

EXPLORING INFLUENCES ON NURSE MOTIVATION IN BUTAJIRA
ZONAL HOSPITAL, ETHIOPIA

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Ten Keywords: Nurses, Motivation, Determinants of motivation, financial incentives, Non-financial incentives, salary, supervision, retention, quality of care and performance, Ethiopia.

LIST OF ABBREVIATIONS/ACRONYMS

AHWO; African Health Workforce Observatory

BZH; ButajiraZonal Hospital

FGD; Focus Group Discussion

HDC; Higher Degree Committee

HIV; Human Immunodeficiency Virus

HSDP; Health Sector Development Program

JLI; Joint Learning Initiative

MOH; Ministry of Health

MPH; Masters in Public Health

TB; Tuberculosis

UWC; University of Western Cape

WHO; World Health Organization



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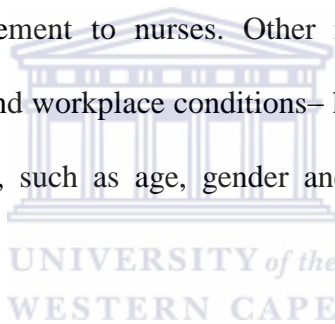
Abstract

Background: Low motivation, defined as an individual's lack of willingness to maintain and exert effort to attain organizational goals, is a problem in Ethiopia. Its consequences are poor quality of health care or performance, lack of retention and inequity. This study explored influences on nurse motivation in Butajira Zonal Hospital (BZH), and specifically investigated the influences of financial and non-financial incentives on nurses' motivation at work.

Methods: A qualitative methodology, consisting of both in-depth interview and focus group discussion (FGDs) data collection methods was adopted. The study population was all nurses working at BZH with more than two years of experience, from which a sample of fifteen nurses (representing a balance of age, gender and category) was purposefully selected. Following informed consent, these fifteen nurses were interviewed by the investigator, and were followed in a second stage by three focus group discussions; with six participants each (total eighteen). Both the interviews and the discussions were conducted mostly in Amharic and tape recorded, transcribed and translated by the researcher.

The data was analysed using thematic analysis. After reading, transcriptions were coded in informants' own words and phrases. These were examined, categorised and consistent themes identified and then coded with keywords to represent the content, which were considered to constitute the 'emerging themes'.

Findings: In both the FGDs and interviews, a number of key themes were identified relating to both nurses' self-reported motivation and the factors influencing this at BZH. Altruism and professional pride ('love of the profession') as a source of intrinsic motivation emerged as a key theme, counterbalanced by a perception of nursing as having significant job risks (e.g. contracting infections from patients). With respect to financial incentives, salaries too low to meet living costs, unfair taxation on overtime payments, and the absence of a salary grading system for nurses was all raised as negative influences on motivation. While team spirit and solidarity amongst nurses was a positive feature of the work environment, relationships between doctors and nurses were described as poor, aggravated by large salary differentials, and perceived indifference of management to nurses. Other non-financial incentives– training, recognition systems, supervision and workplace conditions– had mixed influences on motivation at BZH. Finally, personal factors, such as age, gender and origin or married in the region, influenced reported motivation.



Conclusions and Recommendations: The Ethiopian health system has paid great attention to increasing numbers, expanding training of, and creating specializations for, nurses. However, less attention has been given to their working conditions and the appropriate package of financial and non-financial incentives that will sustain performance and retention. These need to be addressed at the hospital itself, at higher levels of the system and at a broader policy level.

Managing motivation requires keeping a broad perspective and innovative approaches that address the range of influences identified in the study. Solutions should be context based and sensitive to influences beyond the commonly understood sources of motivation.

1. Introduction

1.1. Background

Ethiopia is one of the least developed countries of the world, with the second largest population in Sub-Saharan African. In the recent 2007 census, the country had a population of 73.9 million (AHWO, 2010).

Ethiopia also has one of the lowest health workforce densities in the world (Joint Learning Initiative [JLI], 2004), and some of the worst health indicators globally (Serneels et al., 2007). The national health workforce density is 0.84 per 1,000 population. This is far lower than the standard set by the World Health Organization of 2.3 per 1,000 population (AHWO, 2010). The country is also confronted with extreme intra-country inequalities –urban/rural, inter-regional, and between established and ‘emerging regions’ in particular (Yayehyirad&Damen, 2009). In 2010, there were 2,152 physicians and 21,488 nurses in service, with high proportions of both professionals i.e. 46% and 28% respectively, working in the capital city, Addis Ababa (AHWO, 2010). This concentration in the city is due in part to low health workforce motivation to work in rural areas.

Within the broader field of human resource development (depicted in Figure 1), health workforce motivation relates to strategies (such as financial and non-financial incentives) for performance, retention and recruitment.

Figure 1: Components of Human Resource Development



As Franco et al. (2002: 54) put it: “motivation is an individual’s willingness to exert and maintain an effort towards the organization’s goal”. Motivation is not only a push factor causing uneven distribution of the health workforce, it also affects the performance of the health workforce, the quality of care provided and the efficiency of health care services (Paul, 2009). Various studies on human resources for health have concluded that de-motivation is one of the biggest challenges facing health care services (Mathauer&Imhoff, 2006; Schmidt-Ehry& Seidel, 2003). The negative impacts of low motivation are multiple, affecting not only individual performances- impoverished quality of care, delay at work and absenteeism (Uneke et al., 2008) but also the performance of health care facilities and the health system in general. In addition, it manifests in increased migration of health workers and inequity in access (WHO, 2003; JLI, 2004).

In a recent study in Ethiopia, Serneels et al. (2007:14) identified the performance problems associated with low motivation as: “absenteeism and shirking, pilfering drugs and materials, informal health care provision and illicit charging, and corruption”.

A failing public sector affects the poorer segment of the society most. However, the situation has not received due focus i.e. the influences of motivation and its relation with performance have not been adequately investigated (Serneels et al., 2007).

In an effort to enhance health worker motivation, the Ministry of Health of Ethiopia has developed strategies such as making public sector careers more attractive, introducing new salary scales and improving career structures (Ministry of Health, 1999). The impacts of these strategies on motivation have not been fully evaluated.

1.2. Ethiopian health system context

The Ethiopia health system has been shaped by significant socio-political and economic influences over the last few decades. Those influences are both internal and international in nature.

Prior to the advent of the transitional government in 1993, the country was involved in a long internal conflict that lasted from 1974 to 1991, which impacted the health sector severely. Yayehyirad et al. (2012: 136) described the situation as follows: “The long internal conflict that culminated in the takeover of power by the Ethiopian People’s Revolutionary Front (EPRDF) has exacted heavy tolls on the whole country. A large number of health facilities have been destroyed and/or had stopped functioning, particularly in the northern half of the country”. In the period following 1993, the country was in a state of political change or reform involving a shift from a highly centralized political system to decentralization and democratization. As Yayehyirad et al. (2012: 138) put it: “the democratization and decentralization process is expected to facilitate focus on grass-root problems and ensure more responsive and responsible governance. Healthcare is bound to gain from this process”.

Ethiopia's internal reforms have occurred against a backdrop of growing globalization, responsible for both positive and negative influences worldwide. The radical change in technology and the information revolution have impacted on health plans, even in the remotest areas. Global trends, whether related to donor "conditionalities", Structural Adjustment Policies (SAP), the adoption of the Millennium Development Goals, and shifts towards health systems strengthening (HSS) have all played their part in shaping the Ethiopian health system, influencing approaches to government health expenditure and health priorities (Yayehyirad et al., 2012).

