ADDIS ABABA UNIVERSITY

COLLEGE OF BUSINESS AND ECONOMICS

DEPARTMENT OF PUBLIC ADMINSTRATION AND DEVELOPMENT MANAGEMENT

FACTORS THAT INFLUENCE THE PERFORMANCE OF COMMUNITY HEALTH WORKERS: THE CASE OF ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU

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Factors that Influence the Performa Community health workers: The Case of Addis Ababa City A...stration Health Bureau

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AIDs	Acquired Immune Deficiency Syndrome
AMREF	American Medical Research Foundation
ART	Anti-retroviral therapy
CBDs	Community Based Distributors
CBSVs	Community Based Surveillance Volunteers
CCCs	Community Care Coalitions
CHEWs	Community Health Extension Workers
CHS	Community Health Strategy
CSA	Central statistics agency
CHWs	Community Health Workers
FDRE	Federal democratic republic of Ethiopia
HFA	Health for All
HWs	Health workers
ICCM	Integrated Community Case Management
LMICs	low and Middle Income Countries
MOH	Ministry of Health
MoPHS	Ministry of Public Health and Sanitation
NGOs	Non-governmental Organization
PHC	Primary Health Care
PNG	Papua New Guinea
SPSS	Statistical Package for Social Sciences
WHO	World Health Organization

ABSTRACT

In Ethiopia, Community health workers workforce was adopted as addressing the health care needs of underserved communities. Despite the vast experience with CHWs the burden of disease continues to increase in magnitude and diversity and relatively little scientific evidence is available to answer basic questions notably the determinants influencing the performance of CHW. However both the performance of CHWs as change agents and the feasibility of implementing and sustaining large-scale CHW programs have been called into question. The purpose of this study was to investigate the factors that influencing performance of CHWs in Addis Ababa city administration health bureau. The objectives of the study were to assess the influence of social-cultural, health system practice and policy, economic factors on the performance of CHWs in Addis Ababa city administration health bureau. A descriptive research design was used. Quantitative data collection methods were used. Systematic sampling method was used to identify the respondents. Quantitative data was collected from 145 community health workers of which 140 responded to the questionnaires. Findings showed that from socio cultural aspects, weak family support and from health system practice, too much workload. Also economically (payment, supplies and incentives) were not satisfied CHWS .There should be improved payments, incentives, supplies and workloads needs.

CHAPTER ONE

1.1. Background of the Study

Countries across the globe are striving to attain worldwide health coverage. There is a hugelack of 4.25 million health workers in Africa and Asia, while the distribution of existing health workers within countries is inequitable (World Health Organization, 2016). The principle of Primary Health Care (PHC) was introduced in the Declaration of Alma-Ata in 1978 (World Health Organization, 1978). PHC had already been promulgated for over three decades as a global strategy for ensuring essential health care for all people. The 2014 World Health Organization report recognized shortages of professional health workers as one of the key ingredients in the growing crisis of providing health services, particularly in low income countries (WHO, 2014). The severe healthcare worker shortage in many parts of the world is among the barriers that need to be addressed to improve primary health services (Kober K; 2004).

The global policy of providing primary level care was initiated with the 1978 Alma Ata Declaration. The countries signatory to the declaration considered the establishment of a Community Health Worker (CHW) programme as synonymous with the primary health care (PHC) approach. Shortages in human resources for health and evidence that CHWs can significantly contribute to the health of the population by effectively delivering key interventions in primary and community health care have led to a renewed interest in CHW programmes in Low and Middle Income Countries (LMICs) (Bhutta ZA; 2010). Community Health Workers (CHWs) can make a valuable contribution to community development, and more specifically can improve access to and coverage of basic health services to communities. The use of CHW has also been one of the strategies to address the shortage of health workers, particularly in low income countries (Lehman and Sanders, 2014). However, the review by Lehman and Sanders (2014) showed that although there are some trends, global generalizations about the performances of community health workers are difficult as the topic area and program profiles, structures, focus areas and implementation arrangement are extensive and diverse. The role of CHWs in sub-Saharan Africa has evolved over time in response to changing health care priorities, disease burdens and shortages of human resources for health (Health Systems Report, 2008). The Health Systems Report (2014) further demonstrate that evidence on CHWs from

Gambia, South Africa, Tanzania, Zambia, Madagascar and Ghana were not only cost-effective, but enhanced the performance of community level health programmes.

Despite major strides to improve the health of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor. Vital health indicators from the DHS 2015 show a life expectancy of 54 years (53.4 years for male and55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010. Although the rates have declined in the past 15years, these are still very high levels.

The major health problems and nutritional disorders. More than 90% of child deaths are due top pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often as a combination of these conditions.

In terms of women health, the MMR has declined to 590/100,000, but this is still among the world's highs. The major causes of maternal death are obstructed/prolonged labor (13%), ruptured uterus (12%), severe preeclampsia/eclampsia (11%) and malaria (9%). Significantly, 6% of all maternal deaths were attributable to complications from abortion. The major supply side constraints affecting maternal health are shortages of skilled midwives, weak referral system at health center levels, lack of inadequateavailability of BEmONC and CEmONC equipment, and under-financing of the service. On the demand side, cultural and societal norms, distances to functioning health centers and financial barriers were the major constraints. (FDRE Ministry of Health; Health Sector Development Program IV2010/11 – 2014/15FINAL DRAFT October 2010)

Addis Ababa city government executive and municipal service organ re-establishment proclamation number 35/2012 "Woreda Administration" means the third administrative stratum of the city, which is a unit of sub-city.

Addis Ababa is the Federal Capital of Ethiopia and a Chartered City; having three layers of Government: City Government at the top, 10 Sub City Administrations in the Middle, and 99 Kebele Administrations at the bottom.

According to the 2002 (EFY) Health and Health Related Indicators published by FMoH, Addis Ababa has 10 Hospitals, 26 Health Centers.

In general, study focuses on the factors influencing the performance of community health workers like social-cultural, health system practice and policy, environmental and economical should be highly considered since it affects the operations of health to the community. Therefore, this study tries to those factors affecting the performance of community health workers under Addis Ababa city administration health bureau locates in all 10 sub cities and in selected woredas.

The course the researcher took push to study in the area of factor that affecting performance community health worker. The researchers also want to contribute for the ministry of health and the community by investigate the core performance barrier of community health workers and also interesting in the grassroots level community health development.

1.2 Statement of the Problem

Poor performance of service providers leads to inaccessibility of care and inappropriate care, which thus contribute to reduced health outcomes as people are not using services or are mistreated due to harmful practices. The final report of the Joint Learning Initiative clearly outlines the importance of the workforce in performing services by stating that health workers' number, quality and type of professionalism determine output and productivity, that they manage the other resources, that a large part of the health budget is spent on health workers and that they greatly influence progress (JLI, 2013). A number of articles and documents have reported problems relating to service provision due to poor performance of health workers (including JLI, 2011; WHO, 2016; Lerberghe et al., 2003).

Poor performance results from too few staff, or from staff not providing care according to standards and not being responsive to the needs of the community and patients. As Hughes et al. state: "Most performance problems can be attributed to unclear expectations, skills deficit, resource or equipment shortages or a lack of motivation" (Hughes et al., 2002). These causes are rooted in a failing health system, low salaries, difficult working and living conditions and inappropriate training.

Various theories like Maslow's Need Hierarchy Theory, Herzberg's Motivation- Hygiene Theory, and Vroom's Expectancy Model have been extended to describe the factors responsible for affecting the performance (job satisfaction) of the employees in the organization. Among those factors include working conditions, opportunity for advancement, job safety and security, work load and stress level, relationship with co- workers, organizational policies, leadership behavior, relationship with supervisor, financial reward, the level of pay and benefits and the job itself.

Addis Ababa city administration comprises 10 sub cities in which 1456 community health workers currently distributed throughout the sub cities. (Addis Ababa city administration health bureau).

There are researches conducted on factors affecting the motivation of health workers on nationwide by many researchers in Ethiopia. However, there is gap in conducting research on Addis Ababa health workers especially on factors affecting their performance.

