Extrinsic Factors Affecting Health Worker Motivation in the Context of Task Shifting: Experiences of VCT Counselors in Ethiopia

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MPH Capstone Paper

May 5, 2010

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Abstract

Objective: This paper identifies external factors that influence the motivation of counselors responsible for providing voluntary HIV counseling and testing (VCT) in eight government health facilities in the Oromia region of Ethiopia. This qualitative analysis explores the affect of extrinsic, institutional-level factors on counselor motivation. The specific factors examined include opportunities for additional training and career development, scope of practice, compensation, supervision and management support, relationships with clients, and relationships with other healthcare workers.

Study Design and Methods: Twenty-two in-depth qualitative interviews with VCT counselors and their supervisors were coded and analyzed. Respondents included 12 community counselors, four other VCT counselors and six supervisors. This analysis is part of the larger Voluntary HIV Counseling and Testing Integrated with Contraceptive Services (VICS) study, a proof-of-concept study designed to evaluate the feasibility of integrating family planning services with VCT.

Results: Qualitative interview respondents reported diminished motivation due to lack of additional training and opportunities for promotion; limited scope of practice, particularly with regard to the provision of injectable contraceptives; and low salaries. While supervision structures such as performance targets were not significant motivators, perceived lack of management support was a source of frustration among counselors. Relationships with clients and other healthcare providers in some cases strengthened and in other cases weakened counselors' investment in their work.

Program and Policy Implications: The long-term success of task shifting requires that workers with limited training be given adequate management support, compensation, and training and advancement opportunities. Regulations must be revised to empower lower-level cadres of workers to perform appropriate tasks that will improve the efficiency and quality of their work, such as the provision of injectable contraceptives.

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Introduction

This paper identifies external factors affecting health worker motivation, particularly among counselors responsible for voluntary HIV counseling and testing (VCT) in Ethiopia. Primarily utilizing qualitative methods, this analysis focuses on 22 in-depth interviews conducted with Ethiopian health workers in 2008 as part of the Voluntary HIV Counseling and Testing Integrated with Contraceptive Services (VICS) study. VICS is a proof-of-concept study designed to evaluate the feasibility of integrating family planning services with VCT. The study was conducted in eight public-sector health facilities in the Oromia region of Ethiopia from 2006 to 2008.

Many of the VCT counselors interviewed were "community counselors," workers hired as part of broad task-shifting initiatives intended to expand access to HIV counseling and testing in Ethiopia. These counselors were recruited from the local community and provided with condensed VCT training. Quantitative data from pre- and post-intervention surveys among health workers in these facilities show significant differences in provider characteristics between the two time points, reflecting task-shifting efforts undertaken in the country. This paper examines extrinsic, institutional-level factors that influenced motivation of these counselors, particularly within this context of task shifting. Extrinsic motivation is an important influence on health worker performance and retention.

This analysis found that compensation levels, opportunities for career development and training, and scope of practice were strong influences on health worker motivation. Specifically,

interview respondents reported diminished motivation due to low salaries, lack of additional training and opportunities for promotion, and limited scope of practice, particularly with regard to the provision of injectable contraceptives. In contrast, accountability to supervisors was not a strong motivator, though lack of management support was found to be an important source of frustration. Relationships with clients and other healthcare providers both motivated counselors and in some cases weakened counselor motivation. This analysis concludes with program and policy implications of the findings.

Background

The World Health Organization has recommended expansions of task shifting, or the systematic delegation of certain tasks from more specialized to less specialized cadres of health workers (1). Task shifting has received renewed attention due to widespread human resource shortages and growing healthcare needs, particularly associated with the HIV/AIDS epidemic (2, 3). Increasingly, task shifting is seen as a key strategy in making progress toward the health-related Millennium Development Goals. Responsibility for VCT is frequently shifted to workers with lower levels of training as part of efforts to combat health worker shortages and scale up access to HIV services (4).

Numerous studies suggest that task shifting is effective in scaling up healthcare access while maintaining quality of care. A recent literature review found that task shifting reduces workload on physicians without compromising service quality (5). Other studies have concluded that task shifting is feasible and acceptable (6), that task shifting can lead to significant cost savings (7), and that task shifting results in improved quality and increased access to services, especially among underserved and rural communities (8, 9, 10, 11).

Objectives of this Analysis: This paper aims to describe key external factors that influence the motivation of health workers, particularly minimally trained, paid health workers recruited as part of task-shifting initiatives. While many studies of task shifting have examined the delivery of services by nurses and mid-level providers, fewer have analyzed services delivered by paid community health workers. Similarly, though a number of articles have described anti-retroviral therapy provision by community health workers, less existing research specifically examines task shifting of VCT to community counselors. This paper attempts to contribute to these areas of research.

Further, this study explores the motivation and experiences of community counselors in the context of increasing job responsibilities. The VICS study was conducted to evaluate the integration of family planning counseling and the distribution of contraceptive pills and condoms during VCT service provision. Understanding counselor motivation in the context of expanding job responsibilities is important, as community health workers and mid-level providers are increasingly called upon to perform additional tasks.

A Conceptual Framework for Factors Affecting Health Worker Motivation: Existing literature identifies a variety of factors that influence health worker motivation on the individual, institutional, and community levels. Figure 1 provides a conceptual framework that articulates the relationships among these factors. The framework is further described in this section.

Influences on health worker motivation can be roughly divided into intrinsic factors, or internal characteristics of the individual worker, and extrinsic factors, or external characteristics of the institution, health system, or community (12). In the conceptual framework, intrinsic factors are situated at the individual level, while extrinsic factors span the three levels. This

analysis focuses primarily on extrinsic factors at the institutional level. From a programmatic standpoint, motivational factors in this category may be the most feasible to influence or change.