In the year 1997/98, the transitional government developed the first five-year Health Sector Development Program (HSDP-I), prioritizing disease prevention and decentralizing health care delivery. When this program failed to realize its intended goals, it was succeeded with a new component in the next plan, HSDP-II (2002/03–2004/05), engaging NGOs to implement basic health packages. HSDP-III (2005/06–2009/10) emphasised again increasing the government budget for health and partnership between government and NGOs (Wamai, 2009). In their chapter on Ethiopia for the book "Good Health Care at Low Cost II" (Balabanova et al, 2011), Banteyerga et al.(2011:85) concluded that: "Ethiopia has demonstrated that low-income countries can achieve improvement in health and access to health services". Wamai (2009:283) further indicated that: "Ethiopia has seen positive developments in many health indicators since the democratic government process began...the healthservice system have expanded; overall and percapita health spending has increased significantly;and there is a policy and program forhealth improvements in the country focusing onexpanding primary health coverage universally."

1.3. Health workforce

For a health system to function there needs to be a due focus on human resources. Human resources are the pillar of any health system. The country – after years of neglect on the issue – has increased its focus on human resources (AHWO, 2010), and the increases have been dramatic. During the ten year period 1997-2007, the number of nurses, for example, increased from 2,800 to 18,000 (Wamai, 2009), and in the five year period 2003/4-2009 an additional 6,000 nurses entered the workforce (Table 1). Also significant has been the introduction of the health extension workers that are the “frontline” health workers, of which there were 31,000 in 2009.

Both health and education ministries of Ethiopia have invested greatly in the expansion of health worker training schools through both public and private sectors. As a result, the number of health science colleges has grown remarkably (AHWO, 2010).

Nurses are the second largest category of the human resources for health in Ethiopia, next to health extension workers. The heavy workloads in hospitals, health centres and other health institutions are managed largely by nurses. There are few physicians in hospitals, and nurses are “the eye of health care staff about patients’ condition” (Ethiopian Nursing Association, 2012). As the health work force classification mapping of the country reports (AHWO, 2010:45): “Nursing professionals plan, manage, provide and evaluate nursing care services for persons in need of such care due to effects of illness, injury or other physical or mental impairment, or other physical or mental impairment, potential risks for health.”

Table 1: Number of health workers and health worker/population ratios Ethiopia
(Source:AHWO, 2010).

Health occupation category	2003-4		2009	
	Number	Health workers per 1,000 pop	Number	Health workers per 1,000 pop
Physician (general practitioner, specialist)	1,996	0.0281	2,152	0.0272
Specialist	775	0.0109	1,001	0.0272
Health officer	683	0.0096	1,606	0.0205
Pharmacist	172	0.0024	632	0.0081
Nurses(all types)	14,269	0.2009	20,109	0.2576
Midwife	1,274	0.017	1,379	0.0176
Laboratory technician	2,403	0.0338	1,957	0.0249
Laboratory technologist	NA	NA	866	0.0110
Environmental health professional	1,169	0.0164	1,246	0.0159
Radiographer	300	0.0042	169	0.0021
Health assistant	6,628	0.0933	1,486	0.0189
Frontline health worker	15,752	0.2217		
Health extension worker	NA	NA	30,950	0.3943
Other (health educator, physiotherapist, X-ray technician, dental technician, biologist)	NA	NA	1,733	0.3943
TOTAL	45,817	0.6447	66,314	0.8444

Table 2 below shows the type of nurses and their numbers in the country. The largest category i.e. clinical nurses get training which is comprehensive in nature so that they can serve both as midwives as well as general nurses.

Table 2: The number of nurses in Ethiopia by types (Source: AHWO, 2010).

Type of nurse	Total	Female	Female%
Nurse(BSc degree)	1,700	718	42.2
Midwife	1,350	961	71.2
Clinical nurse	16,404	8,264	50.4
Psychiatric nurse	68	31	45.6
Anaesthetic nurse	174	65	37.4
Public health nurse	951	336	35.3
Other nurse (dental, ophthalmic ORL)	386	193	50.0

Currently, there are a number of Colleges of Nursing, which are both governmental and private/NGO owned, providing two years basic nurse training. On graduation, the Ministry of Health, through the Health Professional Council, will register and license them to practice the profession. The Health Professional Council is a regulatory and advisory body accountable to the Minister of Health in Ethiopia, established in 2002 under the Ministers Act Number 72 of 2002 (Ethiopian Nursing Association, 2012).

The Career Structure program, introduced in 2009, was intended to motivate and retain health workers including nurses. However, this did not satisfy or achieved the intended effect on the health workers, and was subsequently revised in 2011 by the government. The latest proposals are still be processed by the Ministry of Health of Ethiopia and as yet not implemented (MHE, 2011).

In sum, over the last two decades time, nurses have seen improvements in the facilities they work, their workloads have eased as a result of the radical increments in the number of nurses, and specializations have widened.

1.4. Description of Study Setting

Meskan District is situated in the southern part of Ethiopia. It is a densely populated area 133 km away from the capital, Addis Ababa. In 2011, the population size was 174,647, of which 48% were male and 92% lived in rural areas (Mekan District Report, 2011). Islam is the dominant religion in the area. One fifth of men are in polygamous marriages, particularly common among the Meskan and Silti ethnic groups (Desta, 1994). In the District there is one public zone hospital, 7 clinics, 7 health centres and 39 health posts (Mekan District Report, 2011).

The Butajira Zonal Public Hospital is found in a small town of Butajira in Meskan district. It was established in 2002. It was built by the community, and anecdotal evidence suggests that it has high status in the eyes of the community relative to other hospitals. The hospital serves 1.3 million people coming from Meskan and seven other districts. It has 110 beds and provides common clinical services such as emergency, outpatients (OPD), maternity, inpatient (IP), laboratory, as well as more specialized functions such as x-ray and ultrasound investigations, physiotherapy, comprehensive TB and HIV care (testing, prevention of mother-to-child transmission, antiretroviral therapy) and psychiatric care. The BZH has 10 physicians, 56 nurses, 9 midwives, 12 laboratory technicians, 7 pharmacists, and 3 anaesthetists (BZH Report, 2012).

1.5. Rationale for the study

In most developing countries, including Ethiopia, human resource management fails to get proper attention (WHO, 1989). In addition, in resource poor settings, the relative roles of intrinsic and extrinsic motivation, and the influences of incentives on motivation are not yet adequately explored and need more investigation (Dieleman & Harnmeijer, 2006).

Meskan district, as discussed above, is a rural and resource-poor setting. Turnover of health workers is high; many leave for bigger towns and cities. For instance, BZH reports show that the turn-over for physicians and nurses was 36.4% and 13.7% respectively in 2011. From the researcher's experience, users and communities are frequently heard complaining about the quality of services given by health professionals, especially nurses. Patients regularly encounter discourtesy, failure to give the proper care and under-performance by providers. As shown above, the nurse to population ratio in Ethiopia, although increasing, is still very low. The situation worsens as you move from urban to rural areas.

Even though extensive reforms have had positive impacts on nurses, motivational problems remain. In the context of health sector reforms, insight is needed on the determinants of motivation; particularly on how financial and non-financial incentives impact on nurses' motivation in a rural resource-poor setting such as the BZH.