This put to question the performance and thus effectiveness of CHWs as one of the key strategies of health care delivery. It is because of these that the study attempts to examine factors that influence the performance of CHWs in Addis Ababa city administration health bureau. The objectives and research questions below are identified based on these focus areas.

1.3 Objective of the Study

1.3.1General Objective

The purpose of the study is to examine factors that influence performance of community health workers in Addis Ababa Administration health bureau.

1.3.2 Specific Objectives

Having the above mentioned general objectives, the study has the following specific objectives

- To assess the influence of socio-cultural factors on performance of CHWs in Addis Ababa city Administration health bureau.
- To examine the influence of health system practice on performance of CHWs in Addis Ababa city Administration health bureau.

- To investigate the influence of economic factors on the performance of CHWs in Addis Ababa city Administration health bureau.

1.4 Research Questions

To achieve the predetermined general and specific objectives this study answered questions related with factors affecting the performance community health workers in Addis Ababa city administration health bureau. Hence the following are the research questions to be addressed by the study:

- How socio-cultural factor does does influence performance of Community health workers of Addis Ababa city?
- Which health system practice factors influence performance of community health workers of Addis Ababa city?
- What are the economic factors that influences performance of Community health workers of Addis Ababa city?

1.5. Scope of the Study

The scope of the study is limited to community health workers under Addis Ababa city administration health bureau.

The study included all 10 sub cities and in all woredas. A woreda (Which is 10 percent) from each sub city considered to examine factors that affecting the performance of Community health workers and to know the magnitude of the problem on city wide level. One woreda from each sub city selected on a simple random sampling technique.

1.6. Limitation of the Study

In conducting this study, different challenges encountered. The absence easily accessing of documented data and information may be a problem and the researcher forced to go to the sub city and health bureau frequently to obtain the documents.

The researcher was in limitation financial problem the whole expense cover by personally, time, respondent willingness and distance of the branches location.

1.7 Importance of the Study

The Alma-Ata Declaration of 1978 is a major milestone of the twentieth century in the field of public health, and it identified primary health care (PHC) as the key to the attainment of the goal of-Health for All‖ (HFA). Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation (Bryant 2002). PHC aims at bringing health care as close as possible to where people live and work, and can be attained through a fuller and better use of the community resources person. Despite major strides to improve the health of the population in the last one andhalf decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor. Vital health indicators from the DHS 2005 show a life expectancy of 54 years (53.4 years for male and55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010. Although the rates have declined in the past 15years, these are still very high levels.

The major health problems of the country are largely preventable communicable diseases and nutritional disorders. More than 90% of child deaths are due top pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often as a combination of these conditions.(FDRE Ministry of Health. Health Sector Development Program IV 2010/11 – 2014/15 FINAL DRAFT October 2010.page 3). Despite the vast experience with CHWs, relatively little scientific evidence is available to answer basic questions notably the determinants influencing the performance of CHW which will affect to encounter the above preventable problems of community health. Based on 2002 (EFY) figures from the Central Statistical Agency (CSA) of Ethiopia, Addis Ababa Region has an estimated total population of 2,917,295 consisting of 1,389,817 male and 1,527,478 female. 100% of the populations are urban dwellers (CSA 2007).

Addis Ababa has got still many health problems in its community that can be preventable easily in support with CHW commitment toward the problems. The commitment of community health workers can be influenced by many factors. Therefore the researcher is intended to conduct a research on selected factors influencing the performance of community health workers in Addis Ababa City Administration Health Bureau which can hinder their performance in helping the community in prevention their health problems.

In view of the above information, it is important to establish the factors that influence the performance of CHWs.

Therefore there is need to conduct a research on factors influencing the performance of community health workers in Addis Ababa city administration health bureau. The findings will support decision making on CHWs programs.

1.8 Definitions of Terms

Community- a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings **Community Health workers** Community health workers are men and women chosen by the community, and trained to deal with individual and community health problems, working in close relationship with the formal health care system **Performance of Community health workers** is measured in terms of improvement in health status of the population that CHWs serve, increase in utilization of services provided by them, reduction in wastage of resources, the presence and accessibility of CHWs to community members

Socio-cultural A set of beliefs, customs, practices and behavior that exists within a population. International companies often include an examination of the socio-cultural environment prior to entering their target markets.

Health system is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations.

Economic The set of fundamental information that affects a business or an investment's value.

1.9 Organization of the Study

This study would be organized in to five chapters. The first chapter provides an introduction to the study. It contains background of the study, statement of the problem, research questions, objectives of the study, Scope and Limitation of the Study, significance and definition of terms of the study. Chapter two deals with literature reviewed that is relevant to the study. A conceptual framework showing relationship that exists between the identified independent variables was drawn. Chapter three deals with the research design, sampling procedures, research Instruments, data collection procedures, validity and reliability of instruments, data analysis and ethical considerations that will be made while collecting data. Chapter four presents the data as per the objective and gives an interpretation. Chapter five discusses the summary of the findings, the conclusions and the recommendations of the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter presents literature with regard to study objectives; socio-cultural factors, health system policies and economic factors reviewed in order to familiarize with the body of literature and identify any gaps based on which the study conducted.

2.2 The Concept of Performance of Community Health Workers

The concept of using community members to render certain basic health services to the communities from which they come from has at least 50-year history (WHO, 2007). In the 1970s, the importance of community health workers was originally affirmed by the World Health Organization. After the Alma Ata Declaration of 1978, many countries in sub-Saharan Africa began to institutionalize CHW programs as a strategy to extend primary health care to impoverished rural and urban populations and to address the relationship between poverty, inequality and community health (Newell 1975; Standing and Chowdhury 2008; Cueto 2004).

Currently, many actors in the field of global health are reaffirming the crucial importance of community health workers (CHWs) trained to provide primary health care and promote healthy behaviors for their own communities in achieving public health goals in the context of poverty and weak health systems. For instance, 2011 saw the emergence of the Frontline Health Workers Coalition, a coalition not of workers themselves, but of international organizations seeking to make better use of them. Though there is considerable debate over the value and activities that should be assigned to CHWs, major global health-development institutions proclaim No Health without Health Workers, identify massive global shortages of CHWs, and call for innovative and evidence-based policies that improve recruitment and retention of community health workforces (WHO 2006; Watt et al. 2011; Bhutta et al. 2010). The Millennium Development Goals (MDGs) have renewed global attention on human resources management in the health sector and strengthening of health systems. There is some recognition that the present underperformance of health systems and their progress is the result of a legacy of chronic under-investment in human resources (Chen et al, 2004).

Responses to this health human resources crisis‘ have been focused upon quantity and distribution of health workers (HW), their incentives, retention and issues of migration and their effects upon global distribution of HWs (Dolea et al., 2010; Pena et al., 2010; Vujicic et al., 2004). The current health human resource crisis is not just an issue of availability of staff and retention. Motivation and performance of existing HWs is equally important, yet much less attention has been given to these areas particularly the social.

Over the past couple of decades, studies have shown that community health workers (CHWs) can help reduce morbidity and mortality in settings that have traditionally lacked access to health care (Haines AS, Lehmann D, 2007). The intermediation of CHWs in healthcare delivery is widening as they are crucial in increasing universal access to healthcare provision and the attainment of the Millennium Development Goals (Evans DB, Etienne C;2010).

Community health workers are men and women chosen by the community, and trained to deal with individual and community health problems, working in close relationship with the formal health care system (WHO; 2006). They should have basic literacy and numeracy levels. CHWs are considered as a third health service delivery work-force and have evolved with community-based healthcare programmes (Otieno CFK, Ochieng D, Githae MN; 2012). However, their titles, profiles and deployment vary across countries, conditioned by their aspirations and economic capacities (Perez F, Ba H, Dastagire SG, Altmann M; 2009). The roles of CHWs can as well be described as: home visits, environmental sanitation, provision of water supply, first aid, treatment of minor and common illness, nutrition counseling, health education and promotion, surveillance, maternal health, family planning, child health, communicable disease control, community development, referrals, record keeping and data collection (Lehmann & Sanders, 2007).