Individual-Level Factors: One central individual-level component of health worker motivation is intrinsic motivation. Feelings of altruism or religious duty can fuel this type of internal drive. Researchers have pointed out that intrinsic motivation may not be sufficient to sustain strong health worker performance over the long term, particularly if the work is time-intensive or otherwise demanding (12). Extrinsic individual-level factors affecting health worker motivation include pre-service background and education; successful task-shifting initiatives recruit workers with an appropriate level of skill (13, 14). A sense of professional identity and professional conscience can also be included in this category. Previous research has found that health workers with a strong professional conscience experience significant demotivation when work conditions, such as lack of appropriate supplies, prevent them from providing high-quality service (15).

Institutional-Level Factors: On the institutional level, health worker motivation is influenced by factors related to human resources, compensation, opportunities for advancement, and working conditions. Human resource-related factors include supervision and management support (5, 8, 14, 16, 17, 18) and relationships with other health workers (14, 16, 17, 19, 20). Adequate staffing to prevent excessive workload (13, 16, 21), access to higher-level staff for service provision support (6, 22), and status of health workers within the organization (20, 23) are other human resource-related factors affecting health worker motivation.

Also on the institutional level, compensation-related factors include salary (8, 12, 13) as well as perquisites such as housing (21). Several studies have explored the optimal balance among financial benefits, non-financial benefits, and favorable working conditions (15, 21).

Opportunities for career advancement, including training and promotion, comprise another important category of institutional-level factors (5, 8, 13, 14, 15, 21). Finally, factors related to working conditions include the availability of supplies and equipment (8, 13, 15, 16, 21), the ability to provide quality service (15), and the scope and clarity of worker responsibilities (8, 24, 25).

Community-Level Factors: On the community level, factors affecting health worker motivation include community acceptance of and support for health workers (17, 23), as well as the stigma of working with people who may be infected with HIV/AIDS (26). The location of the work site is also a potential influence, as work location can impact access to education for health workers' children and the need for transportation (13, 21).

Methods

Study Design: This qualitative analysis examines the motivation of VCT counselors through in-depth interviews with counselors and their supervisors. This study is nested within the Voluntary HIV Counseling and Testing Integrated with Contraceptive Services (VICS) study, which assessed the integration of family planning services into VCT programs. The VICS study was conducted in eight government health facilities in the Oromia region of Ethiopia from 2006 to 2008; the facilities included six hospitals and two health centers. Sites were chosen based on geographic proximity to implementing partners, availability of human resources, and management support for participation in the study. Implemented by Pathfinder International, Ethiopia, the VICS intervention included developing messages about family planning for VCT clients, training counselors, ensuring contraceptive supplies in VCT facilities, and monitoring services. Detailed description of the intervention is available elsewhere (27).

The community counselors at the heart of this analysis were recruited from the

communities where the target health facilities were located. These counselors were then provided with VCT training as part of a broader task-shifting initiative implemented by JHPIEGO to scale up VCT access. Community counselors were later trained to provide family planning counseling during VCT sessions. These workers were authorized to provide contraceptive pills and condoms, but were required to refer clients to on-site family planning providers for injectable contraceptives, implants, and IUD insertion. VCT counselors who were also trained as nurses could provide injectables.

Data Collection: The in-depth interviews with health workers were conducted in June of 2008, during the final stages of the VICS intervention. Semi-structured interviews were carried out using interview instruments developed by local researchers and the study team, with separate instruments for counselors and supervisory staff. Local researchers conducted all interviews in Amharic; interviews were digitally recorded and transcribed by the interviewer. Transcripts were then translated by separate local researchers with specialized translation training and skills. Interviewers conducted random checks of the transcript translations to ensure accuracy.

Interviews were conducted with 22 healthcare workers, including 12 community counselors, four other VCT counselors with nursing backgrounds, and six supervisors. Demographic characteristics of the VCT counselors are reported in Table 1. Among supervisors, levels of training, position, and status varied widely; those who completed “supervisor” interviews included medical directors, nurses, and lab technicians. Four supervisors were male while two were female.

In addition to the in-depth interviews described in this analysis, the VICS study incorporated cross-sectional counselor surveys conducted before and after the introduction of the family planning integration intervention. The data in Table 2 is derived from these surveys.

Data Analysis: The study team developed preliminary codes through thematic analysis of the in-depth interviews (28). Several members of the study team reviewed the entire set of transcripts and noted common themes; these themes were then compared and condensed into a single list of codes. Codes were subsequently revised to reflect important themes identified through a review of the literature. All interviews were coded using Atlas.ti 6.0 software. The code list was expanded to incorporate additional themes that emerged during analysis; previously coded segments were reviewed to apply new codes as needed. All interviews were coded twice to ensure coding consistency.

Quantitative data on counselor demographic and background characteristics, presented in Table 2, were analyzed with Stata 9.0. Chi-square tests were applied to determine statistically significant differences between the provider cohorts before and after the intervention period.

Ethical Review: Both the Institutional Review Board of the Johns Hopkins School of Public Health and the Ethiopian Science and Technology Commission reviewed and granted ethical approval for this study. Researchers collected oral consent from all study participants.

Findings

Qualitative analysis revealed that training opportunities, scope of practice, potential for career advancement, and compensation strongly affected VCT counselor motivation. In this study, counselors primarily spoke of these influences as demotivators, as opportunities for advancement were scarce. In contrast, accountability to supervisors, exerted through performance targets for example, largely did not influence motivation. However, perceived lack of management support and responsiveness created frustration and lowered job satisfaction.