There are very few studies of the kind at the national level (Serneels et al. 2007), and this study is the first of its kind in the Meskan district. It will assist policy makers to design programs to improve the motivation of nurses in particular and health workers in general working in rural areas in Ethiopia. The study will also provide information on the issue of motivation for the local administrators in particular and the regional government. It will also be used to identify questions for further studies on the issue.

2. Literature Review

This section starts with a definition of the terms “motivation” and “incentives” and how both financial and non-financial incentives play a role in health workers’ motivation. It also examines studies of factors influencing motivation in developing country settings and methods for studying motivation. It concludes with a statement of the research problem.

2.1. Motivation

As Ryan and Deci (2000:54) describe: “To be motivated means *to be moved* to do something. A person who feels no impetus or inspiration to act is thus characterized as unmotivated, whereas someone who is energized or activated toward an end is considered motivated”. As already indicated, Franco and Bennet (2002: 54) define motivation “as an individual’s willingness to exert and maintain an effort towards organization’s goal”.

Motivation is achieved when a motive or drive is realized or fulfilled which in turn results in specific behaviour. These motives or drives can be categorised as either intrinsic or extrinsic in nature. The intrinsic drive comes from within the individual, whereas the extrinsic one is related to rewards that are attained from another person or organization (Omowumi & Samede, 2011). Ryan and Deci (2000:56) define intrinsic motivation: “as the doing of an activity for its inherent satisfactions rather than for some separable consequence”. Rather than external rewards, an individual is intrinsically driven to work or act out of enjoyment or satisfaction (Ryan and Deci, 2000).

In contrast, as Ryan and Deci (2000:60) put it, extrinsic motivation: “is a construct that pertains whenever an activity is done in order to attain some separable outcome”. Under extrinsic

motivation, an individual does an activity as a means for some end i.e. rewards. In other words, extrinsic motivation is associated with incentives, both financial and non-financial.

Operationally, a nurse who is motivated is defined as one that is willing to exert and maintain an effort towards the BZH goal as a result of intrinsic or extrinsic factors, the latter including both financial and non-financial incentives.

2.2. Incentives

The World Health Organization (2000:11) defines incentives as “all the rewards and punishments that providers face as a consequence of the organization in which they operate and the specific interventions they provide”. Adams & Hicks (2000:126) suggest that: “an incentive refers to one particular form of payment that is intended to achieve some specific change in behaviour”.

The International Council of Nurses(2005:1)further describe incentives as: “positive, negative (as in disincentives), financial or non-financial, tangible or intangible”.

Financial incentives include direct payments – such as salary and salary increases, bonuses, housing and other allowances, and loans, as well as indirect payments – such as tuition reimbursement and health insurance premiums (Aljishi, 2009; Mathauer&Imhoff, 2006).

In contrast, incentives like providing unpaid holidays, appreciationand recreational facilities, as well as recognition, supervision and career development are considered to be non-financialin nature (Mathauer&Imhoff, 2006)

Financial incentives are a commonly and persistently described source of influence on the health workforce’s motivation and performance (Shattuck, 2008; Serneels et al., 2005; Kristiansen

&Forde, 1992). Although financial incentives play a valuable role in motivating the health workforce, especially in areas where salaries are very low, they are not the only factor to influence motivation. They may not even be the determining factors (Dieleman&Harnmeijer, 2006; Hongoro& Normand, 2006; Dussault&Franceschini, 2006), and the influence that they exert is “inconclusive” (Lehmann et al., 2005).

Building motivation thus goes beyond provision of financial incentives. In order to achieve the intended goals or results of health care services, one should go beyond financial packages to a more comprehensive approach (Bennett & Franco, 1999). In other words, undue focus on financial incentives as the sole motivating forces could distract from other sources of motivation like non-financial incentives. It can also undermine altruistic values and intrinsic motivation (Giacomini, et al., 1996). In India, non-financial incentives like giving recognition publicly to well-performing health assistants in their respective communities influenced motivation (Michael et al., 2007). Working conditions, including safety, also appear to play a role in health work force motivation (Lehmann et al., 2005).

However, financial incentives cannot be overlooked: they remain an important source of motivation. Therefore, applying a comprehensive approach to workforce motivation i.e. both financial and non-financial incentive is recommended as most appropriate (Serneels et al., 2007).

Elements of a comprehensive incentive package would include (see Table 3): supportive supervision, long and short term training, career development, remuneration, promotion and performance appraisals (Bennett & Franco, 1999). On the other hand, lack of the above mentioned incentives could lead to problems of low motivation (Kolehmainen-Aitken, 2004; Lindelow and Serneels, 2006; Zurn et al., 2005).

Table 3: Elements of a comprehensive incentive package

Financial incentives	Non-financial incentives
<ul style="list-style-type: none">▪ Salary/Wages▪ Bonus▪ Allowance▪ Per diem▪ Insurance▪ Tuition reimbursement	<ul style="list-style-type: none">▪ Supervision▪ Training▪ Career development▪ Working condition▪ Recognition

Some studies present altruistic ideas, like helping the poor, as having an influence on motivation, particularly in rural areas in Ethiopia (Serneels et al., 2007). This points to the role of both extrinsic and intrinsic sources of motivation.

2.3. Factors associated with motivation in developing country settings

There are increasing numbers of studies exploring the associations between incentives, motivation and retention of health workers in developing countries. In a systematic review of health worker motivation and retention in developing countries, the “core” factors affecting motivation across contexts were identified as: financial incentives, career development and management issues. Other influences included recognition, material supplies and good infrastructure (Willis-Shattuck et al, 2008).

However, the specific role and combination of incentives involved in producing motivation varies across countries and contexts (Mbindyo et al, 2009).

A recent study documented the role of altruism in nursing, in which respondents were required to engage themselves in a “director game” which is a standard technique in experimentaleconomics for detecting the presence and powerof altruism in decision-making(Smith et al.,2012). It

indicated that altruism outweighs other factors in the decision-making processes of nursing students (Smith et al., 2012). Other literature also shows that nurses' motivation does not totally depend on financial incentives for the nature of their profession is associated with "helping the community" and "serving others" (Kingma, 2003; Miers, 2007). In addressing staff shortage in remote areas, educational chances or rural allowances also play a significant role (Blaauw et al., 2010).

However, even if a growing data or evidence in relation to health workers is being made available in eastern and southern African countries, there are only few studies on the importance of incentives in motivating health workers particularly in remote areas (Dambisya, 2007). One study, conducted in North West Province of South Africa, showed that even if the rural allowance plays partial role, it also has a negative consequences such as dissatisfaction and division among staff (Ditlopo et al., 2011).



2.4. Methods for studying motivation

The literature approaches the study of motivation both qualitatively (Paul, 2009; Mathauer&Imhoff, 2006; Serneeels& Lemma, 2005) and quantitatively (Manzi et al., 2004). The strength of qualitative approach lies in its focusing on the nature or process within the event – not its distribution (Chopra &Coveney, 2011). This study focuses on the processes involved in nurses' motivation in relation to both financial and non-financial incentives, rather than on its distribution.

2.5. Statement of the problem

In the literature, there is ample evidence that motivation is not influenced by a single factor but that it is a phenomenon influenced by factors ranging from individual, organizational to societal. It is a complex issue. The issue of changing motivations in the context of countries undergoing major health sector reforms such as Ethiopia, or the role of specific local contexts, and the balance of intrinsic and extrinsic motivation in ensuring resilience and performance, are not well understood.



