ADDIS ABEBA UNIVERSITY

SCHOOL OF GRADUATE STUDY

COLLEGE OF EDUCATION AND BEHAVIOURAL STUDIES

DEPARTMENT OF CURRICULUM AND TEACHER PROFESSIONAL DEVELOPMENT STUDIES

FACTORS AFFECTING THE ROLE OF HEALTH EXTENSION PROFESSIONALS IN THE IMPLEMENTATION OF HEALTH PACKAGES IN YEKA SUBCITY OF ADDIS ABABA

BY: ETAFERAHU SEYOUM

SEPTEMBER 2015

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ACRONYMS

AA	Addis Ababa
CHPs	Community Health Professionals
CHW	Community Health Workers
CSA	Central Statistical Agency
DMPA	Depot Medroxyprogesteron Acetate-Depo-Provera
FGD	Focus Group Discussion
FMoH	Federal Ministry of Health
HEP	Health Extension Professionals
HEPa	Health Extension Package
HEPr	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immune Deficiency
HO	Health Officer
HRH	Human Resource for Health
HSDP	Health Sector Development Program
MDG	Millennium Development Goal
TB	Tuberculoses Bacillus
UHEP	Urban Health Extension Program
VCHW	Voluntary Community Health Workers
WHO	World Health Organization
JSI	John Snow, Inc
SEUHP	Strengthening Ethiopia's Urban Health Program

Abstract

The purpose of this study was to assess the Factors Affecting the Role of Health Extension Professionals in the Implementation of Health Packages in Addis Ababa, Yeka Sub city. To this end, descriptive survey design was employed. Both quantitative and qualitative methods were used. Primary source of data were heads and vice heads of Woreda Health Offices and Health Extension Professionals. The secondary sources were relevant policy documents, reports of Woreda Health Offices and minutes of the HEP of Addis Ababa City Administration and the respective Woreda's reports. Sample size of this research on the total of forty four respondents form the Yeka sub-city Woreda Head Officer and Vice Head officer (two in number), from the 14 Woreda Health Offices / two supervisor per Woreda assigned/, then selected one from each (14 in numbers), twenty eight Health Extension Professionals from each Woreda were participated in this study. Respondents used as a sample simple random sampling technique was used to select Woreda's form the total number. Further-more, from a total of 13 Woreda's in the sub-city a proportion of 7 Woredas were considered through systematic random sampling technique. Whereas selection of tow HEPs from each of the seven Woredas who have worked one year and above as a formal HEP in purposive sampling technique. Data gathering tools were questionnaire on self-administer question, interview and focus group discussions (FGD) with heads and vice heads of Woreda Health Offices such as supervisors and Health Extension Professionals. The data analysis lead to the following major finding; (1) according to the data optioned the educational background of HEPs and Woreda health office experts and supervisors, no respondents of HEP having Degree and all the sub-city or Woreda HEPs supervisors were Degree holders , (2) the perception of the community towards HEPs in Yeka Sub-City is low and even they do not consider Health Extension Workers as professionals who have qualifications and experience and have seen low community understanding , (3)The jobs satisfaction of HEPs ,since there is no incentive like up grading , refresher course and per-diem for daily activity , It difficult to say all respondents satisfied , above half of respondents were not satisfied, (4) mainly lack of practical exposure during trainng session means it is fully over run by thoertical assumptions , and (5) majority of respondents response shown that there is shortage or/ and luck of incentive, motivation, training and refresher training, non-monitory remuneration support. Based on the major findings, it was concluded that the health extension service poorly implemented in community awareness on HEPs role and responsibility subjects. Based on the major finding and conclusions drown, it was recommended that Yeka sub-city should conduct continuous community awareness creation program to change the preception of the community on HEP role and responsibility. Beacuse the profession is correlates it self with life of the people, in addition to upgrading to the educational level, HEPs course needs actual practical attachment within the working area rather than fully involved in the theortical assumptions. Moreover, fair and competent working environment is the driving factor for the professionals to stay on job safely Thus, Incentives or reward should be forwarded to the one who had commitement in his/her performance results.

CHAPTER ONE

1. Introduction

1.1 Background

Ethiopia is one of the countries with high mortality and morbidity of mothers and children is said to be one of the highest in Africa (Hailom et.al, 2008). As a response to these challenges, the Federal Ministry of Health (FMOH) sought a primary care strategy that could immediately be scaled up to address the major challenges in the health system, meet the health needs of the people and achieve the World Health Organization's goals as well as and the Millennium Development Goals (MDGs) within a context of limited country resources (Njimudin et.al, 2012).

The Health Extension Program (HEPr), which is a strategy for the scaling up of an institutionalized package of basic and essential promotive, preventive and limited curative health services, was introduced in 2004 as one of the primary components of the second 5-year Health Sector Development Program (HSDP) plan of the 20-year HSDP to meet these challenges (Hailey et.al, 2013). The HSDP is a comprehensive Ethiopian Government national health plan and framework, implemented in four 5-year rolling plans.

The HEPs service package of the country comprises evidence based interventions selected to address the major maternal, neonatal and child health problems as well as the major infectious and communicable diseases (FMoH, 2007) that constitute approximately 60 to 80% of the health problems in the country (Sandy et al, 2010). The Health Extension Program service is delivered at health facility and community levels. The health facility care is delivered from the most basic health facility, and is supported by health centers

through referral linkage. One of the most important elements in any health service delivery system is the Human Resource for Health (HRH). Developing capable, motivated and committed health workers is essential for overcoming these bottlenecks to achieve national and global health goals. Hence, the need to have optimum number and professional mix of human resource for the effective coverage and quality of the intended services is unquestionable (Workneh, 2011.)

In response to the health human resource needs the Ethiopian Government also designed human resource development process, the service delivery modalities, and the progress in service coverage in relation to the implementation and scale up of Health Extension Program (WHO, 2010). Like in many resource constrained countries, the government has been training and deploying different categories of volunteer community health workers (VCHWs) in the past decades. These CHWs include trained traditional birth attendants; community based reproductive health agents and community health agents. However, to accelerate the expansion of primary health care coverage and to ensure equitable access to health services, the government started deploying specially trained new cadres of community based health workers named Health Extension Worker (HEW).

HEWs are required to spend 75% of their time conducting outreach activities by going from house to house in their respective kebele, while the rest of their time they are supposed to be at the health post. All HEWs have completed high school and received additional training for one year at an undergraduate level (FMoH, 2004, FMoH, 2005).

Health Extension Workers are civil servants who received a rapid vocational training (about a year) on 16 health services packages which are under the four components of the

HSDP. The health extension workers are meant to be all females who have at least completed grade 10 and residents of the kebele in which they work. The plan is to deploy two HEWs per kebele and constructing and equipping of health posts (one Health Post per kebele) through accelerated expansion of PHC facilities. These HEWs offer key technical services such as immunization, family planning and health education to the approximately 5,000 inhabitants of each kebele in the rural setting (FMoH, 2005). Unlike to the rural setting, the government chose to use clinical professionals, named Health Extension Professionals (HEP), with three years of Nursing education in private colleges as primary outreach workers and provide them with an additional three months of training to develop to their public health skills (Zewige, 2013).

The Ethiopian government almost eight years of experience in implementing the rural health extension program was adapted for the urban setting nearly three years ago and is an explicit part of the current health sector development plan (HSDP) IV. Ethiopian's urban health extension program is an innovative government plan to ensure health equity by creating demand for essential health services through the provision of health information at a household level and access to services through referral to health facilities (Mirkuzi, 2009). The packages of interventions are in four primary areas: hygiene and environmental sanitation; family health care; prevention and control of communicable and non-communicable diseases; injury prevention, control, first aid and referral. While many interventions are similar to the rural program, some key differences from the rural setting include the prevention and control of non-communicable diseases, mental health and violence and injury prevention, as these are expected to affect the urban populations more significantly (FMoH, 2005).

1.2 Statement of the Problem

The Urban Health Extension Program (UHEP) is a direct emulation of Ethiopia's Health Extension Program, the rural version of it, except some modifications when it was launched for the urban poor in 2009. The main agents of change in UHEP are the Health Extension Professional (HEPs). The global emphasis on the provision of primary health care and community ownership of health care delivery following the Alma-Ata declaration in 1978 has gained a renewed recognition in the era of the MDGs (Lawn et.al, 2008), and that seems to guide the overall activities of UHEP. The recruitment of Ethiopia's HEPs under UHEP, however, lacks resemblance to most global practices in that, unlike Community Health Workers (CHWs,) who belong to the community, the HEWs are government salaried, mid-level health professionals often from elsewhere in the city. The process involves recruiting community members for training on the 16 packages under UHEP. Then the HEPs oversee this community interaction to eventually achieve change in the health seeking behavior of the larger community. Each HEP is required to train 5000 mostly female community members. The intention then is when each of the 5000 trainees under every HEP in turn further trains five community members, there will have been achieved a fair coverage of the community in focus so as to raise the health and sanitation awareness as well as to reduce health inequities through improved access to health care services.

Ethiopia is one of 57 countries in the world with a critical shortage of health workers (WHO, 2009). The need to have health personnel, who take care of peoples' health, with different qualification ranging from specialist doctors to community health workers is an established and globally accepted fact. It was also clear that the required qualification of the

health personnel vary from time-to-time and place-to place. However, using community health workers to substitute for or assist specialists has been a controversial issue between those who say that this is loss of quality care and those who try to balance health care expansion with the available resource (FMoH, 1993). Despite the controversy, the use of community health workers is identified as one of the key strategies to address the growing health shortage of health workers particularly in low-income countries like Ethiopia (FMoH, 2004).

