I do not have proper training on delivery, I refer mothers to health facilities where they can be assisted by a skilled birth attendant. (Rural Female 21, HEW)

Asked about their daily routine, many rural and pastoralist HEWs said they spend their time both in the field serving the community with door to door services and at the health post. Explaining the daily routine of the HEWs one said:

In our work we spend a lot of time on the field. So, we have weekly schedule for household visits. From the five days we spend the three in the field and the rest in the health post to provide various services that include family planning, maternal related care and malaria test and treatment to the community. (Rural Female 22, HEW)

Although performing similar activities with their rural and pastoralist counterparts, most urban HEWs reportedly also include non-communicable diseases such as diabetes, blood pressure, and asthma, in their list of content areas. These added components, according to some urban HEWs, increased their acceptance by the community and thereby motivated them to pay additional home visits.

3.1.4-Gender and Community Acceptance

HEWs experienced that most women in the community preferred women over male health providers; even in emergency health circumstances. For example, one urban HEW explained that women are more open when they are approached by female HEWs. She explained:

They (women) could discuss their secrets. If the health provider is male, female clients would be afraid of their husbands because husbands might think the other way round. (Urban Female 29, HEW)

Key informants from the Afar region described the consequences of the deployment of male HEWs in the health care system. They described how most beneficiaries, particularly mothers, were unwilling to be assisted by male HEWs and how this has contributed to the low utilization of maternal and child related health services.

As much as we can, we are preparing ourselves to replace male HEWs by females HEWs in Afar region, just because the pastoralist community is a little unwilling to receive especially delivery service by male care givers and consequently utilization of maternal health related services such as delivery is very low. (Pastoralist Male 28, KI)

Unlike Afar, the HEP in rural Amhara is reportedly run by all female HEWs. The idea that women prefer female HEWs for maternal and child health issues was repeated by one KI:

Using female HEWs has tremendous advantages in terms of providing the most needed services to mothers and children who are mostly affected by preventable causes. Basically women share their problem to women. Because they are females they give real care and sympathy for mothers and children. It's good. This means they can share their secrets freely and get the service. (Rural Male 26, KI)

3.2-Factors that support/inhibit HEWs motivation

In relation to the second study objective, factors that motivate and de-motivate HEWs such as continuing education and training, career development, remuneration, supervision and recognition as well as personal values or altruism are addressed in the following section.

3.2.1-Continuing Education and Training

Almost all HEWs in the three settings were of the opinion that one of the most important

motivational factors was an opportunity for continuing education. Specific opportunities that were mentioned related to joining higher learning institutions to study at diploma level through passing a Center of Competency (COC) exam, which measures the competence of students before joining colleges or universities in Ethiopia.

HEWs in the rural settings said they welcomed the long awaited educational opportunity (i.e joining college for their diploma) with utmost happiness. But only a few rural HEWs were fortunate enough to join college by passing the COC exam that qualifies them for college enrolment. One rural HEW said:

I am happy that opportunity for further education has been opened up and even some joined college for their diplomas. This I can say is a good motivation to keep us doing our good work to the community, but the entrance exam must consider our level of competency. (Rural Female 28, HEW)

Gaining additional skills through on the job training such as ICCM and CBN, particularly focusing on treatment of children, increased the acceptance of HEWs by the community members. Traditionally the rural people know only general practitioners (medical doctors) offer pills and injectables to treat patients unlike HEWs. One of the HEWs in rural Amhara explained:

Sometimes you come across health problems that you cannot address with your current capacity. Failing to do so hurts your feeling. But now we are beginning to treat children after we have received training. And we are happy for that.(Rural Female 22, HEW)

Some HEWs reported that NGO-initiated trainings were also a source of motivation. One HEW had to say the following: *The training provided by NGOs benefits me personally and my community.* (Pastoralist Male 17, HEW)

While HEWs in rural and urban areas expressed interest in continuing education, the study uncovered that HEWs in Afar were still seeking to complete their basic education.

Now we are playing hide and seek with district officials. They do not want to see us in towns. Frankly speaking we cannot stop our education for extension job. There has to be some other solution. (Pastoralist Male, 17 HEW)

The regional government of Afar as well as the federal government did not expect HEWs recruited from lower grades to quit their education to do health extension work. As a result, what was actually happening in Afar was that almost all of the HEWs were regular students in town and some of them never showed up in their duty stations. This was despite the fact that both regional and federal government informants expected HEWs to implement the health extension program in Afar region. This apparent contradiction was a clear source of frustration for pastoralist HEWs.

Most rural HEWs agreed that despite the opening up of some educational opportunities as a recent development, barriers remained. According to most of them, the COC exam that they are expected to write as a pre-requisite to pursue their education to the next level was too difficult to pass. One of the HEWs in rural Amhara said that of the 99 HEWs serving in her district, only two had the chance of attending diploma courses in college. The rest, she said, could not manage to pass the entrance exam. Most HEWs agreed that the exam mainly focuses on curative health, which HEWs could not practice in rural, urban or pastoralist settings.

We are now on the verge of losing hope. We need education. We need change. If we cannot get an opportunity for further education from the government, we can try privately and that has to be given due credit. Or else they should educate us in our profession and let us improve our life. The more we get educated, the better we can serve the community. (Rural Female 27, HEW)

Rural HEWs felt obliged to take their own chances privately and are attending nursing courses on their own by leaving their job. This was confirmed by one of the key informants from Amhara who said more than 11 HEWs so far had left their job in four years time mainly due to lack of educational opportunity.

Urban HEWs reported similar challenges. Most of the HEWs in urban settings are diploma

holders. Despite their clinical trainings, most of them were deployed to engage in public health sector as HEWs. They reported that their focus on prevention was a barrier to passing the COC exam, which focuses on clinical medicine. Urban HEWs, who have upgraded themselves to degree level through personal efforts, complained that they were not promoted accordingly and this motivated them to opt for other alternatives. The urban HEWs said they were waiting for the federal government to prepare a specially tailored COC exam for HEWs, mainly focusing on preventive health.

3.2.2-Career Development Structure

When the HEP first started, it was reported to be an informal structure in a formal health system. Rural HEWs reported that this negatively affected their motivation and performance over the past eight years. However, a recent development by government to formalize the career structure has been well received.

As part of motivation, the government has arranged a career structure where we can get benefits depending on our years of services. We are really happy about that. (Rural Female 28, HEW)

This change to align the HEW program with other civil servant programs was further explained by a rural key informant as follows:

Frankly speaking, they did not have annual leave as any other civil servants. But now with continuous discussion with labour and social affairs office and the regional health bureau, the situation is improving over the past three to four months now.(Rural Male 26, KI)

Unlike rural HEWs, urban HEWs expressed discontent with the career development opportunities. Urban HEWs reported that they do not have a proper career development system in place for their promotion even after securing certain qualification. One urban HEW said the following:

I do not want to accuse people of not offering the place I deserve as a degree holder, but there is no career development system for HEWs as it was in the health centers and hospitals. (Urban Female 27, HEW)

Most urban HEWs did not know how they were going to develop their career, except the rumour that they would become family doctors. One urban HEW explains the confusion around career development as follow:

The government is saying that we'd be family doctors. (Laugh) Even to become a family doctor we've got to learn and change ourselves. There is no clear promotional policy I know so far. (Urban Female 28, HEW)

The above quote was a desperate voice of an urban HEW who is deeply concerned about her destiny in the future. Many urban HEWs shared the view that no clear career path was available to them. The majority said that they knew of no single HEW who was formally promoted since they began as urban HEWs, which was de-motivating.

Another important concern raised by urban HEWs was that they were not allowed to treat patients in spite of their clinical training in college. Most of them expressed frustration that they have forgotten the clinical elements of their training and cannot even be employed anymore in clinics and hospitals just because of the negligence and lack of support from the city administration. One study participants complained that *"We couldn't do any other job at this time, we have nowhere to go, and we are now on survival mode. We are just working to live."* (Urban Female 24, HEW)

Another HEW added that:

We felt that we are out of the system. We are forgetting everything about clinical nursing. There is no means to practice. We were trained on many things. We were even trained on how to insert Implanon... but we have not done anything with it. We have forgotten it. When I think of the training I received on clinical nursing, I feel so bad inside...How long this thing will continue,

that worries me too much. (Urban Female 24, HEW)

Many urban HEWs hoped that one day the government would make structural adjustment that can treat both urban HEWs and clinical nurses in hospitals on equal footing. However, the majority felt that they were left alone. One of the HEWs said *“I thought they would one day allow us to work as clinical nurses too but as I see it now, there is nothing like that.”* (Urban Female 24, HEW)

Some of the HEWs questioned the continuity of the urban HEP and subsequently offer free services at night for private clinics to gain clinical experience that may help them gain employment by health facilities. *“Truly speaking”,* said one of the HEWs *“I’ll try giving a free service at night for private clinic. I am losing my hope on (the government).”* (Urban Female 24, HEW)

In urban settings, HEWs reported that HEWs having equal qualifications were not given equal benefits. It appeared that the individual authorities in the health bureau decide on the promotion and demotion of urban HEWs. Regarding pastoral HEWs as almost all of them are attending elementary and high schools they do not seem to bother about their future career.

3.2.3-Renumeration

During the time of this research the government launched a salary increase for all HEWs as a result of the new career structure initiative. This was well received by HEWs. The meagre salary scale and the uniform salary for beginners and experienced health workers alike had been a major source of dissatisfaction and had negative consequences in the implementation of the health extension program. One of the HEWs from rural Amhara explained:

For about six years we worked on 500 birr monthly pay. But recently there is salary increment and we are more or less happy about it. I used to get ashamed to receive such small payment after waiting for long lines with other civil servants which mostly earn 2000-3000 birr. (Rural Female 21, HEW)

Another HEW from the same region expressed her satisfaction over the salary raise as follow.

We were forgotten for years but recently there are some encouraging measures are being taken especially salary increment and benefit packages as other civil servants. We are happy about that and grateful for the government. (Rural, Female 28, HEW)

Confirming the above assertions, one key informant from rural Amhara said:

There was no salary difference between beginners and those who were on the job for long. But now, after the introduction of the career structure, HEWs are getting their salary based on merits taking into account their experiences and performance. This helps to avoid the dissatisfaction of some of the health extension workers. Salary raise depending on their service years was also done. (Rural Male 39, KI)

Despite reports that pastoralist HEWs were not found in their duty stations, they had no difficulties in collecting their salaries.