Community health workers performance is complex and there are multiple factors that influence CHWs‘willingness to apply themselves to their tasks and be successful in delivering health services (Franco L, Bennett S, Kanfer R: 2002). Individual HW performance relates to competencies and resource availability; however, motivation to deliver health services is also integral to performance and is underpinned by the organizational structure, the socio-cultural environment and individual characteristics of the HWs (Henderson L, Tulloch J: 2008).

Most research on HW performance has occurred in high-income countries, whereas little attention has been given to HW performance in developing countries (Anyangwe S, Mtonga C; 2007). CHW performance is described not as an attribute of the individual, but rather as a result of the transaction between organizational factors (organizational culture, support structures, resources and processes), social factors (community expectations, social values and peer pressure) and the individual (Franco LM, Bennett S, Kanfer R, Stubblebine P; 2004).

2.3. Social-Cultural Factors and Performance

The performance and motivation of CHWs are influenced by various inherent characteristics of CHWs, such as their age, gender, ethnicity, and even religion, which affect how they are Perceived by community members and their ability to work effectively (Kartikeyan, S, and RM Chaturvedi, 1991). However, the titles, the demographic profile and the deployment of CHWs have varied enormously across countries (Lehmann and Sanders, 2007). The question of who CHWs were and are in terms of gender, age and status, finds many different answers in the literature that reflect the diversity of CHW programs (WHO, 2007). Studies have also differed on whether socio-cultural factors are important determinants of CHWs 'effectiveness (Lehmann & Sanders 2007). Understanding how the socio-cultural factors influence CHWs'performance in conducting their targets is therefore of paramount importance primarily for the adoption of evidence based level one health care service (Ndedda Crispin, AnnahWamae, et al. 2012). Women's preference for giving birth at home is a deeply embedded cultural belief in Ethiopia, resulting in women choosing to deliver with a traditional birth attendant at home instead of with a health extension worker at a health post (Medhanyie A, Blanco R, et al.2012). Similarly, lady health workers in Pakistan have difficulties in following-up newborns because of women delivering in their parents 'house and residing with them for 40 days after childbirth (Bhutta ZA, Memon ZA, Ali I, et al. 2011). Likewise, seclusion of mother and baby after delivery hampers CHW performance in Bangladesh (Azad K, Barnett S, Rego AR, et al; 2010).

In many societies, the husband and mother-in-law are the primary decision-makers (McPherson RA, Tamang J, Baqui AH, et al). In India, grandmothers and mothers-in-law have a big influence on the health-seeking behavior of pregnant women, often resulting in home births.

Two different studies on maternal health in Afghanistan and Bangladesh showed that involving the husbands, mothers-in-law, sisters-in-law and mothers in health education activities reinforced the messages of CHWs and enhanced coverage and acceptability of CHWs in the community(Sanghvi H, Ansari N, Prata NJ, Gibson H, Ehsan AT, Smith JM; 2010).

The gender issue is to a very large extent influenced by wider societal practices and beliefs, and gender relations more generally. Few studies have looked at how gender and gender roles, influence the performances of CHW (Furuta and Salway, 2006). Among some communities such as the Somali, male CHWs find it difficult to pass messages to women. In other communities, resistance from husbands is a key barrier to the participation of women in health related activities. (Boerma et al., 2006). Marriage and child bearing which play a central and prominent role in the traditional African culture may serve as an additional burden on the health workers, affecting their performance (Egwuatu&Umeora 2007). Lehmann et al., 2005 report that family reasons certainly influence decisions of CHWs, but more so for women than for men. Lehmann et al. (2005) conclude that the evidence on performance and job attrition due to a personal situation such as marriage is inconclusive.

Social hierarchies can also form a barrier to CHW performance. From India, Abbott et al. reported that female community based distributors faced challenges in influencing behavior of women with a lower social status (Abbott L, Luke N; 2011). While in another setting in India, accredited social health activists are in demand by all castes and religious groups (Srivastava DK, Prakash S, Adhish V, Nair KS, Gupta S, Nandan D; 2010). According to Prata et al. social structures in Nigeria are extremely hierarchical and local leaders have strong influence on the acceptability of CHWs. This, however, does not necessarily translate into constraints for the CHWs, but still adequate community participation is seen, and CHWs are still able to do their tasks.

According to studies conducted in Uganda, cultural and religious beliefs amongst the target groups made it difficult to approach them and this negatively influenced the level of initiative taken by community reproductive health workers (Martinez R, Vivancos R, Visschers B, Namatovu L, Nyangoma E, Walley J;2008). CHWs' initiative can also be positively influenced by social and cultural values. Community volunteer workers in palliative care in Uganda reported that the cultural desirability of and value attached to the act of helping each other

underpinned their caring role for sick community members (Jack BA, Kirton JA, Birakurataki J, Merriman A;2012).

The sex of the CHW has been shown to influence uptake of services in different contexts. In Afghanistan, Viswanathan et al. reported a preference for female CHWs for the delivery of reproductive health services compared to male CHWs, because the norm was that women should not interact with men outside the family (Viswanathan K, Hansen PM, Hafizur Rahman M, Steinhardt L, Edward A, Arwal SH, et al;2012). Hill et al. suggested that having only male community based surveillance volunteers (CBSVs) working in maternal and neonatal health in Ghana might have limited the scope of the intervention, as families may not want the CBSVs to physically help putting babies in the skin to skin position or help with breastfeeding attachment (Hill Z, Manu A, Tawiah-Agyemang C, Gyan T, Turner K, Weobong B, et al; 2008).

A family planning programme in Guinea recruited a female and male CBD per village. Only the female CBD, according to social custom, was allowed to approach women about family planning. However, male CBDs were able to engage with men and persuade them that family planning was also a men‘s concern (Diakite O, Keita DR; 2009). In India, female CBDs working in promotion and distribution of contraceptives were limited in their interaction with men, which hampered their performance. This was a result of the norms of *purdah*, which strictly regulates interaction between men and women (Abbott L, Luke N; 2011). The same was found for women health volunteers in Iran.

Gender norms and roles affect expectations for income generation of men and women and can influence people to become or remain a CHW. In patriarchal settings, men are expected to be the family breadwinners. A study in Kenya, for example, showed that for this reason, it is difficult for male CHWs to provide voluntary services as it strained their ability to fulfill their financial responsibilities. As a result, they are forced to drop out to search for alternative sources of income. This cultural norm is not the only reason for the higher drop out of male CHWs as compared to female CHWs; it is also indicated that men lacked certain characteristics like instinct for tender care and tolerance that a sick person requires, whereas female CHWs believed it is their natural duty to care. Several studies have reported disease related stigma influencing the performance of CHWs.

In a project involving peer counselors to support clients to adhere to anti-retroviral therapy (ART) in Ethiopia and Uganda, peer counselors‘ performance was limited by some clients not disclosing contact details through fear of having their HIV status known (Gusdal AK, Obua C, Andualem T, Wahlstrom R, Chalker J, Fochsen G;2011).

Stigma also plays a role in Uganda, where CHWs found it difficult to approach clients about family planning and in Kenya, where trained HIV infected peers delivering HIV care at household level defined themselves as health counsellors to avoid the AIDS label and promote confidentiality (Wools-Kaloustian KK, Sidle JE, Selke HM, Vedanthan R, Kemboi EK, Boit LJ, et al.2009).

A great deal of variation exists in required qualifications (WHO, 2007). Many but not all CHW programs require literacy as a prerequisite (Boerma et al., 2006). For instance, Kenyan AMREF programmes require seven years of primary education (Johnson &Khanna, 2004) while a community self-help health development programme in Saridid, Kenya did not consider literacy as selection criteria (Kaseje et al., 1987). Some programmes consider ability to read and write and communication skills (Ande, Oladepo, &Brieger, 2004).

The level of formal education tends to increase the level of general knowledge and hence may positively influence the ability of an individual to deliver. While Lower level of education is associated with low delivery of health care services (Oumaet *al.*, 2005).On the contrary, according to Antwi*et al,* 2013 in a study on factors influencing the delivery of intermittent preventive treatment of malaria in pregnancy in the Bosomtwe district Ghana, there was no association between educational level and delivery of health care services. It is well established that health educators who obey their own health messages are more likely to have impact on delivery of health service (Mulindwa*et al*., 2000). Rayman*et al*., (2010) in a study on factors affecting recruitment and retention of community health workers in a newborn care intervention in Bangladesh found that the services offered by a CHW were influenced by the cluster they come from and the type of house they live either rented or personal.