Zewige (2011) in his study entitled "Improving Maternal Health: MDG-5 and Ethiopia's Urban Health Extension Program indicated there is lack of fulfilling favorable working condition of the HEWs including train them adequately which may be compounded by the attitude of the community towards them and limited acceptance of the HEW in the community. In addition, the author emphasis that unlike the urban HEP, limited researches and assessments has conducted in the Urban Health Extension Program since the program is newly cascaded in the cities and towns of the program.

Likewise, the WHO report (2009) and Hailom's study (2011) depicted that despite the fact that the pilot implementation, which was conducted in five regions of rural settings since the commencement of the Health Extension Program in the country, has showed encouraging results in terms of improvement in certain health indicators and demand for the services provided by the program, it had been mentioned that the HEWs remained with deficiency in their practical skills.

Another cross-sectional study about the HEWs access to information, continuing education and reference materials showed the requirement of better planning and coordination

(Marge, 2011). There are no clear guidelines on their relationship with other health workers at the community level, or on career structures, transfers and leaves of absence. Reporting and Health Management Information Systems in general are weak; work is being done to strengthen them (WHO, 2009).Despite the fact that having such challenges, currently, nothing is known to what extent HEPs are functioning and little is known about the correlates of their roles in the program especially in cities like Addis Ababa. Besides, the referral linkage in the Primary Health Care Unit was not optimal and the country did not tap the full potential of the Health Extension Program.

However, most of the studies focused mainly on the rural HEP and the HEWs engaged. Hence, little attention was given to the role of HEP in the UHEP. Hence, this study is designed to fill in the existing research gap. There is scant knowledge and information on determinants of the roles of Health Extension Professionals in Ethiopia particularly for the Urban Health Extension Program. This study therefore, would offer a considerable insight in to what factors affect the roles of community health professional in Addis Ababa and provide strategic directions for managers of primary health care services as well as policy makers for action.

To this end the following basic research quesions were set:

1. What are training related factors affecting the role of HEPs in Addis Ababa?
2. What are supervisory- support related factors affecting the role HEPs?
3. What are logistics related factors affecting the role HEPs?

1.3 Objectives

1.3.1 General Objective

The general objective of this study was to explore affecting factors on the roles of Health Extension Professionals in the implementation of health packages in Addis Ababa City Administration.

1.3.2 Specific Objectives

1. To identify training related factors that affects the role of HEPs in AA.
2. To explore supervisory-support related factors influncing the role of HEPs
3. To analyse logistic related factors influncing the role of HEPs

1.4. Significance of the Study

It is hoped that this study would have the following significance:

- It would help policy makers and managers in the health sector be more aware of the existing determinants of Urban Health Extension Program;
- It may help practitioners like urban health extension agents and social workers get factual information about determinants of urban health program;
- It may help other interested researchers as a stepping stone to conduct more extensive researches.

1.5. Delimitation of the Study

Addis Ababa City Administration consists of 10 Sub-Cities. However, in order to make the study manageable, only one subcity was considerd in the study. Furthermore only training related factors, supervisory related factors and logistics related factors were dealt with in this study.

1.6. Limitations of the study

This study had also certain limitations. First, it considered only one sub-city out of the 10 sub-cities in Addis Ababa. Hence, it might not adequately represent the situations of health extension in Addis Ababa. However, the focus on one sub-city at least indicates a clear picture of the implementation of health extension program in that particular sub-city and this could be seen as a significant contribution to research in the areas of health extension..

1.7. Definitions of key terms

Health Extension Packages: The Health Extension Package refers to a strategy for the scaling up of an institutionalized package of basic and essential promotive, preventive and curative health services

Health Extension Professionals : are the first point of contact of the community with the health system, delivering integrated preventive, promotive and curative health services, with a special focus on maternal and child health in Urban area at kebele i.e. household, schools and youth centers levels with focus on sustained preventive and promotive health actions.

Health Extension Worker: are the first point of contact of the community with the health system, delivering integrated preventive, promotive and curative health services, with a special focus on maternal and child health in rural setting agrarian population, also the HEWs are required to recruit voluntary community health workers (vCHW) who have had experience in community-based health services, to help implement the HEPr

Model Mathers : the mothers who are living in their respective village and who are volunteers to support health extension program during the implementation of HEPr activity and also be role model for the community.

1.8. Organization of the Study

The study is organized into five chapters. The first chapter deals with introduction, statement of the problem, objectives, significance, delimitation and organization of the study. The second chapter presents review of the related literature whereas the third chapter deals with the research design and methodology. The fourth chapter is concerned with the presentation, analysis and interpretation of data. The fifth chapter presents the summary of the major findings, the conclusions drawn and the recommendations made.

CHAPTER TWO

Review of the Related Literature

UHEP has attempted to align its goals and practices with MDGs and global health initiatives that put a considerable emphasis on access to basic health care and community ownership of health initiatives. It has promoted access and decentralization of health care delivery systems. In the meantime, the health needs of communities extend wider than just access problems. In fact, although quality is always a question, access to basic health care services and communities' willingness to use these services do not seem to be much of a problem that need interventions as big as UHEP, which is the major national urban health program.

The situation entails the need to identify other priority areas for more robust intervention in the role of HEPs in Addis Ababa. This brings us to the issue of social determinants of the roles of HEPs. The basic knowledge is that the process of selection of HEPs; their education and trainings; key roles, competencies, and qualities; issues of health areas focus; supervision, refresher courses, supplies and logistics of HEPs; perception of the community towards HEPs; and career structure are identified as determinants of the roles of CHPs both globally and in Ethiopia in different literatures.

2.1 The Concept of Health Extension Professionals

HEPs are the first point of contact of the community with the health system, delivering integrated preventive, promotive and curative health services, with a special focus on maternal and child health. The aim is to ensure continuity of care throughout the lifecycle (adolescence, pregnancy, childbirth, postnatal period, and adult hood) and also between places of care giving services, and clinical-care settings having wide implications for the achievement of MDGs in Ethiopia.

2.2 Perception of the Community towards HEPs

More than anything else, UHEP is once more an urban campaign meant to change the health seeking behavior of the urban poor community member. To this end, the Program has deployed HEPs who reach out households and communities. Meeting the behavior change objectives is envisaged to be realized through frequent and effective interactions between program beneficiaries and HEPs. The HEPs are not only make house-to-house assessment of target communities, but they also facilitate meetings both with a group of model mothers already trained to reach out their neighboring dwellers and with larger community members. Gatherings sometimes take a more informal scene with traditional coffee ceremony creating a friendly atmosphere (Smith, 2013).

A research conducted in 2013 in Addis Ababa Arada sub-city confirmed that the model mothers' commitment to cooperating with the HEWs for better achievement of the Health Extension Program can sometimes be easily compromised by whether they get some material benefit such as allowance for partaking in trainings. The selection of participants in such trainings also creates tension between the HEW and model mothers that the latter's interest in UHEP interventions at times fail to prevail above their immediate needs. This often leads to a sense of frustration and skepticism among HEPs. Besides, although the mothers seem to have respected the interactive and informative approach of the HEPs, it may not necessarily mean that they have fully understood the professional side of these Nurses. The HEP interviewee, as highlighted elsewhere, lamented that the community associated more professional status with Nurses working in health center as opposed to HEPs working in neighborhoods. This somehow captures the frustration of HEPs with communities' poor understanding that may lead to restricted success in the behavior change trail (Zewige, et al, 2013).

Perhaps the preference of Health Extension Professionals versus community members with mid-level education did not seem to help the situation in Addis Ababa. Unlike the rural Health Extension Program, UHEP has preferred the recruitment of government salaried mid-level health professionals to community health workers who are members of the community they serve. The government may be justified for hiring salaried HEPs because the urban poor will find it difficult to pay these service renderers to make them much more answerable to the community. However, one would wonder if recruiting community members with some high school education after basic health training would have elicited better interaction, mutual trust and acceptance. Perhaps, as much as it has emulated the rural Health Extension Program packages, UHEP may need to look into the experiences of community recruited HEWs in the rural setting, and how much the rural HEWs and their belonging to the community, although paid by the government, has added to the overall success.

2.3 Program Relevance to Beneficiaries

The information provision and the household level interactions between Health Extension Programs and families appear to have highly impressed the model mother respondents in Addis Ababa. However, the Health Extension Program predominantly involves raising awareness followed by little or no mode of intervention in response to the individual and social conditions of households. This has sometimes strained interactions and drained interest among community members (Zewige, 2013). The lack of interest exhibited during the coffee ceremony session teachings was perhaps indicative of how the model mothers were not desperate for awareness in the absence of practical assistance for their

impoverished situation. Many studies imply that the community perceived health not just as a change in health seeking behavior, but also mainly as change in troubled livelihood in Addis Ababa (Ibid).

2.4. The Selection of HEPs

The selection and training of HEP education level and previous experience significantly is affecting their roles and functions. The selection and utilization of CHWs from the very communities in which they lived was found to have increased access to and coverage of the various health extension programs, as the CHWs are available most of the time in their service areas whenever they were required (Patrick, et al, 2009). This revelation is synonymous with the findings of Ruebush et al (2011) and Lewin et al (2009), where CHWs had great impact on increasing the uptake of health services and other outcomes due to the fact that they were from the very areas they were servicing.