Although acknowledging the salary increases by the government, some rural HEWs complained that they could not make any change in their day to day lifestyle. Asked why it was not adequate enough, some HEWs reported that most of the money increased by the government was indirectly taken by the high cost of living currently affecting not only civil servants of the country but indiscriminately affecting most segments of the society. One of the HEWs supports her argument as follow:

When I first heard about health extension program, it was really attractive and I left my job as a development agent in the agriculture sector. The discourse around health extension work in the beginning was very promising. But frankly speaking I could not find the much- talked about salary and benefit packages and support system as I was expecting it. There are no benefit packages and the salary itself was low, which was around 500 birr. But now our salary has been increased to 1030 birr. But still with the soaring prices of goods, I cannot say that it is enough. If you look at one quintals of teff (local grain), it costs more than one thousand birr. We also pay

more than 200 for house rent. In the beginning the farmers were very cooperative and support you in several means. But now even you can buy fire woods with lots of money. Though we get paid almost double of what we used to get, when we go to the market the things we buy with 300 or 400 birr won't even fill a plastic bag. It only lasts for one or two days. So life continues to remain challenging even after a generous salary increment. (Rural Female 28, HEW)

Unlike their rural counterparts, for urban HEWs, who are clinical nurses, the remuneration challenge seemed to be different. They mentioned low payment as de-motivating particularly for those staff members who already gained additional qualification. One of the urban HEWs claimed that still no salary adjustment was made for her even after completion of her first degree through private means. Such experiences were the source of despair for many urban HEWs who are reading in different colleges for their first degrees.

When comparing their work with other clinical nurses in different health centers and hospitals, urban HEWs reported feeling discriminated against. One study participant had to say the following:

It's hard for me to say there is any support. As you can see, in our Woreda there are those who pay from their own pockets for three years of college learning, but couldn't get better salary. For those who are nurses in hospitals and health centers, the government pays for their education and promotes them after studies. (Urban Female 36, KI)

A few of the urban HEWs argued that clinical nurses working in health centers and hospitals should not be treated equally with as urban HEWs. According to them, these clinical nurses have had other financial benefits when they are on duty. But, given the hard work of HEWs, they believed that they deserved better salaries. One urban HEW explained:

When I compare my salary and benefits with nurses in health centers, they get much more than what we earn and we envy our colleagues in other health facilities who are focusing on curative health. (Urban Female 27, HEW)

3.2.4-Supervision

Providing support to HEWs is the primary responsibility of supervisors and coordinators who are operating at district, zonal, regional and federal levels. The following sub-section covers how the supervision support of management was experienced by HEWs.

Many rural HEWs felt that the supportive supervision they received from the district health office encouraged them to perform their job well. For example, one of the study participants confirmed that supervisors in her district were keen to provide HEWs with both technical and managerial support:

They (district supervisors) visit us at least two or three times in a quarter and provide us the necessary support. They stay with us for a week and even longer. We have health centers not far from here and we get support and report to them as well. (Rural Female 22, HEW)

Even in rural Amhara, where there is relatively better support system from supervisors, some HEWs reported irregular and unplanned visits. One HEW complained, “*We are tired of organizing such irregular visits.*”

One HEW raised a concern that such tokenistic supervision may give rise to data that are inaccurate and drive policy makers to take wrong decisions. She explained:

Government has to improve the supervision mechanisms to avoid false reporting down to Kebele level. There has to be a cross checking mechanisms of data secured from rural Kebeles because often times there are big chance of misreporting for the purpose of recognition. (Rural, Female 21, HEW)

Overwhelmingly, the support that urban HEWs , received from their supervisors particularly from the sub cities and city administrations was described as insufficient. Whenever they sought for support from city administration, they said they were told to deal with it rather than finding joint solution for the problem. One HEW explained her experience as follows:

When we do something with the community, they (supervisors) don't support us. They want us to deal with everything on our own. They don't even want to go down and look at it. The usual reason for their lack of support is workload. But, when we fail to deliver, they are the once always pointing fingers on us and making us responsible for any failure. (Urban Female 29, HEW)

Similarly, some pastoralist HEWs said they found it extremely difficult to address the various problems at hand without the actual material and technical support of supervisors at the Woreda level.

As most HEWs in Afar were recruited from lower grades, they said they need the supportive supervision element more than anybody else. However, the reality reported on the ground was quite the opposite. The lack of supervision in Afar area resulted in some HEWs reducing the frequency of visits to the health posts they were assigned to serve. One pastoralist HEW said:

I used to go there (duty station) frequently. But now the district health office does not support us in what we are doing, so the visit is not as frequent as before. (Pastoralist Female 17, HEW)

Pastoralist HEWs complained that district level supervisors consider themselves more as controllers than supporters of the HEP. One HEW asserted:

The hunger, thirst and long distance travel sometimes make you lose hope, but when it coupled with lack of support from your supervisors, it is so discouraging. There were several times that I was about to give up the job. Sometimes they shout at us for wrong doings and never asked us our problems. They are not listening to us. (Pastoralist Male 18, HEW)

3.2.5 Community Response and Recognition

HEWs described that appreciation for their work by the community and their employers as having a lot to do with their motivation. This sub-section describes how non-financial incentives, such as recognition, play an important role for the motivation of HEWs.

Many HEWs study participants from rural Amhara and pastoralist Afar pointed out that their acceptance by the community had increased over the past couple of years. One pastoralist HEW involved in the study said:

The level of acceptance by the community was poor and discouraging before and now it is improving and we are happily performing our job. The community members used to complain that we are in their villages for money, but not to help them to prevent themselves from diseases.(Pastoralist Female 20, HEW)

Another study participant from rural Amhara pointed out that the traditional mindset and practices that normally expose community members to various diseases was now almost non-existent as community members began to accept HEWs and the health intervention program with open arms. Explaining the change, particularly in the area of family planning, one of the HEWs from rural Amhara said:

Now we do not provide intensive education about family planning to the community, we have managed to create the demand so far and community members appreciate and make use of the family planning services. (Rural Female 27, HEW)

Several rural HEWs noted that they were overwhelmed by words of appreciation by the community only after the commencement of a treatment program targeting children. One rural HEW reported that providing treatment for under-five children was positively changing the attitudes of the community towards HEWs. As a result of this treatment, the community has started to recognize the importance of health workers in the villages and extended their appreciation. This in return boosts the motivation of health workers in rural settings. One of the rural HEWs explained as follow:

The treatment has tremendously improved our relationship with the community just because they could see what differences that we are making to the community. Usually they do not take prevention so seriously. Now we are enjoying the credit of our hard work. We also provide

malaria treatment at our health posts otherwise they were supposed to travel long distances and pay for the treatment. With this service the community now considered us as their helpers and shows us love and respect. (Rural Female 21, HEW)

Despite appreciation by the community members, some supervisors do not recognize rural HEWs and that they said lead them to dissatisfaction. One rural HEW noted that government do not have organized and systematic approach that acknowledge HEWs performance but there is a general mentioning of what worked well and what did not in annual and biannual evaluation meetings without knowing specific performance of HEWs.

But this was not true across the board. For example, in pastoralist districts of Afar, people reportedly resist using contraceptives methods, such as condoms. One of the HEWs explained:

There are segments of the pastoral community who do not totally accept some of the teachings of the health extension packages, such as family planning. Especially there are people who do not want to listen about condom. They perceive that condom itself is one of the modes of HIV transmission. They refuse to accept anything about condom. (Pastoralist Female 20, HEW)

Unlike their rural counterparts, urban HEWs reported the community response to be unsatisfactory. Most HEWs experienced a hard time with urban community members. One study participant complained:

Urban community said they do not need health education as countryside people. If they needed health education, they said they can get it from the media. This really affects our emotion. Sometimes you feel you do not want to go back to them again, but it is your bread and butter. (Urban Female 28, HEW)

However, urban HEWs reported that community members were more receptive to support in managing non-communicable diseases such as diabetes, asthma and hypertension. One HEW

said *“urban people are more interested in non communicable diseases than communicable ones.”* (Urban Female 24, HEW)

For the most part, urban HEWs, reported that the only form of recognition that they received was their own weekly feedback sessions, where they informally appreciate each other at the office level. One HEW said that the health worker who performs well during the week was recognized by colleagues.

It appears that the low level of community acceptance of the urban health extension program coupled with the sole focus on preventive health is linked to de-motivation of HEWs and thereby to poor performance by urban HEWs in their respective districts. In addition government did not express appreciation.

Absence of appreciation by the community to urban HEWs was identified as major source of de-motivation. Many interviewed HEWs complained that the community members were not happy about what they were doing. One HEW stressed that the urban community never considered their work as valuable.

I want to please the community with my public health work. When we see the community pleased then we’d love our profession. But, I am afraid this is not the case in our work right now. (Urban Female 28, HEW)

For urban HEWs, their work was only recognized through state owned media organizations. They rarely receive direct and formal recognition from both the community and the government. Most urban HEWs said that there were no formal methods in Addis Ababa to show appreciation and give rewards. Two study participants illustrate the point as follows:

We frequently listen to the media that there is change by health extension workers; Ok...it is fine. Let us say things are changed, but what is the reward for those who brought the change? Uh...we ...must have a hope for tomorrow for us to work today. (Urban Female 24, HEW)

Another urban HEW said:

We are working very hard to meet the set goals of urban health extension program. But looking at our acceptance by the community is really disastrous. And as long as the government pays me, I keep on doing what I am doing. There is no appreciation, neither by the community nor by the government. For your surprise, there is nobody who says thank you and God bless you. This is real pain for me. (Urban Female 29, HEW)

Urban HEWs also reported tendencies of community members considering them as political agents. One HEW attributed the lack of community appreciation to a poor understanding of the HEP.

If I work in health centers or hospitals and treat and give some sorts of treatment such as pain killers to people, the community might understand the benefit and as a result would give appreciation for our good work. That would be a great reward for us to accomplish our job passionately with a lot of energy. But that is not happening now. The urban community never understood the importance of health extension program. (Urban Female 29, HEW)

Most pastoralist HEWs claimed that they are appreciated by majority of the pastoral community members as they said they were recruited from their own vicinity and provide them with health education in the language they could easily understand.

3.2.6-Personal Values/Altruism

Intrinsic factors also emerged that motivate health workers to focus on doing their job properly and yield the desired results.

Some rural and pastoralist HEWs claimed that the main drive that compelled them to accomplish their job with satisfaction was love of the poor community that they are serving. One HEW from rural Amhara expressed her feeling as follows:

In spite of the various challenges that I have as a woman in rural villages, I find health extension work very interesting and rewarding. You are saving the lives of children and helping mothers in their health needs. There is nothing that makes you much happier than serving mothers and children. (Rural Female 22, HEW)

Most rural HEWs confirmed that there was no calling more important than serving your own poor community. Saving the lives of mothers and children through vaccination services, assisting mothers to have clean and save delivery and offering timely referral were reported to be among the activities of HEWs in rural Amhara. According to them, this sense of service to the community made them proud of being HEWs.

Most rural and pastoralist HEWs reported that they do not consider the pay check at the end of the month. Their love of community outweighs financial considerations. One of the pastoralist HEWs was quite emphatic about this point:

What keeps me in the job is not the 500 birr salary. Only the love of my community and my sense of responsibility are my drives to do my job. I have sense of duty and keen interest to support my community. I feel that I am much more important than clinicians who are in town. (Pastoralist Male 18, HEW)

Most urban HEWs reported that their personal motive and passion for their health extension job ultimately declined due to their restricted job description and poor acceptance of the community.

3.2.7- Housing and Transportation

Poor working conditions, such as absence of housing facilities and lack of means of transportation to health posts, were de-motivating factors for HEWs, particularly in some rural and pastoralist areas.