Our analysis found that relationships with clients could either bolster or undermine

counselor motivation. Similarly, relationships with other healthcare providers variously enhanced or diminished counselors' sense of investment in their work. The social dynamics of low status created by task shifting strongly influenced these relationships. Finally, the positive motivating factors identified through these interviews were largely intrinsic, such as counselors' desire to help clients by improving their awareness.

Additional Training

The community counselors consistently expressed a strong desire for additional training. Prior to beginning their service, community counselors underwent one month of intensive training on HIV counseling and testing; with the VICS project to integrate contraceptive services, they completed one week of complementary training on family planning. Community counselors expressed several reasons for their desire for further training. Some hoped to gain enhanced skills, allowing for improved service delivery, while others believed that additional training would bring opportunities for promotion and increased salary.

Almost half of the community counselors specifically expressed a hope to expand their knowledge and skill set through further training. Community counselors as well as other VCT counselors cited a need for refresher courses to reinforce current knowledge; several managers also mentioned a need for refresher trainings.

"We need additional courses.... The courses they gave us are three or two days long. They give us big books and we have to finish them in two or three days…. They need to give us longer courses concerning family planning... Sometimes you don't remember some things you saw in a hurry, and this [can lead to] a problem on your job." —Community Counselor, 22-year-old male

"We haven't had [a] refresher course... I took training only... for five days. It is difficult for us to understand it all at once; we are not health officials." —Community Counselor, 22-year-old male

Many counselors expressed altruistic reasons behind their desire for additional training; counselors felt that such training would enable them to provide better service to the community. Moreover, some counselors and managers believed that lack of appropriate training could negatively impact service quality:

"Lack of knowledge might [be] a problem. A person cannot speak about what he is not trained on, or about something he doesn't know. When he is forced to speak about something he doesn't know or about something he is not trained for, it could have an impact." —Community Counselor, 26-year-old male

Overall, potential opportunities for additional training were seen as an important motivating factor among community counselors. Seven counselors and one supervisor described training as a source of motivation and a booster to morale. Possible opportunity for additional training also motivated some workers to remain in their jobs rather than seek employment elsewhere.

Scope of Practice: Provision of Injectables

Depth of training is closely related to scope of counselor responsibilities. Among community counselors, the ability to provide injectable contraceptives was particularly an issue. Currently in Ethiopia, government regulations prohibit provision of injectables such as Depo-Provera by health workers who are not clinically trained. This restriction is notable because injections are by far the most popular form of modern contraception in the country. DHS survey results from Ethiopia in 2005 indicate that injectables account for nearly 70% of current modern method use (29). While the safety of injection provision by health workers with limited training is a commonly cited concern, new technologies such as UniJect syringes can minimize threats to patient safety (30).

Community counselors expressed a strong desire for training in the provision of injectable contraceptives. The ability to provide injectables directly would eliminate the need to

refer patients for this service. Such referrals create significant inefficiencies for both the counselor and the client; most of the workers interviewed felt that direct provision of injectables would enable counselors to more efficiently meet client needs, improving quality of care.

Community counselors also mentioned that direct provision of injectables could improve access and quality of care by addressing client psychosocial barriers. Many patients are reluctant to be referred for family planning services; in particular, some fear being seen by community members while accessing contraception. Therefore, counselors felt that acceptance of contraceptives would be higher if community counselors could avoid referral through the direct provision of a range of contraceptives. The lower quality of service due to the need to refer led to frustration among some counselors. Further, several community counselors pointed out that provision of injectables by the community counselors would reduce workload for other hospital staff.

"They have given us [the responsibility] to work on family planning. If they gave us the training and we had the knowledge, we could give Depo here. This itself will reduce our workload. We spend too much time looking for a nurse, and also for those who want Norplant, we take them to the referral place because clients don't know where it is.... I want to learn how to give Depo. It is useful for us because it saves time." —Community Counselor, 22-year-old male

"We are not trained to give injection for those who are looking for Depo. We refer them to another room, and there are [clients] who don't want to go there and be seen by a lot of people. If we are trained to give this service, it is like doing two things at once, and it helps to decrease the load on the nurses." —Community Counselor, 21-year-old female

"...We have to be supported to provide Depo injections… to keep the quality of the service, to scale up the service, and to make the service confidential.... [Some clients] fear their families [if they] use pills. But if they are injected with Depo, there is not any problem as a consequence. [A female client] dislikes to be seen while taking Depo from the family planning [department]... she doesn't want to go there. But if it [Depo provision] could be here, she can get the service within one room and can return home through the back." —Community Counselor, 25-year-old male

All of the twelve community counselors independently expressed a desire to receive training that would enable them to provide additional contraceptive methods, particularly injectables.

Career Development

The counselors' desire for additional training and expanded scope of practice signals an interest in career advancement. Desire for promotion and career development opportunities was nearly universal among respondents. Both counselors and supervisors also saw opportunity for promotion as an important motivator. As one community counselor explained, there is incentive to strive for excellence when effort is rewarded. At least some of these community counselors appeared to associate promotion with higher salary. Several counselors also viewed opportunities for career development and further training as a vote of confidence in their value and ability.

In this analysis, lack of career advancement opportunities was frequently cited as a significant demotivator. Two supervisors explained that community counselors could not be promoted without further education.

"As long as they are community counselors, where could they be promoted? The jobs we have do not apply for those who have counseling training. Thus, there cannot be promotion for them. Maybe [they could be promoted] if they [had] taken education related to health." —Supervisor, 42-year-old female

This comment points to the institutional barriers that community counselors face in seeking career development opportunities.

Compensation

Overall, there was widespread sense that the salary provided to the VCT counselors was too low. Community counselors, other VCT counselors, and managers expressed this view. This analysis found that all community counselors earned a salary of 500 Ethiopian birr per month, with take-home pay of 465 birr (approximately $46.50). Given an average client load of 30 clients per day, this salary translates to approximately 15 cents earned per counseling session. In contrast,

salaries provided to nursing staff were significantly higher, ranging from 658 to 1692 birr (approximately $66 to $170) per month, dependent on the level of training.