Most studies found that previous experience and some level of formal education were often emphasized as part of the important criteria for selection of CHWs. The reasoning was that past experience of CHWs in similar or quite related interventions could enable them to implement the interventions with confidence while minimizing obvious mistakes that they would have committed during their previous practices, hence affirming the notion that the more practice and experience CHWs encounter the more effective they can become (Lehmann and Sanders, 2007).

There are also some broad trends; CHWs can be men or women, young or old, literate or illiterate. More important is an acknowledgement that the definition of CHWs must respond

to local societal and cultural norms and customs to ensure community acceptance and ownership. For CHWs to be able to make an effective contribution, they must be at least carefully selected (Asedu, 2006).

As it was mentioned in literatures, a minimum level of elementary education is needed in most countries. Some also recruit illiterates like in Colombia and Khavar project in India. Some evidences suggested that the involvement of local health staff and full community participation in the candidates' selection decreased the dropout rate (Lewin et al, 2010).

2.5. HEPs Education and Trainings

Despite the gains in physical access to HEP services, the utilization of some services is very low, which could be due to challenges in both supply (poor service quality &service availability) and demand (awareness & cultural barriers) side (Teferra, et al, 212 and Hailay and Awash, 2013). Although many aspects of primary healthcare are normally provided by low-level professionals or lay persons with training, it is the quality of training that determines the quality of service and performance of the program (Armstrong, eat al,2004 and Kitaw et al, 2007).

Most studies also showed that for CHWs to be effective, they need to be properly trained in whatever intervention they are to implement. Although the training approaches and duration varied across the different interventions, there was strong emphasis on training in all the interventions, with training duration ranging from 2 weeks to 15 months. In most studies training was conducted in the communities where CHWs were supposed to

implement their interventions, whereas in others a mixture of both clinic and community based training was adopted. These findings concur with other findings where it was argued that initial and continuous training was even more important at influencing CHWs performance than who was to be selected as a CHW (Ashwell and Freeman, 2012). It is further argued that training CHWs within the very communities they are serving would strengthen their performance as this would enable them to acquire firsthand experience and be in position to avert the expected challenges (Ande et al, 2004).

The multitasking by providing 16 service packages by HEWs could affect the availability of services, resulting in inefficiencies of some of the program components (Hailay and Awash, 2013). Despite the physical access to health posts, the number of people per HEW (about 2,500 people), which is higher than the widely recommended number of people per community health worker (Singh, 2011 and McCord et al, 2013), could also affect service availability and utilization (Dussault, 2006).

2.6. Sample Size the HEPs Serve

The population size and range of services HEPs can efficiently cover are also some of the factors that can influence HEPs' performance. Findings of studies revealed that these two interrelated factors differed across the interventions, but what seemed to be evidently common was that population coverage seemed to depend on the kind of services being offered either preventive or curative. For curative and technical services such as management of malaria in children, injection provision for DMPA and essential newborn care, HEPs were allocated relatively smaller and manageable populations or individuals to follow up. These findings tend to conform to the literature which indicated that for CHWs

to be effective, they should cover a certain optimal population size with an optimal range of services in order to avoid work overload and fatigue (Prasad and Muraleedharan, 2007). In the Ethiopia case one HEP is responsible to address the health needs of 5000 people using the HEP however there is no any study which assessed whether these size of population would affect the quality of their intervention or not.

2.7. Incentives

Sources of HEPs motivation were identified at the individual, family, community, and organizational levels. At the individual level, HEPs are predisposed to volunteer work and apply knowledge gained to their own problems and those of their families and communities. Families and communities supplement other sources of motivation by providing moral, financial, and material support, including service fees, supplies, and money for transportation, and help with their work and HEP tasks. Resistance to HEP work exhibited by families and community members is limited. The organizational level (Government and its development partners) provides motivation in the form of stipends, potential employment, materials, training, and supervision, but inadequate remuneration and supplies discourage HEPs. Supervision can also be dis-incentivizing if perceived as a sign of poor performance (Jesse, et al, 2013).

Even if some studies were not explicit on the kind of incentive packages they offered to HEPs, those who did explicitly stated that they paid a monthly salary, in most cases that was slightly higher than the minimum wage of the particular country where the study took place. However, others provided non-monetary remuneration such as back bags, gumboots, umbrellas & t-shirts among others (Jane et al, 2013). These findings also concur with the

findings of Bhattacharyya et al (2011), where it was argued that there was no single package of incentives that can ensure that CHPs remain motivated and working for long but rather a mixture of them, which can enhance enthusiasm and hence their effectiveness.

2.8. Salary and Per-diem

Compensating HEPs has a number of important benefits for both the healthcare program and the communities it serves. First, payment for meaningful work provides a needed income for those in resource-limited settings. Second, compensating HEPs can strengthen their role as an essential member of the clinical team, thereby creating a stronger "bridge" between the community to the clinic or hospital-based setting. Third, payment particularly when it is a fair wage and paid on time can serve as a source of motivation for HEPs in performing their work reliably and effectively. Fourth, payment can also increase the amount of time HEPs are available on a weekly basis, can prevent turnover, and can promote program consistency. Finally, investments in CHWs can potentially increase uptake in medical services, promoting adherence to HIV and TB medication and resulting in long-term improved health outcomes in the community (Vian et al, 2011).

2.9. Work Load-Issues and Activities

The Health Extension Programs package includes 16 essential health services under 4 major program areas of care: (1) family health, (2) disease prevention and control, (3) hygiene and environmental sanitation and (4) health education and communication. The specific activities of HEPs include educating households on health and environment benefits of the various interventions, as well as demonstration, supervision and even

assisting households in construction of necessary infrastructures such as latrines, garbage disposal pits and improved cooking stoves which augments the work load of them (Hailay and Awash, 2013). In Ethiopia the effectiveness of CHWs has sometimes been questioned and they have often suffered from pressure from 'Vertical' health program, each of which expects the workers to focus on activities relevant to their particular program. Numerous programs have failed in the past because of unrealistic expectations, poor planning and an underestimation of the effort and input required to make them work (WHO, 2011).

2.10. Supportive Supervision

Better outcomes were observed when HEPs were offered sustained and supportive supervision within the structure and functions of the health team. When it occurs continuously, this type of supervision becomes a routine part of a health worker's job. Such supervision can have a motivating effect on health workers and is an opportune time to provide follow-up training, improve performance and solve other systemic problems. It is also important to underline that certain tasks can be safely delegated only if supervision is provided on a constant basis (Francesca et al, 2010 and Karabi et al, 2011). In the study conducted in South Africa it was observed that supportive supervision requires motivation on the part of supervisors and staff to adopt new behavior, locally appropriate tools and the investment of time and resources (Uta et al, 2012). In Brazil, for example, 30 CHW are under the supervision of one nurse and, in the family health teams, four to six are supervised by a Nurse. Also of importance were the commitment of the top management and the integration of the program into existing human resource management systems (Francesca et al, 2010).

Moreover, a study from Mali in the role of community health workers found out that 38% of CHWs did not receive any supervision during the last six-months of the study. Although it is widely accepted that the supervision of CHWs need to be undertaken by both the community and professional health workers, this is often not the case in most developing countries including Ethiopia (Freddy, et al, 2009). Barriers such as social distance between health personnel, CHWs and communities due to poor understanding of community participation have been highlighted (Loevinsohn, et al, 2008). Studies have shown that when supervision of the village-level health services was vigorous and extra resources were directed to primary health care, child mortality drastically improved (Hill, 2010). Community health interventions require a minimum of supervision to CHWs that will contribute to the quality of basic care provided at district and local levels (Freddy, et al, 2009).

Systematic supervision is also a necessary part of a successful CHW program. It is imperative that CHWs have clear expectations, and are regularly supported and mentored as they fulfill the goals of the CHW program. Integral to structured supervision are clear job descriptions, consistent feedback meetings, and ongoing training and education. Supervisors should be able to perform all the tasks a CHW is expected to perform and be familiar with reporting and recording as a core component of their managerial skills. Supervisor training should also emphasize coordination between CHW programs, clinical programs, and health facilities through coordination meetings and integrated work plans (Prasad BM and VR Muraleedharan, 2007)

An assessment by the Center for National Health Development in Ethiopia of May 2006 had found that good guidelines for team supervision exist and that a lot of attention was given to the supervision of HEWs at all levels. The study, which was conducted about the influences of CHWs in Ethiopia, identified that the most common barriers to CHWs productivity are lack of supplies, lack of supervisory support, skill limitations and low levels of community trust (Hailay and Awash ,2013). The Ethiopian government also with the intention of quality improvement and job satisfaction trained and deployed HEW Supervisors, who are trained and equipped with the necessary logistics. These supervisors are mostly from Woreda Health Offices and sometimes also from the health centers where they are based (Dolea, et al, 2010).

2.11. Logistics and Supplies

Infrastructural support, in particular the reliable provision of transport, drug supplies and equipment is another weak link in CHW effectiveness. While some projects, such as the Somali one, recognized the dependence of the project's success on reliable transport early on and attended to it with the setting up and maintenance of a fleet of vehicles, other projects struggled to maintain regular transport, thus interrupting drug supplies, and in scattered areas the mobility of CHWs (Lehmann, 2011).

In many of the developing countries particularly supplies and logistics are widely acknowledged in the studies as vital determinants for sustainable quality service provision by CHWs. Despite this fact, it was known that large-scale CHW programs have often neglected these areas, mainly, because they had overlooked their cost in the planning stage (Kadzandira, 2007).

