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 workforcedensities 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 0.84per 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".