

Addis Ababa University College of Health Science

School of Public Health

Factors Affecting Health Extension Workers motivation in selected rural districts of Ethiopia:

A qualitative study

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Acronyms

AIDs	Acquired Immune Deficiency Syndrome
ASHA	Accredited Social Health Activists
CHWs	Community Health Workers
EDHS	Ethiopian Demographic Health Survey
FMOH	Federal Ministry Of Health
HEP	Health Extension Program
HEW	Health Extension Workers
HRH	Human Resource For Health
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
ICCM	Integrated Community Case Management
LMIC	Low And Middle Income Countries
PI	Principal Investigator
RCT	Randomized Controlled Trials
RA	Research Assistant
SDG	Sustainable Development Goals
SNNPR	Southern Nations, Nationality And Peoples Region.
WDA	Women Development Army
WHO	World Health Organization

Abstract

Background: The Health Extension Program (HEP) in Ethiopia is a core component of the broader health system and is one of the strategies implemented with a view to achieving universal coverage of primary health care to the rural population within the context of limited resources. There is scanty evidence on factors influencing motivation of health extension workers (HEWs) in Ethiopia. This study aimed to explore factors affecting motivation of rural HEWs.

Methods: A qualitative case study design was used. In depth interview data collection methods carried out for comprehensive understanding of factors affecting motivation among rural HEWs. HEWs working in rural areas are the primary study population. Two districts were selected from Oromia and SNNPR based on accessibility to carry out the research. Sixteen study respondents (no refusal) were sampled considering a wide range of variation in multiple aspects of HEWs like service year, marital status and career level (level III and level IV). The principal investigator collected all data. All interviews were recorded, transcribed, translated, coded and thematically analyzed based on similarities, differences, and associations. Atlas.ti (*v 7.5.7*) was used to analyze the data. Quality assurance of the study was considered from selection of study design to data analysis and report writing.

Result: Factors affecting motivation HEWs were identified at the individual, family, community, and organizational/system levels. Love of work and pride to serve community is personal level motivators. However, workload and burnout were among de-motivating factors at individual level. Moral and domestic work supports are main family level source of HEWs' motivation. At community level, increased respect, acceptance and task sharing motivated HEWs. On the contrary, less acceptability of health service by the community de-motivated HEWs. Slow progress in career advancement; poor supervision, support and governance from leaders, inadequate material availability, no transfer policy, insufficient financial earning were labeled as de-motivating factor at health system/organizational level. Among the motivating factors at organizational level, regular supportive supervision by health center, availability of supplies and on the job trainings were identified.

Conclusions: Workload, remuneration, career advancement, transfer policy and leadership support require more attention. Functional linkage with health center, regular training and community engagement are essential to maintain level of motivation.

1. Introduction

1.1. Background

Numerous countries around the world have established community health programs as a means to expanding access to health services among vulnerable populations(1). As a focus of the Sustainable Development Goals(SDG) (2), there is an increasing need to understand how to best implement community based health programs such as community health worker (CHW) program to ensure equitable universal health coverage. The World Health Organization (WHO), particularly in low-income countries, has identified the use of community health workers as one strategy to address the growing shortage of health workers. The umbrella term "community health worker" (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they are from (3).

In general, health workers account for the largest share of public expenditures on health and play a crucial role in efforts to improve the availability and quality of health services. However, evidence has shown that poor health worker performance may be limiting the effectiveness of health system strengthening efforts. A critical factor affecting health worker performance is workers' motivation, which has been defined as the individual's degree of willingness to exert and maintain an effort towards organizational goals (4,5). Good performance is associated with intervention designs involving a mix of incentives, frequent supervision, continuous training, community involvement and strong co-ordination and communication between CHWs and health professionals, leading to increased credibility of CHWs(6).

Comparable to Community Health Workers in other countries, Health Extension workers (HEWs) in Ethiopia an important component of health service provision at the community level. As the backbone for the HEP, HEWs make it possible to target those who need improvement in their access to health services(7–9). The most recent data indicates more than 38,000 HEWs have been trained and deployed across the country(9). The health extension program was originally launched in 2004 in order to create access to promotive, preventive and basic curative health services with the goal of improving health outcomes in Ethiopia by targeting households and communities(7,8). The HEP has made important contributions to Ethiopia's achievements including improved sanitation facilities, access to modern family planning, maternal and newborn healthcare practices; expanded vaccination services; malaria control and prevention, and reduction of new HIV infections(7–11).

In Ethiopia, HEWs have greatly improved availability of health workers, particularly in rural areas(8). The program has improved the skewed distribution of health facilities and human resources. As a result of the deployment of health extension workers, the human resources for health (HRH) doubled within few years(7,9,10,12,13). Health Extension workers and HEP are part of the primary level of care and linked as essential components of the health care delivery system the country.

However, the country recognized HRH management challenges including urban/rural and regional disparities, poor motivation, retention and performance(5,9). In the HEP implementation, irregular/no supply of drugs and lack of adequate skill, poor infrastructure, lack of career development and low remuneration were among the contributing factors for the poor motivation and low performance of the HEP(12–15).

There are few studies conducted into areas related to motivation of HEWs in Ethiopia. What little research present is quantitative in nature and lacks of richness in information on factors affecting motivation of HEWs.

This study was designed to present detailed evidence on the sources and prohibitory forces of motivation on HEWs and improve the existing knowledge about determinants of HEWs' willingness exert their full effort and produce good performance in their work in order to contribute to the provision of effective health services. It presents evidence about factors related to motivation among HEWs in a systematic and disaggregated way: individual, family, community and health system factors.

1.2. Statement of the problem

The human asset is a key input that makes the difference for successful organizations. The health sector is not an exception to this rule. In fact, Poor health worker performance is limiting the effectiveness of health systems strengthening efforts. Health worker motivation is one of the critical factors affecting health worker performance(4).

In Ethiopia, HEP is one of the strategies adopted with a view to achieving universal coverage of primary health care to the rural population. Different studies indicated that HEP has shown substantial outcome in areas related to disease prevention, family health, hygiene and environmental health. The program has also improved the skewed distribution of health facilities and human resources(7,9,12,13,16).

Since the launching of the program, much emphasis has been given to the deployment of HEWs to achieve the target. 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. Only a few studies have been undertaken on motivation of HEWs that are limited in scope.

This study explored (de)motivating factors that may influence HEWs performance. Policymakers and program managers at some point in the improvement and amendment of Health Extension Programme will consider these research findings. In addition, the themes emerging qualitatively from this study can be used to develop existing evidences and strategically design motivation packages for HEWs.

2. Literature review

2.1. Motivation and Performance of Community Health Workers

Community based Health Workers increasingly are made a formal part of health systems in low and middle-income countries (LMICs), with expanding tasks. Reviewed studies have shown that CHWs' performance is influenced by a multiple factors which the policy makers and program managers should take into account while designing and adjusting CHW program(2).