3. Aims and Objectives

3.1. Aim

To explore influences on nurses' motivation at Butajira Zonal Hospital.

3.2. Objectives

Specifically, the study investigated the following at BZH:

- the perceived levels of nurses' motivation
- the role of financial and non-financial incentives on nurses' effort at work

4. Methodology

4.1. Study design



In this study, a qualitative approach was used to investigate what is both a sensitive issue and an internal state which are hard to measure– the motive or driving force that can determine one's act or behaviour at work (Miles & Huberman, 1994). The approach is better able to explore what is in the mind of nurses– their beliefs and perceptions of the impact of incentives on their motivation (Maier et al., 1994). This study focused particularly on how beliefs and attitudes of nurses are influenced by financial and non-financial incentives.

4.2. Study population, Sample size and Sampling procedure

The study population was all nurses in BZH in 2011, namely, 56 nurses and 9 midwives. Sampling in qualitative research does not aim at statistical generalization to the whole

population. It is rather purposive and intends to explore the complex issues under study not its distribution (Rice & Ezzy, 1999). The recruitment of nurses was purposive. Firstly, in order to get adequate information, only nurses with more than two years of experience were included in the sample. Secondly, nurses were selected to represent the cross-section of wards, gender and category (midwife vs. general nurse). There are nine wards in the BZH, clustered into 5 areas of activity (medical, surgical etc.). At least three nurses were selected for in-depth interview from each cluster, from amongst those volunteering to participate, giving a total sample of fifteen nurses. Nine females and six males were selected, based on their proportions in the study population.

Nurses from five of the nine different wards were approached to participate in three focus group discussions (FGDs). The focus group discussions included a mix of those who participated in the interviews and new participants. In total, there were eighteen FGD participants, of whom fourteen were female and four were male. Two of the FGDs were sex mixed and the third only female.

The sample sizes were determined by the level of “saturation” attained, namely, the point where further sampling offered no new insights in to the subject of analysis.

4.3.Data Collection Methods

The study used in-depth interview and focus group discussion (FGD) methods. An in-depth interview method is able to get rich data on the issue of motivation. It provides flexibility and adaptability in exploring the influences of financial and non-financial incentives on nurses’ motivation. Such in-depth interviews also enable adjusting the mode of interview in order to probe deeper on interesting replies (Robson, 1993). An interview guide was developed for the in-

depth interviews (see Appendix I) and the interviews were conducted in private to avoid distraction. The interviews were approached initially with open ended questions followed by prompts in relation to incentives and also probing when the interviewer felt that there was more to be said.

Unlike in-depth interviews, focus group discussions offer an opportunity to explore diverse views, and compare and contrast the different views in the dynamics of the group (Serneels & Lemma, 2005).

A FGD guide was used for the discussions (see Appendix II). Three focus group discussions were undertaken after the in-depth interviews in order to build on/discuss issues raised by interviewees. As with the in-depth interviews, the FGD guide began with open-ended questions.

All interviews and FGD were conducted by the researcher who is the coordinator of Butajira Rural Health Program Office, a demographic health surveillance site. This office regularly collects vital events like birth, death, migration and other socio-economic data and causes of death, including from BZH. The existing collaboration was helpful for getting information on and ensuring entry by the researcher into the hospital. Both the interviews and the discussion were run mostly in the local language i.e. Amharic. The interviews and focus group discussions were audio-recorded, and transcribed and translated by the researcher.

4.4. Analysis

The data was analysed using thematic analysis. Thematic analysis entails the process of searching for or uncovering the common patterns or threads that are woven through the entire set of data (Gifford, 1996). After reading, transcriptions were coded in the informants' own words and phrases; the informants words were examined, categorised and consistent themes were

identified, then coded with keywords to represent the content and which then formed 'emerging themes'. (MPH course notes, 2011:1).

4.5. Rigour

The rigour of a qualitative study is what validity is for a quantitative study. It also confers credibility to the study. In this study, effort was made to apply criteria which help to ensure the rigour of the study (Cresswell& Miller, 2000) as follows:

- The triangulation method was applied by using both in-depth interviews and focus group discussions to investigate nurses' motivation.
- Prolonged engagement: The investigator is working in Butajira Rural Health Program as coordinator, where the BZH is one of the key stakeholders. In this capacity, the investigator is privileged to make frequent visits to BZH. This prolonged engagement led to the initial observation that health professionals are leaving for other areas, and the importance of understanding how workplace incentives influence nurses' motivation at the hospital. The BZH and Butajira Health Program Office work independently. There is no power relationship between the investigator and staff at the hospital which could in some way have affected the degree of honesty expressed in interviews and FGDs.
- An adequate description of the setting has been attempted so that it will not be difficult to relate the findings to other settings.

4.6. Limitations

The study sample does not aim at representativity. The findings of the study will not be used to make statistical generalizations and the results of the research are limited to the description of the experiences of nurses in the BZH. Within these limits, however, the results of the study

provide insights into the determinants of nurses' motivation at work and the role of financial and non-financial incentives on motivation in the study area and in other similar settings.

5. Ethical considerations

Ethical approval was obtained from the University of the Western Cape Research Committee and Addis Ababa University, School of Public Health, Ethical Review Committee. Permission to undertake the proposed study was obtained from the Regional Health Bureau. A letter was sent to the Director of BZH explaining the nature of the research and requesting assistance in case of need. The research proposal and the approval from the Higher Degrees Committee of UWC were attached to the letter. The scope of the research was explained before administration. A consent form was presented and signed by each participant after being informed about the purpose and the scope of the research. Confidentiality and anonymity were assured to all participants. Each person was interviewed by the investigator in a closed office after which the notes and recordings were filed under assigned names. Neither the notes nor the recordings had the name of the individual interviewed. Participants were allowed to withdraw from the research at any stage, although this did not actually happen. Participants in the focus group discussions were asked to sign confidentiality agreements regarding information disclosed by members of the group during discussions. No names were recorded. There were no incidents of sensitive information disclosed causing distress during focus groups.

6. Results

6.1. Characteristics of respondents

A total of 15 in-depth interviews were conducted with nurses, of whom 3 were midwives. Their ages ranged from 23 to 45 years, and work experience from 2 to 26 years. A further 18 nurses participated in the FGDs, of whom 2 were midwives. Table 4 further shows the characteristics of the participants. Overall, most respondents fell in the 20-29 age group and had 5-9 years' work experience.

Table 4: Characteristics of respondents

		Interviews		FGD	
		Female	Male	Female	Male
Nurses		6	6	12	4
Midwives		3	-	2	-
Age	20-29	4	4	10	1
	30+	5	2	4	3
Years of experience	2-4	3	3	3	-
	5-9	4	6	9	4
	10+	2	-	2	-

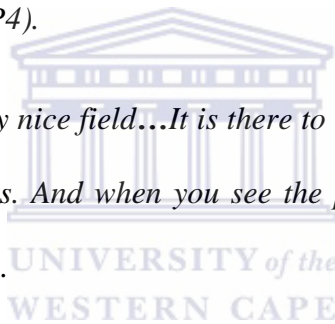
In both the FGDs and interviews, a number of key themes were identified relating to both nurses' self-reported motivation and the factors influencing this at BZH. These themes are: the place of altruism, professional pride ('love of the profession'), perceived job risk, the role and nature of financial and non-financial incentives and personal factors. Each of these is explored in turn. In the quotes, respondents are referred to by the method and participant number: i.e. or the in-depth interviewees (Interviewee-X) and for the FGDs (FGD X, Participant P X).