Most rural HEWs expressed dissatisfaction about their living and working conditions. They said they were living in rented house or were travelling long distance to towns. According to them,

such things adversely affected their health, motivation and performance. One rural HEW said:

Frankly speaking, what is expected from us to do and the basic facility provided by the government do not match. We want a place to live. We do not have to pay much money for house rents. Since there is no house for us in rural area, I had to travel more than an hour everyday from Woreda town to my health post to perform my duty. That definitely affects my actual performance. We need houses to do our work properly either in rural or urban area. It's hard for a woman to go back and forth to work. We do not ask for a farm land but a small house to live. (Rural Female 28, HEW)

Absence of shelter in rural settings came out from the study as one of the salient feature that demotivates rural HEWs and they would like to have housing provided. One HEW said *“First and foremost we want the government to build shelter for us.”*(Rural Female 28, HEW)

Some HEWs further noted that, the situation of their health post begs the attention of the government. One HEW said *“the health post that we are working from is now dilapidated and need immediate renovation before it falls.”* (Rural Female 22, HEW)

The issue of housing was even more critical in towns than in rural and pastoralist districts. With the increased impact of cost of living in Addis Ababa, most HEWs were unhappy about the money they pay for house rents and wanted the government to do something about it. One urban HEW said:

I live in a rented house. Indeed, with the current high living expense and with this meagre salary, the pay for house rent is becoming beyond my means. The cost of living is amazingly increasing nonstop. (Urban Female 28, HEW)

For some other urban HEWs, who were living in their family quarters, housing was less of a problem. However, they said they think of the future with fear, unless a housing allowance is provided to them by the government.

Poor access to transportation was most visible and critical as a problem in pastoralist areas of Afar. According to pastoralist HEWs, one had to travel a long distance to reach to a health post mostly due to the scattered settlement pattern of the pastoral community. Pastoralist HEWs identified absence of means of transportation as a major challenge that prevents them from actively performing their duties. HEWs in Afar reportedly travel from 40km to 60 km from district towns to their duty station in the pastoral village that they were assigned to work. They were unable to stay in the duty stations as almost all pastoralist HEWs interviewed were attending school in town. These young HEWs expressed their dire need of transportation means to go back and forth from their Woreda town (where they are enrolled as students) to their health posts, at least during weekends.

One HEW lamented how, due to the absence of transportation, HEWs could not help mothers and children who are suffering from communicable diseases such as cholera, which was a common phenomenon in the region. Transportation challenges in Afar were not limited to only HEWs. Supervisors also found it as big challenge.

3.2.8-Competing Work and Life Priorities

When first deployed at the age of 18, most female HEWs in rural area were not yet thinking about marriage and family life. However, as they age, this is now one of the competing priorities of most rural HEWs. This sub-section of the report describes their implications on the motivation of HEWs.

Married HEWs complained that they spend their time in rural Kebeles and did not find enough time to spend with their husbands, who usually stayed in district towns. This was described by many as a source of disagreement at home. According to them, some marriages ended up with divorce, mainly because HEWs often had chosen their job above their husbands. When asked about her personal life and work, one HEW shared the following:

I got divorced just because my husband could not understand the nature of my work. I spend my time in the rural area and I was not accessible to him whenever he wants me. Besides, we don't

meet in breakfast and lunch time. Even at night I was too tired. You guys are difficult creatures.(laugh) He made me to choose between my marriage and my work and I preferred my work and sacrifice my marriage to health extension work. (Rural Female 28, HEW)

Study participants described how some other HEWs faced similar situations and had chosen their husbands and left their jobs. Unless someone was married to a rural male, being a HEW and at the same time being a married woman was extremely difficult said one HEW. One of the HEWs jokingly concluded her remark by saying:

You cannot run love and marriage from a distance, like distance education. Regarding my personal life, I do not dare to ask the government to assign...husband for us. This is impossible and it is my personal responsibility to improve myself and get into town.(laugh) The government won't help us on this, it's something I got to do on my own (laugh).(Rural Female 27, HEW)

Most of the study participants in rural Amhara shared similar experiences finding it difficult to balance children and husband responsibilities with their extremely demanding health extension job. Often in rural Amhara, HEWs described a difficult choice between having a family life through marriage with their husbands and being financially self sufficient and support their family. One of the study participants had to say this:

My husband wanted me to leave the job and stay together but I don't want to quit my job. With the high cost of living, I do not want to beg. I want to stay in the rural Kebele and support my family... We can see each other with my husband during weekends and holidays. (Rural Female 27, HEW)

Rural HEWs in general felt that health extension work was uncomfortable for females who were already married with a husband from Woreda towns or regional cities. However this issue was not raised by urban and pastoralist HEWs

3.2.9-Unrealistic Performance Expectation

The health extension program of Ethiopia expects every HEW to graduate up to 500 model families in a year time. The motivational and performance consequences of failing to do so are described in the following sub-section.

Some HEWs described that ambitious targets set by the government to achieve big results in a short given period of time as encouraging false reporting. This, according to them, affects the actual result on the ground and consequently, the intrinsic motivation of HEWs.

We are lying because the government bodies really appreciate figures like 100 percent performance without cross checking whether the gains are real or not. This really discourages those who perform less than 100 percent, but did a quality job. This still made us to give 100 percent for our superiors to make them happy temporarily and to avoid unnecessary blame. But the 100 percent report definitely is multiplied by zero when you come and see actual performance on the ground.(Rural Female 21, HEW)

Rural HEWs found this situation to be frustrating as they were expected to perform more than what they were capable of.

For urban and pastoralist HEWs such complaints were not raised at all. For urban HEWs their low community acceptance and absence of curative aspects of health from their job description may probably ease their burden. For pastoralist HEWs they spend most of their time in attending schools and even most of them do not perform the minimum requirements.

Summary Table: For HEWS motivating and de-motivating factors

No	HEWs by settings	Factors Motivating HEWs	Factors De-motivating HEWs in Ethiopia
1.	Rural	- Continuing education - Trainings - Career structure - Remunerations - Supportive supervision - Personal value/Love of community work - Community acceptance	- Lack of housing-facilities - Workload and unrealistic performance expectation of government - Competing priorities such as work life balance
2.	Urban	- Continuing education - Career path	- Lack of supportive supervision - Low level of community acceptance - Low payment - Absence of clear career path - Lack of government appreciation
3.	Pastoralists	- Continuing education - Community acceptance and recognition - Personal value/altruism	- Lack of supportive supervision - Absence of means of transportation

3.3-Government Perceptions of Support provided for HEWs

Key informants who participated in the study were asked to describe their perceived support that they provided to HEWs in their respective rural, urban and pastoralist regions, particularly in relation to HEW motivation. They mentioned factors related to motivation that they believe support the health extension program in the country as follow.

Key informants study participants

	Number	Age (mean, range)	% Male
Setting			
Federal	1	28	100%
Regional	3	38.3 (28-49)	100%
Woreda(districts)	3	29.0 (25-36)	75%

3.3.1-Education and Training

Corresponding with the input of almost all HEW participants in rural, urban and pastoralist settings, educational and training opportunities were noted as being of great importance for the motivation of health workforce in the health extension program.

The KIs described several educational and training opportunities organized by the government to upgrade the status of HEWs. One KI described the situation as follows:

It is natural for HEWS to seek for educational opportunity to improve their organizational and personal goals. To achieve this goal, the federal government of Ethiopia has put a system of distance education for HEWs to upgrade themselves to at least a diploma level. This initiative could not bear the desired results, as there is no electricity in rural areas for HEWs to study. Besides, the medium of instruction is in English languages and HEWs found it very difficult to understand the modules by themselves. A summer course was also arranged for them to meet their goal of improving their education but this was also not as successful as expected and the regional government is considering other options of expanding formal conventional college education. (Rural Male 39,KI)

All key informants in the study regions agreed that the national COC exam was too difficult for HEWs to pass, resulting in HEW dissatisfaction. As a result of the exam's difficulty, explained

one KI, only 1,700 HEWs so far has gotten the opportunity to pursue their education at the diploma level. Two reasons for not passing the exam were said to be related to HEW challenges in understanding the questions in English and the clinical aspect of the exam, which is not covered in HEW training. Asked about the long term and short term solution, one of the key informants said the following:

But there is nothing that we can do about the language, as the medium of instruction of the country is English. Personal commitment, such as reading and studying hard, seemed to be the only way out, rather than complaining time and again that the exam should be given in local languages such as Amharic, Afan Oromo or Tigrigna. Besides, maximizing the education opportunity for HEWs is critical to boost their confidence in their work and for their personal benefits and we are planning a specially tailored exam for HEWs.(Rural Male 39, KI)

Another key informant at a higher level suggested experience sharing forums among regions. He noted that promising practices, such as arranging summer tutorial classes, should be taken into account to improve the situation.

The situation in the pastoralist area was more extreme. In Afar all of the KIs interviewed acknowledged that there was a huge problem of implementing the health extension program mainly due to serious capacity limitations of HEWs. As described in the previous sections, HEWs in Afar were recruited from lower grades while the basic national recruitment criterion was a minimum of grade 10 complete. This capacity limitation was perceived to impede the performance of HEWs in pastoralist areas. One of the key informants from the government acknowledged the deep rooted unique problem in Afar as follows:

Afar has got several challenges when implementing the HEP program. In other regions, the primary criteria to be a health extension worker are grade 10 completion. But in our region we have to assign at least two people in each Kebele. Getting grade 10 completes in some Kebeles are extremely difficult, so we are duty bound to select grade 5 and 6 students. Getting fifth and sixth graders were even difficult in some Kebeles. There are some Kebeles with no schools at all...we are obliged to assign someone from the district towns or neighbouring Kebeles where

relatively better educated HEWs are available. In line with their low level of education, their ability to properly attend trainings is also limited accordingly. (Pastoralist Male 27, KI)

Despite all the challenges, one of the KIs said the regional government was now planning to undertake new recruitment procedure to improve the situation. Explaining the plan, the key informant said:

The serious capacity limitation of HEWs greatly affects the performance of the health extension program in our region. For this we are devising different strategies such as providing continuous capacity development trainings and new recruitment criteria, which mainly includes only grade 10 completes and above in the new cohort of HEWs. Giving tailor-made training for newly recruited HEWs is also fundamental to retain them in their work station and help them produce the necessary results. (Pastoralist Male 27, KI)

According to the key informants, in addition to the government, several organizations, especially international NGOs, organized various trainings for HEWs on a wide spectrum of health issues such as TB, HIV/AIDS, water and sanitation. Those trainings according to both KI and HEWs were reported to be the source of motivation for many HEWs. However, for regional and federal government officials these unplanned and sporadic trainings were believed to have negative impact for the overall health extension program. Government officers perceived that most HEWs attended the trainings not for the sake of seeking better knowledge but for gaining what was perceived to be “unfair” financial benefits. According to one KI, the inconsistencies of the allowance paid by the government and some NGOs for attending training could be the source of dissatisfaction for HEWs. This was reportedly being addressed through the collaborative efforts of the government and stakeholders from the civil society organizations, as follows:

Relatively high payment of per diem by NGOs, make HEWs and government managers to fight over things that are not related to the work. But now no NGOs are allowed to go down to the Kebele level and provide trainings and pay per diem directly to HEWs. (Rural Male 39, KI)

3.3.2-Increased Remuneration

Financial incentives, including salaries and benefits, were reported by KIs to be important motivating factors for HEWs in the previous section of this study.