Several studies indicated that motivation is among factors, which directly linked to the performance of CHWs. A lancet published in 2005 signified that special point must be made about health workers' motivation as it is key a determinant of performance(4). A systematic review done on design factors influence performance of community health workers in low and middle income countries has found that improved motivation was one of CHWs level factors that leads to desired impact such as equitable reduction in mortality and morbidity, and improved well being of the community(6). Recent studies in Ethiopia have also shown factors associated to motivation of health workers were identified as key for their success. For instance, HEWs' time motion study and one qualitative research conducted on HEWs' relationship with the community and health sectors in the Sidama zone of the South Nation Nationalities and Peoples Region of Ethiopia found that motivation and factors leading to motivation were central for the performance of HEWs(15,17).

2.2. Factors affecting motivation of Community Health Workers

Most researches done on de(motivating) factors of CHW have identified multiple source of motivation. Some of the factors come out from CHWs -intrinsic and others are external -environmental/extrinsic factors.- A systematic review of 140 papers from middle and low income countries found factors like frequent supervision, continuous training, facilitation of support of traditional leaders or regular community meetings, could enhance community trust and respect towards CHWs and thereby CHW motivation. The same review report clearly revealed financial incentives increased performance of CHWs when compared with CHWs not receiving financial incentives, these should be predictable(6). In contrary to these, some financial incentive strategy negatively affects the performance of community health workers. Pay for performance incentives were a cause of dissatisfaction and stress due to the nature of their amount, structure, disbursement among accredited social health activists (ASHA) in India. The study postulated, based on the nature of incentive, ASHAs may have been pushing those services that were incentivized, such as female and male sterilization(18). Similarly, case study of five countries (Ethiopia, India, Bangladish, Nepal and Iran) reported utilizing minimal economic incentives to part-time CHWs tend to limit CHWs' focus, with financially incentivized activities becoming central. They can, however, improve outcomes in well-circumscribed areas(19).

Study conducted in Tanzania denoted that CHWs were predisposed to volunteer work and apply knowledge gained to their own problems and those of their families and communities, which were identified as individual level source of motivation. Families and communities supplement other sources of motivation by providing moral, financial, and material support, including service fees, supplies, money for transportation, and help with farm work and CHW tasks. The

government and its development partners provide motivation in the form of stipends, potential employment, materials, training, and supervision(20). Related findings reported from study in India. Love for work, and financial incentives were individual level motivators, while community support and recognition, organizational commitment and pride, regular training were identified as environmental level motivators(21). Randomized controlled trials (RCT) conducted in Mozambique and Uganda revealed participatory community engagement and innovative supervision approach lead to improvements in coverage of appropriate treatment for children with diarrhea, pneumonia and malaria; and CHW retention rate, motivation and performance(22). But irregular, infrequent, fault-finding (not supportive) supervision approach and perceived as sign of poor performance found to be de-motivating factors for CHWs(20,23). Previously mentioned studies have also pointed out job burnout, poor personal health, job insecurity and less career development opportunities were the individual level de-motivators(18,20).

One evidence from Ethiopia which was done at three points in time (2003/04, 2006, and 2009) targeting public sectors health workers, in which HEWs were included, clearly found that health worker motivation significantly increased over the study period, including two indicators of motivational outcomes—overall job satisfaction and self-perceived conscientiousness, and two indicators of motivational determinants—pride and self-efficacy. However, two other dimensions of motivation—satisfaction with financial rewards and satisfaction with facility resources significantly decreased(5). This study found the pride index is higher among health providers working in health centers than among those working in clinics/health posts but the opposite was true in terms of self-efficacy. Evaluation of HEP in Ethiopia, which was conducted in 2011, found that over the period of 3.5 years of HEP implementation, the overall attrition rate was 6.5% over the program period. However the attrition rate difference per region where 0% attrition rate is found in Afar, while it was 33% in Harari. The major reasons for leaving their job include personal reasons like health issue and marriage, work environment factors like salary and reasons like change of work(24). Parallel study found that a third of the HEWs expressed satisfaction about their housing condition whereas (96%) of HEWs thought that, HEWs are important for the success of HEP and 87% attested that CHWs fully participate in the implementation of HEP. Majority (79%) of the HEWs were unsatisfied with their monthly salary. Among the HEWs who attended refresher courses, only 41% expressed satisfaction about the course. This study also revealed that HEWs had a positive perception about their supervisors while relationship and support from health center (62%) was moderate(13). However, one qualitative study done in Sidama, south region has shown that top-down supervision and deferring expectations from the community and health sector regarding HEWs' tasks, sometimes negatively affecting motivation and satisfaction of HEWs. Inadequate training possibilities hampered relationships and discouraged HEWs(17). Time motion study of HEWs conducted in 2015 has identified Pride of serving the community and seeing positive change were among Motivating factors frequently mentioned among HEWs while slow professional career growth, inadequate in-service refresher training and financial limitations, both personal and institutional were among de-motivating factors(15).

Table 1: Conceptual framework for Health Extension Worker (de)motivators

Perspectives	(+/-)[1](De) motivating factors
Individual level	(+) love for work
	(+) Commitment to public service
	(−) Burnout
	(−) work load
Family level	(+) Moral support
	(+) Help with work
	(−)Unable to fulfill family role due to work overload
Community level	(+) Increased respect, recognition and sharing tasks
	(−) Lack of demand
	(+) selection by the community to serve as HEWs
	(−) Not meeting community expectations
Health system/organizational level	(+) Poor governance and leadership
	(+) Training
	(+) Supportive supervision
	(−) Inadequate monetary earnings
	(−) Insufficient supplies and job aids
	(−) Poor supervision
	(−) Lack of transport
	(−) Nature of service provided

Source: *adapted from Alam et al,2012* (25)

[1] *(+) Motivator; (−) Deterrent*

3. Objective

3.1. General objective

The main objective of this study is to identify factors affecting motivation of rural health extension workers (HEWs).

3.2. Specific objectives

The specific objectives of this study are:

- To assess the motivational factors for HEWs to perform their expected roles.
- To identify barriers or de-motivating factors among HEWs

4. Methodology

Study setting: The study was conducted in two districts- *Boset* woreda in Oromia and *Alaba* special woreda in SNNPR.

In Ethiopia, a majority of the population (83.6 percent) resides in rural areas (26). According to the Demographic and Health Survey (DHS) 2016(27), overall, 36 percent of currently married women are using a method of family planning: 35 percent are using a modern method and 1 percent are using a traditional method. The prevalence of HIV/AIDS is 1.4 (from total population) and incidence of tuberculosis is 258 (per 100,000 people)(28). Availability of health workers, the doctor, health officer, nurse and midwife to population ratio is 0.7 per 1000 population, far below the minimum threshold of 2.3 doctor, nurse and midwife to 1000 population ratio required to ensure high coverage with essential health interventions(29).

The 2007 national census(30) reported a total population of Boset woreda was142,112, of whom 73,925 were men and 68,187 were women; 26,514 or 18.66% of its population were urban dwellers. The majority of the inhabitants practiced Ethiopian Orthodox Christianity, with 60.57%

of the population reporting they observed this belief. While 15.64% of the populations were Muslim, 14.45% of the population practiced traditional beliefs, and 8.37% were Protestant. The climate is characterized as temperate or locally called woinadega, the mean annual temperature is about 17.6 - 22.5 C and the mean annual rainfall falls between 601-1200mm. According to the administrative report from the woreda, one hospital, 7 health centers and 33 health posts providing service in the woreda. A total of 250 health professionals deployed in the woreda out of which 77 are HEWs.