VCT counselors described the low salary as "a problem," "not satisfying," and an "obstacle." Many respondents also expressed concern that it was a struggle to meet basic expenses. Over half of the respondents who were directly responsible for the provision of VCT, including eight of the twelve community counselors, stated that the salary was too low when considered in relation to their workload.

"The salary we are getting paid does not match the work we do. We are doing a great deal of work and it is hard. Sometimes you take your work home through thinking about [clients'] problems…. When you see it from that point of view, it is hard to say you are getting paid... You might say, 'what do I get after working this hard?' It will make you lose hope and make you look for other choices." —Community Counselor, 22-year-old male

"We all are worried about our salary.... Our salary is not compatible with our work. This [HIV/AIDS] is something that can happen to our brothers and sisters and our aim is to help them, not the salary. [But] these days 500 birr does nothing; it is even hard to buy coffee." —Community Counselor, 25-year-old female

"When you [consider] salary and workload... they [the hospital management] don't do anything for me. Those things reduce my feeling for work, but otherwise I am happy with what I do." —Community Counselor, no sex or age given

In addition, all of the supervisors mentioned the need to provide additional payment or other forms of incentive for the VCT counselors.

"Money is the number one question... [The community counselors] are getting paid only 500 birr; it is too small. [They] are not happy with what they are getting. Life is expensive now and they complain…" —VCT Supervisor, male, no age given

Three community counselors and one other VCT counselor cited low salary as a reason to consider employment elsewhere; some mentioned that NGOs, for example, are not restricted to a government pay scale. The widespread nature of this sentiment suggests that low salaries have serious implications for program sustainability.

Many respondents described salary increases as a way to improve working conditions or boost morale. One manager pointed out that a higher salary would improve the confidence of the community counselors, perhaps because they would feel that their work was valued more highly. Two VCT counselors mentioned access to bottled water as a desirable non-financial perquisite. One community counselor also noted that accessing his pay presented significant frustrations.

Importantly, several community counselors pointed out that their compensation remained unchanged even as they were asked to assume additional responsibilities associated with family planning integration. This situation compounded the sense that their salary was not aligned with their job responsibilities.

"The salary we get is low... There is this additional job, and there should be some kind of benefit... Everybody should get what he worked for. This holds you back from working because you work for long and you get tired, but the money you get is low. If you are paid well, it will attract you to do your job... and you will do it with interest." —Community Counselor, 22-year-old male

"The counselors did not get any additional salary [with the introduction of family planning] counseling. There is workload. The work is boring and risky.... You have to exert strong effort to change the attitude of the patient." —VCT Counselor, Nurse, Psychiatrist, 53-year-old male

Supervision and Management Support

While the VCT counselors interviewed for this study largely agreed that factors such as compensation and promotion were important influences on motivation, many felt that accountability to a supervisor was not a significant influence on performance. For example, several counselors dismissed the idea that they were working to meet performance targets. Some mentioned that their client load already exceeded established targets.

"It is not for the report; I counsel this number [of clients] because it is my job and I have to serve my people." —Community Counselor, 32-year-old female

"We don't worry about fulfilling a report requirement because we do more than what is expected of us…. We do this because we feel responsible, not because anyone pushes us…. Nobody should

get between you and your job. It is when you are motivated by yourself and happy that you do VCT counseling well. If someone is pushing you to do your job, you might not do it well. You have to be able to hear other people's heart, share their burden and problem." —Community Counselor, 22-year-old male

While counselors were, for the most part, not motivated by accountability to a supervisor, nearly all of the counselors mentioned a desire for stronger supervision. Half of the community counselors stated that they received no supervision or management support from the supervisors at their facilities.

"There is no one who comes to supervise me, only the director comes once in a while to ask us how many clients we see each day and whether people are using family planning methods." —Community Counselor, 22-year-old male

"There is no one in this facility who is assigned to supervise us except people coming from Pathfinder from Oromia." —Community Counselor, 21-year-old female

When asked about who was responsible for supervision, one counselor responded:

"We don't know. Everyone manages us: the medical director, the administrative [personnel], the matron, everyone." —Community Counselor, no sex or age given

Interviews with supervisors revealed that several internal managers lacked basic familiarity with the activities of the counselors. The medical director of a large hospital was not aware of the program to integrate contraceptive services with VCT, while the lab technician overseeing VCT activities at a smaller health center was unable to answer questions about the availability of supplies, the adequacy of counselors' knowledge, and the level of client need for family planning services. Several supervisors noted that their workload and other responsibilities prevented them from providing in-depth oversight of VCT activities.

"There is no one in particular who gives attention only to VCT. The [HIV supervisor] does this in addition to his main work, like me; I do this when he is not here, in addition to my main work." —Medical Director, male, no age given

Perhaps as a result of the absence of a specified supervisor, or because of the other priorities competing for supervisors' attention, many of the counselors perceived a lack of management support in their work. Some counselors specifically mentioned the dearth of feedback on their performance, explaining that feedback could improve the quality of services provided to clients. Supervisors also have a role in ensuring availability of adequate supplies and equipment; this function was not fulfilled in several of the study facilities.