2.12. Job Satisfaction

Job satisfaction is an important determinant of health workers motivation, retention and performance (Blaauw et al., 2013). Studies have established the relationship between employee job satisfaction and performance (Lam. & Baum, 2001; Gardner & Pierce, 1998). It is has been found that a satisfied worker has increased productivity, better physical and mental health and is loyal to his/her organization (Fischer & Sousa-Poza, 2007). (Atkins et al. 1996) found that dissatisfied hospital workers impact negatively on quality of care, patient loyalty and hospital profitability. There is notable problem of their high attrition rates as a result of low job satisfaction stemming from inadequate pay, family reasons, and weak community support system (Chevalier et al. 1993).

2.13. Conceptual Framework

The literatures undertaken on the community health workers reviewed above identified a couple of determinants of health workers with community health programs implementation which include; the reluctant of some community health workers to reside in their operational zones, weak supervision of the community health programs and works of community health workers, inadequate logistics and equipment, increasing workload and gradual shift in focus on promotive and preventive to curative care, high attrition rate and desire of community health workers to further their educational career in other disciplines. Based on the literature reviewed, conceptual framework will guide the analysis of determinants of the roles of health extension professionals is adapted (fig.1). All the correlates indicated in the conceptual frame work will be considered in the analysis whether in the bi-variety and multivariate. The roles of HEP in its dichotomies form will be considered as dependent variable and the determinants indicated in figure 1 were considered as explanatory variables in this study.

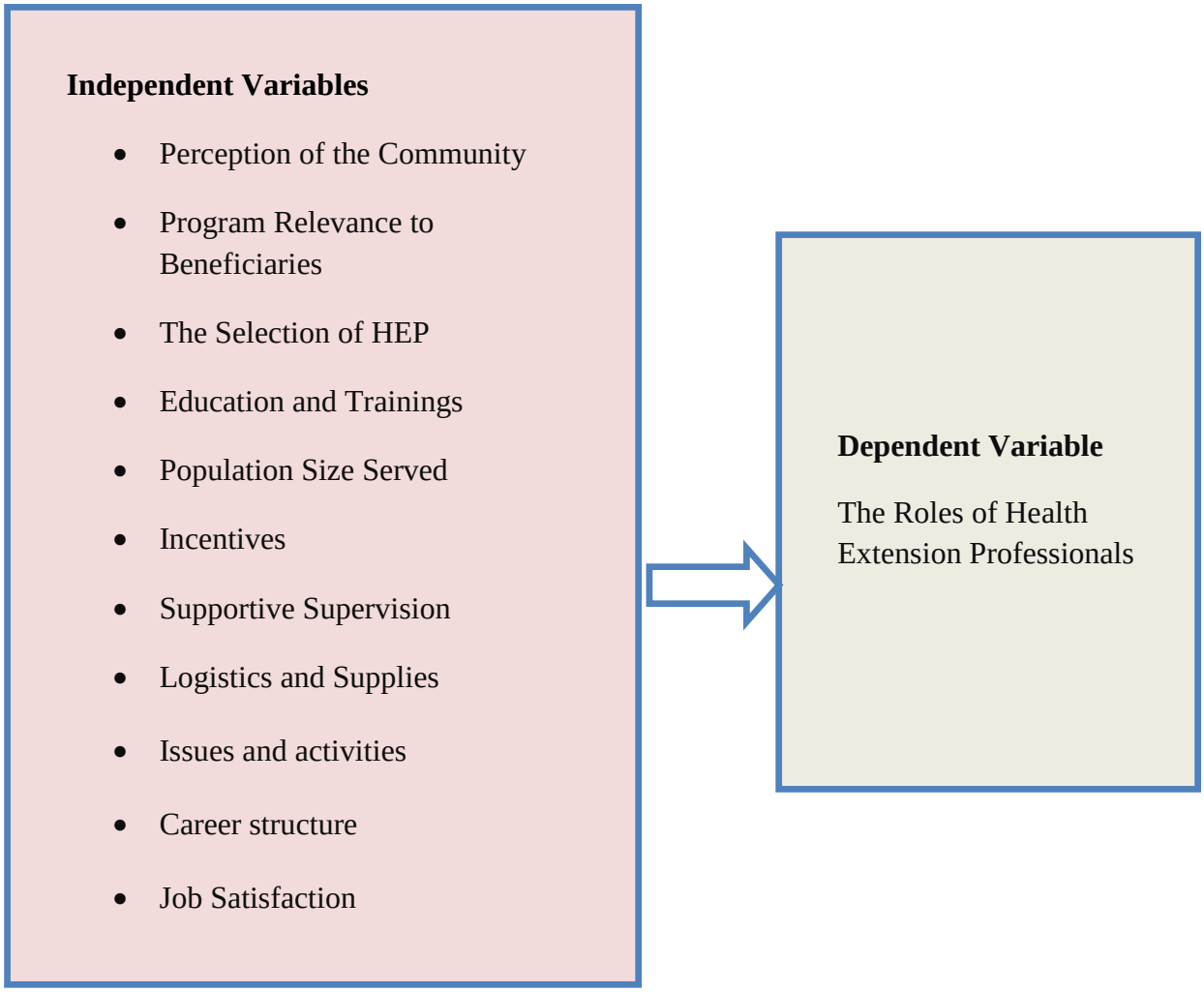

Figure.1. Conceptual Framework

CHAPTER THREE

Research Design and Methodology

3.1. Design of the study

The purpose of this study was to assess factors affecting the role of health extension professionals in the implementation of health packages at Yeka sub-city in Addis Ababa. Therefore, the convenient research design is descriptive survey design. Accordingly, Best and Khan (1984: 24) explained the nature of descriptive survey as, it describes, analyzes and interpreters conditions that exist. Thus, it is therefore instrumental for this study to describe factors affecting the role of HEP in Addis Ababa with special reference to Yeka sub-city.

In light of this, Cohen and Manion (1994) suggest that a survey approach is a small or large scale, always uses necessary data collection instrument such as questionnaire. This study therefore used this data collecting tools together with self-administered questionnaire, interview and focus group discussions (FGD) to obtain the necessary data.

Thus, this research gives a clear description of the factors that affect the roles of HEP in the implementations of the Health packages at Yeka sub-city.

3.2. Description of the Study Area

Yeka subcity is one of the highly populated sub-city in Addis Abeba. According to Addis Abeba City Adiminstration, in the sub-city 403, 098 people are residing in differnt location. Out of this 52% of them are female & 48% of the peopel are male.

In the beginnig of the project their were about 183 Health Extension Workers (HEWs) and 26 supervisers. Currently there are 163 HEP & 19 supervisers.

3.3. Sources of Data

In this study, both primary and secondary sources of data were used. The primary sources of data obtained from heads and vice heads of Woreda Health Offices and Health Extension Professionals. The secondary sources of data were collected from relevant policy documents, reports of Woreda Health Offices and minutes of the HEP of Addis Ababa City Administration.

3.4. Sample Size and Sampling Techniques

From the entire ten sub-cities of Addis Ababa, Yeka sub-city was selected by using simple random sampling technique. Out of 13 health centers, 7 (50%) were selected by using simple random sampling technique. In addition, 2 Yeka sub-city head vice persons, 14 supervisors and 28 health extension workers were selected by using purposive sampling technique.

Table 1: Population and sample size of the study

No	Targets of Sampling	Population Size	Sample Size	Percentage	Sampling techniques
1	Sub-cities in Addis Ababa	10	1	10%	Simple random
2	Health Centers in Yeka Sub-city / attend all HC	13	7	50%	Simple random sampling
3	Yeka sub-city Health Center Head Vice	2	2	100%	Purposive sampling
4	Woreda Health Center supervisors	28	14	50%	Proportionally identified from Health Centers.
5	Health Extension Professionals with one and above one year of work experience /from each Health Center 2 HEPs /	156	28	17.94	Purposive sampling

3.5. Data Collection Instruments

3.5.1. Questionnaires

A structured questionnaire was prepared in English language and then translated in to Amharic this is to avoid the language barriers while collecting the data from the respondents for the quantitative part. The questionnaire consisted of only close-ended question items and two parts. The first part dealt with background characteristics of the respondents whereas the second part consists of 11 sections. The question items were structured in line with the basic questions set in the research study.

3.5.2. FGDs Guide

Public health education personals that have an experience in dealing with health education for adults moderated the FGD assisted by other two personals that were assigned with the capacity of taking notes. For conducting the FGD, five questions were prepared and it was conducted by using Amharic language for convenience. FGDs were conducted before undertaking the quantitative data collection, so that relevant adjustment was made on the approaches that applied during the quantitative data collection.

3.5.3. Semi-Structured Interview

The researcher employed a semi-structured interview to generate in-depth information from health officials from the Yeka sub-city included in the study as well as from higher health officials at Yeka sub-city level. Eight questions were prepared first in English and then translated into Amharic. The interview was conducted by using Amharic language for convenience. To sum up, the use of various data collection tools were useful for the purpose of triangulation and it increases the validity of the study.

3.6. Ethical Considerations and Clearance

The manner in which the questions were asked that is by whom, when, where and how well the interview were conducted determines the quality of the data and the safety of the respondents. Because the issue of performance of employees and functionality of their responsibility is sensitive to track the fact, considering this, efforts were made to follow the WHO guidelines regarding ethical considerations on this issue as follows:

Prior to initiating the interview, all eligible Health Extension Professionals and the community were explained regarding the purpose of the interview at large and the need to ensure confidentiality. An informed verbal consent also needs to be obtained during the orientation. Respondents were also informed that they have unalienable right to discontinue or refuse to participate and to ask questions.