Almost all KI perceived that the recent salary increases by the government would motivate most of the HEWs to perform well. According to KIs, the HEWs monthly salary had recently increased from on average \$ 30 to \$ 60 USD.

One urban KI believed that urban HEWs, unlike any other health staff, are happy about their financial benefits paid by the government. He said a financial incentive was given every month for urban HEWs for their telephone and transportation expenses. The key informant considered the financial benefits as special treatment for urban HEWs and expected them to demonstrate better performance in their work.

Unlike any other government offices, the health bureau of Addis Ababa city administration put in place a system where we acknowledge and recognize health extension workers. For example, we offer an incentive of 343 birr every month to health extension workers on top of their salary for their telephone and transportation expenses. This is not easy. This is done by the city administration to motivate and retain them to accomplish a better job. They are happy about this. (Urban Male 48, KI)

This government perception did not correspond to inputs from urban HEWs, who expressed their appreciation of the increases, but still felt that their incomes were not keeping pace with rampant inflation.

3.3.3-Supervision, Including New Structure

Like HEWs, KIs accepted that supportive supervision plays an important role for the motivation of health workers. Most KIs also acknowledged that the supervision part of the health extension program was problematic.

One KI believed that the government has done its level best in designing, developing and disseminating the necessary policy and strategic documents that facilitate and help supervision in the regions. However, this KI believed that the issue was in implementation of these policy and strategic frameworks at the local levels. He explained:

The ministry is discharging its lofty responsibility in developing appropriate policy and strategy for supervision and the implementation of the strategies and programs at the lower administrative levels, but they become more problematic due to absence of proper monitoring and supervision. The Woredas and Zones do not consider the health extension program as their key task and, as a result, the support system is very loose. (Male 28, KI)

Another KI illustrated how human resources and lack of disinterested supervisors at local levels is inhibiting supportive supervision in pastoralist Afar:

....even though supportive supervision is necessary and we are doing it in stricter terms, it requires the necessary manpower at all levels of administration. ... People were performing HEP work in addition to their other assignments in Afar regional health bureau. ...At least the HEP case team at regional level requires more than three officers to fully manage and supervise HEWs in 32 districts of the region but that was not the case now. (Pastoralist Male 27, KI)

Although not frequent, some of the KIs in urban setting said they provided support to HEWs in their respective areas. According to them, they provided practical support to HEWs in the areas of improving relationship between HEWs and community members, addressing problems by having open discussions with community members and practical support, such as providing physical demonstrations of latrine construction. One of the urban supervisors involved in this study explained how supervisors work in close collaboration with HEWs in conflict management.

There are some neighbours who are in conflict due to misunderstanding of use of drainage. There are those who let the dirt cross the other person's enclosure. It could be from lack of

awareness or due to personal reasons. But, we go door to door and tell them that letting the dirt go through the other person's compound doesn't hurt only that person, but also themselves. We persuade them and make peace among them. (Urban Female 36, KI)

This, KI noted that due to the weak implementation of the supervision program in the country, the government put in place another system that formally engaged health centers as a cluster of five health posts and assign supervisors as part of the health system, with all financial benefits and incentive packages. In the previous arrangements the HEWs were more answerable to the Kebele and Woreda administrative offices than the health centers, which will change with this new system. The system was described as follows:

The health center and health posts together formed a primary health care unit run by one head, which can benefit close to 25,000 people in the surrounding areas. In this way the various experts and professionals in the health center such as health officers, midwives, lab technicians, nurses and pharmacists will provide hands-on support to HEWs in their area of expertise. For example, if a HEW encounters a delivery problem, she can automatically be assisted by midwives in the health center. The big shift in this regard is that now, in the new scheme, HEWs report to the head of the health center instead of reporting to the district administration. This I believe will give huge support to the HEWs, because previously there was only one supervisor for one district and that supervisor was expected to support HEWs in all the 16 packages, which was basically challenging and impossible both in terms of competence and reach. (Rural Male 39, KI)

Some KIs in this study believed that the new supervision system would help HEWs to receive supportive supervision closer to their health posts. According to some KIs, new benefits packages including adjustment of new salary scale and authority for the head of health center will make the health centers now responsible for supervising the health posts. The new system was considered to be an important solution for addressing supervision and follow up problems of the HEP.

According to one of the KIs in Afar transportation problem was one of the biggest contributions

to poor supervision in Afar. He considered a recent settlement program initiated by the government as a good opportunity.

The settlement of the people is not convenient for the health extension program. Now the new resettlement program – a program of bringing the villages together – is in a pipeline. It seems a good program if it is implemented. This might be helpful for the health extension program as well.(Pastoralist, Male 25 KI)

3.3.4-Competing Priorities

When first recruited as rural HEWs, the government decided to recruit only female candidates, with a view to create job opportunities for them and better address the health problems of mother and children. One KI said from the 39,000 HEWs in the country more than 98% of them were female. However, a rural KI noted that deploying all female HEWs was not without a challenge.

...the challenge that we have right now is that most HEWs are married. Most of the husbands are in town and this has become the cause for some HEWs to leave their job and others to travel to town to spend time with their husbands. It is my personal impression that such a thing would seriously affect the amount and quality of their services to the rural community. (Rural Male 39, KI)

Reflecting on HEWs marital status, another key informant involved in the study made the case that:

As a human being, they want to get married and have children. As any person this should not be hindered. So we cannot advise them to marry this or that person, because it's their personal decision. It's hard for me to comment on this. (Extended laugh) (Federal Male, 28 KI)

In general, the KIs interviewed for this study did not present any solutions to the issue of female HEWs having to balance family and work priorities.

3.3.5-Career Development

Although HEWs in urban settings complained about the absence of a career path, one of the KIs argued that there was a functioning system which was designed particularly for HEWs:

Just as other professions there is a workable career structure for urban health extension workers. They can grow to supervisor level... The organizational structure in the health center and health extension program is different, but it is not in a way that benefits one structure over the other. As any worker, the career structure doesn't differ. ... We treat them as professionals with the workers at health centers. If they perform well, we even give them political appointments and promote them to a higher position. (Urban Male 48, KI)

Asked about how the career development structure entertains those urban HEWs with a first degree, another key informant explained:

So long as they are urban health extension workers, the government knows them by diploma qualification. As to me, those who hold their degrees through private means may leave this job and join other government organizations, as the government has not yet recognized any degree holder in urban health extension program. (Federal Male 28, KI)

This explanation demonstrates a tacit acceptance among some KIs that retention will remain an issue for highly qualified HEWs under the current career development structure.

HEWs interviewed for this study complained that they were not treated equally with clinical nurses in hospitals. Interestingly, one urban KI perceived that HEWs were not prevented from developing their clinical skills. According to this KI, the government even wants them to work in close collaboration with health centers and hospitals. However, the key informant acknowledged that, the health posts and the health centers themselves are not willing to work together. The informant went on to say that “currently government is working towards addressing these problems through structural adjustments.” (Urban Male 36, KI)

3.3.6-Recruitment

Most KIs agreed that employment of HEWs was made based on the recruitment criteria set by the government of Ethiopia for rural, urban and pastoralist settings.

However, it should be noted that some supervisors believe that many pastoralist HEWs in the research area were handpicked by district officials without the involvement of community members and other stakeholders, as it was done in rural area. One KI noted that district administrators abused their power and recruited HEWs having some blood relation and favoured those belonging to the same clan. This, they said, impaired the whole system of implementing the health extension program in pastoralist areas.

4-Discussion

As the major part of the primary health care, the Ethiopian HEP is designed to play a critical role in addressing community health through cadres of health extension workers. Deployed in 2003 throughout the country, HEWs have various personal and professional experiences to share particularly in relation to their motivation to their work. This chapter addresses what emerged as critical issues for HEWs, according to the study objectives and in light of the existing literature on health worker motivation.

4.1. Perceived Impact

While implementing the 16 health packages, HEWs and KIs believed that the HEP was having a positive impact, particularly in the areas of reducing child mortality and malaria incidence, among others. The changes they claimed in this study are supported by Ethiopian Demographic and Health Survey (EDHS) 2011⁴. According to the survey, under five child mortality has dropped from 123/1000 in 2005 to 88 /1000 in 2011, use of insecticide treated nets increased from 1.3 percent to 42 percent the contraceptive prevalence rate increased from 15 percent to 29 percent; stunting in under-five children declined from 52 percent to 44 percent and the total fertility rate decreased from 5.4 to 4.8.^{4, 42} The change has also been widely acknowledged by the national and international community in various forums. For example, the HEP has played an important role in the reduction of HIV incidence in Ethiopia.⁴³ Another study by World Health Organization showed that remarkable results has been registered in the areas of family planning, control of HIV/AIDS and intervention related to immunization⁴⁴

Despite the overall positive impact, differences in implementing the HEP packages emerged by setting. Most of the rural HEWs and some urban HEWs reported that they managed to decrease child mortality, which seems plausible. However, the situation in Afar was completely different. Some of the pastoralist HEWs could not even recall most of the contents of health extension packages; leave alone contribute to the reduction of child mortality in their areas.

Furthermore, despite reductions in child mortality, HEWs uniformly reported that they continued to witness mothers dying in their vicinities, which they attributed to insufficient training on

assisting clean and safe delivery. The study indicated that maternal mortality remains to be formidable challenge for the country's health care system. This is supported again by EDHS data, which puts maternal mortality at 673/100,000 in 2005 and 676/100,000 in 2011⁴ Unlike the reduction of child mortality, maternal mortality was a clear source of dissatisfaction for HEWs functioning in all settings⁴. According to EDHS 2011, only 10 percent of mothers deliver in health facilities and less than one percent of them were assisted by HEWs.^{4, 42} One study conducted by the WHO attributed the poor performance in maternal health with skill deficiency of HEWs^{44, 45} A similar study illustrated that lack of ongoing and refresher training was a major barrier in proper functionality of CHWs when adequate time was not allocated for the practical aspect during their initial training.²⁶ In this study as well, HEWs complained that they could not get practical delivery skills during their practical exercises when they were in training centers.