6.2. Altruism

Overall, the nurses interviewed at BZH expressed high levels of intrinsic motivation for their work as nurses. In both interviews and FGDs, the idea of altruism, namely a positive sense or feeling derived from helping others, was persistently described. This was seen as an important source of motivation for their work. The issue was described in different ways:

... patients get care which they do not get from their family. This satisfies you more than anything else. That is what makes the profession different. Nothing is more pleasing than helping the needy. We are satisfied with our job because of that (FGD-1, P4).

Nursing is a very nice field...It is there to reach to those who are worried and stressed, patients. And when you see the patients cured, you get satisfaction (Interviewee-11).



The altruistic drive was also reported as a source of happiness. In turn, happiness has an effect on motivation at work. A 35 year old nurse described it as follows:

The thing that makes me happy about nursing is that there are many worried people out there who need care. When I help them get cured that makes me happy (Interviewee-1).

This was shared by a younger 23 year old nurse who put it as follows:

Overall being a nurse is likable. You have satisfaction. That is to say the work you do makes you happy as you mostly treat patients and after you have given

them care the patient will be ok. That will satisfy you. There is of course work burden but the satisfaction out weighs [the burden] (Interviewee-2).

Those who reported good motivational levels through caring for patients were also likely to talk about their “love of the profession”. One interviewee described it as follows:

As a professional, I do care about patient. If I see a patient in any ward, I cannot help supporting the patient. Immediately, I found myself providing help. I love my profession (Interviewee-13).

Even those nurses who reported deteriorating motivational status described their professional duty and the inherently altruistic nature of the work as motivating.

The nature of the work itself forces you to be motivated. Whenever you see those in pain, you wish to be there to help. For instance, when a breathless baby comes, gets treatment and finally sees changes or improvement that is a source of motivation (FGD-3, P3).

Even if I am de-motivated, the nature of the work will not let you be indifferent. Because I am de-motivated I cannot say I will leave the patient (FGD 4, P5).

6.3. Risky Job

While altruism was an overriding positive sentiment in interviews and FGDs, some factors were equally consistently negative influences on nurses’ motivation at work in BZH. When asked in an open-ended manner about “dislikes” or “not so good” aspects of nursing, the issue of fearing contamination was present across all the responses. Both interviewees and FGD participants

pointed out that there were no vaccinations for health workers for diseases like hepatitis B. This threatened not only their health but also their motivation at work. A 45 year old nurse with 26 years of experience spoke of these dangers:

When you work as a nurse, it needs your sacrifice and it can endanger you.

While you are working, you may face an emergency case; that time you could be endangered by viral infectious diseases. You may not be careful during such situations. Our hospital only cares about the work, there is no support in this regard. For instance, there are immunizations for hepatitis B in other hospitals but not here. It will be good to free nurses from such threats (Interviewee-11).

The risk of the job is what makes them dislike their profession. A female nurse indicated as follows:

What I can add on the bad side of being a nurse is the risk. No choice except facing the risk.

The bad side of nursing is that it is full of risks. That makes it worse compared to other professions (Interviewee-12).

A 36 year old midwife described that:

Nursing is also a profession which provides service or cure by sacrificing yourself. These times there is hepatitis B. While the nurse is giving treatment for a hepatitis B infected woman, the patient can be epileptic and at that time

you may hold her not to be harmed when she is about to fall. That time the nurse gave her life (Interviewee-12).

6.4.Financial Incentives

As expected, the theme of financial incentives was consistently raised in both the in-depth interviews and FGDs. It clearly has a major role in influencing nurses' motivation. The most persistently mentioned aspect about financial incentives is that compared to workloads, the payment i.e. salary, associated benefits and over time work is very low. A 35 year old nurse with thirteen years' experience put it as follows:

... I was not in good mood when you called me for the interview because of the salary, for it is very low. The other financial incentives, like duty i.e. payment for overtime work especially night shift, are good for motivation. But they are also very low. They are also taxed. Many of the nurses complain about it. Many nurses feel like they want to leave because of this (Interviewee-13).

Or as another put it:

In general terms the salary for nurses is very low. The benefits are not also enough. You are not paid in accordance with your work.

These are the things which are not good for nurses in their work (Interviewee-11)

A male nurse repeatedly explained that:

When you are paid for the duty i.e. payment for over time at night shift, it will be taxed which the nurses do not like. This is because after long hours of work [all the night], you do not feel good when taxed. In addition, the amount you get 45 birr [less than \$]) is less than daily labourers' pay. After tax you will get 33 birr [less than \$]) with which you cannot even have enough breakfast meal, you work only for food (Interviewee- 7).

Obviously, the salary makes you think not to continue in the profession for it is not enough not only here but in the country as a whole. Many nurses are leaving their job because of the salary. When you relate the salary with the work you do and the living cost, it is not fair (Interviewee-3).

Another nurse also related the salary to living costs:

...the living cost is high therefore I am dissatisfied with my work. I cannot manage my family properly for the salary is not enough to cover my family's expenses. Fair pay will play a good role to motivate nurses (interviewee-6).

The financial incentives were related with providing good quality of care. A 45 year old nurse with 26 years of experience indicated that:

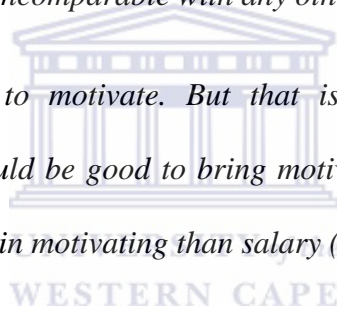
If the salary of nurses is improved, get due benefits... then it is possible to provide good quality of care (Interviewee-11).

You need to have good amount of salary in order to buy what you need. The living cost also has an impact. So if we get good salary, I think it will be motivating to provide good quality of care (FGD-1, P1).

For some nurses, however, salary was a less important source of motivation than wishing to see the patient cured and more generally, the high status of the profession.

We will be happy to have good salary but our salary is too low compared to our work. But what motivates me more is when I see a patient get cured following my treatment. Good salary has a motivating impact. However, the patient's cure is incomparable with any other incentives (FGD-3, P1).

Salary is good to motivate. But that is not the only reason. The work environment should be good to bring motivation. The status of the profession by itself is better in motivating than salary (FGD-1, P4).



6.5.Non-financial incentives

Non-financial incentives including training, supervision, career development and recognition, are among the themes that emerged from the interviews as having a direct influence on nurses' motivation at work.

6.5.1. Training

Almost all nurses felt that in-service training and updating their knowledge had an effect on motivation. A male participant in FGD-2 put it as follows:

No question that training motivates you. When you are at work, you have to be up to date. If you have a knowledge gap, you will fill it with training and you will be satisfied (FGD-2, P1).

Training is good. It helps one to get additional skills. It should not be associated only with income. It provides an opportunity to come back with a refreshed and new spirit to work. And it will bring good motivation (Interviewee-8).

Training also ensured good quality of care. In the FGD-1 a participant indicated that:

...the nurses should also have trainings...these all make you provide good quality of care (FGD-1, P5).