Finally, individual self-administered question planned to be conducted using anonymous questionnaire form. Trained Health Extension Professionals fill self administer questioner to increase the openness of the respondents and to handle guilt and other reactions that might follow.

The Adult and Lifelong Learning Unit of Addis Ababa University also approved the data capturing tools and the study. Besides this, the Yeka sub-city Health office and respective Office authorities were informed at all levels and need to give written permission to conduct the research.

3.7. Methods of Data Analysis

This study was conducted by employing both qualitative and quantitative data analysis methods. To assert this, Flick (2002) suggested that quantitative and qualitative methods should be viewed as instrumental rather than as rival camps. Furthermore, Creswell, et.al (2003) argues that combining both quantitative and qualitative methods in educational and social science researches sounds good.

Therefore, based on the basic research questions and objectives, statistical tools such as percentile, mean and standard deviation is used to interpret quantitatively the data obtained from close-ended questions of the questionnaire. Hence, quantitatively, numerical expressions were used to express the degree of implementation of the key performance indicators of HEPs at Yeka sub-city.

The data obtained from the open-ended questions, interview, and focus group discussions were also interpreted qualitatively based on the theoretical frame work of HSDP-IV (Health Sector Development Program IV) and the status of implementation of the HEP. Finally, the quantitative data triangulate with qualitative data. This means that the percentile and mean calculated response of the respondents from the questionnaire cross checked with the result of the interview and information obtained from the quarter report and focus group discussions.

3.8. Report Writing

The organization and presentation of the findings of the study in the report were strictly followed the conceptual frame work in order to systematically identify different determinants and their implications on the functions and roles of HEP. It was also clearly

depict the overall status of the functions of HEP. The results from the qualitative information provide supportive evidences to the findings of the quantitative part of the study. Concepts, definitions and results from the literature review also use to put the findings of the study in to perspective.

3.9 Hypothesis

The hypotheses that were tested during analysis of this study include:

1) Job satisfaction increases the capacity of the HEP ability in discharging their responsibilities as a Health Extension Professional.
2) Logistics and supplies particularly the reliable provision of transport, drug supplies and equipment is among the correlate of the roles of HEP.
3) The HEPs to be effective, they should cover population size which is less than 5000 people to avoid work overload and fatigue.
4) In service refresher trainings significantly affect the roles of HEP in Addis Ababa HEP context.

CHAPTER FOUR

Presentation, Analysis and Interpretation of Data

The objective of this research was to assess factors affecting the role of health extension professionals in the implementation of health packages in Yeka Sub-city In chapter three, the research methodology of this research, sample size, sampling techniques, the data gathering instruments, sources of data, methods of data analysis and ethical considerations were presented and explored in brief. Using the designed research methodology of the research, descriptive survey approach was used in this research. Thus, the crude data obtained from the respondents Health Extension Professionals and the FGDs held with Woreda Health Center Head Officers and Vice Head that tape recorded, were analyzed and interpreted by employing both qualitative and quantitative data analyzing methods. Based on this, this chapter mainly focused on analysis, interpretation and discussion part, on factors affecting the role of Health Extension Professionals in Addis Ababa particularly at Yeka Sub-City in implementation of health packages.

The analysis was made in terms of the basic research questions raised in the beginning chapter of the study and the objectives of the study. Then, the results were presented and discussed from the data collected from the questionnaire that contained the following factors and the 9 month report of health extension program of the base year.

Personal characteristics background and effort of each Health Extension Professional's factors: this includes variables such as sex, age, work experience, educational background, religion, marital status, and their Health problems if they are handicapped, salary, per-diem, benefits or incentives, motivation and how benefits or incentives are taken place.

Supplies and logistics factors: these includes Health Center /Health Post drug supplied consistently, medical equipment, registration book, availability of vehicle for HEP, transportation allowance, effective communication, getting enough stationeries and distance from Home to Health Center.

Perceptions of the community factor it includes monitoring of activities by committee, involvement of the committee, the perception and values of the community towards HEP.

Satisfaction and future aspiration factors: these factors include variables such as working independently staying in the profession, satisfied on the present carrier, and decision to leave or stay in their profession.

Adequacy of training and supportive Supervision: this includes taking adequate training, supervision, comments whether in written or oral based on the frequency of supervision.

Program relevance to beneficiaries factor: This factor includes the communities interest and perception towards HEP.

Generally, the basic variables are thirty-four and each variable is thought to effect the HEPs implementations of health packages. Some of these variables are discrete, and others are continuous. The variables are included in the study are presented below.

4.1. Background characteristics of respondents

Under this section the respondents' age, sex, marital status, religion and educational background analyzed.

Table 4.1. Respondent's background

No.	Item		Respondents			
			HEP		Sub-cities & Woreda office	
			No	%	No	%
1	Sex	Male	-			
		Female	28			
Total			28	100	16	100
2	Age	18-25	5	7.85	2	12.5
		26-34	20	71.42	8	50
		35-43	2	7.14	6	37.5
		44-50	1	3.57	-	-
Total			28		16	100
3	Religion	Orthodox	24	85.7	11	68.75
		Muslims	1	3.52	2	12.5
		Protestant	3	10.1	3	18.75
		Others	-	-	-	-
Total			28	100	16	100
4	Educational Background	9-12	1	3.52	-	-
		10/12 complete	3	10.7	-	-
		12+certificate	4	14.2	-	-
		Diploma	20	71.48	-	-
		Degree	-	-	13	81.25
		Degree & above	-	-	3	18.75
Total			28		16	100
5	Marital Status	Single	18			
		Married	10			
		Divorced	-	-	-	-
		Widowed	-	-	-	-
Total			28	100	16	100

Table 4.1. Indicates that the background characteristics of Health Extension Professionals and Yeka sub-city's Health Center Officers age, sex, religion, educational background and marital status. The importance of the background information about respondents lies in the fact that it helps the researcher judge whether the respondents have appropriate qualification and work experience in relation to the health profession or not.

Concerning the age of HEP, the majority of HEPs were 5(17.85%) of 18-25 years, 20 (71.42%) of 26-34 years, 2(7.14%) of 35-42 years and 1(3.57%) of 44-50 years. This shows that majority of HEPs in the 7 Woredas were in early adult age group. The rest 2(7.14%) of 35-43 and 1(3.57%) of 44-50 age group are middle adult group. This implies that almost the entire HEP are in early adult age group and they are socially, economically and psychologically active.

Regarding the sex of HEPs, all of the respondents 28(100%) were female with regard to the religion of the respondents, were 24(85.7%) of Orthodox, 1(3.57%) of Muslim and 3(10.7%). From this we can conclude that the large number of HEP, were followers Orthodox Christianity.

Regarding the educational background of HEPs, 1(3.57%) of them grade 9-12, 3(10.71%) of them grade 10^{th} or 12^{th} completed, 4(14.28%) of them grade 10^{th} or 12^{th} plus certificate and 20 (71.48%) of them Diploma Holder in Nursing. This indicates that three forth of Health Extension Professionals were diploma holders this implies that most of HEPs were educated in minimum grade 9^{th}.

Concerning the marital status of the respondents, 10 (35.71%) of married and 18(64.28%) of single. Thus shows that most of HEPs were single, 6 (64.28%) . It is therefore possible to

conclude that being single may have advantage for more concentration in their day to day activities abut also they will have less sense of understanding for the community and parenting . Thus being single or married as HEP has some influencing factor.

Regarding the age of sub-cities and Woreda's health office experts and supervisors, the majority of health officers and supervisors are between the age of 18-43. This being early adult group indicates that they are more active and also they are up-to-date informed for the health sector program.

Regarding the sex of Woreda health supervisors, and office experts, the majority 12 (75%) of the respondents are male and the rest 4(25%) of them were female. This indicates that most of the supervisors and health experts are male may be due to the fact that male are more exposed in management area than female.

Concerning the religion of Woreda officers and sub-city HEPs, supervisors, most of the respondents were Orthodox Christian 11(68.75%). The rest 31% of respondents were Muslim and Protestant. This may be because of the fact that the followers of Orthodox Christian in Addis are greater than other religion.

With regard to the sub-city's HEPs, supervisors and Woreda Health Officers educational background, almost all of the respondents are Degree holders. The majority of the respondents 13(81.25%) are Degree holders and 3(18.75) of them have Degree and above.

As it described in the table above, the marital status of Yeka Woreda Health Officers and supervisors, the majority of respondents (56.25%) were married and the rest 7(43.75%) responded they were single. This indicates that the number of respondents who were married in management level were greater than that of the Health Extension Professionals.

4.2. Assessment of Supplies for HEPs

Table 4.2. Respondents views concerning the supplies for HEPs

No,.	Items		Respondents (HEPs)	
			Number	%
1	Access to Health Centerfor HEP	Highly accessible	-	-
		Accessible	2	
		Less accessible	19	67.85
		Not accessible	7	25
		Total	28	100
2	Drug consistency/ supply in the health center	Very high	-	-
		High	1	3.57
		Medium	12	42.85
		Low	15	53.57
		Total	28	100
3	Availability of medical equipment	Very high	1	3.57
		High	2	7.14
		Medium	12	42.87
		Low	13	46.42
		Total	28	100
4	Availability of Registration book or card for patients	Yes	28	100
		No	-	-
		Total	28	100
5	Availability of Communication facilities with experts or staff	Very high	3	10.72
		High	7	25
		Medium	13	46.42
		Low	5	17.85
		Total	28	100

Table: 4.2. Above table shows that the status of logistics for HEPs at Yeka sub-city. As it is indicated in the table, the accessibility and availability of logistics for HEPs at Yeka sub-city was measured by the number of respondents divided by the total sample population in the area, irrespective of health center, drug consistency medical equipment, registration book /card for patients and communication facilities with experts or staff.