"We have encountered shortages of material and it has a lot of process to get the material from the store. There is no one who is in charge to provide us the necessary material. If we need a laboratory material, we ask the head of the laboratory department; if we need gloves, we ask the medical director. We just want anybody who [will] take control of this thing for us."
—Community Counselor, no sex or age given

"Since I come here, I want to work [with] data, graphs, but there is no one who [will] give me paper, pen. I work with my own pain. This is the way the hospital works. I work here because of the community; there is nothing else that keeps me from being hired by [a] private [sector employer]." —Community Counselor, 35-year-old male

Perceived non-responsiveness of management contributed to a sense of lacking management support. Five counselors mentioned that management had not responded to specific requests that they had made, generating frustration, particularly when the problem for which they sought help degraded quality of care.

"In this room, it is necessary to have a clock because we test by time, but we don't have one…. We put clients' files on the desk and this is not good for clients' confidentiality. We need file cabinet. When the supervisor and the medical direct visit, we try to explain and ask them. They promise to fulfill everything, but still there is nothing." —Community Counselor, 22-year-old male

Conflict between the procedures learned through trainings and expectations of management was another important issue raised during the interviews. Again, this conflict exacerbated the sense that management support was inadequate. Many counselors explained that training protocols

stipulated a certain maximum number of clients, while managers expected the counselors to see a much higher number of patients. Some managers simply required that the counselors saw all of the clients who came to test, a number often much higher than the maximum specified in the training. As a result, counselors were frequently forced to condense their counseling messages; some expressed a concern that this led to compromised service quality. In sum, unrealistic expectations regarding client load and length of counseling clearly created stress and frustration for some counselors.

"During the time of the training, we were told that we are going to give counseling for eight people and a maximum of ten. People come here… so we counsel all the people present that day; we counsel 20 to 35 people. We do this not to send them back [without receiving the service]." —Community Counselor, 25-year-old female

Despite these widespread problems of inadequate supervision, some interviewees discussed actions that managers had taken to improve working conditions and respond to client need. For example, one hospital had designated additional VCT rooms to decrease client waiting times and counselor workload, while another hospital was in the process of constructing new VCT rooms. Another facility had recently taken steps to improve client confidentiality.

Notably, much of the supervisory support that the counselors did receive was provided by external organizations such as Pathfinder. Ten interviewees mentioned external supervision without prompting.

"Those coming from Columbia [University] are the ones that help us and ask us what we need." —Community Counselor, 25-year-old female

"We do have continual supervision from the trainer body [Pathfinder]…. They supervise us, and this leads me to think that they give respect and attention to our profession, [as a result] my interest to work increases." —MCH Coordinator, 36-year-old male

One counselor pointed out that several different external bodies oversaw different aspects of the

HIV activities of the facility, such as ART and family planning integration, creating a highly fragmented supervisory system.

Client-Counselor Relationship

Interactions and relationships with clients were also found to influence counselor motivation. The changing counselor characteristics associated with task shifting clearly affected these relationships. With less experience than other VCT counselors, community counselors were more likely to encounter questions or situations that challenged their knowledge, in some circumstances undermining their confidence. On the other hand, community counselors were more likely to share characteristics and experiences with clients, creating rapport from which many counselors gained significant job satisfaction.

Table 2 presents quantitative data on VCT counselor characteristics at the beginning and end of the VICS study period (described above). Differences in the provider profiles at the two time points reflect task-shifting efforts undertaken in Ethiopia during the study period but not associated with the VICS study. Several significant differences are apparent in the provider characteristics in the later survey compared to those in the earlier period. For example, in the earlier period, 86.7% of VCT counselors had been trained in nursing, compared to 18.7% following the introduction of task shifting. However, VCT counselors in the later survey were significantly more likely to have received specific training on family planning. Dispensing knowledge about oral contraceptive pills was also higher after task shifting was implemented, though the difference between the earlier and later periods was not statistically significant.

While specific family planning knowledge was higher among the counselors in the later period, the in-depth interviews revealed that many new community counselors encountered situations that highlighted their limited education and lack of training. For example, several

community counselors reported that some of their clients were more knowledgeable about HIV than they were. Four counselors noted that they had been unable to answer some client questions. This dynamic caused frustration for community counselors.

"If there is a client coming who has more knowledge than the community counselors and [is] asking challenging questions, and if the community counselors are unable to answer these questions, this has its own effect on the quality of counseling service." —MCH Coordinator, 36-year-old male

Perhaps because of their relatively low status, some community counselors also faced disrespectful or aggressive clients.

"Some people think they are counselors themselves and want you to leave them alone in order to finish fast. Some of them might come drunk and insult you."—Community Counselor, 22-year-old male

Importantly, while such circumstances often created frustration among counselors, relationships with clients also served as a positive motivator. Many counselors derived significant satisfaction from their relationships with clients. Further, after task shifting, counselors were more likely to be young and unmarried. They shared these characteristics with many of their clients, and these commonalities often created a basis for rapport.

"I am young and free, and when they see I am young, a lot of young clients come to me. I give them good counseling on the issues they raise." —Community Counselor, no sex or age given

"What encourages me is my clients… especially the students… There are times I work at another place; the students call me [there] and ask me to discuss generally about HIV…. This is what makes me very happy." —Community Counselor, 25-year-old male

"Sometimes there are clients that even become [like] family, and this kind of thing makes me happy." —Community Counselor, 21-year-old female

Relationships with Other Healthcare Workers

Like relationships with clients, counselors' relationships with other healthcare workers also acted

as both a demotivating and a motivating influence. Again, changes in the counselor profile and counselors' status associated with task shifting proved important.

The lack of respect that counselors perceived from other healthcare workers was a significant demotivator. In some cases, counselors' low status appeared to be reinforced by their position as contractors rather than permanent facility employees. Contractor status was universal among the community counselors interviewed for this study.