A female nurse, 23 years old with three years' experience also made reference to the role of “per diems” or payments received during training as a source of motivation:

Training plays an important role. It updates what you learned. It widens the service... the one who went for training will apply what he learned; consequently, the work will be performed well/better. The payment received during the training will have motivating impact at his work...(Interviewee-2).

6.5.2. Supervision

Supervision also played an important role in motivation as long as it was supportive. This is reflected by a number of nurses in both the FGDs and interviews:

If the supervisor comes and gives us feedback, it will be good. If it is not supportive but rather fault finding, I do not think it will motivate... (FGD-1, P3).

To make supervision more supportive, respondents believed that supervisors should be from a health background, which was apparently not always the case. This came up in FGD-1:

If the supervisor is out of the health profession..., he will not help in the supervision (FGD-1, P6).

...the supervisor should be from within the health profession. Otherwise, it will not be helpful for he does not know about patients' care and other things (FGD-1,P3).

...In some hospitals you heard that a biology teacher can be your supervisor. This cannot be useful (FGD-1,P5).

6.5.3. Career development

Respondents voiced strong complaints about the absence of career development in the hospital and indicated that it is gravely needed for their motivation. A 23 year old female nurse with three years' experience expressed her opinion that:

Career development brings great change in nurses' motivation...For instance, I do not want to continue in my current status. If career development is available, I think there will be an increased motivation. That is what we need (interviewee-2).

No career development is implemented in the BZH. If there is such kind of thing, you will be motivated because you will be upgraded (FGD-1, P1).

Another participant emotively expressed his opinion by comparing nursing with the grading processes of other occupations, saying:

When we see a military organization, you have different grades which go with its level of payment. When we come to our situation, you have beginner nurse, head nurse and expert. But there is no difference in payment. They are all the same. The head nurse gets the same salary as the beginner nurse. This is one of the reasons that affect quality of care(FGD-1, P5).

A BSc degree nurse, 35 years old with twelve years' experience illustrated this by saying that:

There are noopportunities for further education. You can only learn in private. Even after you get your BSc nurse degree, there is no change in your position and work (Interviewee-1).

6.5.4. Recognition

BZH conducts a program every year to give recognition to those nurses who perform well, by giving them rewards such as gifts e.g. mobile phones. The selection of nurses for these rewards is made by a committee with members from different wards.

A female participant who got rewards two times felt that:

When your work gets recognized, it will make you happy. First you do your work by self-initiation and in the meanwhile when your work gets recognized by the institution, it will motivate you more at your work. For instance, I was rewarded two times; the first one was two years ago and the second one is in this year. I was very much happy. It makes me think that I am doing well and am better motivated (FGD-3, P3).

It is noted that its effect goes beyond the one who is rewarded as he/she will serve as a role model and motivated others to work as well as she does. The participants of one FGD illustrated this as follows:

She will be our model (FGD-3, P5).

It makes you think that if I work just like her, I will be rewarded (FGD-3, P4).

Even we try to dress the way she wears her gown (FGD-3, P4).

A number of nurses recommended that the selection process should be fair and just. Otherwise, it can have the unintended effect of lowering the motivation of those who fail to be rewarded.

They repeatedly said that it will be good to increase the number of nurses to be included for the reward. A 30 year old female nurse from the paediatric ward expressed her view that:

...there is no certificate of appreciation for nurses except for a nurse who, once a year, will be selected for reward (Interviewee-3).

6.5.5. Nurse-doctor relationship

The nurse-doctor relationship was a recurring theme, mostly as working against nurses' motivation. Among the participants of the FGD-2, one illustrated this:

When you see the relationship between highly qualified physicians and nurses, they do not respect us. The physicians do not seem to realize that we have some knowledge. They undermine us (FGD-2, P1).

A participant indicated that the administration “focused only” on the physicians and gave them preferential treatment:

...the bad side is that the administration thinks that there is no difference if there are nurses or not in the hospital. They focus only on physicians (FGD-2:P2).

...even the gown has difference in quality and design among professionals. That in itself has a negative effect on the nurses (FGD-2, P1).

Another factor that has an influence on nurses' motivation is freedom in work or lack of autonomy and independence. As expressed by one interviewee:

...we do not do anything without a physician...always if you are there the physician also should be there...you do not have independence...you do nothing by yourself... even when you see faults, you cannot stop them. Do only what we are told to do...you want to help the patient but this feeling of inferiority will badly influence you. For it limits your freedom of work; you say it is better to give up being a nurse (Interviewee-7).

Another participant also expressed her view that:

You do not have independence in your work. It makes you wait for orders even when it is simple, that I do not like (FGD-3, P5).

6.5.6. Team Spirit

Most respondents concurred that there was a good team spirit in the hospital:

I have seen some other hospitals...compared to those hospitals there is stronger team work and also better understanding among each other at work.

There are times I personally cover the night and afternoon shift because of the love and team spirit. We miss and like each other (Interviewee-14).

Team spirit and solidarity (“sisterhood”) amongst nurses was frequently noted by both FGD participants and interviewees as a factor influencing their motivation and performance. As expressed by a participant:

What is good in Butajira Hospital is the team spirit. There is a kind of sisterhood. That makes me happy in my work (FGD-1, P4).

The findings also show that the team spirit is associated with the quality of care the hospital provides. As noted by another participant:

...If there is team spirit there will be good quality of care for patients (FGD-1, P3).

The “love among the staff” was a feature of the hospital that promoted retention:

...there is love among the staff. You like that very much (FGD-2, P5).

6.5.7. Working Conditions

The working conditions examined included availability of medical equipment and number of nurses. Nurses made a link between working conditions and quality of care as illustrated below:

If medical equipment are not made available, it will affect the quality of care. For instance, in a ward we need to have at least four or five oxygen tanks but they are not available. That will reduce the quality of care...you feel in this circumstance that the patient will be harmed (interviewee-13).

Shortage of nurses is another factor that prevents good quality of care. A female nurse with five years of experience said that:

The nurse to patient ratio is very low in the hospital. There is shortage of nurses. This is the reason that makes us not to provide good quality of care...In this medical ward you have only two nurses who cover all the activities when we must have been four (interviewee-12).

6.5.8. Management

Hospital management was generally portrayed as playing a negative role in motivation, in their discrimination between nurses and physicians, their lack of transparency, and the failure to avail incentives like gowns and bed sheets on time in every year and to respect the rights of nurses.

...But you see no transparency in the leadership especially whenever there is training; it is not transparent and not fairly distributed. Benefits like

yearly distribution of gowns and bed sheets for nurses in BZH are not made available on time (Interviewee-4).

In order to provide good quality of care, first the rights of the professionals should be respected. They should be getting the deserved benefits (Interviewee-4).

6.6. Personal Factors

Both in the FGDs and interviews, family related factors were the most commonly identified reasons to continue working at BZH. The following are some of the views:

...I got family and children [in Butajira] so I do not think it will be good to go away (FGD-1, P4).

What makes me continue working here is that I am married. That is personal (FGD-1, P3).

I am here because I have my family here (FGD-2, P4).