Based on the 2007 census(31) conducted by the Central Statistical Agency of Ethiopia (CSA), Alaba special woreda has a total population of 232,325, of whom 117,291 are men and 115,034 women. With an area of 994.66 square kilometers, Alaba has a population density of 233.57; 26,867 or 11.56% are urban inhabitants. A total of 49,028 households were counted in this woreda, which results in an average of 4.74 persons to a household, and 47,205 housing units 93.84% of the population said they were Muslim, 4.62% practiced Ethiopian Orthodox Christianity, and 1.2% were Protestants. From the admistrative report of the woreda, two hospital, 9 health centers and 79 functional health posts present providing services. A total of 250 health professionals and 77 HEWs deployed in the woreda.

Study design: A qualitative case study design was applied for this study. Exploratory type of case study used to explore factors affecting motivation of HEWs at different level.

Study population: HEWs working in rural area were the primary study population.

Sampling and recruitment: The sampling for HEWs for the study occurred at four levels. First, the researcher purposively selected two regions of Ethiopia namely Oromia and SNNPR. Secondly, two Woredas (districts) were purposively selected from each region to have some variability of regional contexts. Thirdly, having selected the Woredas, relatively nearby and located in distant from town (but reachable) Kebeles from each district was purposively selected. A total of 16 kebeles were selected-Nine kebeles from Oromia region and seven from SNNPR region. Finally, in consultation with Woreda health offices, one HEW per kebele was included in the interview. To represent a wide range of variation in different aspects of HEWs, service year, marital status (married and unmarried) and career level (level III and level IV) were the key background variables. For HEWs to be eligible in the study, they must have been staying in their deployment field for at least five years. The reason for this is participants of the study needed to have been working long enough to interact with the community and programme to reflect on both positive and negative experience. Considering background profiles of HEWs, to obtain focused and in-depth views of the target population, we conducted in depth interview with selected sixteen participants. Nine of HEWs were from Oromia region, Boset woreda and seven of them were SNNPR regions, Alaba special woreda.

Data collection and management: Structured in-depth interviews data collection technique using an open-ended question was applied. Sixteen in-depth interviews were done with HEWs. Nine of the interviews were conducted at a health post and seven were at health centers based on the interest of HEWs. The interviews with HEWs were conducted in Amharic and Afaan Oromoo. Data collection tool was developed considering local context. The tool was originally prepared in English. Then it was translated and retranslated into local language to make sure

their linguistic and conceptual equivalence and cultural appropriateness of the area. 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 Kebeles from the two woredas who were not participating in the study. Principal investigator who is fluent in both languages (A/Oromo and Amharic) did data collection. The researcher also had previous experience of handling interviews with HEWs. The entire interviews were audio recorded. The audio tapes were transcribed daily after the interviews in Amharic and Afan oromo. We then translated in to English and transported to Atlas.ti software. We also tried to jot down key points using notebook during the interview.

Data Processing and analysis: We analyzed the data by ordering in accordance to the research objectives. Atlas.ti (v. 7.5.2) was used to analysis the data. The in-depth interview data was coded in line with pre identified thematic areas from the literature review and study objectives. However, we also coded important data inductively based what is emerged from our row data. A colleague, who has good experience in qualitative study consulted to independently code a sample of interviews and his feedback was considered to ensure the inter coder reliability. The data is thematically analyzed based on similarities, differences and associations.

Trustworthiness: The principal investigator who has more than seven years experience about the program did all data collection process and organization. He has also a training on qualitative research method and previous experience of qualitative data collection. Language was not a barrier to communicate with the interviewees as data collectors is excellent in listening, speaking and writing both local languages (Amharic and Afan Oromo). We interviewed each participant for 23-30 minutes. Participants were well explained about the aim of study and values of all information collected. We then tried to probe the participants in detail to have a clear understanding of the topic under study. All interviewees that were contacted to participate in the interviews voluntarily contributed. All interviews were conducted in neutral and free of disturbance environment. We collected data from HEWs working in rural (agrarian) areas. HEP in Ethiopian can broadly categorized in to two based on setting, structure of the program and HEWs' background-Urban HEP and rural HEP (agrarian and pastoralist HEP). In this study, we focused on rural (agrarian), which constitutes the largest proportion of HEWs. Even though slight variations exists in program management, structure, content, approach of service delivery and background HEWs are uniform across agrarian regions. Considering aforementioned program background, we purposively selected two districts from two agrarian regions namely Oromia and SNNPR. Therefore, our analysis and recommendations in this study refer HEWs/HEP in rural specifically the agrarian one. Some background of the participants were also taken in to account like level of education, marital status and work experience (5 years and above) as all variables may have an implication on the finding. According to the national HEP guideline, HEWs in rural (agrarian) are female, completed 10^{th} grade and have at least one year training on the program (certified in level III) and recruited from the community they are serving. Data were captured using voice recorder and key points with notebook. At the end of the interviews, summary points were presented to the study participants to check the information that data collector captured in appropriate way. During data analysis software (Atlas.ti) used. Data coded and thematically categorized based on their meaning. Colleague who has good experience in qualitative study was also consulted to code sample interviews. Then, we discussed on differently coded concepts and final agreed codes were considered in the analysis. In addition, a

the thesis at very draft stage and processes of data collection debriefed with colleague who previously worked on HEP at ministry level. Finding from this study discussed and triangulated with different previous research findings conducted. We made analytical discussion about different factors affecting motivation of rural HEWs at different level. Both the findings and discussion are presented in accordance with the study objectives.

Ethical consideration: Ethical issues are considered and addressed during this study. Ethical approval was obtained from Ethical Review Committee of Addis Ababa University School of Public Health. Regions and Woreda officials were communicated and permission was received prior to the start of data collection. Privacy, confidentiality, and justice were ensured and the respondents were treated with the appropriate level of respect. Participants were asked to participate voluntarily and informed consent forms were provided and explained. After participants fully understood the study purpose, risks/benefits and right to withdrawal, written informed consent was received (See Consent form: Annex I). All the information collected was strictly confidential. The tape recordings and written notes are kept in a secured place. Participants of the study were de-identified as described and the specific Kebeles where the study was undertaken are not mentioned in this report. We did not pay any money to the study participants for their contribution. However, we reimbursed cost of transport for participants from distant kebele that we conducted the interview at health center.

5. Results

5.1. Demographic characteristics

Demographic characteristics of the 16 HEWs interviewed are summarized in Annex I. We have taken nine participants from Oromia region, East Shoa zone, Boset Woreda whereas seven were from SNNPR, Alaba special woreda. All respondents were female with mean age of 27.5.

Table 2: Demographic characteristics of HEWs

Characteristic		Number (n=16)
District	Boseti (Oromia region)	9
	Halaba (SNNPR)	7
Marital Status	Married	10
	Single	6
Years of work experience as HEW	5—10	10
	10—15	6
Level of Education	Level III	8
	Level IV	7
	BSC	1

5.2. Factors affecting motivation of Health Extension workers

From interviews, four levels describing factors affecting motivation of rural HEWs identified: individual, family, community, and health system (including governance and leadership). Each thematic area are described as follow.