4.2. Gender Specific Issues

Both HEWs and KIs interviewed in the study reported that almost all HEWs were female of above 18 years old, except in pastoralist areas. The difficulty of finding women with grade 10 completion was given as an explanation for differences in Afar. The recruitment of female candidates was mentioned by KI as important step for the health of mother and children in the community. This practice is consistent with other similar studies conducted in developing countries in Africa, Asia and Eastern Europe^{33, 38, 39} However, the sex of community health workers seemed to be not a matter of worries in Latin America and Africa.²⁸ Nevertheless, in this study, from the point of view of HEWs, being a woman and placed in a rural setting was also very challenging, particularly in terms of not only finding marriage partner but also maintaining marriage and travelling long distances. Having children and taking care of them due to the demanding nature of the HEWs job was also reported to be difficult for female HEWs who were expected to provide door to door services. It is unlikely that women placed apart from families would be highly motivated. However, government KIs did not seem to have a solution for this tension. It is interesting to note that gender issue is to a very large extent influenced by larger societal practices and beliefs and gender dynamics in that particular community.²⁸

4.3. Community Response

The community response to the HEP, as experienced by HEWs in this study, was quite varied in urban, rural and pastoralist settings. In rural Amhara, even though it was a gradual process, community acceptance had reportedly been increased. This was partly attributed to the introduction of child treatment services by HEWs. The research revealed similar perceptions of acceptance in pastoralist Afar. A study conducted in 1985 also confirms that equipping village health workers with curative skills gives the workers greater credibility in the eyes of the community.⁴⁶ However, this assertion must be considered with caution, as it was made by pastoralist HEWs who said they could not go to their duty stations due to their regular school attendance in district towns. As such, their familiarity with the community attitudes towards them in the duty stations was questionable.

The perceived community response in Addis Ababa city towards HEWs was reported to be less satisfactory. The “know-it-all” attitudes of the residents as well as lack of trust by the community discouraged urban HEWs to a great extent.

4.4. Remuneration and Benefits

Failing to compensate HEWs adequately resulted in losing the professional services of some HEWs, critically important for the smooth implementation of the health extension program.

As mentioned in this study, the salary of rural HEWs had more than doubled from 500 birr to 1030 birr. Most HEWs reported that they were very much encouraged by the move of the government. In poor countries like Ethiopia financial incentive such as salary increment is considered to be a major motivating factor for HEWs. This finding is supported by several other studies conducted in developing countries³⁵. Despite their happiness about the recent salary increase, the study indicated that the ever increasing cost of living took away most of their gains. The study also revealed that failing to link financial incentives, in the form of salary and other benefits, to performance and educational attainment resulted in the attrition of a significant number of HEWs. This loss of human resources, if sustained, will ultimately pose challenges for the proper functioning of the primary health care system in the country.

Some localized government responses to staff retention were noted in this study. For example,

the Addis Ababa city administration health bureau was proud of providing some 343 birr transportation and telephone allowance for urban HEWs. The health workers are appreciative of the good gesture of the city administration, but did not consider the incentive as a major motivator due to the high cost of living they are experiencing. This suggests that government must review incentive policies in line with inflation.

The study also identified that the high amount of money paid by some NGOs as allowances during meetings and training sessions were good motivators for HEWs. However, the government was wary of these inconsistencies and its adverse effect on the motivation of HEWs who are unable to attend such trainings. The concern emanated from the small amount of allowances paid by the government. Consequently, some KIs believed that HEWs fight for fringe benefits they are getting as a result of certain trainings rather than focusing on their responsibilities of serving the community.

4.5. Education and Training

Factors related to educational opportunities were identified in this study as a universal motivating factor for all HEWs working in rural, urban and pastoralist settings.

While this study consistently found educational opportunity as key motivation across the board, limited opportunities in rural areas and the absence of such opportunities in urban settings seriously affected the motivation of HEWs. This is consistent with a study, which found that educational opportunities, especially when linked with career development, are the main sources of health workers motivation³⁸

Training opportunities were also identified as one of the motivating factors for HEWs when such opportunities were fairly administered. However, they became a key de-motivator when training opportunities were not fairly distributed. A study conducted in Ethiopia indicated that trainees do not receive the same amount of stipends depending on various factors including the whereabouts of the trainees.²⁰²² HEWs also complained that there is elements of favouritism as well.

The study revealed that serious capacity limitations of pastoralist and rural HEWs, particularly in the area of assisting delivery, appears to be a main de-motivating factor for HEWs. Specifically, HEWs expressed a desire for appropriate training to assist clean and safe delivery, as maternal mortality still remains a formidable challenge of the country.

Although increased workload is traditionally considered to inhibit health worker motivation and job performance, this is not necessarily the case when additional work is linked to skill development. According to the WHO, health workers sometimes perform only health promotion tasks, which can be disappointing to communities that lack basic treatment services.²³ For example, rural HEWs expressed great satisfaction when they were given additional responsibilities of providing treatment to children after receiving training on ICCM and CBN, initiated by NGOs. They perceived this training as helping them improve their services and enabled them to avoid time consuming and frustrating referral processes.

Lack of health knowledge was particularly acute in pastoral Afar and identified to be the major inhibitor of HEWs serving the pastoral community. Their capacity limitation was also reflected on their inability of attending standard trainings mostly prepared at the federal level. Another research also emphasised that building the capacity of community health workers is instrumental to be productive in their efforts of health care delivery.⁴⁷ This finding is also complimented by another study conducted in Ethiopia.^{22, 48} Whether existing HEWs could be capacitated was questioned. One KI suggested that replacement of HEWs was a viable option to make the HEP work in pastoralist area.

The study found that continuing education was mentioned as one of the single most motivating factors for HEWs in all settings. This is consistent with one earlier study conducted in Ethiopia.¹⁹ However, the KIs did not mention plans to change the existing training opportunities. One such opportunity was a strategy to help HEWs continue their education at diploma level and above through passing the COC exam. However, rural and urban HEWs were concerned about the difficulty of passing the exam with their limited ability of English language as well as their lack of exposure to curative health, given the clinical focus of the COC exam. Although government has sought to set up tutorial classes and experience sharing forums to learn from one another, this

is perceived to be insufficient by the HEWs. Rather, HEWs have requested a specially tailored examination that suits their public health practice.

4.6. Career Development

Some studies have indicated that career development is an important motivator for health workers^{18, 21} This study also found that career development opportunities were being operational in rural Amhara, but there was no clear career path in Addis Ababa. Particularly Majority of rural HEWs expressed their joy over career development opportunities available in their region. Urban HEWs, in particular, were extremely dissatisfied with the absence of the career development opportunities, with some reported to being on the verge of leaving their job.

Urban HEWs, who were diploma holders with three months HEP training, were extremely unhappy about having their duties restricted to preventive health. Although trained for nursing, they were unable to practice their training in the community given the blanket prevention focus of the HEP. Though prevention is key to the Ethiopian health system, restricting urban HEWs who are clinical nurses from providing curative services has become a source of dissatisfaction, which in turn has had a negative impact on their performance. Their lack of practice in clinical nursing has also impacted negatively on the likelihood of their passing the COC exam, which is a gateway to allowing them to pursue a higher degree. The KIs did not seem to have an immediate solution for this, defending the prevention focus of the HEP, as close to 80% of the national disease burden was reported to be caused by preventable causes²

Urban HEWs complaints that even after attaining some sort of educational advancement, they could not see clear promotional policy, that has been identified as a common de-motivator of health workers in many countries^{21, 38} The research also revealed that the perceived preferential treatment of clinical nurses in hospitals over HEWs, particularly in relation to overtime payment, was a major source of HEW dissatisfaction in urban settings. The argument of one of the KIs about the presence of proper well functioning career development structure was at odds with what almost all HEWs described. The argument of the KI could be partly true and partly defensive, as the informant was responsible for urban HEP. Nevertheless, the fact remains that

urban HEWs do not perceive a clear promotion strategy by the government, which is affecting their motivation.

HEWs were discouraged by their inability to support the community due to their limited health knowledge, particularly in the area of treatment, which they believe to be the prime interest of the Ethiopian community at large. This reinforces a similar study conducted in southern Ethiopia, in which community members encouraged HEWs to include curative services in their program¹⁸ HEWs in both urban and rural settings argued that community members do not respect health workers who are only involved in prevention. The recent efforts made by NGOs and the government in providing training to rural HEWs to treat under-five children and the increase of community acceptance towards them could be taken as a case in point.

This study indicated that urban HEWs have never been acknowledged by the community for their work even though recognition by client was identified by many studies as one of the main factors motivating the health workforce.^{32, 37, 38} According to urban HEWs, the community perceived urban HEWs as political spies, who have missions other than health education. This in fact has negative implication to their work. However, interestingly, a health care professional David Werner suggested that community health care workers need to act as political agents and discharge additional responsibilities, as the underlying cause of poor health in communities is not necessarily related to prevention and treatment of diseases, but rather the inequitable distribution of wealth and land that exists in the community.⁴⁹

According to this study, urban HEWs were at times dealing with highly educated clients who had developed know-it-all attitudes. Such encounters de-motivate HEWs.

It appears that the low level of community acceptance of the urban health extension program coupled with the focus on the preventive health reduced the urban HEWs motivation to perform well in their respective districts.

However, as discussed above, rural HEWs started to provide treatment for children and began to build rapport with the local community and some words of acknowledgement were reported to

be forwarded to them. That helps rural HEWs to stay motivated and accomplish more.

It was common to see the late Prime Minister of Ethiopia and other regional authorities providing award to heroes and heroines in the agricultural sector. However, HEW, felt that their works had never been recognized. They reported that only a few managers congratulated and thanked HEWs in public and then only during midterm and annual meetings. One study also showed that acceptance, support and respect from the community and the formal health system are essential for CHWs to be effective.⁴⁷ In another experimental study conducted in Zambia, social recognition was identified to be the most effective motivator when compared to economic intuitions⁵⁰

4.8. Housing and Transportation

Housing and transportation were reported in this study as key motivating factors for HEWs to stay in their duty stations. One of the most interesting findings that came out in this study was that Afar HEWs need transportation more than anything else, specifically motorbikes or bicycles which they can take to their duty station. As most of pastoralist HEWs were students in big towns, they need transportation to visit the pastoral community during the weekends. This was consistent with another study, which also found out that the absence of transportation was one factor hindering health workers from accomplishing their work, particularly in remote areas.^{38, 41, 51, 52} The availability of reliable transportation system affects how well CHWs are able to meet their performance expectations.⁴⁷

The study noted that housing was not much of motivational factor for pastoralist HEWs as they could stay with their relatives during the few days that they visit the nomadic areas. However, with the high cost of living, rural and urban HEWs were in desperate need of housing facilities. A similar study in Ethiopia pointed out that housing was one of the major motivating factors for health workers²¹.

4.9. Work- Family Balance

The research found that marriage impacts on HEWs motivation, particularly in rural areas. When employed at the age of 18 for most of unmarried rural HEWs, marriage was not that much of an issue. However, as they grow older, they have started to look for their matches, which according to them is impossible in rural areas. Rather, they have boyfriends in urban settings, relatively far from their health posts. Similarly, the husbands of most married HEWs stayed in towns, creating friction in their relationships. The issue of work and life balance has a very serious implication for the attrition of trained workforces, particularly in rural areas. This finding was also supported by a study in Nigeria which explained the attrition rate of young unmarried health workers in rural areas⁵³ Female rural HEWs interviewed in this study described being left with only two choices, one was their personal life with marriage and the other one was retaining the hard won job opportunity they had.

In contrast to this finding, studies conducted in some other countries have suggested that married female health workers are most likely to stay in their duty station than vice versa^{34, 36} Of course, in these studies the husbands were living in the same location. Although deploying women as health workers was extremely important, the absence of strategies to address the issue of creating a conducive family environment has implications in the quality of health care in the country.