I grew up here. I got family here. I am here to serve the uneducated community that educated me (interviewee-9)

7. Discussion

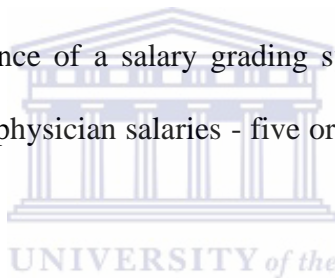
Nurses in Butajira Zonal Hospital expressed high overall levels of professional fulfilment and willingness to do their jobs. Despite low salaries, dissatisfaction with non-financial incentives and poor management, they insisted on altruism and “love of the profession” as keeping their motivation alive. This emanated primarily from compassionate feelings towards patients and their healing role in restoring them to health. As raised earlier, the literature suggests that financial incentives are not the sole factor motivating nurses to work. Rather the nature of the profession is very much associated with a sense of ‘helping the community’ and the altruistic tendency of “serving others” (Miers, 2007; Kingma, 2003; Smith et al, 2012). In rural Ethiopia, Serneels et al (2007) also present altruistic ideas like helping the poor as having an influence on motivation and as a valuable “tool” to retain and motivate nurses.

Motivation of nurses at BZH can thus be described as having a strong inherent or intrinsic nature. Rather than external rewards, an individual is intrinsically driven to work or act out of enjoyment or satisfaction (Ryan and Deci, 2000; Omowumi & Samede, 2011). An altruistic tendency or the desire to help others and a need to contribute to the community is the major reason for choosing nursing as a career among other professions (Boughn, 2001; Prater & McEwen, 2006; Zyberg & Berry, 2005). However, this source of motivation often fails to get due focus or recognition.

An important source of nurses’ motivation specifically at BZH was the apparent good team spirit which prevailed among nurses. During the fieldwork, this was observed particularly amongst the midwives at the hospital. In addition, most of the nurses had come from surrounding health

centres, and working at BZH with its better facilities and situation was perceived as “one step higher” as a workplace, and may have influenced attitudes to the job.

The research further highlighted the important role that financial and non- financial incentives play in influencing on nurses’ motivation in BZH, even if not the sole factors. The salary and overtime payments (“per diem”) for the night shifts were consistently described as very low and too little to meet living costs. While the salary scale of nurses is uniform across the country, the night shift payments are not only better in other regions but also taxed in the region where BZH is situated. This was a major source of complaint as it unusual to tax “per diems”. Some thought of leaving the profession or moving to other cities as a result. In addition, the more experienced nurses viewed the continued absence of a salary grading system and career structure as very problematic. Finally, the gap with physician salaries - five or more fold what nurses get monthly – was perceived as unfair.



In contexts where salaries are extremely low, financial incentives are bound to have particular importance in motivation, and in influencing turnover (Normand & Thompson, 2000; Gray& Phillips, 1996).However, even if the importance of financial incentives will be dominant (Hongoro& Normand, 2006; Dussault&Franceschini, 2006; Dieleman&Harnmeijer, 2006), non-financial incentives are also well recognized as influencing motivation(Mathauer&Imhoff, 2006). Studies in four African countries found that non-financial incentives (study leave, training, support and feedback from supervisor) to be an important factor for motivation (Stilwell et al., 2004).

Nurses in BZH expressed that incentives such as training, supervision, career development and recognition were valuable as sources of motivation, but that these were generally poorly

implemented. While team spirit and solidarity amongst nurses was a positive feature of the work environment, relationships between doctors and nurses were described as poor. Male nurses were more sensitive to the dynamics of the nurse-doctor relationship, and were also more critical of the perceived failure of management to tackle this.

During the course of the study, the investigator came to realize that the BZH as an organization appeared to undermine its human resources, with the leadership failing to recognise the value-adding importance of altruism amongst staff, or to treat their issues sensitively. Instead, expressions of appreciation of the sense of caring came principally from the community.

In addition to the influences described above, the study also showed that factors like the perceived risky job has a role to play in influencing motivation. Working conditions, including safety, have been described elsewhere as influencing health work force motivation (Lehmann et al., 2005). The personal factor particularly the status of marriage or having families in the area is a major factor for retention at BZH.

The study had limitations:

- What nurses' say in interviews may not actually correspond with the reality of their actions with respect to performance and retention.
- Participants in the FGD were sometimes more cautious in their comments in the presence of colleagues than with the investigator during the one-on-one in-depth interviews.
- It is possible that the framing of the initial interview questions – asking participants to describe what was good and not so good about being a nurse - invited the emphasis on altruism and professional pride found in the study. Different questions asked in a different sequence may not have produced the same results.

- The study was limited to a qualitative approach. It could have benefited from a quantitative perspective.
- The inclusion of administrative and other relevant staff could have benefited the study in providing additional insights and also raising awareness of the issues.



8. Conclusion

The Ethiopian health system has paid great attention to increasing numbers, expanding training and specializations for nurses. However, less attention has been given to their working conditions and the appropriate package of financial and non-financial incentives that will sustain performance and retention.

The findings on nurse motivation at BZH indicate that motivation amongst nurses has to be viewed comprehensively in that it:

- has a strong intrinsic dimension
- is currently inadequately addressed by both financial and non-financial incentives
- is influenced – positively and negatively - by the quality of relationships in the workplace environment: amongst nurses themselves, between nurses and other hospital stakeholders (such as doctors and managers), and with the community
- is influenced by perceived management fairness and transparency or the lack of it
- is influenced by hospital specific, regional and broader systems factors and policies.

In dealing with motivation, the concerned bodies should take into account these various sources of influence on motivation. Failure to properly consider these will lead to de-motivated staff and in turn poorer performance, deteriorating quality of care and high turnover.

Managing motivation requires keeping a broad perspective and innovative approaches. Solutions should be context based and sensitive to influences beyond the commonly understood sources of motivation. The literature tends to consider mainly financial and non-financial incentives.

However, comprehensiveness should go further to include factors such as altruism so as to ensure that capacity to respond to the issue of motivation will be well managed.

9. Recommendations:

At the country or regional level:

- Review the financial incentive program for nurses in general in accordance with living costs
- Develop a comprehensive approach to motivation, recognising that both financial and non-financial incentives positively influence motivation, but also that motivation goes beyond incentives and includes factors such as altruism and personal factors
- Develop incentive programs that are context specific rather than implementing externally developed incentive programs. One example of this could be to reform the regional tax system standardization across regions for per diem or overtime payments.

At the BZH level:

- Avail necessary vaccinations for the safety of the health workers, as is done in other hospitals
- Widen training packages and ensure fair access to training for nurses
- Develop a supervision style that is supportive and appoint supervisors from amongst health professionals
- Give better recognition to nurses as a non-financial incentive in the package
- Develop a mechanism/strategy for managing inappropriate nurse-doctor relationship; and ensure fair and non-discriminatory treatment of nurses and doctors

- Recognise the importance of team spirit in motivating the health professionals and strengthen it
- Fill the gap in availability of medical equipment

For further study:

- As studies on incentives are few in Ethiopia and especially in the region, further studies are needed using both qualitative and quantitative approaches, and highlighting its significance as a neglected issue in the Ethiopian health system
- The role of altruism and team spirit in motivation needs further study.