5.2.1. Motivating factors

5.2.1.1. Individual level

Commitment to public service

Personal commitment to service the community was one of the prominent motivating factors across respondents. For example, some HEWs noted their feelings as follows.

"*… Mothers come to us when their children get sick. We can manage some cases at kebele level. We also provide health education. In general, serving community and taking care of their health gives me a pleasure." (P13, age 28)*

*"I like to serve my community because I am serving my mothers and sisters. I am from the community I am serving now**."** (P11, age 28).*

Providing service to more at-risk community groups like mothers and children was also pointed out as an additional source of motivation of HEWs.

"When we compare the current health status with the time when we started our service, there is a big difference. We give priority to mothers and children because they are susceptible for health risks. This is encouraging." (P3, age 26).

"…I love and value my job because we mainly work on mothers and child health… For example, I am very happy treating malnourished children. You know malnutrition is a killer. After I bear a child, I can understand how a mother gets trouble about her child's health problem." (P4, age

28).

Achieve desired level of performance

Health Extension workers were motivated when they saw the changes in the community because of their efforts.

"When I compare the current health status with the past 11 years back, around the time I started this job, I have seen a great improvement. This by itself motivates me." (P1, age 30)

"I achieved training of model households, and was able to declare an open-defecation free kebele. Because of this, I was selected as best performer and I was ranked 1st and 6th from the catchment and woreda respectively." (P2, age 26).

Love of work

Respondents pointed out that their love of their work was an important motivator. HEWs said:

"Professional responsibility is among the things which motivates me to work as a HEW" (P2, age 25).

"I love my job because I saved a lot of life within these 11 years of experience. When you work, you have to love your job first."(P3, age 26)

"...Even though it is challenging, it is interesting. I am still working since I initially believed in to work with even small salary" (P2, age 25).

5.2.1.2. Family level

Family Support

HEWs reported receiving positive reinforcement from their families, with only passing reservations expressed by some family members due to the nature of the work. Moral and domestic/household activities are types of support mentioned by HEWs they get from their family. Asked about family level factors of motivating factors, some interviewed HEWs illustrated their experience as follow.

"I have a support from family. They want to see my achievement." (P12,age 27).

"My family supports me in household activities to take a break." (P5, age 27).

3.2.3. Community level

Community acceptance

HEWs reported positive reception and respect by the community members that motivates them.

For example, HEWs said:

"There were people within the community who supported us and helped their neighbors understand what we were there to do face. Such people motivate you. I do not have a challenge in that regard. The community accepts my service. I know this when the community translate my health education in to practice." (P6, age 28).

"They are the reason for our successes. They fully accept as true what we recommend for their health. They have a preference to consult us even though we do not have adequate medicine to treat for their illness. They come to get referral service from us." (P12, age 27).

Support from community

HEWs described support they obtain from the community through organized women group in terms of sharing their tasks especially on health promotion and community mobilization. The common structure/group that was mentioned across the participants was the Women development Army/group (WDA/G). Women development Army is a community level structure. These structure starts by networking the larger group 1 to 30 and the smaller 1 to 5 households. A network of 1 to 30 household is called women development group. Similarly, on average six household networked which is 1 to 5 networks. One two five is a subset of development team. On average one development team has five 1 to 5 networks. Both groups have a leader that is selected by their members. The leaders are expected to be model in terms of health service package implementation. HEWs focus on those development team leaders. The training is mainly on 16 HEP packages.

"Women development groups in the community support us in mobilizing community for immunization, distribution of bed net, check mothers not to deliver at home, latrine utilization and so on..." (P7, age 25)

"There are organized Gare (development team) and 1 to 5. We transfer messages for those leaders and then they forward them to their followers. Presently, our work is becoming easier because of their support. In the past, we would visit all households but currently, I have 41 Gare that I am expected to orient them well about health issues I need their support. Therefore, they can manage the issues during their monthly and bi monthly meeting. We try to attend their meeting if we can. If we could not attend their meeting, we communicate them through phone call as most of them have it" (P12, age 27).

5.2.1.3. System level

Supportive supervision

Supervisors provide an important link between the HEWs and the Health center on one hand and HEWs and health system in broader on the other. In both districts, the supervisory system appeared to be organized into two aspects: HEWs and supervisor at health center of reference,

and administrative level like kebele and districts. They get both technical and logistic support from health center of reference. Health extension workers agreed the significant contribution of supportive supervision in strengthening their capacity gap.

"The health center has also already assigned supervisors for me. Moreover, they provide me a support I may need. They go up to household level to support me. They are not faultfinder for things that are not properly done. Such kinds of blaming existed previously but now, including health center head, supporting me by going to the community level." (P6, age 28)

"Health center gives us support. We get support on weekly bases. From health center, two focal are assigned for each kebeles. We share our programs to our assigned supervisors. Then based on our schedule, they give us necessary support including community level activities. Support area includes, chart and record keeping, defaulter identification, EPI services and so on. The communityalso wants to see new faces. Therefore, we use these peoples to convince the society about difficult packages for us to implement, like latrine construction. Some packages which community has good awareness about them are easy for us and we can achieve by ourselves." (P7, age 25)

Training

HEWs reported that regular training is necessary to gain new knowledge in view of emerging health issues. HEWs felt empowered through the acquisition of knowledge and skills on newer issues in community health through training. They were interested in learning and gaining new health related information so that they remain well informed to help their community. Financial compensation for the training time was also mention as motivating.

"Training also helps us to build our knowledge in addition to the compensation we get from the time of training. This in turn motivates us to work more." (P6, age 28).

"In terms of training, we regularly get update for the new developments; I can't say any problems with that. There is Integrated Refresher Training program and new updates always included in it. We get the training every year, it is adequate". (P10, age 29).

5.2.2. De-motivating factors

5.2.2.1. Individual level

Workload

HEWs identified workload as the major cause of their de-motivation. Many activities have been added to the HEP program since the instigation of the program (for example, integrated community case management (ICCM), Implanon insertion, sepsis management etc). Work overload also led to poor performance and burnout. For instance, HEW described this:

"There is work overload. Usually it is called 16 packages but we work more than 30 packages. We go door to door to provide the service. We also register what we have done on family folders and we prepare report as well." (P2, age 25)

This challenge is more exacerbated when the number of HEWs is below the standard or the catchment number of the population is beyond the average. The issue was described by HEWs as follows:

"There are many kebeles with only one health extension worker. Nevertheless, there are also many campaigns that cannot be achieved with one HEW. This makes the work more challenging" (P2, age 25)

Burnout

HEWs mentioned that burnout; because of the nature of work (Health extension service packages), compensation, workload and scope of work is a source their de-motivation to work as HEWs.

"Our tasks are becoming massive which is a reason for my loss of interest towards my assigned tasks." (P8,age 30)

Mismatch of HEWs' workload and inadequate payment was mentioned as reason for frustration of HEWs. Furthermore, HEWs mentioned that failure to achieve the expected performance de-motivates them. For example, HEWs said,

"The amount of payment and nature of work doesn't match. And yet, it is known that national level performance is mainly the reflection of our contribution…." (P3, age26).