4.10. Altruism

Despite challenges, one of the key motivational factors that keep HEWs in their work place and dedicated to health extension work was the intrinsic work satisfaction that they got from serving the community. Many HEWs shared a sense of service and commitment to the community and love of the work, without any external motivating factors. This was true in other settings as well.^{54, 45} A study conducted in Rwanda indicated that majority of the health workers chose their career because of their desire to help their people⁵⁵.

4.11. Unrealistic Expectations

A key study finding was that unrealistic expectations of health officials led HEWs to produce false data, which was accepted without verification. KIs did not agree with HEW claims that the targets were unrealistic and claimed that any target set by the government was based on

empirical evidence. Although the targets may have been evidence based and appropriate, it appears that the government has not provided the necessary inputs, such as supportive supervision and equipment, needed by HEWs to meet the targets. As a result, HEWs are frustrated that they cannot produce the desired results, particularly in urban and pastoralist settings. A study conducted on quality assurance of health care services also identified that addition of work responsibilities as one of the influencing factors of health workers practices.²⁴

4.12. Supervision

A study conducted in 2007 in Ethiopia indicated that supervision plays critical role in addressing HEWs challenges especially those who are living in remote places with the community.²¹ That study indicated that if supervision was supportive, it could be one of the sources of health workers motivation.²¹ Another study by Global CHW indicated that the success of CHWs initiatives hinges on regular and supportive supervision.²⁶ In this study, some supervisors were reportedly supportive and had the ability to motivate workers, while the aim of some others appeared to be commanding and controlling health workers, which de-motivated HEWs.

Some KIs acknowledged that some of the appointed supervisors lacked knowledge on the contents of the 16 health package, which limited their ability to provide support. When combined with a tendency to dictate mandates or targets to the HEWs, close collaboration was deterred. Government attempts to deploy adequate supervisors was noted. However, to date, financial and technical capacity limitations have hindered such efforts. One promising direction shared by a KI is the integration of supervision with the health center. This was believed to be a sustainable solution for supportive supervision related activities. In this arrangement, there will be clear line of duty and avoid unnecessary confusion. Also, the health centers, as a cluster of five health posts, would have the necessary benefit packages such as financial incentives with additional authority to serve as a support hub for any technical and administrative support that the HEW may require.

Most of the supervisors in the original arrangement were specialized in environmental health and they could not provide full support to HEWs. In the new structural arrangement, all the different

health professionals, including health officers, pharmacists, nurses and others are expected to provide technical backstopping to HEWs. This may ultimately help HEWs to build their capacity on various health issues. In addition, the practical experience could help them to pass the COC entrance exam (mostly focusing on clinical aspects of health) and achieve their academic advancements aspiration.

This study suggests that the very presence of supervision plays a critical role in maintaining the quality of health extension work. This finding was also supported by other findings in Ethiopia and other developing countries.^{19, 32, 40} A study conducted in Malawi indicated that improving the management and supervision of health workers would have a significant improvement of health coverage in a cost effective way. (VSO) Maintaining quality supervision was identified to be an area of challenge for the regional government of Amhara.

The federal government of Ethiopia applied a policy of decentralization to implement its health sector development program. In terms of their passing autonomous decisions, the decentralization policy works in some regions and did not work in some others. KIs acknowledged the problem related to supportive supervision and blame the limited implementation capacity of government bodies at regional, zonal and at district level in achieving the desired results. This is consistent with a study that pointed out that supervision in large scale and national programs usually are irregular and nonexistent when compared to small scale ones.²⁶

4.13. Comparison of HEWs motivation and government perceived HEW support priorities.

It is apparent in this study that HEWs and KIs considered financial remuneration, educational opportunities and trainings as well as supportive supervision as key motivational factors of health extension workers in Ethiopia. However as highlighted in the study results and earlier discussion, the perception of some key informants and what HEWs were actually thinking were different in many instances.

The issue of marriage emerged as one of the salient factors of motivation in rural Amhara, which is not perceived as policy priority by the government. Most of the KIs in the region acknowledged the problem but could not allow the transfer of married HEWs to where their spouses are. In the opinion of the researcher, the issue of family and work balance requires the serious attention of the government.

The study also revealed that there was no policy provision for transfer of HEWs from one place to another place under any circumstance. As research shows that those health workers deployed in their area of origin tend to stay longer than workers coming from different areas, this is an important point to consider.²⁵

4.14. Limitations of the Study

All the interviews in this research were conducted by the researcher, who is a 35 year old highly educated man while most of the HEWs were female above the age of 18 years old, with a grade 10 completions and a year of health training. This mismatch of age, gender and educational level may have affected the findings of the study, as HEWs could not speak freely with the researcher. Despite conducting HEW interviews in a culturally appropriate place and having a female note-taker, the researcher suspected a degree of social desirability bias by HEWs. The findings in this study are qualitative and not meant to be generalizable for all HEWs and settings.

5-Conclusions and Recommendations

5.1-Conclusions

The health extension program is considered to be the main vehicle for community health in Ethiopia. To maximize the effectiveness of the HEP, health extension workers must be supported and motivated.

This study has explored the experiences of HEWs while accomplishing their works in rural, urban and pastoralist settings of Ethiopia, with a focus on motivational factors. The study compared this to how government perceives its support of HEWs.

Most of the HEWs interviewed expressed a sense of duty to serve their community. Rural HEWs in particular were satisfied with their achievements, especially in the area of family planning and child health. Many HEWs expressed a desire to improve their skills to contribute even more to the communities they served.

Supportive supervision, continuing education, career development opportunities and salary have been identified by rural HEWs as major motivating factors for improving the service they deliver in their respective areas.

The sense of serving community and high level political commitment have been recognized as major motivational factors for HEWs in the three settings. Recognition by the government and members of the community was also found to motivate HEWs in rural and pastoralist settings.

Competing interests, such as marriage and family issues, inadequate shelter, and unrealistic performance expectations were factors inhibiting motivation of rural HEWs in Ethiopia. Poor supervision, insufficient training and lack of capacity, and competing interests as well as absence of transportation were mentioned by pastoralist HEWs as de-motivating factors.

For urban HEWs the major factors identified as de-motivating included the absence of career development, limited recognition and the problem of housing.

Government efforts to improve the availability of educational opportunities and monetary incentive packages for all HEWs in the country were acknowledged by HEWs. However, HEWs argued that barriers still existed because of difficulties in passing COC exam and due to inadequate financial incentives, given the high cost of living in the country.

In order to address the problem of poor supportive supervision, key informants described new structural adjustments with new benefit packages for supervisors. These have yet to be implemented.

The emergence of competing priorities such as marriage and family matters in rural Amhara and career development opportunity in urban areas needed special and careful treatment to motivate and retain workers in their duty stations. As noted in the Discussion chapter, there seems to be no immediate solution in sight to address such burning motivational issues.

The issue of transportation and recruitment of appropriate staff in pastoralist areas also calls for an urgent and comprehensive action related to HEW motivation. More fundamentally, poor recruitment practices should not be used as an excuse for not addressing the health need of a pastoral community that requires more advanced skill. Grade five and six students are not capable of addressing the health of the pastoral community.

HEWs play a pivotal role in Ethiopia's HEP. As such, their motivation should be given special consideration to support them to continue doing their health care activities in a productive way.

5.2-Recommendations

Based on the study findings, the following recommendations have been made on how government can improve the motivation of HEWs in rural, urban and pastoralist settings of Ethiopia.

5.2.1. Rural HEWs motivation

- To play a proactive role to make use of role models in the community. These people need to be in a formal structure where they can get proper training and serve back the community.
- To continue the training opportunities opened up for HEWs in the area of child treatment such as ICCM, CBN, use of long acting contraceptive methods and clean and safe delivery.
- To offer skill development trainings on delivery and community dialogue to help HEWs contribute to reduction of maternal mortality, given their expressed frustrations with the current state of things.
- To offer formal educational opportunities such as diploma and degree level to be given to all rural HEWs for their personal development and for the benefit of the rural community. Tutorial classes in English language needed to be given to increase the chance of HEWs passing the COC entrance exam.
- To verify of grassroots data at all levels of government to support decision making and to motivate hard working HEWs. Supervisors need to work in close consultation with HEWs to avoid false reporting. This is closely linked to ensuring that targets are realistic, given the resources provided.
- To give special consideration to married women, because they need to be with their families to serve the community with passion and energy.
- To construct houses for HEWs and building standard health posts that can be suitable for delivery, treatment of children and storage of medicines is critical for the quality of care and for motivation of rural HEWs.

5.2.2. For Urban HEWs Motivation

- To put in place mechanisms where health extension workers are promoted and recognized on a formal and regular basis.
- To create linkages between health centers and urban health posts to help urban HEWs provide some clinical services too in an integrated manner.
- To give special attention for salary increment, and other benefits important for transportation and housing as the cost of living in Addis Ababa becoming more and more difficult.

5.2.3. For Pastoralist HEWs Motivation

- To provide continuous capacity development trainings for HEWs taking into account the pastoralist community.
- To provide training for regional, zonal and district as well as Kebele officials on human and resource management to ensure the health benefit of the pastoral community.
- To devise new recruitments criteria which include only grade 10 completes and above in the new cohort of HEWs. Gradual replacement of existing HEWs is necessary.
- To provide motor bikes and/or bicycles as a short term solution for addressing transportation problem in Afar region.
- To construct and staff more schools with necessary man power in pastoralist area help HEWs stay and offer health services while attending their own education in the community.

- To make health posts in Afar answerable to health centers for effective supportive supervision and quality health care services. The involvement of the federal government in supervision and recruitment is also highly recommended in this study for getting at least basic health services to the pastoral community. As a short term solution, arrange a winter campaign to compensate the work lost during summer time, as many of the HEWs in Afar are attending school.

5.2.4. Additional recommendations for the three settings

The government, through supportive supervision can build the limited capacity of regional actors to properly implementing policies and strategies centrally developed by the government. The federal government needs to closely supervise all the activities of HEP in the regions. It also need to set realistic target and be duty bound in monitoring and evaluating the proper implementation of its policies and guidelines by allocating appropriate budget and human resources. Close follow up of linkages between health posts and health centers is also essential to strengthen supportive supervision.

Inter-sectoral collaboration among public, private and civil society sectors is deemed essential to motivate HEWs and fulfil community health demands.

A strong communication strategy including interpersonal approaches through community meetings and media campaign using TV, radio and newspaper need to be devised for community awareness of the HEP program to increase recognition and appreciation of HEWs.

5.2.5. Future research

A follow up quantitative study would provide an indication of the scope of various practices and perceptions that emerged from this study particularly focusing on motivation of HEWs in different settings. Key issues to include in such a survey include: financial and non financial factors contributing for the motivation of health extension work force. The study would also need to assess the contribution of HEWs for maternal health among others.