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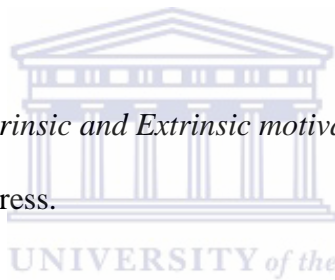
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Appendices:

Demographic information collected on study participants

1. Age_____

2. Gender

Male_____

Female_____

3. Work experience _____

In-depth interview and group discussion guide

1. What are the good things and not so good things about being a nurse?
2. What do nurses like and dislike about their work at ButajiraZonal Hospital?
3. What are the things that make them want to provide good quality of care? Or want to continue working at the hospital?
4. What kinds of things have influences on your motivation at your work? Probe for:
 - a. Role of salary and other financial incentives
 - b. Relationships with supervisors
 - c. Training
 - d. Career patting
 - e. Other forms of recognition



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InformationSheet

Project Title: Exploring influences on nurse motivation in ButajiraZonal hospital, Ethiopia

What is this study about?

This is a research project being conducted by AbiotWeldemariamTaye at the University of the Western Cape. We are inviting you to participate in this research project. The purpose of this research project is to explore influences of nurses' motivation in ButajiraZonalHospital.

What will I be asked to do if I agree to participate?

You will be asked to tell me about influences on nurses' motivation especially how both financial and non-financial incentives play a role in nurses' motivation in the hospital. The interview will take about 40-50 minutes. The questions all concern the issue of motivation among nurses in the hospital.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information and what you say confidential. At all times, I will keep the source of information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been

collected. If we write a report or article about this research project, your identity will be protected.

This research project involves making audio recordings of the interview with you. This is because taking only notes can fail to capture every bit of information needed for the study. The audio recorded information is only accessed by the investigators. It will also be locked away and at the end of the project will be destroyed.

What are the risks of this research?

There are no known risks associated with participating in this research project. However, if distressing memories or conflicts are evoked by the interview, we will arrange counselling or support.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about the issue of motivation among nurses in the Butajira hospital. We hope that, in the future, other people might benefit from this study through improved understanding of the role of incentives on nurses motivation. This study will also assist policy makers to design programs to improve the motivation of nurses in particular and health workers in general in Ethiopia. The study will also provide complementary information on the issue of motivation for the local administrators in particular and the regional government in general. It will also be used as a source of questions for further studies on the issue.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify. In other words, in the process if you do not feel to proceed or like to stop or do not want to give information, you are free to do so.

Is any assistance available if I am negatively affected by participating in this study?

We do not anticipate that you will be affected negatively for participating. However, as outlined earlier, if distressing memories or conflicts are evoked, counselling or support will be provided.

Things that may affect your willingness to participate

The interview may touch on issues which may be sensitive or affect you emotionally. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I ask anything which you see as intrusive.

What if I have questions?

This research is being conducted by AbiotWeldemariamTaye from School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact AbiotWeldemariamTaye at: 25911988632 and abiot_welde@yahoo.com and the supervisors: Prof. Helen Schneider and Dr. YayehyiradKitaw who are contactable at +27 21 959 3563 and 251-911-228601, respectively

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17

Bellville 7535 tel: +27-21-959 2809

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.





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Record of Informed Consent to Conduct an Interview

Date:

Interviewer: AbiotWeldemariamTaye

UWC Student no: 3083131

Tel: 25911988632

E-mail: abiot_welde@yahoo.com



Institution: Addis Ababa University School of Public Health Butajira Rural Health Program

Interviewee's pseudonym:

Place at which the interview was conducted: Ethiopia, Butajira

Thank you for agreeing to be interviewed. What follows is an explanation of the purpose and process of this interview. You are asked to give your consent to be taped when we meet to conduct the interview.

1. Information about the interviewer

I am a student at the SOPH, University of Western Cape. As part of my Masters in Public Health, I am required to conduct a mini thesis. I will be focusing on determinants of nurses' motivation. I am under the supervision of Prof. Helen Schneider and Dr.YayehyiradKitaw who are contactable at +27 21 959 3563 and 251-911-228601 respectively.

2. Purpose and contents of interview

The purpose of the interview is to explore information about the influences of nurses' motivation at ButajiraZonal hospital. The contents of the interview will be issues in relation to nurses' motivation in the hospital.

3. The interview process

The interview will take about 40-50 minutes. In the process, if you do not wish to proceed or do not want to give information, you are free to do so. The interview will be conducted verbally. No blood or any other test will be taken in the interview.

4. Anonymity of contributors

At all times, I will keep the source of information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected.

5. Agreement

5.1. Interviewee's agreement

The interviewee is asked to give his/her consent below.

5.2. Interviewers agreement

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published and unpublished research at later stage without further content. Any change from this agreement will be renegotiated with you.

Signed by interviewer: _____

Signed by participant: _____

Date: _____

Place: _____





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Consent Form to Participate in Focus Group Discussion

Date:

Interviewer: AbiotWeldemariamTaye

UWC Student no: 3083131

Tel: +25911988632

E-mail: abiot_welde@yahoo.com



Institution: Butajira Rural Health Program, Ethiopia

Interviewee's pseudonym:

Place at which the interview was conducted: Butajira, Ethiopia.

Thank you for agreeing to participate in a focus group discussion. What follows is an explanation of the purpose and process of this type of group interview. You are asked to give your consent for an audiotape of this focus group discussion.

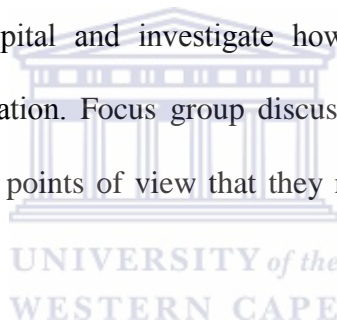
1. Information about the interviewer

I am AbiotWeldemariamTaye, a student at the SOPH, University of the Western Cape. As part of my Masters in Public Health, I am required to write a mini thesis as part of completion of my Master's Programme. I will be focusing on motivation among nurses in ButajiraZonal hospital. I am accountable to Professor Helen Schneider and Dr.YayehiyiradKetaw who contactable at +2721593563 & 251-911-228601 respectively.

Here is some information to explain the purpose and usage of the focus group discussion.

2. Purpose and contents of interview

A focus group discussion is a kind of group interview. It will assist me to explore those influences of nurses' motivation in the hospital and investigate how both financial and non-financial incentives influence nurses' motivation. Focus group discussions allow participants to interact with each other and discuss other points of view that they might not think of in an individual interview.



3. The interview process

I ask questions to start and guide a discussion among the participants and at times will probe further based on the responses of participants in order to facilitate further discussions. At times I may encourage more quiet participants to share their views but at no time will anyone be forced to say anything. All participants are asked to participate freely while respecting the views of other participants. We will start by completing the basic demographic information about participants. The focus group discussion will be recorded.

4. Anonymity and confidentiality of contributors

Protecting the anonymity and confidentiality of all participants, including you, is of utmost importance. By agreeing to participate in this discussion, you also agree to keeping the identities of all participants confidential, and to avoid divulging or discussing their identities or anything that was said by participants outside of this discussion.

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected and analyzed.

5. Things that may affect your willingness to participate

The discussion may touch on issues which may be sensitive or affect you emotionally. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. I would appreciate your guidance should I or other participants ask anything which you see as intrusive.

6. Agreement

6.1 Participant's agreement

I, the interview participant, indicate my consent to participate by signing below. I understand that consent to participate in the Focus Group Discussion also means that I promise not to divulge the identity of any of the participants, or to divulge or disclose anything that was said by participants during the discussion outside of this Focus Group Discussion.

6.2 Interviewer's agreement

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

Signed by interviewer: _____

Signed by participant: _____

Date: _____

Place: _____