"I become motivated when I see changes from the community side. For example, maternal and child deaths were common in my kebele; there was a high prevalence of malaria. However, a change can be witnessed in the trends after health education provided at large. On the other hand, it discourages me when I do not see any changes in some HEP packages. For instance, I question my efforts when I see low coverage of latrine utilization in my catchment." (P9, age 30)

5.2.2.2. Family level

Unable to fulfill family role

HEWs have a concern that they were unable to fulfill their family roles and spend time with them due to busy time they have. Daily work related travel is considered unsafe and inconvenient for women.

"Even if I love my job, in the future, I will search for other work opportunity around town to get time for my child and family. This job is more challenging for those who get married like me." (P2, age 25).

"We also work on the weekend; our children ask us to be with them at least on the weekend. We also need go to church on Sunday as well but most of the time we can't do it because of the work overload we have." (P2, age 25).

5.2.2.3. Community level

Less demand from community side

HEWs reported limited negative experiences or reactions from the community but did cite instances of community members rejecting health messages. This depends on the awareness level of community about health issues. For example, one HEW reported,

"We visit every household. Individuals' behavior is different. Some respects others do not. There are individuals who do not have positive attitude. Therefore, it is boring and makes you hopeless to work in such way. This is a reason why we do not be effective with our work. When a community doesn't accept our service, and implement the package, and fail to respect us, we develop negative attitude to our profession." In other cases, "It was very strange. We encountered a lot of hesitation at the start of our work especially when I worked at my first kebele" (P10,age 29).

"…In fact, some segments of community may not accept some medicine unknowingly especially during campaign, for example, in taking Zithromax medicine. This is because still there is a group of community whose level of knowledge about health is poor. Such a community requires persistent support and follow up until they aware of its importance." (P7, age 25).

5.2.2.4. System level

Poor supervision approach

Supervision skills and approach are important determinants of motivation among HEWs and an approach that relied on faultfinding rather than support were reported as de-motivating factor. Some HEWs identified this as a problem. Furthermore, Infrequent and non-systemic supervision types were pointed out by HEWs that created discomfort for them.

"Health centers try to provide us technical support to their level best. However, sometime, the support across the kebele is not similar. It depends on the capacity of assigned individual from health center to specific kebele. Sometimes, health professionals, who do not have proper orientation about our works, come to support us. Nevertheless, to the reverse, they get back with support from Health Extension workers. People come from woreda and FMOH focus on the accessible kebeles and most of the time all kebeles are not equally covered. Supervision type should be systemic as well. It shouldn't be done when the top managers ordered the next level to do so." (P12, age 27)

"Sometimes kebele managers use offensive words in front of our community, they don't even choose appropriate words for feedback. They are also faultfinders. Now a day, we started to ignore their support and working with them." (P3, age 26).

Leadership and governance

Understanding the role of leadership is a key for the successfulness of a program. However, in this study, HEWs mentioned they receive minimal support especially from kebele level leaders. Some also feel that the program is not getting appropriate attention by the government. HEWs said:

"The government does not pay attention to this program. I rate the lowest in this regard. Sometimes leaders do not consider us as part of the system. Even, we do not get support when we face social problem. Some years back my coworker raped while walking alone for work. Then no one supported for her moral at least when she asked for transfer to another kebele. Since then I do not have positive attitude for my profession because the same things could have happened to me as well, if I were she. At least, they do not care for our moral. We do not have responsible body that stand by our side." (P9, age 30) .

"Though some improvement is being observed, attention to a program is on–off kind. Local (kebele) leader's attention depends on the attention from the above on a particular health program." (HEW4, age 28)

Shortage of Supplies

Majority of the HEWs mentioned that tracer drugs and supplies, which are expected to be available at health post (HP) level do present. However, HEWs mentioned that they lack some medical equipment to provide full services at health post level. For instance, HEWs described this as follow:

"In our kebele, we do not have refrigerator to put antigen and provide EPI service routinely. Because of this, we sometimes let mother go who come from long distance without providing immunization service for them. This leads to lose of thrust from our community." (P4, age 28)

"We lack medical equipment to implement level four health service packages, as per the standard." (P7, age 25)

Continual training and career advancement

Continual training helps to improve HEWs' knowledge and skill to render quality of service at the community level. De-motivating factors that mentioned in this regards were limited opportunity to upgrade, unfair selection of HEWs for training, blurred career structure; and failure to lining up salary increment and service package after completion level IV training. For example, HEW described:

"A personal effort to upgrade your career has no value. You must wait from the government to upgrade your educational level, which is very slow moving. Such approach upsets me as human being. I sometimes put a question to myself if the program was designed based on research or evidence. Any human being wants some improvement but the actual practice here is different. For example, I have my BSC degree from private college with monthly payment of 470 birr,

which was difficult for me to afford. Nevertheless, I am still working as level III health extension workers position. I benefited nothing from it." (P10, age 29)

Monetary earning

In this study, almost all HEWs agreed that their salary payment was below their expectation especially when compared with their workload. On the other hand, the payment scale lacks uniformity among HEWs with similar educational level and service years even within the region.

"…it is better to say we are working for free. For example, I have worked for 9 years but my salary is still less than 2000 birr. Our activities are too various…So our salary does not match with the work we are assigned for. I think salary is a big issue to be given a due attention" (P4, age 28).

"Health care workers do not get a satisfactory salary in general. However, in other sector like teachers, they work relatively less with better payment. Let alone the amount of payment, it lacks uniformity across similar level of career and service year within our region." (P7,age 25)

Nature of service

The HEP is designed to be rendered at community level focusing on health promotion and disease prevention activities. Health extension workers are the main actors and provide the service mainly by going door to door, at community and health post level. HEW stated such service delivery approach is not easy especially in geographically wide and sparsely populated kebeles. In some kebeles HEWs pointed that they are expected to walk long distance from their duty station to reach all households. The problem seems more complicated in such areas, especially where the transport service is not available. Therefore, nature the service, approach of service delivery itself caused de-motivation for HEWs. HEWs stated their experience as follow.

"Our work is door to door. You must go house to house to teach the community practically. Such approaches create challenges to us. It is tiresome." (P5, age 27)

"We cover large geographic area, up to 27 km away from work station. Since we don't have transportation service, we sometimes pay for transport from our pocket." (P13, age 28)

"It is three hours walk distance from our respective town. When we face such obstacles increase, we lose moral to continue performing our tasks. (P11, age 28)

Scope of work

In this study, participant mentioned that additional tasks burdened their routine activities. These additional packages are non-health related and from other sectors.