Low levels of education and health knowledge in the population pose a challenge for CHWs in Kenya, who are perceived by some people in their communities to be ignorant and uncooperative (Takasugi T, Lee AC;2012). Community reproductive health workers in Uganda reported that misconceptions about contraception were the major factors hindering their work (Martinez R, Vivancos R, Visschers B, Namatovu L, Nyangoma E, Walley J;2008).

However, this could be interpreted as an attitude of the CHW rather than a contextual factor. Christianity is well established in Papua New Guinea with over 90% of the population belonging to a Christian denomination (NSO: 2000 National Census National Report*)*. The churches provide roughly 50% of Papua New Guinea‘s education and health services; the influence of Christianity also extends to government services, however, with most government HWs identifying as Christian (Kelly A; 2009).

The role of religious faith inspires a need to do good and take care of those who are suffering and has been described as a culture of service‘ that influences the practices of HWs in Papua New Guinea (Jayasuriya R, Razee H, Bretnall L, Whittaker M, Yap L, Chakumai K;2011). The impact that Christian frameworks have on sexual and reproductive health service delivery in PNG has been explored with both potential positive impacts (e.g., greater adherence to antiretroviral therapy for those attending church facilities) and negative impacts (e.g., the reluctance of staff to give out condoms due to their religious beliefs)

2.4 Health System Factors (practice and policy) and Performance

Several authors note the importance of engaging with the various social structures that exist in the community, such as the local leadership, women‘s groups, community-based organizations and faith-based groups, to broaden the ownership of the program and support for the CHWs themselves (Sauerborn et al., 1989; Tripiboon, 2001). Lewycka et al. (2010) note that support from a local women‘s group improved health care-seeking within the community (Dubowitz et al., 1995).

In her evaluation of a CHW program in Ecuador, Mangelsdorf (1988) found that the presence of a health committee in the community was associated with better CHW performance in the areas of prevention and maternal-child health. However, the role community groups and other community structures can play in the CHW program needs to be clearly established (Sauerborn

et al., 1989). Walt et al. (1989) note that some community structures, such as village health committees, have been weak, inactive, and ill-equipped to engage in the process of supporting and generating demand for CHW programs.

The formation of community structures specifically focused on CHWs appears to have a strong role in generating demand for CHW services as well as in increasing the level of respect a community may have for CHWs (Marsh, Wray, Worku, &Mezgabu, 1999; Wagner, 2012). A recent report on the efficacy and sustainability of World Vision‘s long- standing Community Care Coalitions supports the contribution of CCCs as critical platforms for the coordination of services within communities. Among other things, the CCCs have been effective in creating and sustaining demand for health services (Wagner, 2012).

These results indicate that viable CHW-specific associations increase demand for CHWs and also strengthen the operational link between the health system and the community. Community structures are key to supporting the CHW and giving her legitimacy in the community. Health committees working with officials from the public health sector, schools and NGOs strengthened CHW programming in South Africa (Dick, Clarke, van Zyl, & Daniels, 2007).

In Jamkhed, India, farmers‘clubs supported CHWs and helped CHWs to solve problems. In Brazil, community committees became an informed public monitor of the CHW program (Tendler&Freedheim, 1994). In Navrongo, Ghana, community engagement to support the work of the Community Health Officers was a critical part of its CHW program, which documented a pronounced impact on child mortality.

In many African societies, traditional systems of village leadership, social networking, and social organization foster volunteerism for agricultural production self-help, and village governance. In Navrongo, Ghana, these traditional forms of social cooperation are used to mobilize support for community health and family planning. The approach involves constituting health-care action committees from existing counsels of elders, mobilizing traditional peer networks and implementing supervisory services with extant traditional village self-help schemes.

While CHWs are the service providers, outreach to men is through durbars (community gatherings) which foster widespread knowledge of the program elements (Debpuur et al., 2002). In Mali, new community oversight committees supported the work of CHWs as well as planned and conducted health activities in their villages.

The oversight committees also provided a link between the village leadership and the CHWs. When health committees have minimal engagement with CHWs, CHW status, morale and performance can be adversely affected (Gilson et al., 1989).

2.5 Economic Factors

The economic context and its influence on the performance of CHWs have been highlighted in a number of studies; they related mainly to livelihoods, technology and willingness to volunteer and requested compensation for services rendered. Economic hardship could influence willingness to go an extra step to perform some duties, health-seeking behavior, and could lead to stress of CHWs. A lack of financial or material compensation for services rendered could lead to an inability of CHWs to provide for their family and is particularly exacerbated in areas of pervasive poverty (Maes K, Kalofonos I; 2013).

Poverty of the community could also influence the work of CHWs. Maes et al. reported that a food crisis not only affected CHWs, but also led to lack of food among clients causing distress to CHWs (because they saw their clients suffering). Poverty could also prevent people from seeking health services in general, because of the expense incurred for accessing the services (Sadler K, Puett C, Mothabbir G, Myatt M; 2012). There are numerous CHW programs that compensate the CHWs by allowing them to charge fees for services and/or sell health-related commodities and drugs in their communities.

BRAC is one of the largest NGOs implementing a CHW model with this type of financial support. This financial support does not come from the formal health system or from other fundraising efforts of the NGO. The Nepal Female Community Health Volunteer Program has established local endowment funds, the interest from which is used to provide sustainable, although quite modest, financial support to the CHWs.

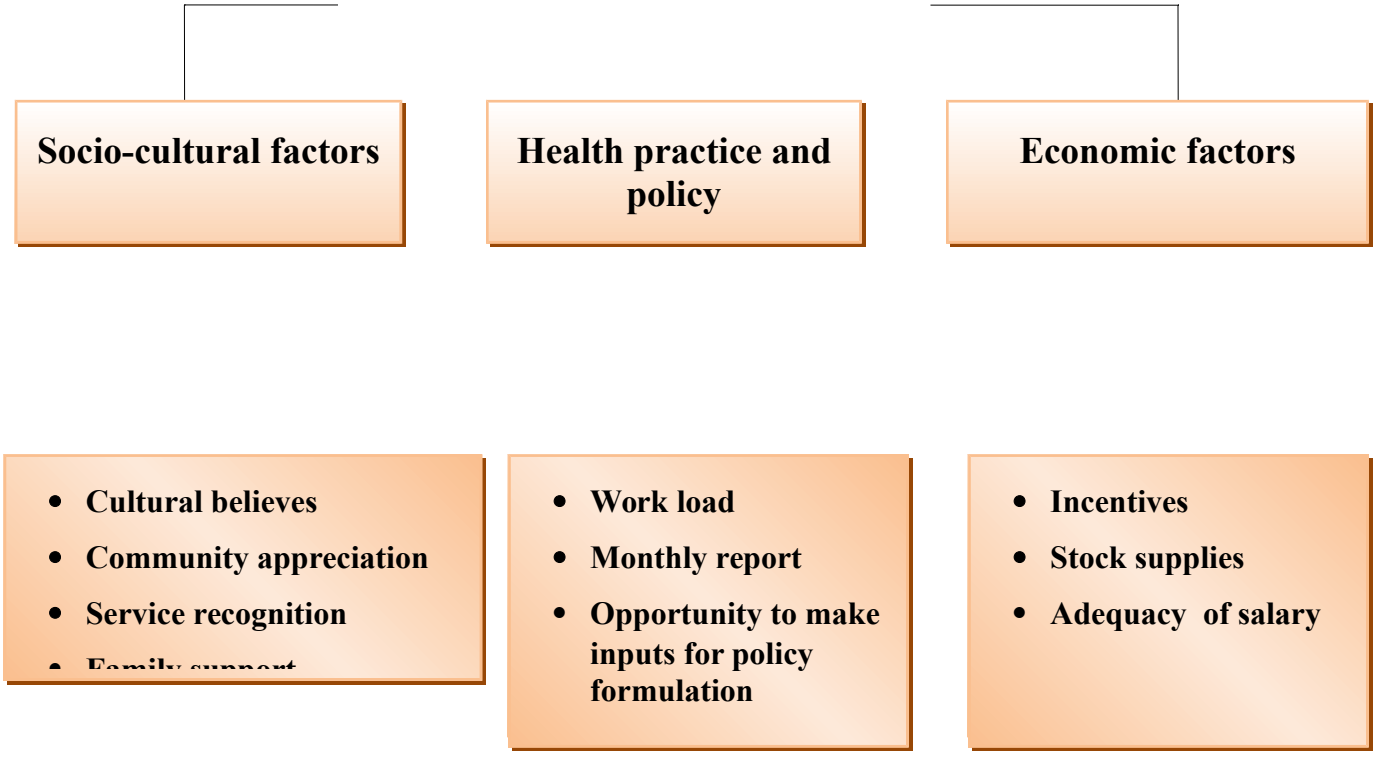
The studies that exist have highlighted that economic incentives, primarily through supplementary income from the sale of medicines and other health-related products, can improve performance of CHWs, and dissatisfaction with earnings can be a main reason for dropping out (Alam, K., Tasneem, S., &Oliveras, E. 2011). A study of urban CHWs in a BRAC program found that while social incentives are important for motivation, financial incentives are the most commonly discussed factor and supersede other incentives.