Regarding the access of Health-Center in Yeka sub-city, Largest number of the respondents 19(67.78%) give their opinion as there was less access of Health Center to implement the health packages. Next to this, 7(25%) of the respondents responded that there is low access of health center in Yeka sub-city. This clearly indicates that lack of access of Health Center is one of the key performance indicators of the Health Packages that should be addressed vary well at city as well as in the targeted area of Yeka sub-city, Since out of total respondents only few 2(7.15%) of HEPs say that there is access of health center

Likewise, concerning drug consistency in sub-city level, the majority of the respondents 15(53.57%) of HEPs low drug consistency, and 12(42.85%) of them say medium their opinion. The rest 1(3.57%) of HEP responded there is high drug consistency. This implies that almost all of the respondents agree that there is low and lack of drug consistency in the Woredas that the researcher observed.

Regarding the medical equipment, the majority of the respondents give their opinion that there is low availability of medical equipment. In light of this, 13 (46.42%) of HEPs low, 12(42.87%) of them medium, 2(7.14%) HEPs high and 1(3.57%) of them were very high. This shown that, majority of the respondents agreed that there is low and medium availability of medical equipment such as injection units, dressing set and delivery kit. Therefore, the Yeka sub-city health extension program needs help or medical equipment at least the items that handy for emergency problems in the form of emergency kit from the city government as well as federal ministry of health (FMoH) to implement the health packages in the city in line with the Federal Health Sector Development Program IV (HSDP-IV).

Regarding the registration book or card for patients, all of the respondents give their opinions as 'Yes' that is 100% concerning communication facilities with experts or supervisors, the majority of respondents gave their opinion to the extent to be 'medium' that is 13 (46.42%), 7 (25%) of the respondents give their opinion on the success of communication facilities to be 'high'. A few 3 (10.72%) respondents give their opinion on the communication facilities to be 'very high' and the rest 5 (17.85%) of HEPs were say low communication facilities with experts or supervisors

The above calculated percentage composition of the respondents opinion on the assessment of logistics for HEPs in Yeka sub-city was less accessible, low and medium. Although, the respondents opinion on the access and availability of equipment and communication facilities seem to be subjective. To avoid this subjective and biases focus group discussion was held .The focus group discussion (FGD) conducted on April, 15/2014G.C for the sub-city level among 7 supervisors and Woredas health officers. The FGDs questions and the respondents' answers were tape-recorded. These FGDs and the respondent's answers reported as follows:

Focus Group Discussion Guide for supervisors and Woredas health officers **(FGD)**

How the HEPs logistics and supplies managed?

Actually according to the Health Package Program, HEPs are not involved directly on treating the patients. If the patients found at home, it is expected to refer or tell to the patients to go to health facilities for farther treatment while they are doing their home to home visit. Since HEPs are working on health package the community members expected to get immediate help. Thus, this may hinder the implementation of health packages and HEPs face loss of trust within the community.

4.3. Assessment of Logistics for HEP

Table 4.3. Respondents views regarding logistics for HEPs

No,.	Items		Respondents (HEPs)	
			Number	%
1	Level of access to office vehicles for HEPs	Very High	-	-
		High	-	-
		Medium	-	-
		Low	28	-
		Total	28	100
2	Taxi fair if transportation service is not available	Very high	-	-
		High	8	28.57
		M edium	10	35.71
		Low	10	35.71
		Total	28	100
3	Availability of stationeries recording of activity	Very high	-	-
		High	1	3.57
		Medium	10	35.71
		Low	17	60.71
		Total	28	100

Table 4.3. This table indicates that a total assessment of logistics such vehicle, taxi-fare and stationeries. Regarding access of vehicle for HEPs, all of the respondents, 28 (100%) of HEPs given their opinion as to the extent in which they do have low access for vehicle for their work. This implies that there is no transport service for HEPs yet. Instead they have been given three hundred EB for telephone and transport allowance while they are doing their daily activity. In relation to taxi-fare if service is not available, majority of the respondents responded 20 (71.50) of medium and low and the rest 8(28.57%) of high.

Concerning access of stationeries for HEPs, the majority of respondents, 17 (60.71%) says their opinion as 'low' access of stationeries such as notebook, pen, pencil, etc…, 10 (35.71) of the respondents state their opinion on the access of stationeries for HEP to be medium. Only one respondent (3.57 %) gave her opinion attain as high.

In general, the calculated percentage on the opinions of the respondents from the access of logistics seems to be subjective. As a result to minimize this doubt and biases open ended interview and FGDs was held.

4.4. Perceptions of the Community towards HEPs

Table 4.4. Respondents views about perception of the community towards HEPs

No.	Items		Respondents (HEPs)	
			Number	%
1	Did the community understand your profession as Nurse	Very high	2	7.14
		High	2	7.14
		Medium	7	25
		Low	17	60.71
		Total	28	100
2	Model mothers are provided with by some materials benefit such as allowance for part taking in training	Yes	24	85.72
		No	4	14.28
		Total	28	100
3	If your response is "yes" for Q.no. 2 above, have you ever developed a sense of frustration	Yes	15	62.5
		No	9	37.5
		Total	24	100
4	Is the community happy and accept HEPs roles	Yes	7	25
		No	21	75
		Total	28	100

5	Does the community respect and considered HEPs as Nurse like in the hospitals or clinics.	Yes	5	17.85
		No	23	82.14
		Total	28	100
6	Does the community utilizing the Health Centers / Post services	Yes always	1	3.57
		Yes, some times	9	32.14
		No	18	64.28
		Total	28	100
7	If your response is " yes "what service are preferably utilized	MCH	3	10.72
		Environ. Protection	1	3.57
		Disease Prevn. & contro.	14	50
		Health educa. & commun.	10	35.71
		Total	28	100

Table 4.4. Shows an assessment of the perception of the community towards HEPs. It is widely recognized that perception plays a great role to facilitate or hinder an individual's activity. In light of this, Morgan et.al. (1996) described perception as the way an event in the world and the world itself looks sounds, feels, tastes or smells by him/her. Thus, it seems apparent that the community's perception in HEPs has an important role in determining either positively or negatively their engagement in Health Extension Professionals (HEPs).

For items to what extent the community understand your profession as Nurse who work in clinics or hospitals?" the majority of the 17(60.71%) respondents were gave their opinion to be low, 7(25%) of the respondents responded that as medium and the rest 4(14.28%) say

that high and very high. This indicates that majority of community perception of HEPs labeled towards low and medium. This implies that it requests more efforts to do lots of campaign on the community awareness about HEPs. Since commitment of HEPs with full participation of community in health packages has crucial role to perform all activity as scheduled and to achieve best performance supporting community's perception should be in place side by side with HEPs exertion.

Concerning "Are model mothers compromise by some materials benefit such as allowance for partaking in training?" majority of the respondents, 24(85.72%) said yes and the rest 4(14.28%) of the respondents said "No". This suggests that majority of HEPs are influenced or exposed by the community's perception and less attention. This is may be due to their lack of knowledge towards health extension workers and their role in the community.

Because of the community's perception majority of the respondents save their opinion as they have developed a sense of frustration, that is 15(62.5%). The rest 9(37.5%) of HEP responded 'NO' and this is because they do not care about the community's perception and they have self-esteem and confidence on the present career.

In light of this, concerning questions, is the community happy and accept HEPs roles? The majority of HEPs said 'No', that is 21(75%). 7(25%) of the respondents gave their opinion regarding the community's perception to be 'No' they are happy and accept our role. This suggests that still large number of the respondents felt the community have negative attitude towards HEPs.

For item, “is the community respect and consider HEPs as Nurse like other hospitals or clinics Nurses ?”, large number of the respondents, 23(82.14%) said ‘No’. this indicates that community were not perceive the HEPs like other hospitals or clinics Nurse , HEPs involved to implement the sub-city health packages such as disease prevention, environmental control and health care. This implies that there is a positive correlation between the community and HEPs. This means if the community have good perception, the HEWs are liable to do the job or to implement the health packages. Other 5(17.85 %) HEPs said that “yes” that means community consider HEPs like other hospitals or clinics Nurse.

Regarding the community’s utilization of Health Center or Health Post service, majority of the 18(64.28%) respondents gave their opinion show as low. Others 9(32.14%) respondents said Yes sometimes and 1(3.57%) responded Yes always. all services are available and ready to provide but according to the HEPs ranked 14 (50 %) of respondents say the community more utilize Disease Prevention & control, other 10(35.71%) respondents preferred health education and communication, 3(10.72%) of the say utilized more Mather to childe health, 1(3.57%) respondent said environmental health and protection. This indicates that majority of the people in Yeka sub-city prefers Health Center / Health Post form private clinic or hospitals.

Generally speaking, the perception of the community towards HEPs in Yeka Sub-City is low and they do not consider Health Extension Workers as professionals who have qualifications and experience. Due to this, there is substantial gap in implementing Health Extension packages in Addis Ababa, Yeka sub-city. According to HEPs ranked the Community utilizing of the health center service mostly was in Disease Prevention & control.