"The tasks assigned to us have no problem but we are also expected to involve agricultural and education sector related activities. This creates workload to us. We go for field to work on agriculture…. We also participate in identifying children those eligible for school. However, we

do not get such support from other sectors. It would have been much better and fruitful if sector like education, agriculture and health work in integrated way..." (P9, age 30)

"We are busy with some non health activity. For example, one of health extension workers expected to be a member of kebele cabinet. So, this HEW unwillingly gets engaged in political activities most of the time." (P3, age26)

Unfulfilled expectation

From the study, lack of clear information from the beginning of the training about occupation, place of work after completion of their training was the main causes of HEW de-motivation. HEWs stated:

"I was registered from my preparatory school. I did not have the right information at the time. I was expecting to be graduated as nurse. I grew up in town. When I back after completing my training with HEW profession, I was assigned in remote area. Therefore, my expectation was not realized." (P15, age 27)

"I I had been told to serve the community I was. However, I could not get a chance to be assigned to my kebele that I was selected from. I wasn't, at least, assigned in neighbor kebele, I was assigned to remote kebele where majority of the community speaks other language (Amharic) though I speak Afan Oromo." (P14, age 26)

Transfer of HEWs

HEWs felt getting the chance of transfer from one area to another is not existing as system,. However, sometimes, it has been observed when transfer happened for selected HEWs with unclear procedure. This act created disappointment for HEWs.

"It is difficult for us without any change though we got a chance of upgrading. We need also a change as community getting better in terms of health. We cannot get a chance to leave the rural area even if we get more education opportunity." (P1, age 30).

"There is lack fair management regarding transfer. Area where I am working is found in remote distance. I worked there for long time. I have also observed that some newly employed HEWs in accessible kebele by social relationship." (P11, age 28)

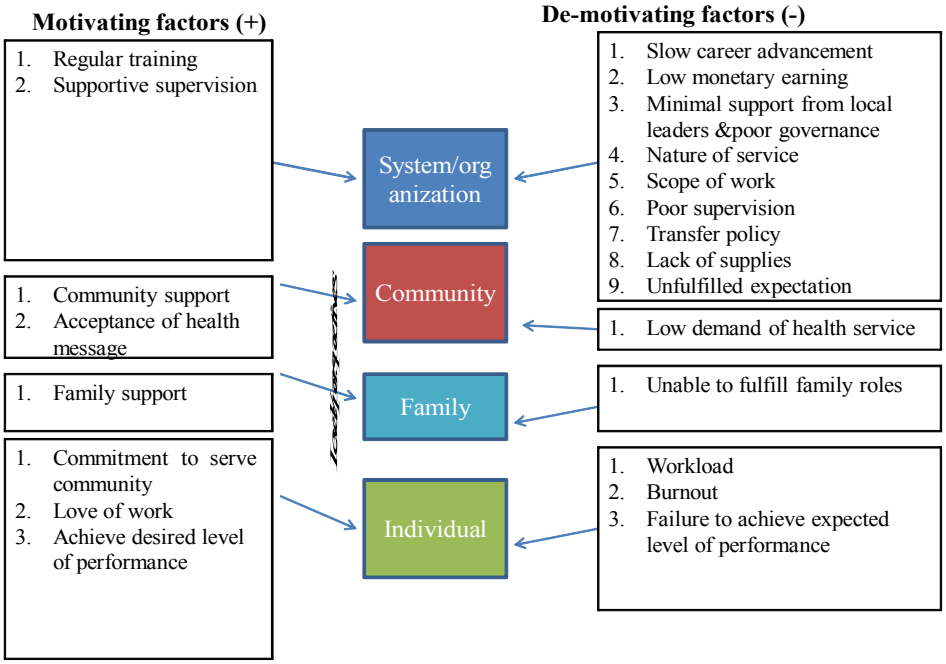


Figure 1: Factor affecting motivation of rural HEWs

6. Discussion

The data presented here identified four level of HEWs motivation: individual, family, community and system/organizational level. Love of work and pride to serve community are personal level motivators. HEWs identified workload and burnout among individual level de-motivators. Moral support and domestic work support are among family level source of HEWs' motivation. However, unable to fulfill their family roles and spend time with them due to thier

busy time de-motivated HEWs. At community level, increased respect, acceptance and task sharing motivated HEWs. However, less acceptance of health service by the community de-motivated HEWs. Slow progress in career advancement, poor supervision and support, inadequate material availability, insufficient financial earnings were labeled as de-motivating factor at health system/organizational level. Among the motivating factors regular supportive supervision, availability of supplies and on the job trainings were identified. These findings closely matched Alam et al. (25) conceptual framework explaining factors affecting CHW retention, although the specific factors presented within each level of the framework are not identical.

According to this study, pride to serve community, witnessing positive changes in the community and love of work were among the prominent motivating factors that were frequently mentioned by HEWs. Previous studies conducted in Ethiopia on general health workers have revealed that staffs get motivated in seeing people experience recovery from illness or positive outcome. Additionally, serving the country and individual communities was rewarding for staff of at all levels (5,15,32). HEWs reported that their workload is heavy, and they were unable to complete all they are supposed to do. However, this workload is mainly due to the nature and approach of service delivery, judging from the interview, their tasks that are out of the scope of their job and frequent campaigns have worsened the problem. A recent case study conducted in three countries (Brazil, Ethiopia and Nepal) has also shown that HEWs are much stretched and struggle to find time to complete their household activities. The case study recommended to consider additional HEWs per catchment(33). But another study which assessed how HEWs spend their time by direct observation of HEWs has shown HEWs were spending their working time by waiting for patient at health post level and unstructured activities(15,32).

Although, few HEWs discussed the existence of familial support in sharing domestic activities and rearing their child, most of them expressed concern that they were unable to fulfill their family roles and spend time with them due to busy time they have. Daily work related travel is considered unsafe and inconvenient for women. Especially their husbands also blame them for neglecting their children. Family objection was a major motivational barrier to perform their job. Some previous studies have found families have a great role as a source of both discouragement and positive support of the CHWs(18,20,21,34–37). These study findings describe the role of family by financial, domestic activities, farming and moral support. These findings are also limited to community health workers who voluntarily engaged community health activities. However, in this case, HEWs are a formal government employee and salaried civil servant. Therefore, this makes difficult to compare our finding with the available literatures.

Recognition and reception of health services by the community was cited as being one of the most important motivating factors for health workers similar to other studies.(6,17,20). The other critical finding in this study was the support provided by the community to HEWs mainly by sharing tasks. It was widely recognized that the Women Development Army (WDA) leaders have been supporting HEWs in identification and referrals of pregnant women, conducting postnatal care follow-up, mobilization of communities for immunization campaigns and health education in the community. However, HEWs described that, presently, this structure is not functioning well and further suggested the revitalization of the WDA will largely contribute to their success. This finding is similar with some other study(15,17,32).This study also revealed

that the less acceptance of health messages by the community was among the de-motivating factors.

Supervision has a number of indirect effects on HEWs in addition to the evidence produced by other literatures (4,6,15,18,20–23): skills development and perception by the HEWs as part of the health system. However, faultfinding and non-supportive supervision styles resulted in demotivation of HEWs. Health centers of reference are responsible to provide technical and logistic support in this study. HEWs positively described the frequency and content of support from health center they were receiving. They have a focal person from the health center who technically support them on weekly bases at a minimum; and receive logistics, which are expected to be available at the Health post level from the health center. This finding also indirectly evaluates the implementation health center and health post linkage guideline((38) developed by Federal Ministry of Health, which states HEWs are, both technically and administratively, answerable by catchment the health center. Our finding in this regard also seems as improvement has been shown from the evaluation of HEP which was conducted in 2010(13).