Financial incentives were considered critical in sustaining the CHW program in Tanzania. This finding is also supported by a study done in South Africa, which concluded that non- monetary incentives served as enablers while monetary incentives were thereal incentives (Kironde&Klaasen, 2002). There are few examples of large-scale programs which have been consistently supported financially by the community. One example is the Chinese barefoot doctor program, which lasted from the 1950s until 1984 (Gilson et al., 1989). Another example of CHW remuneration by communities is a primary health care program developed by the Ministry of Health in the Northwest and Awday regions of Somalia in the 1980s (Bentley, 1989).

2.6 Conceptual Framework

This conceptual framework tries to explain how contextual factors influence CHW performance at the CHW level (e.g., motivation or competencies), the end-user level (e.g., influencing health-seeking behavior), or by influencing broader CHW programme performance .These factors relate to community (most prominently), economy, socio-cultural, and health system policy and practice and form a complex interactive web. They represent characteristics of settings in which a CHW programme operates and sometimes serve as preconditions for the performance of CHWs or CHW programmes.

Fig 2.1 Conceptual Framework



Source: Author

Summary of the literature

CHW socio-cultural characteristics like gender, age, marital status, social status and selection of CHWs from within the community they serve may have an influence on CHW performance, although our review shows a mixed picture on the influence of these factors. Previous studies found that CHW retention rates are higher in programmes which selected CHWs based on past performance and CHWs who are trusted members of the community better reflect the linguistic and cultural diversity of the population served. The medical profession is regulated and restricted in all countries; legislative and professional regulatory frameworks inform which professional can perform which task. Few studies however reported on regulatory frameworks. Regarding the health-related procedures CHWs are authorized to perform.

The economic context and its influence on the performance of CHWs were highlighted in a number of studies; they related mainly to livelihoods and willingness to volunteer, and requested compensation for services rendered A lack of financial or material compensation for services rendered could lead to an inability of CHWs to provide for their family and is particularly exacerbated in areas of pervasive poverty. The willingness to become a CHW could be influenced by the wish to earn an income or the hope of being compensated eventually, especially in situations where there is high unemployment or fewer opportunities.

CHW productivity is influenced by a complex interplay of the four elements that comprise an enabling work environment-workload, supportive supervision, supplies and equipment, and respect. Appropriate incorporation of these elements in a CHW programme provides CHWs with the working conditions conducive to doing their job more effectively. However, there is scant empirical evidence regarding which element of the work environment is the most important, or the exact degree to which one element or a combination of elements has a larger or smaller influence on the overall work environment and, in turn, CHW productivity. As we seen from the literature of review there is no a statement which mention if researches conducted or not on the issues of factors that affect the performance of community health workers on Addis Ababa city administration.

1.8 Knowledge Gap

From the reviewed literature there is no conclusive tidy package of incentives which is successfully tailor made to motivate CHWs to continue performing. Rather, a complex set of factors affects CHW motivation and attrition, and how these factors play out varies considerably from place to place. There are a limited number of studies evaluating demographic characteristics of the level one health service provider such as age but not by gender and marital status. However several studies have examined the role of education status, residents; source of income; knowledge of the health provider and attitude and practice. On health system factors, there are so much literature on cost of financing but not on community based health care financing; quality of services; governance; accessibility and availability of drugs and supplies however the findings are inconclusive and inconsistent. Studies on the role of supervision and technical support, monitoring and evaluation; communication and leadership; patient- provider relationship; area covered by community health worker are limited.

The question of how to sustain a long-term CHW program and to retain CHWs requires additional investigation. There is no research conducted in area factors that affecting the performances community health workers at Addis Ababa city administration health bureau.

In community factors the role of family support; recognition of health services; community participation and security have been examined but the results are inconsistent across studies. The role of beliefs, traditions and norms; knowledge of community health worker and the service they offer; motivation and privacy and confidentiality have not been fully explored

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter present information on the research design, target population, sample size, data collection methods, sampling procedures and research instruments. It also presents the methods used for measuring validity and reliability of the research instruments. Data collection and data analysis procedures are also discussed.

3.2Background of Addis Ababa city administration health bureau

Provision of Establishment:

- In accordance to proclamation number 25/2001, article 1, number 7 on the reestablishment of Addis Ababa City Administration executives and municipality organs.

- Year of Establishment: In January 19 85, established for the first time under the Ministry of Health of the transitional government, acquiring its own legal authority and responsibility as Addis Ababa Health Bureau and in the same year in February it is formed once again as region 14 health bureau for the first time.

Vision:

- To create a healthy society in the city government and make the Addis Ababa City a model city in Africa with quality provision of health services.

Mission:

- Through the collaborative undertaking of disease prevention by the public and stakeholders rendering speedy, fruitful and quality health services so as to create healthy and productive citizens.

Values:

- Accountability
- Transparency
- Quality service
- Knowledgeable and faithful leadership and performance
- Change oriented
- Professional ethics
- Patients first

Source: http://www.addisababa.gov.et

3.3. Research Design

Research design refers to the way a study is planned and conducted. It entails choosing the subjects who participate in the study. The techniques and approaches for collecting data for the subject and the procedures (Kumssa, 2011). The study were adopt descriptive research design. According to Kothari (2009), descriptive research is used when the problem has been well designed. Structured questionnaires were used to survey, socio-cultural, health system and economic factors.

3.4. Sources of Data

The study employed both primary and secondary sources of data for its successful achievement.

Primary data was collected from the employees through structured questionnaires. Secondary data was collected from sources like prior researches, journals articles, books, internet websites and manuals etc.

3.5. Method and Tools of Data Collection

Qualitative research concerned with qualitative phenomena, that is, phenomena relating to or involving quality or kind. In this study structured questionnaires containing close ended questions have been used to collect primary data and Secondary data was collected by referring different articles, books, and the company's manuals.

3.6. Target Population

The target population for this studyconstitutes of community Health Workers in Addis Ababa city administration health bureau.

3.7. Sampling Technique and Sample size

Sampling is the that part of a statistical practice which concerns the selection of individual observations intended to yield some knowledge about a population of concern, especially for the purposes of statistical inference (Ghoshi, 2002). The most straight forward type of frame is a list of elements of the population preferably the entire population with appropriate contact information. According to Kothari (2006), sampling provides a valid alternative to a whole population because surveying an entire population may lead to budget, time constraints and delay result analysis.

The population of the study included all 10 sub cities and in all woredas. A woreda (Which is 10 percent) from each sub city considered to examine factors affecting the performance of CHW and to know the magnitude of the problem on city wide level. One woreda from each sub city selected on a simple random sampling technique.

3.8. Method of Data Analysis

First the data obtained through the questionnaire were computed with the use of Excel sheet and computer software programs. Then data was coded, grouped and analyzed using appropriate values which were suitable for conclusion and recommendations.

The researcher has also used descriptive statics such as frequency, percentages, mean values and charts which made the research to be clear and easily understandable.