4.5. Satisfaction and future aspiration

Table 4.5. Respondents views regarding their satisfaction and future aspiration

No.	Items		Respondents(HEPs)	
			Number	%
1	Are you doing your work independently?	Yes, always	10	35.71
		Yes, often	10	35.71
		Sometimes	5	17.85
		No	3	10.73
		Total	28	100
2	Are you satisfied being HEP?	Yes, always	5	17.85
		Yes, often	5	17.85
		Sometimes	12	42.88
		No	6	21.42
		Total	28	100
3	For Q. 3 above, your response is “yes sometimes” or no, why?	Lack of upgrading	-	-
		Lack of refresher course	-	-
		Lack of incentive	13	46.43
		Insufficient salary	10	35.72
		Uncomfortable working envir.	5	17.85
		Total	28	100
4	What is your future aspiration?	Stay as HEP	2	7.14
		Upgrading	12	42.87
		Move to private / NGO	10	35.71
		Stop to be employed	4	14.28
		Other	-	-
		Total	28	100
5	Aspire to upgrade to what profession?	Nurse	17	60.72
		Environment health	2	7.14
		Pharmacy technician	3	72
		PHO	6	21.42
		Other	-	-
		Total	28	100

Table 4.5. Shows HEPs perception and future aspiration towards the profession. Responses related to working independently, the 10(35.71%), respondents ranked Yes always, also 10(35.71%) respondents Yes often, 5(17.85%) of respondents ranked they do their work independently sometimes. The rest 3(10.72%) of the respondents responded didn't work independently. This result is somewhat at odds with the focus group discussion data in which the supervisors and Woreda's health officers responded "*we work together with the HEPs all the time*". Thus, the quantitative results of the HEPs questionnaires a contradictory message.

As can also been from the same table, above 12 (42.87%) of HEPs were sometimes satisfied with their work being in this profession. Next to this, 6 (21.46%) of the respondents did not satisfy being HEP and the rest 10(35.71%) of the respondents, half (17.85%) of each were satisfied always and yes, often. However, the analyses indicate that the greater 42.87% and 21.42 % of respondents found less satisfied and not satisfied respectively.

The reason that 13(46.42%) respondents were ranked as less satisfied and not satisfied due to lack of incentive. Other 10 (35.71%) respondents ranked as insufficient salary payment. And 5 (17.85%) of the respondents gave their opinion that they feel there working environment is uncomfortable. This implies that most of HEPs were not satisfied and they found there is lack of encouraging incentive, insufficient salary and uncomfortable working environment respectively.

As can be seen in Table 4.5, item 12, 42.87% of respondents indicated that they aspire to upgrade. Besides others 10(35.71%) HEPs want to move to private sector or NGOs. About

4(14.28%) of respondents suggested that they will stop to be as employer and 2 (7.14%) of respondents want to stay as Health Extension Worker.

4.6. Assessment of Training Adequacy

Table 4.6.. Respondents views concerning adequacy of training for HEPs

No	Items	Responses	Respondents (HEPs)	
			Frequency	Percentile
1	Have you trainned on HEP packages before commenced your job?	Yes	22	78.57
		No	6	21.42
		Total	28	100
2	The training was adequate for my present job?	Strongly agree	4	14.28
		Agree	17	60.71
		Partially agree	1	3.57
		Disagree	11	39.28
		Total	28	100
3	For Q number 2 if your response is disagree	Theortical Trainng	-	-
		Practical Traing	10	90.90
		Both	1	9.09
		Neither	-	-
		Total	11	100
4	Have you be taken a refresher course or on job training	Yes	23	82.14
		No	5	17.85
		Total	28	100
5	If yes, how frequent it is	Every 3 month	1	4.34
		Every 6 months	6	26.08
		Every Year	1	4.34
		Unidentified	15	65.21
		Total	23	100
6	What is your field of professional study	HEWP	11	39.28
		Public Nurse	-	-
		Nurse	3	10.72
		Clinical Nurse	10	35.71
		Lab.Technician	1	3.57
		Pharmacy	3	10.72
		Total	28	100

Table 4.6. shows HEPs Assessment of training adequacy, responses related to trainning on HEP packages before commenceced on there job most of the, 22(78.57) respondents ranked “Yes” and others 6(21.42.) Respondents says that “No” It indicates that the professsionals are attended on job trainng rather than trained them before engaging on job as profession.As can also seen from the same table above 17(60.71%)of HEPs agreed and assumed the theoretical part of training they have been attended for the profession is quite enough to run the job. On the contrary 11(39.28%) of respondents disagreed and blames the trainng as inadequacly to fully be inculcated in the job as professional. From 11 respondents who were disagreed on the adequacy of the training. 10 respondents say forwarded reason mainly lack of practical exposure during trainng session means it is fully over run by thoertical assumpions. Only one respondent say that not only missing practical session but also theoretical part by itself was not adequate.

As can be seen in the above table item refresher course or on job training, 23(82.14%) of respondents indicated that they were taken refresher course or on job training. And few 5 (17.85) respondents go aginst to the precense of refresher course or on job trainng. Regarding the frequency of the refresher course or on job trainng, eventhough the training time is not scheduled according to 15(65.21%) respondents pointed out. But some of 6(26.08) respondents say that refresher course or on job trainng was given every 6 month However, 2 respondents say that on job training was scheduled every 3 months and every year.

As one can seen in the above table the respondents for the last item about HEPs What is there field of study , most of the 11(39.28) and 10(35.71%) respondents fall between Health Extension Profession and also clinical Nurse respectively. Very few 6(21.44) respondents

are fall between Pharmacy and Nurse. And 1(3.57%) of the respondents confirms her study of profession as labratory techinician.

4.7. Issues of supportive supervision

Table 4.7. Respondents views about the provision of supervisory support

No	Items	Rating scales	Respondents (HEPs)	
			Frequency	Percentile
1	How often are supervised?	Always	7	25
		Often	10	35.71
		Some times	9	32.14
		Seldom	2	7.14
		Total	28	100
2	To what extent are you supervised in your professional endevour?	Every day	-	-
		Every month	22	78.57
		Every 6 month	4	14.28
		Every year	2	7.14
		Total	28	100
3	Who is your immediate superviser?	Head of Health Center	2	7.14
		Woreda HO/ supervisor	26	92.85
		Total	28	100
4	Do you have work plans	Yes	24	85.71
		No	4	14.28
		Total	28	100
5	Do you have access to failed printed materials?	Yes		0
		No	28	100%
		Other		0
		Total	28	100
6	Do you report activites accomplished in respective your work plan?	Yes	16	57.14
		No	12	42.85
		Total	28	100

Table 4.7.shows HEPs Assessmen of suppotive supervision. Supervsion is a means of creating a stage for knowledge , experience sharing , opportunity to proved technical support and ways of collecting feed back. Thus, responses related to the frequency of supervsion by supervisor to HEPs fall on often by 10 (35.71%) respondents , and others 9 (32.14%) say supervision done some times, few 7(25%) respondents gave there respond as always. The rest 2(7.14) say supervision was done seldom.

professsionals are give on job trainng rather than trained them before. This result is somewhat at odds with the focus group discussion data in which the supervisors and woreda's health officers responded " we work together with the HEPs all the time". Thus, the quantitative results of the HEPs questionnaires a contradictory message.

As can also been from the table, above 22 (78.57%) of HEPs forwards supervision was given every month and 4(14.28%) of the respondents get supportive supervision in every six month . In every month were assumes the trainng they got for the profession is quite enough to run the job. Some other 2(7.14) says that every year.

Supervision ususally preferd to be given by the one who is near to the profesionals beacuse it may be simple to give technical support and feedback . In the same ways most of HEP confirms that the supervision was given by Woreda Health Officers /Supervisors/shown by 26 (92.85%) respondents. Some other 2 (7.14) respondents say supervision was given by head of the Health Center (7.14%). Supervision should be followed by disscussion over the strong and weak points of the activity done based on planed of operation .As can be seen in Table 4.6, item 4, 24 (85.87%) of respondents indicated that there is work plan others 4 (14.28) of them say don't have any work plan or planning habits.

Item no.5 almost all of the respondents 28 (100 %) didn't have any access to printed recording formats to accomplishments in line with HMIS formats.

Report writting is the mandates part for HPEs in the professional works what they are accomplished daily cumulative recorded in monthly base . for some of the HEPs' this is a fact forwarded by 57.14%. on the contrary 42,85% of the responsents ahd no any planning habits shown by 42.85% of the respondents.

4.8. Issues related to per-diem and salary of HEPs

Table 4.8.Respondents' views concerning the salary and per-diem of HEPs

No	Items		Respondents(HEPs)	
			Frequency	Percentile
1	Do you think your salary is fair wage for your work	Yes	3	10.72
		No	25	89.28
		Total	28	100
2	Are you receving your salary/ any payment on time?	Yes	20	71.43
		No	8	28.51
		Total	28	100
3	Do you have any form of per-diem	Yes	-	-
		No	28	100
		Total	28	100
4	Are you satsified with it if there is per-diem	Yes	12	42.87
		don't know	8	28.57
		No	8	28.57
		Total	28	100
5	Have you ever been promoted based upon the results of your performance evaluation?	Yes	5	17.85
		No	23	82.14
			28	100

Table 4.8.shows concerning about salary and per-diem of HEPs. Money is one of the motivational factor for HEPs job performance . Fair and competent salary is one most important factor for the professionals to stay on job . Accordingly 25 (89.28%) HEPs' of the respondents were go against the payments or the the salary given by their office and they were not believe that the payment not fair . Other 3 (10.72%) respondents say salary that given for HEPs was fair. Regarding to the payment time for HEPs 20 (71.43) of them say that it was paid on time where as other 8 (28.51) of them disagree about the timely payment. About per-diem which should include during working hours no one HEPs agreed the availability of per-diem, so all 28 (100%) respondents respond there was no per-diem.