"Here, they don't see us as a member of the staff. For example, if they give gowns to other staff, they don't give [them to] us…. We have to nag them to get a chair or anything, or else we ask other members of the staff to borrow… We have motivation for work, but we are not seen as members of the staff and we feel bad." —Community Counselor, 22-year-old male

"I am not a permanent employee. When they are giving gowns to other employees, they don't give [them to] us. When I think about that, it kills my morale. What makes me happy is that I share... with the community their problem. But [when] I see the problem I face under the management of the hospital, my love work reduces." —Community Counselor, no sex or age given

However, relationships with other healthcare workers, and particularly with other community counselors, were also a significant source of positive morale. In discussions about training, eight counselors independently mentioned the value of "skills sharing" sessions with counselors from other facilities. Such meetings provide an opportunity for community counselors to share information with others who face similar challenges. Thus, "experience sharing" appears to foster a feeling of belonging to a professional community, reinforcing pride in counseling work and a sense of professional identity.

Positive Motivating Factors

Notably, most of the factors identified through our analysis functioned as demotivators in the context of the VICS study. However, a few sources of positive motivation did become apparent through the qualitative analysis. The desire to help others was widely cited as a motivator.

"Even if they tell me to work 15 people per day, I choose to work 40 to 50 people. I work not for the money but for the community. It is my sisters and brothers that are going to get hurt here [by HIV]…. It is not for the money or for my boss… I work with my own motivation…. Even sometimes I miss the [transportation] service that takes me home." —Community Counselor, 35-year-old male

Additional motivating factors mentioned by the counselors included an interest in the work, a desire to perform job responsibilities well, a sense of religious duty, and a belief that the provision of counseling service would benefit the country. Many of these motivators qualify as intrinsic factors. Extrinsic positive motivating influences included institutional and community recognition as well as client appreciation.

Discussion

This qualitative analysis primarily examines extrinsic, institutional-level factors affecting the motivation of VCT counselors in the context of task shifting in Ethiopia. Several studies have found that factors such as adequate compensation, supervision, and opportunities for career development are important to the success of task-shifting initiatives (2, 8, 31). Other research has identified key challenges in task-shifting programs, including lack of recognition for workers and problematic relationships with other healthcare staff (20). This analysis suggests that health worker motivation is a key pathway through which these elements influence the success of task-shifting initiatives.

The various motivating and demotivating factors identified in this analysis interact and overlap. Opportunities for career development, for example, are closely related to salary increases and are typically associated with additional training. At times it was difficult to distinguish whether an expressed desire for training was underpinned by a desire for additional compensation, a desire to gain new skills and deliver improved service, or both.

Many factors that are not inherently directional were described in this analysis as demotivating influences. For example, while salary and opportunities for advancement have the potential to motivate workers, this analysis consistently found that staff motivation was undermined by low salaries and limited prospects for advancement. The dearth of positive motivators identified in this analysis suggests that long-term counselor retention may be poor. Worker attrition has obvious implications for program sustainability.

Additional Responsibilities: Several of the findings of this study are intuitive. It is predictable that career development opportunities and salary increases, for example, are important motivators among health workers. However, surprisingly, this analysis suggests that certain carefully selected additional responsibilities can in fact *reduce* workload in some cases.

In particular, training community counselors to provide injectable contraceptives would empower these workers to offer injectables directly, avoiding a time-consuming and often frustrating referral process. This additional responsibility for the counselors could also potentially improve the quality of service for clients by reducing psychosocial barriers in accessing contraception. Thus, adding provision of injectable contraceptives to the job responsibilities of community counselors could improve efficiency and quality of care, with the likely consequence of improving job satisfaction and reducing frustration. As this example suggests, community health workers must be empowered to provide a range of appropriate services.

In contrast, most additional responsibilities increase counselor workload. The addition of family planning counseling and contraceptive provision through the integration intervention is a clear example; many counselors noted that their workload grew significantly as a result of this intervention. Nonetheless, the counselors largely supported integration efforts because they

believed that these services met client need. Many counselors felt that workload should be reduced by adding staff rather than by curtailing job responsibilities.

Overall, this analysis suggests that if workers with lower levels of training are expected to assume additional responsibilities, they must receive adequate training and supervision. If significant responsibilities are added, health workers should be given sufficient time to complete these responsibilities. As appropriate, additional staff must be recruited to ensure that existing health workers are not overwhelmed by the added demands.

External Supervision and Program Sustainability: This analysis revealed widespread supervision of counselors by external bodies such as NGOs and research organizations. This reliance on external supervision threatens program sustainability. If external organizations withdraw their involvement, counselors will be left without needed oversight and support. Related programs, such as family planning integration in this case, will likely deteriorate as a result. If implementing organizations wish to ensure the long-term sustainability of their programs, stronger efforts must be made to involve and work through existing supervision structures at the facility level.

Client-Counselor Relationship: This analysis shows that task shifting creates important changes in the client-counselor relationship, shifts that can interact with counselor motivation. First, because community counselors have significantly less training than other VCT counselors, they might struggle to answer questions from knowledgeable clients. As a result, such counselors can have difficulty establishing credibility with and earning respect from other healthcare workers. These dynamics are likely to drain counselor satisfaction and motivation. At the same time, because newly recruited community counselors are younger and less likely to be married,

they may more easily establish rapport with younger clients, a key target group. Many of the community counselors in this analysis reported significant satisfaction derived from relationships with clients.

Limitations: These study findings have several limitations. First, this analysis lacks longitudinal data. It would be useful to understand how the identified factors influence counselor motivation over time. It is possible that counselors' frustrations could mount with time, exacerbating burnout. Alternatively, counselors could develop adaptive strategies to cope with frustrations, improving their job satisfaction. This study does not capture these longitudinal dynamics.