3.9 Ethical Considerations

The researcher observed ethics in the process of data collection and presentation. The researcher explains the purpose and objective of study to respondents. The data collection tools administered in conducive environment. The respondents assured of total confidentiality and that the information collects only for research purpose.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSIONS

4.1 Introduction

This chapter presents the findings of the study on the factors influencing the performance of community health workers (CHWs) in Addis Ababa city administration. Detailed analysis of the data, interpretation and explanation of the results with regard to objectives and the research question are given. The findings are based on information from questionnaire survey from a representative sample of 140 CHW. A total of 140 respondents against a target of 145 (CHW) participated in the study. This was a response rate of 96.5%.

4.2 Response rate

The researcher sort to collect data from CHWs by use of a research questionnaire. A sample of 145 questionnaires were printed and distributed. 140 questionnaires were correctly filled and returned representing 96.5% response rate while 5 questionnaires were never returned.

4.3 Demographic characteristic of the respondents

	Characters	N	Percentage
Gender	Male Female	- 140	0% 100%
Age	Below 20 years 20-29 years 30-39 years 40-49 years 50-59 years 60+ years	2 92 46 - - -	1.4% 65.7% 32.%
Marital status	Married Single Separated/ widow	60 80 -	42.9% 57.1%
Level of education	Primary Secondary Tertiary University	 5 30 105	 3.6% 21.4% 75%

The total number of 140 CHWs was interviewed using questioners. The demographic characteristics of the study sample was as shown in Table 4.1

Table 4.1: Demographic characteristics

The total number of 140 CHWs responded to the questionnaire. The demographic characteristics of the study population are as shown in Table 4.1 above. 140 (100%) of the respondents were female. From the findings, 2(1.4%) of the respondents were of age under 20 years, 92 (65%) of the respondents were of age 20-29yrs, 46 (32.9%) of the respondents were of age 30-39 yrs, 0 (0%) of the respondents were of age 40-49 yrs, 0(0%) were of age 50-59 yrs and only 0(0%) were of age above 60yrs.

On the marital status of the respondents, the findings showed that 60(42.9%) were married, 80(57.1%) were single and 0 (0%) were separated/widowed. The findings also showed that 0 (0%) of the respondents had completed primary education, 5 (3.6%) had completed secondary education, 30(21.4%) of the respondents had completed tertiary education and only 105(75%) were university graduates.

4.4 Results on factors tool.

This section presents the analysis and interpretation of different factors and these factors include, socio-cultural, health system and economic factors related to that affect the performance of community health workers in case Addis Ababa health bureau.

The questionnaires have been designed in Likert-scale mode which comprises ("Strongly Agree" rating **5** points, "agree" rating **4"**, neutral" rating **3**"Disagreement" representing **2**and strongly agree rating **1**points.In this statistics, all frequency, percentage and mean scores have been used so that the data gathered through the questionnaire were exhaustively analyzed and interpreted.

4.5 Findings on socio-cultural factors:

It'sundeniable that social and cultural factors, or other factors, play a key role in affecting the performance of workers.

The survey results of this questionnaire have brought the following findings which are properly tabulated and analyzed below.

Table 4.2 SOCIO-CULTURAL

Factors	Options	Frequency	Percent	Mean Scale	Remark
The community appreciates your work	Strongly agree Agree Neutral Disagree Strongly disagree	5 97 6 18 14	100%	3.4	
How is the support from immediate family members?	Very high High Neutral Low Very low	13 25 29 70 3	100%	2.8	Strongly Agree = 5 Agree =4 Neutral = 3 Disagree = 2 Strongly Disagree= 1
There are supports to facilitate your work from the community.	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	7 82 11 30 10	100%	3.3	
There are some cultural believes in the community that are in conflict with organizations policies.	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	0 5 10 108 17	100%	2.0	

Factors	Option	Frequency	Percent	Mean scale	Remark
Communities recognizethe service you offer to them.	Strongly agree Agree Neutral Disagree Strongly disagree	12 57 30 30 11	100%	3.2	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1
All community members show you respect when you are attending to them.	Strongly agree Agree Neutral Disagree Strongly disagree	2 52 20 57 9	100%	2.9	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1

4.5.1 Community appreciation of the work

The respondents of this question seemed to almost prefer agree ones. They gave moreemphasis to agree whichshow result like, 97 employees have expressed their agreement, 6 were indifferent, strongly disagree rating 14 and strongly agree 5whereas 18 were in disagreement. The mean value on this respect was 3.4 which are justifying their preference. Therefore the workers knowthere service appreciated by the community.

4.5.2 Supports from immediate family members.

The respondents of this question seemed to be in disagreement. Because the significant numbers of them are feel that their families are not feel happy in what they do for their community. The figures show that 13 of them were say very high and 25 of them say high that, they get support from their family and 29 of them have not any feeling, however 70 are says low and 3 of them are says very low which shows they are unhappy with their family support for their service to the community. The mean value itself (2.8) reflects that majority of the staff members arefeel that their family does not support them.

4.5.3 Supports to facilitate a work from the community.

This assessment shows that majority of the respondents are agree that the community recognize their service. For instance 82 of the respondents have agreed and 7 of them strongly agreed, however 44 of the employees were indifferent. On the contrary 16 of the respondents have showed disagreed as well as 10 of them strongly disagree, but still the mean value remained 3.3 which shows that majority of the respondents are agree with the statement. Withthat we can conclude that most of the employees are feel that the community recognizes their service.

4.5.4 Cultural believes that are in conflict with organizations policies.

The survey results of this question indicate that, many of the respondents are in disagree which are about 108 respondents and 17 of respondents say strongly disagree .10 respondents also remained indifferent however about 15 employees have agreed and none of them say strongly agree. The mean value was 2.0 which indicate disagreement on the presence of cultural believes that oppose the organization policy.

4.5.5 Communities recognition.

This assessment shows that majority of the respondents are satisfied with the community recognition toward the work of community health workers. For instance 12of the respondents have strongly agreed and 57 of them have agreed, however 30 of the employees were indifferent. on the contrary 30 of the respondents have showed disagreed and 11 also strong disagreements, but still the mean value remain 3.2 which show the majority of the respondents are agreed on the communities recognition of what they do for them. With that we can conclude that most of the employees are satisfied on this aspect. Therefore this should be encouraged

4.5.6 Communities respect.

On this respect majority of the respondents have expressed their dissatisfaction and some of therespondents believe that communities respect them when they deliver services to them however, the majority respondents as mentioned not agreed on this issues. The numerical distributions show that 57 respondents have disagreed and 9 strongly disagreed whereas 12 respondentshave preferred to be neutral. On the other hand 26 respondents have agreed and 2 are stronglyagree on the subject matter.In the final analysis, as the survey results are indicating a disagreement of employees, the management should device a kind of strategic mechanism to invent and implement in way that bring out attitude change of the society so that they respect the service delivered to them by the community health workers.

Table 4.3 Health Systems Factors

Factors	Options	Frequency	Percent	Mean Scale	Remark
How can you rate the workload that you handle at a given period?	Very Much Much Enough Little Very Little	23 77 30 7 3	100%	3.8	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1
There are enough supervisions on your works	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	7 35 10 83 5	100%	2.7	
There are feedbacks from your supervisor.	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	7 23 30 67 13	100%	2.6	
There are opportunities to make in puts in to policy formulation	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	12 96 10 20 2	100%	3.7	

Factors	Options	Frequency	Percent	Mean scale	Remark
There are trainings that you attend as community health worker.	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	3 37 40 52 8	100%	2.8	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1
Your supervisor gives you adequate support and attention.	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	14 30 18 73 5	100%	2.8	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1
Care and support are always available to you in the form of counseling at the work place.	Strongly Agree Agree Neither agree nor disagree Disagree Strong disagree	2 25 30 70 10	100%	2.5	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1

4.6Health System Factor

The other factor that significantly influences the performance of community health workers is a policy trend on health issues or health system practice of a given country.

Under health system factors the researcher analyzedsome issues which mentioned below.