Among the basic requirement to select and train HEWs is they are preferably from the community they serve to increase community acceptance(12). In consistent with other review findings(33) the interviewed HEWs were selected from other area. Selections of candidates from urban area were also reported. Another de-motivating factor related to recruitment processes was lack of clear information about future career structure, role/job description and benefit packages created unrealistic expectations.

Insufficient earning and slow professional career growth were among de-motivating factors frequently mentioned by HEWs. The latter is more worsened by lack of clear selection procedure of HEWs for continuing training and lack of any improvement/advancement in scope of work. In this study HEWs felt they have small monthly wage because: 1) the pay is not enough to meet basic needs; (2) the pay is not enough when compared to their workloads; and (3) when their workload is compared to that of other health workers, their pay is not equitable and, 4) payment scale lacks uniformity across the districts. Others study also found that amount of payment for HEWs and Health workers in general is not satisfactory which have negative impact on their performance(5,15,24).

As it clearly depicted in some literature (39–41), regular on the job refresher training is the most important factors of Health extension workers. Previous studies found that on the job training for health extension workers were suboptimal in terms of regularity and it usefulness (13,15,17,24,32). However, in this study, HEWs described it in relatively positive way about the content and frequency of refresher training they were receiving. This might be due to the recent national plan of regular refresher training for HEWs.

In many literatures, contribution of good leadership and governance has been documented for the successful implementation of HEP (7,9). Even though kebele managers and upward administrative structures have key roles, the responsibility of planning, monitoring and over all coordination of HEP is decentralized to health centers(38,42). Our studies revealed that the administrative support and over all leadership by kebele managers, woreda health office

mentioned as becoming minimal. HEWs also cited, currently, the program has minimal attention by the government at all level. This further explained by absence of motivation scheme for HEWs, unclear management of human resource issues like ambiguous career path and no guidance on transfer of HEWs.

Housing and transportation were reported in this study as among motivating factors for HEWs to stay in their duty stations. HEWs mentioned the currently distributed bicycles are not conducive to them and they are not utilizing them. Therefore, HEWs need motorbikes or bicycles, which are suitable for female especially for those working in remote areas. 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(8,13).

7. Limitation

This study may be affected by the following factors. 1) The findings in this study are qualitative and not covered urban and pastoralist context, which limits to easily generalize this finding for all settings. However, this can be improved by triangulating the findings done in other setting before. 2) The researcher conducted all the interviews in this research, while all of the HEWs were female. Woreda health office and health center HEP coordinators also involved in facilitating selection of interviewees. Therefore, we suspected this mismatch of gender and involvements of their supervisor to some extent may induce of social desirability bias by HEWs. We tried to avoid this by in-depth probing and convincing the purpose of the study.

8. Conclusion

In this study, HEWs interviewed were motivated by serving the community, love of work, seeing positive change in the community and achieving desired level of performance. Workload is one of the most prominent de-motivating factors for HEWs.

Community support in the form sharing some tasks trough organized women development group/army identified a motivating factor from community perspective. Lack of recognition and receptive to their health service by a community is not much concerned HEWs per this finding.

Functional linkage between Health center and surrounding Health posts helped HEWs to get technical supportive supervision and logistic supplies. Slow-moving continuing education and career development opportunities have been identified the key de-motivating factors from system point of view. Inadequate salary and lack of uniformity in payment have also been frequently mentioned by HEWs as main cause of their dissatisfaction.

HEWs supplied with logistic regularly by health centers but health extension workers who upgraded their education to level IV were not providing expected service due to absence of required supplies.

From this finding, loose leadership support and governance for the program is an indicator of poor attention for the program by the government, which in turn created discomfort among HEWs.

9. Recommendations

The following recommendations are forwarded for Federal Ministry of Health and Regional Health Bureaus.

I. Design financial and non-financial motivation packages/strategies for HEWs. This may include but not limited to, housing, transportation, salary, support and recognition system, and regular on the job training.

II. Advocating Health Extension Program (HEP) through different approach to improve community engagement, support of leaders at all level and others sectors involvement.

III. Additional quantitative studies are needed to measure work burden and to have clear indication of number additional staff requirements per catchment/unit.

IV. Greater community mobilization and support by the WDA may improve HEW efficiency and impact. Therefore, revitalizing the existing WDA structure with clear roles and responsibility is very essential.

V. Improve HEWs career advancement opportunity with apparent scope of work and service packages

VI. Re-examine the transfer policy and procedure for HEWs.

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Annex I: Participants' profile

Participants in order of their interview	Sex	Age	Marital status	Work experience	Level of Education
P1-1st participant	F	30	Married	11	IV
P2	F	25	Married	7	IV
P3	F	26	Single	11	IV
P4	F	28	Married	10	III
P5	F	27	Single	8	IV
P6	F	28	Single	9	III
P7	F	25	Married	9	IV
P8	F	30	Married	10	IV
P9	F	30	Married	11	III
P10	F	29	Married	10	BSC
P11	F	28	Married	8	III
P12	F	27	Single	8	IV
P13	F	28	Married	8	III
P14	F	26	Single	8	III
P15	F	27	Single	8	III
P16	F	28	Married	11	III

***P= Participants**

Annex II: Consent form

Hello, I am ….. working for the research team studying (de)motivating factors for HEWs. I am going to give you information and invite you to be part of this research. We would like to understand

better factors that motivate or de-motivate HEWs. We hope this information will help to improve this situation.

Procedures including confidentiality

If you agree we would like to interview you about personal/individual related, health system and community related factors for HEWs. The interview will take place in a private space where nobody can hear us and last about 40 minutes.To make sure that we do not forget or change what you are saying I will tape record the answers you give. Everything that will be said, written down will be kept totally confidentially. Your name will not be recorded or written down. Notes will be kept in a locked place. Only the team of researchers will have access to the notes and will be destroyed at the end of the study. The findings will be attributed to the study subject in general and not to your area so that nobody can recognize the setting.

Risk and benefits

You can refuse to take part or withdraw at any time. You do not have to give us any reason for not responding to any question, or for refusing to take part in the interview.This study will help to improve the health extension program.

Sharing the results

After the study is completed, we will be sharing the results to all stakeholders. The results will be available in written form. If you would like to receive a copy of the report, please let us know and we will make this possible for you.

Consent and contact

- Do you have any questions that you would like to ask?
- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed by the respondent

The purpose of the interview was explained to me and I agree that…… (Name of person) is interviewed.

Signature ----------Date ----------

Annex III: Interview guide

Table 3: Interview guide

General objective:

- To identify sources of motivation and de-motivation among rural health extension workers (HEWs).