Second, the generalizability of this study is limited. The study sites were selected based on facility interest and geographical factors rather than through a randomized design, limiting external validity. Managers of these facilities agreed to take part in the study; their interest suggests that these managers may be more supportive of integration than others in the region. This is especially important to note because, even in the study facilities, counselors frequently perceived a lack of management support. Thus, lack of management support and supervision may be even more problematic than this study suggests. Further, the health workers in this study may have received more extensive training than other VCT counselors in Ethiopia. Again, inadequate training was identified as an important challenge for counselors; this problem may be even more pronounced among the general population of community counselors in Ethiopia.

Finally, while the study team developed the coding schema collaboratively, a single researcher performed coding. However, interviews were coded twice to ensure that codes were consistently applied.

Program and Policy Implications

Task shifting has increasingly been promoted as a way to address critical human resource shortages in much of the developing world. Broad task-shifting efforts in Ethiopia have already changed the landscape of VCT provision. Importantly, task shifting affects all of the factors influencing health worker motivation identified in this analysis, including salary, scope of practice, opportunities for career development, and need and desire for supervision and additional training. Task shifting also fundamentally changes counselors' relationships with clients and other healthcare workers. As task-shifting efforts gain more traction, policymakers must bear health worker motivation in mind and consider related implications for worker retention and long-term program sustainability.

This analysis suggests that task-shifting efforts must include a focus on career development, additional training, and adequate compensation if workers are to be retained. Programs should consider potential career promotion ladders for lower-level health workers, including appropriate salary increases. Possible mechanisms for promotion include certification programs and gradual introduction of additional job responsibilities. This analysis reveals that community health workers are eager for opportunities to expand their knowledge and gain new skills in order to advance professionally and better serve their clients. Such opportunities have the potential to improve health worker job satisfaction while increasing quality and efficiency of care. The costs of additional training and salary increases must be considered against the costs of attrition, including the costs of training replacement workers.

This analysis also shows that stronger efforts must be made to align training and management expectations. Managers' requirements that counselors serve high numbers of clients may force counselors to trim counseling messages, creating a concern among counselors that

they are delivering an inferior service. As discussed above, research has found that health workers experience significant demotivation when they are unable to provide quality service to clients due to health system constraints (15). Thus, the conflict between management expectations and training instructions has the potential to erode community counselor motivation, with consequences for job satisfaction and worker retention.

Finally, as the example of injectable contraceptive provision demonstrates, it is important to empower lower-level cadres of workers to execute their responsibilities with maximum ease and efficiency. Regulations must be revised to enable trained community health workers to provide an appropriate range of services.

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Figure 1:
Conceptual Framework of Factors Affecting Health Worker Motivation in Task Shifting