4.6.1 Workload

The most obvious general observation that has been found from the entire survey was that, workers have much work load. Having said that, the numerical results show that, 77 of the respondents rate much on the presence of work load 30 of the respondents rates enough of work load, however, 7 rates little and about 3 were very little.The mean scale on this topic was 3.8 which indicate that most of the employees are working inover loaded conditions.

4.6.2 Adequacy of supervision

Regarding supervision majority of the respondents have negative feeling, meaning83 of the respondents are disagree and 5 of the respondents are in strong disagreement, whereas10 respondents still remain indifferent.7 of the respondents says they agreed strongly and 35 of them just agree. The mean value of 2.7 is indicating that, themanagement should work more on employee supervision.

4.6.3 Feedbacks from supervisors

It can be observed from the table that among the total respondents 23 have greed up on thisaspect and 7 are strongly agree, whereas 30 were indifferent. On the contrary, majority of the respondents, meaning, and 67have disagreed and 13 are strongly disagreed on the presence of feed backs from supervisors. The mean scale of 2.6 shows there is no supervisor's feedback to employee.

4.6.4Opportunities to make in put in to policy formulation

On this regard 96 of the respondents have agreed, 12 of the respondent rates for strongly agree and 12 respondents remain neutral whereas 27have expressed their disagreement and 2 are for strongly disagreeing. These figures show that majority of the employees have opportunity to make in puts in policy formulation. So as the mean scale is showing 3.7, the majority of workers agree on the involvement workers on policy formulation. Therefore this trend should keep going very well.

4.6.5 Availability trainings

The most obvious general observation that has been found from the entire survey was that,workers do not attaining training very well that can increase their attitude and ability. This experience is common in the majority of Ethiopianpublic organizations. Having said that, the numerical results show that, 37of the respondentshave expressed their agreement on the presence of training and 3 strongly agree however 52havedisagreed and 8 strongly disagree. About 18 were indifferent.

The mean scale on this topic was 2.8 which indicates that most of the employees are not attained training very well, so that the management is urged to keep continuous training and keep the employees' confidence high.Which also indicates that management should work onproviding fair and appropriate opportunity of domestic and abroad trainings. It is clear that theobjective of any training or capacity building is not to benefit individuals, rather to expediteorganizational development.

4.6.6 Supervisors adequate support and attention

Support and attention create a positive culture that both employees and employers benefit from. The benefits support and attention allowing employees to work a flexible work hours are numerous, from increasedproductivity to fewer missed days. Support and attention are very vital to provide employees withjob satisfaction, better health, increased work-life balance, and less stress. They also benefit employers through higher productivity levels,employers are able to retain qualified employees and save money as well.

Unfortunately the survey results are showing the opposite, about 73of the respondents are indisagreement and 5 were strongly disagree as well as 18 were indifferent however 27 were in agreement and 14 strongly disagreement with the presence of support and attention. It might be very important if the management could see the problem and fix it as much as possible.

The mean scale of 28 requires the management to work hard on support and attention and positive impact may see soon on the productivity thecommunity health workers.

4.6.7Care and support in the form of counseling at the work place

As per the assessment, most of the employees were dissatisfied as they are not considerablyinvolved in care and support process in relation to their sections. About 70 of therespondents were in disagreement and 10 were strongly disagree. Also 19 of the employees were indifferent whereas 30 ofthe respondents have agreedand 2were strongly disagree

The mean scale on this distribution was found to be 2.5, which is closer to 'Disagreement', so itcan be concluded that employees are dissatisfied of care and support which requires the organization to work hard on this.

Table 4.4 Economic Factors

Factors	Options	Frequency	Percent	Mean Scale	Remarks
There are enough stock of supplies	Strongly Agree Agree Neither agree nor disagree Disagree Strongly disagree	14 59 40 20 7	100%	3.4	Very agree = 5 Agree =4 Neutral = 3 Disagree =2 Strongly disagree = 1
There is Enough cash payment on what you do for the community.	Strongly Agree Agree Neither agree nor disagree Disagree Strongly disagree	0 6 10 70 54	100%	2.3	
You are currently receiving incentives for your good performances.	Strongly Agree Agree Neither agree nor disagree Disagree Strongly disagree	5 36 20 60 19	100%	2.6	

4.7Economic Factors

Economic hardship could influence willingness to go an extra step to perform some duties, health-seeking behavior, and could lead to stress of CHWs. A lack of financial or material compensation for services rendered could lead to an inability of CHWs to provide for their family and is particularly exacerbated in areas of pervasive poverty.

Managers should always strive to keep their workers motivated and satisfied with their jobs and the organization. Motivation is directly linked with employee productivity and indirectly linked with employee retention. Financial factors are one of the important tools toanswer this question and achieving organizational objectives.

The table below reflects all findings related to non-financial incentives provided by Ethio-Telecom and the narratives are also presented below the table.

4.7.1 Stock of supplies

Regarding stock supplies majority of the respondents have positive feeling, meaning59 of the respondents are in agreement and 14 of the respondents are in strong agreement, whereas22 respondents still remain indifferent. 20 are disagree as well as 7 of them are rate on strongly disagree. The mean value of 3.4 is indicating that, the management should work more on stock of supply so that the workers can encouraged to do more for their community.

4.7.2 Cash payment

As per the assessment, most of the employees were dissatisfied. About 70 of the respondents were in disagreement and 54 of them strongly disagree.19 of the employees are indifferent whereas 30 of the respondents have agreed and none of them are strongly agree.

The mean scale on this distribution was found to be 2.3, which is closer to ‘Disagreement’, so it can be concluded that employees are dissatisfied of their salary which requires the organization to work hard on this.

4.7.3 Incentives

This scenario shows that majority of the employees are not satisfied on receiving of incentives. Because 60 of the respondents have disagreed, 19 of them are strongly disagree and 20 of the employees were at the middle however 36 of the respondents have disagreed and 5are strongly agree.

The mean value of 2.6 shows that majority of the respondents are dissatisfied in their salary. With that we can conclude that even though most of the employees are satisfied on this aspect, the health bureau should exert more efforts to create more efforts to enough payment for the workers.

In other way, Managers should always strive to keep their employees motivated and satisfied with their jobs and the organization. Motivation is directly linked with employee productivity and indirectly linked with employee retention. Non-Financial Motivators are one of the important tools to answer this question and achieving organizational objectives.

4.8 Feedbacks on the Open Ended Questions

Open-ended questions are exploratory in nature which allows the respondents to provide any answer they choose without forcing them to select from concrete options. Questions that have more than one right answer, or ones than can be answered in many ways, are called open-ended or divergent questions.

With that said while coming back to the four open-ended questions, many respondents have mentioned different answers. The following conclusion has been taken from the combined answers of respondents for the first question……..

4.8.1 What is your religion?

About 98 respondents have given answers for this question and the rest have left it opened.89 of them said that “Christian”. Few people mentioned that they are “Muslims “

So the bottom line indicates that, most people are Christian.

4.8.2 How communities appreciate your work?

In this regard, only 62 respondents have replied and the rest have left opened. While generalizing the answers, majority of the respondents stated that they appreciate us by ” giving respect and in collaboration “.

4.8.3 How many times are you supervised per quarter?

67 respondents almost all of them stated that once per quarter the supervised.

4.8. 4. How is your performance judged?

All means 47 of them respondents stated how their performance judge is that by how well they do their work.

CHAPTER FIVE

5. SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATION

5.1. Summary of Findings

The survey study results of this paper have generated many findings under the title of "Factors that influencing the performance of community health workers under Addis Ababa health bureau". The survey analysis has summarized all the findings in to three categories as follows. The first category has summarized the findings based on socio-cultural and the second one has focused on the findings on the health system. The third one was discussing all the findings based on economic factors.

The gender and religion of the CHW has been shown to influence uptake of services in different contexts. In Afghanistan, Viswanathan et al. reported a preference for female CHWs for the delivery of reproductive health services compared to male CHWs, because the norm was that women should not interact with men outside the family (Viswanathan K, Hansen PM, HafizurRahman M, Edward A, Arwal SH, et al, 2012). In India, female CHWs working in promotion and distribution of contraceptives were limited in their interaction with men, which hampered their performance. This was a result of the norms of Purdah, which strictly regulates interaction between men and women (Abbott L, Luke N, 2011). Being female could influence mobility of CHWs: two studies from Bangladesh reported that ShasthyaShebikas (CHWs) were seen as being ―not decent if they went out in the night, particularly in rural areas (Alam K, Tasneem S,

Oliveras E, 2012).