References

1. CSA. The 2007 National Census Preliminary Report for Ethiopia, 2008.
2. Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Development program(HSDP III) 2005 and Health and Health Related indicator 2006/2007. 2006.
3. Hogan MC, Foreman KJ, Naghavi M, et al. Maternal Mortality for 181 countries,1980-2008:A Systematic Analysis of Progress Towards Millenium Development Goal 5. 2010.
4. CSA. Report on Ethiopian Demographic and Health Survey(EDHS) 2011.
5. Chen L, Evans T, Anand S, et al. Human Resource for Health: Overcoming the Crises. *Lancet* 2004; **364**: 1984-90.
6. Federal Democratic Republic of Ethiopia Ministry of Health. Health and Health Related Indicators 2000. Addis Ababa,Ethiopia; 2008.
7. Global Workforce Alliance. Ethiopia's Human Resource for Health Program,Country Case Study, 2006.
8. World Health Organization. Global Health Atlas.
9. Kloos H. Primary Health Care in Ethiopia under Three political Systems: Community Participation in a War-torn Society. *social science medicine* 1998; **46(45)**: 505-22.
10. Hall JJ, Tayler R. Health for All Beyond 2000: The Demise of the Alma Ata Declaration and Primary Health Care in Developing Countries. *MJA* 2003; **178**: 17-20.
11. Federal Democratic Republic of Ethiopia Ministry of Health. Health Extension Program in Ethiopia. In: Health Extension and Education Center, editor.; 2007.
12. Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Development Program:Woreda Based Annual Core Plan(EFY 2003). 2010.
13. Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Development Program (HSDP III).Annual performance Report. Addis Ababa,Ethiopia, 2009.
14. Federal Democratic Republic of Ethiopia Ministry of Health and Abt Associates. Fourth National Health Account Report. Addis Ababa,Ethiopia, 2010.
15. USAID/HealthSystem 20/20. Health Care Financing Reform in Ethiopia: Improving Quality and Equity. 2012.
16. World Health Organization (WHO). The World Health Report: Health Systems financing,the path to Universal Coverage. Geneva, 2010.
17. Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Development Program (HSDP IV).Annual Performance Report. Addis Ababa,Ethiopia, 2012.
18. Bekele A, Kefale M, Tadesse M. Preliminary Assesment of the Implementation of the Health Services Extension Program:The case of Southern ethiopia. *Ethiopian Journal of Health Development* 2008; **22(3)**: 302-5.
19. Ye-Ebiyo Y, Kitaw Y, G/Yohannes A, et al. Study on Health Extension Workers: Access to Information,Continuing Education and Reference Materials. *Ethiopian Journal of Health Development* 2007; **21(3)**: 240-5.
20. Kitaw Y, Ye-Ebiyo Y, Said A, Desta H, Teklehaimanot A. Assesement of the Training of the First Intake of Health Extension Workers. *Ethiopian Journal of Health Development* 2007; **21(3)**: 232-39.
21. Teklehaimanot A, Kitaw Y, G/Yohannes A, et al. Study of the Working Conditions of Health Extension Workers in Ethiopia. *Ethiopian Journal of Health Development* 2007; **21(3)**: 246-59.

22. Seifu A. Training Human Resources to Improve Maternal Health:A case Study of Pastoralist Health Extension Workers in Afar and South Omo,Ethiopia2011 May 24, 2011. (accessed).
23. World Health Organization. Strengthening the Performance of Community Health Workers in Primary Health Care. Geneva, Switzerland; 1989.
24. Rowe KA, de Savigny D, Lanata FC, Victora GC. How Can We Achieve and Maintain High-Quality Performance of Health Workers in Low Resource Settings? *Lancet* 2005; **366**: 1026-35.
25. Federal Democratic Republic of Ethiopia Ministry of Health. Report on the Assesment of Factors Contributing to and Affecting performance of Health Extension Workers in Selected Woredas of Amhara National Regional State and Southern Nations and Nationalities and People's Region. Addis Ababa,Ethiopia, 2008.
26. Bhutta Z, Lassi Z, Pariyo G, Huicho L. Global Experiences of Community Health Workers for Delivery of Health Related Millenium Development Goals:A systematic Review ,Country Studies and Recommendations for Integration into National Health Systems. Geneva: World Health Organization, 2010.
27. World Bank. The Health Extension Program in Ethiopia. Washington DC: World Bank, 2013.
28. Lehmann U, Sanders D. Community Health Workers:What do we know about them?.The State of the Evidence on Programmes,Activities,Costs and Impact on Health Outcomes of Using Community Health Workers. Geneva, 2007.
29. Haines A, Sanders D, Lehmann U, et al. Achieving Child Survival Goals:Potentiall Contribution of Community Health Workers. *Lancet* 2007; **369**(9579): 2121-31.
30. Lewin S, Munabi-Babigumira S, Glenton C, et al. Lay Health Workers in Primary and Community Health Care for Maternal and Child Health and the Management of Infectioous Diseases. 2010; (3).
31. Sigh P, Sachs J. 1 Million Community Health workers in sub-Saharan Africa by 2015. 2013; **6736**(12): 62002-9.
32. Mathauer I, Imhoff I. Health Worker Motivation in Africa:The Role of Non-Financial Incentives and Human Resource Management Tools. *BMC* 2006; **4**(24).
33. Franco LM, Bennett S, Kanfer R, Stubblebine P. Determinants and Consequences of Health Worker Motivation in Hospitals in Jordan and Georgia. *social science medicine* 2004; **58**(2): 343-55.
34. Lehmann U, Dielman M, Martineau T. Staffing Remote Rural Areas in Middle-and Low-Income Countries: A Literature Review of Attraction and Retention. *BMC* 2008; **8**(19).
35. Henderson NL, Tulloch J. Incentives for Retaining and Motivating Health Workers in Pacific and Asian Countries. *BMC* 2008; **6**(18).
36. Fragar JL, Depczynki CJ. Beyond 50.Challenges at Work for Older Nurses and Allied Health Workers in Rural Australia:A Thematic Analysis of Focus Group Discussions. *BMC* 2011; **11**(42).
37. Mbindyo P, Gilson L, Blaauw D, English M. Contextual Influences on Health Worker Motivation in District Hospitals in Kenya. *BMC* 2009; **4**(43).
38. Willis-Shattuck M, Bidwell P, Thomas S, Wyness L, **Blaauw D, Ditlopo P**. Motivation and Retension of Health Workers in Developing Countries:A systematic Review. *BMC* 2008; **8**: 247.

39. Save The Children Every One. Women on the Frontlines of Health Care: State of the World Mothers 2010. 2010.
40. Yimer E. An Assesement of the Implementation of Health Extension Program in Selected Woredas of South Wollo Zone of Amhara Regional State. Addis Ababa: Addis Ababa University; 2010.
41. Mukasa G. AMREF's Experience of MNCH in Pastoralist African Communities. UK: AMREF, 2009.
42. CSA. Report on Ethiopian Demographic and Health Survey (EDHS). 2011.
43. Federal Democratic Republic of Ethiopia Ministry of Health. HIV/AIDS and Health Related Millenium Development Goal:The Experience in Ethiopia. 2010.
44. Argaw H. The Health Extension Program (HEP) of Ethiopia:Summary of Concepts,Progress,Achievement and Challenges. 2007.
45. Devkota B, Teijlingen Ev. Why did they join? Exploring the Motivation of Rebel Health Workers in Nepal. *Conflictology* 2012.
46. Sandlers D. The struggle for Health Medicine and the Politics of Underdevelopment. London Macmillan 1995.
47. Jaskiewicz W, Tulenko K. Increasing Community Health Workers Productivity and Effectiveness;A Review of the Influence of the Work Environment. *Human Resource for Health* 2012; **10**(1): 38.
48. Seifu A. Training Human Resources to Improve Maternal Health:A Case Study of Pastoralist Health Extension Workers in Afar and South Omo,Ethiopia. (accessed May 24 2011).
49. Werner D. The Village Health Worker: Lackey or Librator? World Health Forum; 1981: 46-68.
50. Ashraf N, Bandiera O, Lee S, Musconda M. Can Strategic selection and Remuneration Improve Retention and Performance of Community Health Workers? *ipa* 2012.
51. Willis-Shattuck M, Binwels P, Thomas S, Wgness L, Blaauw D, Dotlopo P. Motivation and Retention of Health Workers in Developing Countries:A Systematic Review. *BMC Health Science Research* 2008; **8**(247).
52. Mukasa G. AMREF's Experience of MNCH in Pastoralist African Communities. UK: AMREF, 2009.
53. Ebuehi O, Campbell P. Attraction and Retention of Qualified Health Workers to Rural Areas in Nigeria:A Case Study of Four LGAs in Ogun State,Nigeria. *Rural and Remote Health* 2011.
54. Devkota B, Teijlingen VE. Why Did They Join?Exploring the Motivations of Rebel Health Workers in Nepal. *Conflictology* 2012.
55. Paul F. Health Worker Motivation and the Role of Performance Based Finance Systems in Africa:A qualitative Study on Health worker motivation and the Rewandan performance Based Finance Initiative in District Hospitals. *Development Destin Studies Institute* 2009.

Appendix A

Information Sheet

A. Individual Interviews

Health Extension Workers (HEWs)

This information sheet and consent form will be translated into Amharic. During the recruitment phase (January 1, 2012 - January 15, 2012), the researcher will identify potential participants and will spend some time with each one individually to read and explain this information sheet and consent form to them and to answer any questions that they may raise. Those agreeing in principle to participate must be given a copy of the information sheet in their preferred language and allowed adequate time to reflect on its contents and their implications before being asked to sign the informed consent form.

The Study is Exploring factors affecting HEWs Motivation in urban, rural and pastoralist districts of Ethiopia.

Consent Form Introduction

Hello and welcome. Thank you for giving me your time. My name is Sisay Abebe Shega. I work for an organization named Lambadina Institute Health and Development Communication. I am registered at the University of Witwatersrand in South Africa. This study is being conducted as part of my degree requirements. The purpose of this study is to get a better understanding of the experiences of health extension workers in three districts of Ethiopia.

You are invited to volunteer to participate in this research that is being conducted in East Este Woreda of Amhara region, Mille Woreda of Afar region and Yeka sub city of Addis Ababa city administration. You should not agree to participate in this study unless you fully understand what is asked of you and are completely happy with all the procedures involved. If you do not understand the information or have any other questions, feel free to ask the interviewer.

Purpose of this interview

The purpose of this study is to collect information to understand your experience as a Health Extension Worker. If you agree to take part in an individual interview, I will ask you some questions about your background and your experiences while working as health extension worker. The interview will take a maximum of 50 minutes

You have been invited to take part in the study because you are a health extension worker in East Este/Mille districts/Yeka sub city. Your views will help me to understand your experience of being a health worker.

What procedures are involved?

You are being asked to participate in an interview. With your consent, I will be asking you some personal information and questions related to your motivation experiences at work. A female note- taker will be with me during the interview. There are no right and wrong answers to the questions; I want to know about you and your work.

I would like to use this voice recorder to record what you say so that I do not miss anything. The audio tape will be destroyed after two years of the end of the project. After the interview the recordings will be written down word for word and then translated into English. I will be using this written document and note-takers note to write my research report. Your name will not be written in the documents. No one outside of the interview will be able to tell, from the written document, what you have said.

I may want to ask you more questions at a later stage. If this is the case, I will again ask for your written consent to take part in additional interview and again your participation will be entirely voluntary.

Are there any risks or discomforts from participating in this study?