No.	Thematic areas	Topics/issues	Methods	Respondents
1	General profile	• Age----sex…….. Name of Woreda----- Name of Kebele…… • Marital status a) married b) single c) divorced d) widowed • Level of education: a) level III b) level IV • Experience ------		
2.	personal related factors of HEWs for (de)motivation	What personal and/or work related factors that encourage or discourage you to work as HEW? • love for work • Commitment to public service • Desire for knowledge to help self and family • Self-efficacy • work load and Burnout • job security	In-depth interviews	HEWs
3.	Family and community related factors for HEWs (de)motivation	a) How do you describe roles of family that motivate or de-motivate you? b) How do you describe roles of community that motivate or de-motivate you? • Support from family and community • Perception of community towards HEW and HEWs' task (respect, recognition and sharing tasks and lack of demand) • selection by the community to serve as HEWs	In depth interviews	HEWs
4.	Health system related factors for HEWs (de)motivation	What are health system level source of motivating or demotivating factors? How? • organizational commitment and pride • Training • Supervision • monetary earnings • availability of supplies and job aids • Material support including bicycles and job aids • Nature of service provided by HEWs	In-depth interview	HEWs

Table 4: Interview Guide- Amharic Version

አጠቃላይ ዓላማ • የገጠር ጤና ኤክስቴንሽን ሰራተኞችን የስራ ተነሳሽነትና ተነሳሽነት ማጣትን ምንጭ የሆኑ ጉዳዮች ለመለየት፡፡				
ተ.ቁ	ጭብጥ	ርዕስ	የቃለ መጠይቁ ዘዴ /አይነት	የጥናቱ ተሳታፊዎች
1	አጠቃላይ መረጃ	• እድሜ----ፆታ…….. የወረዳው ስም----- የቀበሌው ስም…… • የጋብቻ ሁኔታ ሀ) ያገባች ለ)ያለገባች ሐ) የፈታች መ) ባሏ የሞተባት • የትምህርት ደረጃ : ሀ) ደረጃ III ለ) ደረጃ IV • የስራ ልምድ በዓመት --------		
2.	የስራ ተነሳሽነትና ተነሳሽነትን የሚቀንሱ ግለሰባዊ የሆኑ ጉዳዮችን በተመለከተ	በጤና ኤክስቴንሽን የስራ ተነሳሽነትና ተነሳሽነት ማጣትን ምንጭ የሆኑ ግለሰባዊ ጉዳዮችን በተመለከተ? • የስራ ፍቅር • ህብረተሰቡን ለማገልገል ያለው ቁርጠኝነት • ቤተሰብንና ረስን ለመርዳት • በስራው ላይ ለራስ ያለው ግምት • የስራ ጫናና መሰላቸት • የስራ ዋስትና	ጥልቀት ያለው ቃለ መጠይቅ	ጤና ኤክስቴንሽን ሰራተኞች
3.	የስራ ተነሳሽነትና ተነሳሽነትን የሚቀንሱ ቤተሰባዊ ወይም ማህበረሰባዊ የሆኑ ጉዳዮች	ለስራ ተነሳሽነትና ተነሳሽነት ማጣትን ምንጭ የሆኑ የማህበረሰቡን ድርሻ እንዴት ይገለፃል? • ከህብረተሰቡና ከቤተሰብ የሚታገኘው/ ያለው ድጋፍ • የህብረተሰቡ ለጤና ኤክስቴሽን ስራዎች ያለው አመለካከት(ክብር , እውቅና መስጠት እና ስራ ላይ እገዛ ማድረግ የአገልግሎት ፍላጎት አናሳ መሆን) • ለጤና ኤክስቴንሽን ሰረተኝነት በህብረተሰቡ ተሳትፎ መመረጥ	ጥልቀት ያለው ቃለ መጠይቅ	ጤና ኤክስቴንሽን ሰራተኞች
4.	የስራ ተነሳሽነትና ተነሳሽነትን የሚቀንሱ ከጤና ስርዓት ጋር የተያያዙ ጉዳዮች	በጤና ስርዓቱ ውስጥ ለስራ ተነሳሽነትና ተነሳሽነት ማጣትን ምንጭ የሆኑ ጉዳዮች ምንድናቸው? እንዴት ይገለጻሉ? • የተቋሙ ቁርጠኝትና እና እውቅና መስጠት • ስልጠና • ድጋፋዊ ክትትል • የገንዘብ ገቢ • የህክምና ቁሳቁስና ለስራ አጋዥ የሆኑ ማጣቀሻ • ቁሳዊ ድጋፍ ለትራንስፖርት የሚያስፈልግ ሳይክል • በጤና ኤክስቴንሽን የሚሰጡ የጤና አገልግሎቶች ሁኔታ	ጥልቀት ያለው ቃለ መጠይቅ	ጤና ኤክስቴንሽን ሰራተኞች

Table 5: Interview guide – Afan Oromo Version

KaayyoGooroo • Hojjattoota Eksteenshinii fayyaa badiyyaatiif kaka'uuumsahojji fi kaka'uumsa hojii laafifisuuf wantoota sababa ta'an addaan baasuu.

Lak	*Yaada qabatamaa*	*Mata duree*	*Mala/ haalaodeefannonittiargame*	*Hirmaattota*
1	Odeefannoo waligalaa	• Umurii----Saala……..Maqaaaanaa----- Maqaagandaa…… • Haalagaa'ilaa A) kanHeerumte B)kanHeerumtee c) kanHiikte D) AbbaanManaakanjalaaDu'e • SadarkaaBaruumsaa : A) III B) IV • Muuxannoo Hojjii ----		
2.	Dhimmota dhuunfaa ta'an	Kaka'uumsa hojjii qabaachuu fiqabaachuu dhabuu Hojjattota Ekisteenshinii fayyaa dhimma dhuunfaa wajjin wal qabatee: • Jaalal Hojjiiqa baachuu • Hawwaasa gargaaruf kutannoo qabaachuu • Maatifi Maatii gargaaru • Ilalacha ofiifi qabu cimsuuf • Hojjiin Heddummachuufi nuffuu • Hojjii qabaachuu	Gaafifdeebi gadifageenyangochuu	Eksteenshiniifayyaa
3.	Dhimmoota maatii fi Ummata wajjin walqabate	Kaka'uumsa hojjiii qabaachuufi qabaachuu dhabuu fi gahee hawaasaa akkamiti ibsama? • Hawaasaa fi maatiiirraa gargaarsa argatu Ilaalcha hawaasni sagantaa eksteenshinii fayyaaf qabu (kabaja , beekamtiikennuu fi hojjiiirrattigargaarsakennuufiiitti fayyadammumma saganttichaa xiqqaata'uu) • Hojjaattotni Eksteenshinii fayyaa Hawaasaan filatamuu isaanii	Gaafif deebi gadi fageenyan gochuu	Eksteenshiniifayyaa
4.	Dhimmoota Caasaa /sirna fayyaa fayyaawajjin walqabatan	Sirna fayyaa keessatti Kaka'uumsa hojjii qabaachuufi qabaachuu dhabuuf sababa kan ta'anmaal maalfaadha? Akkamitti ibsamu? • Kutannoo/kaka'uumsa dhaabbatichaafi fi beekumttii kennuu • Leenjii • Hordoffiif deegarsa • Galiiqarshii • Meeshaa hojjii tajaajila fayyaa kennuuf gargaaru (medical supplies and job aids) • GargaarsaMeeshaa fi geejibaafkanta'usaaykiliijiraachuu • Haala/umamatajaajilafayyaaEkisteenshiniifayyatinkennamu (nature service provided by HEWs	Gaafif deebi gadi fageenyan gochuu	Eksteenshiniifayyaa