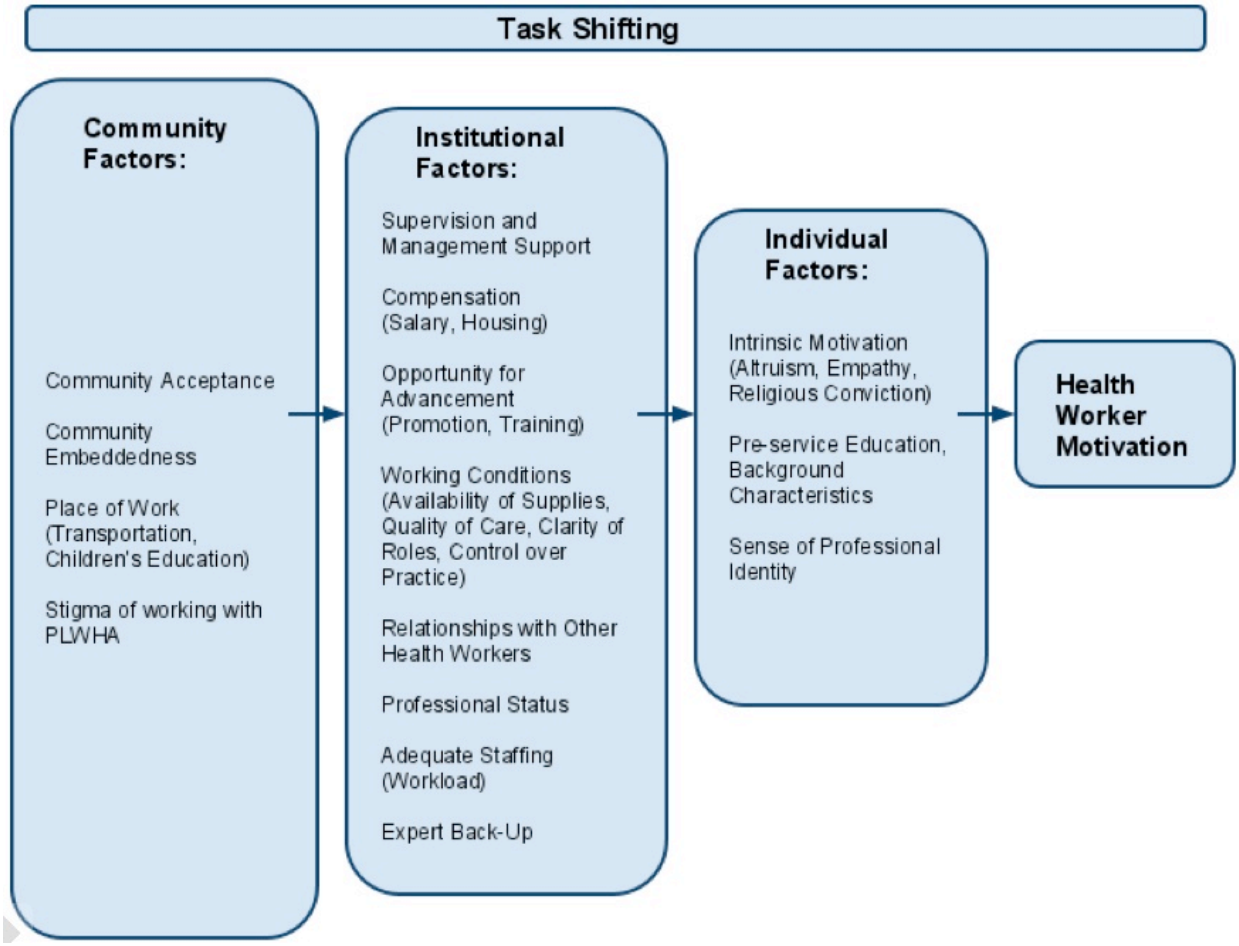

Table 1: Characteristics of Counselors Completing In-Depth Interviews

Characteristic	**Community Counselors**	**Other VCT Counselors**
	Number	Number
Number of Interviewees	12*	4*
Sex		
Male	6	3
Female	4	
Age		
20-29	8	
30-39	2	2
40-49		
50-59		1
Marital Status		
Married	2	3
Not Married	8	
Number of Children		
None	8	
1	1	2
2	1	
3+		1
Highest Level of Education		
Less that 12th Grade	5	
Completed 12th Grade	4	
Nursing Training		3
Other Professional Training	1	
Time in Current Job		
0-2 years	9	1
2-5 years		2
Not Reported	1	

*Demographic and training characteristics reported for 10 community counselors and three other VCT counselors. Data on two community counselors and one other VCT counselor was discarded due to data quality issues.

Table 2: VCT Counselor Characteristics at the Beginning and End of the VICS Study Period

Note: These data are taken from two quantitative cross-sectional surveys at the beginning and end of the VICS study. In-depth interview respondents are not necessarily represented in this data.

	Pre-intervention N=15	Post-intervention N=16	p-value
Demographics			
Sex			
Male	33.3	50.0	
Female	66.7	50.0	0.35
Mean age	36.1	29.9	0.06
Marital status			
Never married	0.0	43.8	
Ever married	100.0	56.2	<0.01
Education level			
Secondary	40.0	56.3	
More than secondary	60.0	43.7	0.37
Religion			
Orthodox	66.7	56.3	
Muslim	0.0	25.0	
Protestant/other	33.3	18.7	0.10
Number of children			
0-1	40.0	62.5	
2-3	60.0	37.5	0.21
Work experience			
Trained as clinical nurse	86.7	18.7	<0.01
Mean duration of VCT experience (in months)	34.0	26.0	0.23
Mean time since last VCT training (in months)	29.0	20.0	0.17
Mean daily client load for facility	13.7	21.9	<0.01
Mean number of counseling rooms in facility	1.5	1.8	0.35
Family planning knowledge			
Skills learned in last FP training			
High	35.7	56.3	
Low	14.3	43.7	
Never trained in FP	50.0	0.0	<0.01
OCP dispensing knowledge			
High	60.0	68.8	
Low	40.0	31.2	0.61
Attitudes toward integration			
Feel FP supplies in VCT are adequate	53.3	62.5	0.38
Feel workload is too heavy	60.0	62.5	0.89
Supportive of FP/VCT service integration	66.7	75.0	0.61

Appendix 1: Codes Applied to In-depth Interviews

Client Factors:
Client characteristics
Client knowledge (Includes client misconceptions about FP, HIV; concerns about side effects)
Client interest / Client need (FP & testing)
Client shyness or guardedness
Client barriers (including faith) / Access
Psychosocial barriers / Confidentiality
Client motivation for FP, testing
Client-related challenges

Working Conditions, Work Practice:
Workload/client load
Length of counseling period
Work space
Definition of roles and responsibilities (clear, lack of) / Scope of roles
Depo provision / Referral practice
Logbooks
Supplies / Equipment / Shortages
Task-shifting
FP practice
Integration
Screening/"reading" clients
(i.e. selective counseling based on client profile)
Informed choice

Monetary and Non-monetary Motivators/Disincentives
Salary issues
Career development / Promotion opportunities
Additional training
Current training
Status / Professional Identity / Status as contractors / Respect
Recognition / Client appreciation
Relationships with other healthcare workers or managers
Physician or expert back-up
Management support / Supervision / Management responsiveness or action
Feedback / Evaluation
Failure to deliver on promises
Altruism / Religious or cultural motivation / Interest / Intrinsic motivation
Sense of duty
Stigma of working with HIV/AIDS
Transportation / Housing / Kids' education
Additional duties allowances

Provider Factors
Provider characteristics (including lack of knowledge or training)
Counselor Selection, pre-service education, background
Interviewee attitudes toward FP and VCT integration
Client-Provider Relationship (including dissonance - i.e. educational level, age difference, HIV knowledge)
Relations with Community (Acceptance / Embeddedness)
Job satisfaction / Burnout (other motivators/demotivators)
Sense of superiority/inferiority
Job security

Other (Macro Factors):
Coordinating bodies / funders
Legal / Regulatory / Government factors

Follow-up to MPH Goals Analysis Paper

Through my MPH year, I hoped to gain expertise in specific content areas. In my Goals Analysis paper, I explained that I wanted to broaden and deepen my familiarity with issues of reproductive health and access to contraception in the developing world. This capstone project has allowed me to achieve these goals. Specifically, I have learned a great deal about integration of conceptive services and VCT as well as contraceptive delivery through task-shifting efforts. In working with the VICS study, I feel that I have gained an understanding of how programs play out on the ground and the challenges associated with implementation. Also in my Goals Analysis paper, I identified skills that I wanted to develop this year. I have fulfilled many of these goals as well through my capstone project, solidifying my familiarity with both qualitative research and the conventions of academic writing. Further, the presentation of my capstone findings will allow me to practice my oral communication and presentation skills.