We will conduct the interview in a private and safe place we both will feel comfortable. You may feel uncomfortable in answering some of the questions. You do not have to answer any question that makes you uncomfortable.

Possible benefits of this study

You will get no direct benefits from participating in this study. However, the information collected from this study will be helpful and taken in to account in addressing challenges of health extension workers and enhancing their motivation in Ethiopia.

What are your rights as participant?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time without giving any reason. Some of the questions might be very personal. Please remember that you are free not to answer a question if it makes you feel uncomfortable. Also you are free to leave the interview at any stage and for any reason. Whether you chose to take part in the interview or not, it will not affect your work.

Confidentiality

All the information that you give in this study will be kept strictly confidential. The consent forms that you will be asked to sign will be securely stored and access will be limited to the researcher and supervisors at the University of the Witwatersrand. The consent forms cannot be linked to the answers you give to the questions. The results of the study will be presented in a respectful manner and no information, which could enable anyone to identify you personally, will be reported. The researcher will work with colleagues and supervisors to make sure you are kept informed about the progress of the project and to share with you any reports or publications we produce.

Costs

There is no cost to you participating in this study.

Compensation

You will not be paid for participating in this interview.

Has this study received ethical approval?

The Human Research Ethics Committee of the University of Witwatersrand has given written approval for this study. The reference number for this study is M110949. Ethics Committee makes sure that all research undertaken by Wits students respects the rights and dignity of participants.

If you want any information regarding your rights as research participants, or complaints regarding this research study, you may contact the chairperson of the University of the Witwatersrand, Human Research Ethics Committee (HREC), which is an independent committee, established to help protect the rights of research participants at (011) 717 2230/1.

If you have any questions about the research you may contact:

The researcher, Sisay AbebeShega

Lambadina Institute Health and Development Communication

Cell 0911639394

Off. 0116189780/79

E mail sisaymc@yahoo.com

P.O.BOX. 626 code 1029

Addis Ababa

Ethiopia

INFORMED CONSENT FORM

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. He explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study.

I have received the information leaflet for the study and have had enough time to read it on my own and ask questions. I feel that my questions regarding participation in the study have been answered to my satisfaction.

I have been told that the information I give to the study will together with other information gathered from other people, be anonymously processed into a research report and scientific publications. I am aware that this report, and any publications from it, will be shared with me and other concerned health extension workers and that will keep me informed about the progress of the research.

I am aware that it is my right to withdraw my consent in this study without any reason. I hereby, freely and voluntarily give my consent to participate in the study.

Participant's Name.....

Participant's Signature.....Date.....

Researcher's Name.....

Researcher's Signature.....Date.....

Witness's Name.....

Witness's Signature.....Date.....

INFORMED CONSENT FORM—Audio-tape

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. He explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study.

I am aware that my voice will be recorded. I have been told that only the research team will hear the audio recordings. I have been told that the audio recordings will be destroyed two years after the study.

I am aware that it is my right to withdraw my consent in this study without any reason. I hereby, freely and voluntarily give my consent to be audio taped in the study.

Participant's Name.....

Participant's Signature.....Date.....

Researcher's Name.....

Researcher's Signature.....Date.....

Witness's Name.....

Witness's Signature.....Date.....

A. Interview Guide for Health Workers

Part I: General Information

No	Background Information	
1	Age of participant	
2	Highest grade Achieved	
3	How long have you worked as a health extension worker?	
4	Settings	Rural 1 Urban 2 Pastoralist 3

Part II: Interview guide for health workers

Questions for HEWs:

1. Can you describe your work to me?
 - a. General description
 - b. Typical day description
 - c. Any changes over time
2. Can you describe your relationship with the community that you're serving?
3. Can you describe your relationship with your supervisor and work colleagues?
4. How have you found the experience of being a Health Extension Worker?
 - a. Professionally, e.g. support systems, recognition, etc.
 - b. Personally, e.g. living in the assignment area, relationships, etc.
5. What do you think about your future as a Health Extension Worker?

Appendix B

INFORMATION SHEET

B. Individual Interview

Key Informants (Health Extension Program Coordinators)

These information sheet and consent forms are translated into Amharic. During the recruitment phase (January, 1- 2012 - January 15, 2012), the researcher will identify potential participants and will spend some time with each one individually to read and explain this information sheet and consent form to them and to answer any questions they may want to raise. Those agreeing in principle to participate must be given a copy of the information sheet in their preferred language and allowed adequate time to reflect on its contents and their implications before being asked to sign the informed consent form.

The Study is Exploring factors affecting HEWs Motivation in urban, rural and pastoralist districts of Ethiopia.

Consent Form Introduction

Hello and welcome. Thank you for giving me your time. My name is Sisay Abebe Shega. I work for an organization named Lambadina Institute Health and Development Communication. I am registered at the University of Witwatersrand in South Africa to do research to get a better understanding of factors affecting HEWs motivation in three districts of Ethiopia.

You are invited to volunteer to participate in this research that is being conducted in East Este Woreda of Amhara region, Mille Woreda of Afar region and Yeka sub city of Addis Ababa city administration; you should not agree to participate in this study unless you fully understand what is asked of you and completely happy with all the procedures involved. If you do not understand the information or have any other questions, feel free to ask the interviewer.

Purpose of this Interview

The purpose of this study is to collect information to understand factors affecting motivation of health extension workers while performing their work in their deployment areas. You are invited

to take part in an individual interview. I will ask you some questions about yourself and the government's current plan and future strategies for factors affecting motivation of HEWs. The interview will take a maximum of 5 minutes.

You have been invited to take part in the study because you are a health extension program coordinator in East Este/Mille districts/Yeka sub city. Your view will help me to understand the current and future strategies of the government about factors affecting your motivation at work.

What Procedures are involved?

You are being asked to participate in an interview. With your consent I will be asking you some personal information and questions related to the current and future motivational strategy of government of Ethiopia regarding its health extension workers. There are no right and wrong answers to the questions; I want to know about government's HEWs motivational strategies and factors that affect them.

I will be using this voice recorder to record what you say. The audio tape will be destroyed after two years of the end of the project. After the interview the recordings will be written down word for word and then translated to English. I will be using this written document and note-takers note to write my research report. Your name will not be written in the documents-only a unique identification code will be given so that no one outside of the interview will be able to tell, from the written document, what you have said.

I may want to ask you more questions at a later stage. If this is the case, I will again ask for your written consent to take part in additional interview and again your participation will be entirely voluntary.

Are there any risks or discomforts from participating in this study?

I will conduct the interview in a private and safe place where we both will feel comfortable. You may feel uncomfortable in answering some of the questions. You are free to not to answer any questions that makes you uncomfortable.

Possible benefits of this study

You will get no direct benefits from participating in this study. However the information collected from this study will be helpful and taken in to account in addressing factors affecting motivation of health extension workers in Ethiopia.

What are your rights as participant?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time without giving any reason. Please remember that you are free not to answer a question if it makes you feel uncomfortable. Also you are free to leave the interview at any stage and for any reason. Whether you chose to take part in the interview or not, it will not affect your work.

Confidentiality

All the information that you give in this study will be kept strictly confidential. The consent forms that you will be asked to sign will be securely stored and access will be limited to the researcher and supervisors at the University of the Witwatersrand. The consent forms cannot be linked to the answers you give to the questions. The results of the study will be presented in a respectful manner and no information, which could enable anyone to identify you personally, will be reported. The researcher will work with the staff to make sure you are kept informed about the progress of the project and to share with you any reports or publications we produce.

Costs

There is no cost to you participating in this study.

Compensation

The researcher will not pay any money to the study participants for their contribution.

Has this study received ethical approval?

The human Research Ethics Committee of the University of Witwatersrand has given written approval for this study. The reference number for this study is M110949. The ethics committee makes sure that all research undertaken by Wits students respects the rights and dignity of participants.

If you want any information regarding your rights as research participants, or complaints regarding this research study, you may contact the chairperson of the University of the Witwatersrand, Human Research Ethics Committee (HREC), which is an independent committee, established to help protect the rights of research participants at (011) 717 2230/1.

If you have any questions about the research you may contact:

The researcher, Sisay Abebe

Lambadina Institute Health and Development Communication

Cell 0911639394

Off. 0116189780/79

E mail sisaymc@yahoo.com

P.O.BOX. 626 code 1029

Addis Ababa

Ethiopia

INFORMED CONSENT FORM

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. He explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study.

I have received the information leaflet for the study and have had enough time to read it on my own and ask questions. I feel that my questions regarding participation in the study have been answered to my satisfaction.

I have been told that the information I give to the study will together with other information gathered from other people, be anonymously processed into a research report and scientific publications. I am aware that this report, and any publications from it, will be shared with me and other concerned health extension workers and that will keep me informed about the progress of the research.

I am aware that it is my right to withdraw my consent in this study without any reason. I hereby, freely and voluntarily give my consent to participate in the study.

Participant's Name.....

Participant's Signature.....Date.....

Researcher's Name.....

Researcher's Signature.....Date.....

Witness's Name.....

Witness's Signature.....Date.....

INFORMED CONSENT FORM—Audio-tape

I hereby confirm that the person seeking my informed consent to participate in this study has given me information to my satisfaction. He explained to me the purpose, procedures involved, risks and benefits and my rights as a participant in the study.

I am aware that my voice will be recorded. I have been told that only the research team will hear the audio recordings. I have been told that the audio recordings will be destroyed after two years of the study.

I am aware that it is my right to withdraw my consent in this study without any reason. I hereby, freely and voluntarily give my consent to be audio taped in the study.

Participant's Name.....

Participant's Signature.....Date.....

Researcher's Name.....

Researcher's Signature.....Date.....

Witness's Name.....

Witness's Signature.....Date.....

Key Informant Interview Guide

Part I: General Information

No	Background Information	
1	Age of participant	
2	Sex	Male 1 Female
3	Educational status	
4	How long have you worked as health extension program coordinator?	
5	Settings	Rural 1 Urban 2 Pastoralist 3

Part II. Key Informant Interview Guide

Questions for key informants

Could you please describe your role within the Health Extension Program, specifically how you interact with HEWs?

How HEWs are currently supervised and managed in your area?

Probe on what aspects of their work are monitored, how decisions are made, etc. as themes arise

Can you describe any **strategies or systems** you know of that the government has put in place to support HEWs?

Probe to differentiate between the strategies & systems as designed and how they are actually being implemented

Can you comment on the quality of these forms of support?

Can you describe any additional ways that you believe government could be supporting HEWs?

Appendix C

HREC Approval

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mr Sisay Abebe Shega

CLEARANCE CERTIFICATE

M110949

PROJECT

Exploring Factors Affecting Health Extension
Workers Motivation in Selected Urban, Rural
and Pastoralist Districts in Ethiopia

INVESTIGATORS

Mr Sisay Abebe Shega.

DEPARTMENT

School of Public Health

DATE CONSIDERED

30/09/2011

M1109490DECISION OF THE COMMITTEE*

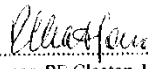
Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE

16/01/2012

CHAIRPERSON


(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor : Sara Nieuwoudt

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...