1. The first category has focused on assessing the findings of socio-cultural factors. In thisCategory some socio-cultural aspects to include; (religion, community appreciation, family support, recognition of community and cultural believes)have been conversed.

The gender and religion of the CHW has been shown to influence uptake of services in different contexts. In Afghanistan, Viswanathan et al. reported a preference for female CHWs for the delivery of reproductive health services compared to male CHWs, because the norm was that women should not interact with men outside the family (Viswanathan K, Hansen PM, HafizurRahman M, Edward A, Arwal SH, et al, 2012). In India, female CHWs working in

promotion and distribution of contraceptives were limited in their interaction with men, which hampered their performance. This was a result of the norms of Purdah, which strictly regulates interaction between men and women (Abbott L, Luke N, 2011). Being female could influence mobility of CHWs: two studies from Bangladesh reported that ShasthyaShebikas (CHWs) were seen as being not decent if they went out in the night, particularly in rural areas (Alam K, Tasneem S, Oliveras E, 2012). From socio-demographic part as the researcher asses the genders community health workers, it found that all of community health workers are female and no one male found.

In case of religion majority of workers are followers of Christianity.

As a result, two aspects of the respondents seemed to be happy on this aspect. For example the average mean of two questions were more than 3.5points, however the rest of two aspect, scored below 3 points.

2. The second category has focused on assessing the findings of health system factors. In this category health system related to include; (workload, appointment letter, monthly report and input for policy formulation) have been discussed. As a result, majority of the respondents seemed to be happy on this aspect. For example the average mean of three questions were more than 3.5points, however only one aspect (workload), scored below 3 points.

3. The third category was of course related to economic factors which most of the employees have showed more negative interest. The results of this survey show that, majority of the respondents are unhappy with the economic factors includes :(stock of supplies, enough cash payment and incentives) and seemed to be relatively unstable.

In other way about 105 community health workers say that increment of salary can motivate them than other type of incentives.

5.2. Conclusion

This topic is shortly discussing on the results of the survey based on the research questions we established in the beginning and factors influencing the performance of community health workers in case of Addis Ababa city government health bureau .

According to the survey the following results have been found:

Socio-cultural factors can influence access to and uptake of (CHW) health services. As CHWs are part of the context in which clients are living, it is often assumed that they are better able to understand constraints as a result of socio-cultural factors, compared with other health workers. Social and cultural norms should be taken into consideration when selecting CHWs to address community preferences regarding gender and social status. Some communities prefer female CHWs yet they may be less able to perform because of societal and gendered restrictions in mobility or communication with male clients. Gender roles and relations shape processes and experiences within the community and within the health system and CHWs have a critical interface role between both sides. The functionality of the health system as a whole has an influence on CHW performance. From our literature review, it is clear that necessary arrangements regarding incentives, family support and supplies are often inadequate and that CHWs‘ expectations regarding these issues do not correspond with reality. Performance- or output-based incentives could lead to competition or neglect of unpaid tasks, hampering CHW performance. In order to bring positive change to health systems, health policy and systems research that fully accounts for context is required. To be successful, CHW programmes require regular and reliable support. High work load also can hamper the performance community health workers.

Although cash incentives might lower attrition rates, increase productivity and accountability of CHWs, such reward systems can present unforeseen negative consequences depending on how they are handled. Such payments can undermine community support and since money is never enough, CHWs might inevitably demand for more money and benefits. For smooth implementation of community health interventions, monetary incentives should be reasonable, sustainable, regular and comparable across all CHWs. The salary they earn now is not enough to handle their life properly.

5.3 Recommendations

Since family role on the performance of community health workers, attitudes of community should change.

There is a need for government and partners to explore sustainable financial incentives for CHWs: allowances, reimbursements among others. Therefore policy formulators should consider the problems.

There is a need to explore non-financial incentives for CHWs that are performance based e.g. exchange tours, badges, recommendations letters, and certificates of attendance. This model has been effective in countries like India.

There should be improved stock supplies in order to strengthen the work of workers. This will improve support to their community very well.

Government also should see possible alternatives to increase their monthly income so that they motivate more to help their society better than before.

There should be also need for balance recruitments gender and religious.

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APPENDIX

Addis Ababa University College of Business and Economics

Department of Public Administration and Development Management

MASTER OF PUBLIC MANAGEMENT and POLICY

QUESTIONNAIRE TO BE FILLED BY COMMUNITY HEALTH WORKERS AT ADDIS ABABA HEALTH CENTERS.

Dear Respondents,

This questionnaire is designed to gather information about factors influencing the performance of community health workers in Addis Ababa city administration health bureau. All responses will be used to conduct a study for the partial fulfillment of Master's Thesis in Public Management and Policy. I would like to assure you that you will be guaranteed anonymity as I do not ask your name here and your responses will not be used for any other purposes other than the intended purpose. I am grateful for your cooperation in advance!

Background information

Please indicate your choice by putting a thick mark (√) among the given alternatives

SECTION A: SOCIO-DEMOGRAPHIC DATA

1. **Gender**

(a) Male {} (b) Female {}

2. **Age**

a) Below 20 years { } b) 20-29 Years { } c) 30-39 Years { }

d) 40-49 Years { } e) 50-59 Years { } f) 60 + Year{ }

3. **Marital status**

a) Single { } b) Married { } c) Widowed/Separated { }

4. **Level of education**

a) Primary { } b) Secondary { } c) Tertiary { } d) University { }

6. What is your Monthly income in Birr?

a) Below 1500 { } b) 1501 -2500 { } c) 2501 – 3500 { } d) 3501 - 4500 { }

e) 4501 – 5500 { } f) 5501 – 6500 { } g) Above 6500

7. How long have you practiced as a CHW

a) Less than six months { } b) six months -1Year { } c) 1 -2 Years { }

d) 3 -4 Years { } e) Above 5 Years { }

SECTION B

Socio-cultural factors

1. What is your religion?

……
……

2. A community appreciates your work.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strong disagree

If strongly agree or agree, how does the community appreciate your work?
……
……
……
……
……

3. There are supports to facilitate your work from different parties.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

If agree or strongly agree, from who
……
……
……
……
……
4. How is the support from immediate family members?

A) Very high { }

B) High { }

C) Neutral

D) Low { }

E) Very low { }
5. The community recognizes the services you offer to them.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

6. Community members show you respect when you are attending to them.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree
D. Disagree

F. Strongly disagree

If agree or strongly agree,
how?.....
.....
.....
7. There are some cultural believes in the community that are in conflict with organization‘s policies.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

If strongly agree or agree state them
……..
……
……
……
Health Systems factor

1. There are trainings that you attended as a community Health worker.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

If agree or strongly agree, which one?

a) Community Strategy {}
b) Community dialogue {}
c) Home Case Management { }
d) Others specify……

2. How many times are you supervised per quarter?
……
…….

3. Supervision you always get is enough.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

4. There are feedbacks from your supervisor.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

5. Your supervisor gives you adequate support and attention.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

6. You do receive results on performance appraisal that is conducted on quarterly basis.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

7. There are opportunities to make inputs into staffing policies and procedures?

A. Strongly Agree

B. Agree

C. Neither agree

D. Disagree

F. Strongly disagree

8. Care and support are always available to you in the form of counseling at the workplace.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

9. How is your performance judged?
……
……
……
……
…….

12. How can you rate the workload that you handle at a given period?

a) Very Much {}

b) Much { }

c) Enough { }

d) Little { }

c) Very Little { }

Economic factors

1. Enough cash payment on what you do for the community.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

2. You are currently receiving incentives for your good performances.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree

3. Which of the following in kind incentives are you receiving currently?

a) Community recognition { }

b) Management of a commodity kit { }

c) Career advancement opportunities { }

d) Payments { }

h) If others specify

…….....

……

……

4. There are enough stock of supplies in your organization.

A. Strongly Agree

B. Agree

C. Neither agree nor disagree

D. Disagree

F. Strongly disagree