As can also been from the same table, above 12 (42.87%) respondents gave their opinion agreed if there is per-diem . And equal number of the respondents are either escapist or I don't have any interst towrds per-diem shown . 16 (57.14 %) say half of them don't know any idea about the per-diem payment and the other half disagreed about the per-diem.

Salary increment or promotion based on evaluation makes professionals to dedicate themselves on the work they are engaged on. However for most of the respondents in the study area there is no any uprising or up lifting following their performance evaluation shown by 23(82.14%) of the respondents. Others 5(17.85%) disagree that was based on work performance.

The extrinsic elements of motivation encapsulate all economic benefits made available to compensate staff for their services, effort and/or achievements. Some of these elements according to Khan et al. (2010), include salary, promotion, retirement and other workingreward benefitsKhan et al. (2010), who analyzed the role reward plays in

motivating employees of commercial banks of Kohat, Pakistan.The second type of measure of performance involves ratings of individuals by some one other than the person whose performance is being considered. The third type of performance measures is self-appraisal and self-ratings. As aresult, the adoption of self-appraisal and self-rating techniques are useful in encouraging employees to take an active role in setting his or her own goals. Thus, job performance measures the level of achievement of business and social objectives and responsibilities from the perspective of the judging party (Hersey and Blanchard, 1993).

4.9. Availability of Incentives for HEPs

Table 4.9.Respondents views concerning availability of incentives

No	Items	Resonses	Respondents (HEP)	
			Frequency	Percentile
1	Any sort of benefits or incentives	Yes	7	25
		No	21	75
		Total	28	100
2	Motivations from family, community or health offcers	Yes	9	32.14
		No	19	67.85
		Total	28	100
3	Capacity development supports such as training or refresher courses	Yes	5	17.85
		No	23	82.14
		Total	28	100
4	Availability of non-monitory remuneration such as back bags gumboots,t-shirts ...	Yes	2	7.14
		No	26	92.85
		Total	28	100
5	If yes how often have you been receving incentives	Quarterly	-	-
		Bi-annually	1	3.57
		Annualy	27	97.43
		Total	28	100

Table 4.9.shows incentive and related facts of HEPs. Most 21 (75%) respondents for item in the above table forwarded that there is no any incentive or benefits given by their office and some of the 7(25%) respondents professionals say yes they have been got some benefit or incentive.

It had encouraging impact for recordable performances. However for the study area professionals 19(67.75%) of the respondents didn't get any verbal recogntion or motivation from community health officers and family. 9(32.14 %) respondents have got motivation from the community, HO and family. About capacity development supports like training/refresher course 23(82.14%) of the respondents didn't attended such kind support from the office. Very few 5(17.14%) respondents deduced they have got support.

Availability of non-monitory remuneration had its own impact for professoinals, Verbal motivation form family or friends can make them to feel recognized. Accordingly the finding 26(26 %) of respondents said that there is no support beside to that, only 2 (7.14 %) respondents say yes. All respondents except one say if there is some item to prove it may be given annually. In general word majority of respondents response shown that there is shortage or and luck of incentive, motivation, training and refresher training, non-monitory remuneration.

Huczynski and Buchanan (2007) argued that Motivation is a combination of goals towards which human behaviour is directed; the process through which those goals are pursued and achieved and the social factors involved. Luthans (1992) says , Motivation is a combination of needs, drives and incentives. Motivation is defined as the process that starts with physiological or psychological deficiency or need that activates behaviour or a drive that is aimed at a goal or incentive.

Mullins (1999) says, The underlying concept of motivation is some driving force within individuals by which they attempt to achieve some goal in order to fulfil some need or expectation .

Mullins also distinguishes between extrinsic motivation related to tangible rewards such asmoney; and intrinsic motivation related to psychological rewards such as the sense of challenge and achievement .

Some offices try to trap their professionals to stay on job by making more per-diems and less salary. However in the study area of HEPs' there was no fair salary as amentioned before and there were no any per-diems too forwarded by 100% of the respondents. This may have its own negative impact to increase turnover for the profession specifically in the research site.

CHAPTER FIVE

Summary, Conclusion and Recommendations

5.1 Summary

The purpose of this study was to assess factors affecting the role of Health Extension Professionals in the implementation of health packages at Yeka sub-city in Addis Ababa. To this end, descriptive survey design was employed and both quantitative and qualitative data were gathered. Sources of data were heads and vice heads of Woreda health offices and health extension professionals. Data gathering tools were questionnaire, interview and focus group discussions (FGDs).

Yeka sub-city was selected from the ten sub-cities by using simple random sampling technique. This was because Yeka sub-city is where the researcher lives and could have better access to information. With regard to this, The sample size of this of this study , one Yeka sub-city Woreda Head Officer and Vice Head Officer (two in numbers), from the 13 Woreda Health Offices half of (seven in numbers), from 14 Woreda supervisor seven (one from each woreda) , and twenty eight Health Extension Professionals from each Woreda. Generally, the sample size of this research was forty four individuals.

From those 13 Woredas, seven Woereda's were selected by using simple random sampling technique. Further-more, stratified proportional sampling technique was used to select HEPs from the seven Woredas.

Thus, the quantitative data obtained from the respondent Health Extension Professionals through the questionnaire and the qualitative data gathered from Woreda Health Center

Head Officers and Vice Heads through the FGD were analyzed and interpreted by employing both quantitative and qualitative data analyzing methods. The analysis was made in line with the basic research questions indicated in Chapter one , Then, major findings were presneted as follows:

The major findings:

1. The study disclosed that the qualification of HEPs and Woreda health office experts and supervisors was not up to the standard. This indicates that the educational qualification of HEP, need further upgrading specially for those who are below Diploma level, mainly the certificate and grade 10th or 10th complete + Certificate. This is because staying as they were may be some hindrance when they describe a kind of disease or health problems while they are doing identification of problems in the community. On the other hand, it was found out that the majority of both experts and HEPs were the Orthodox Christians..

2. The study revealed that access to logistics was found to be medium. Likewise, the available equipment and communication facilities were not fairly distributed for services.eem to be subjective. During the FDG, it was pointed out by one of the participants as follows:

   The status of logistics for HEPs at Yeka sub-city, the accessibility and availability of logistics for HEPs at Yeka sub-city was measured by the number of respondents divided by the total sample population in the area, irrespective of health center, drug consistency medical equipment, registration book/card for patients and communication facilities with experts or staff.

3. Regarding access of vehicle for HEPs, the study indicated that 28(100%) of the respondents rated the the availabnility of vehicles for transportation as “low”. Instead they have been given three hundred EB for telephone and transport allowance. Regarding stationary material even though it is not enough, there is a somewhat available basic stationary item according to the HEPs respond. It is possible to raised issue of logistic on FGDs with sub city officials, as they discussed and pointed out conclusion was similar to the respond of HEPs.
4. On Assessment of the perception of the community towards HEPs, generally speaking, the perception of the community towards HEPs in Yeka Sub-City is low and they do not consider Health Extension Workers as professionals who have qualifications and experience and have seen low understanding of community. Due to this, there is substantial gap in implementing Health Extension packages in Addis Ababa, Yeka sub-city. On the FGD the official believed that

   There is gab on the community awareness , But it was not that much exaggerated as the HEPs stated , we are working together to change the community behavior and tackle problem , now a days the problem is not similar to that was at the beginning when HEPs started work . More over the community tried to support the program, especially model mothers are very supporting. About health facility utilization, all the community members are utilized health centers more and more due to HEPs great role on Disease Prevention & control awareness

   It was possible to discuss with model mothers how HEPs job supported my model mother and other community members, as model mother said:

   we tried to support HEPs when they do have home to home visit, community conversation meeting and other campaign too by announcing time and place of meeting , we are like a bridge between the community and HEPs . Also when there

is any health problem in the village or individual's residence, for environmental sanitation and other issue model mothers tried to inform HEPs for farther professional action

5. In the main summary about the satisfaction and future aspiration the analyses indicate that the greater 42.87% and 21.42 % of respondents found less satisfied and not satisfied respectively. The jobs satisfaction of HEPs , since there is no incentive like up grading ,refresher course and per-diem for daily activity ,it difficult to say all respondents satisfied , above half of respondents were not satisfied . On focus group discussion the officials in which the supervisors and Woreda's health officers responded that:

   We work together with the HEPs all the time, although HEPs have their work plan and there responsibility when there is any additional technical support always the supervisors are ready to give back up.

6. Assessment of training adequacy, as can seen from the finding 17 (60.71 %) of HEPs agreed and assumed the theoretical part of training they have been attended for the profession is quite enough to run the job. On the contrary 11 (39.28%) of

respondents disagreed and blames the trainng as inadequacly to fully be inculcated in the job as professional. From 11 respondents who were disagreed on the adequacy of the training. 10 respondents say forwarded reason mainly lack of practical exposure during trainng session means it is fully over run by thoertical assumpions

7. The study indicated that the frequency of supervsion by supervisors was found out to be medium, as 22 (78.57%) of HEWs asserted that it was conducted once in a month, and (14.28%) of the respondents said that it was conducted only once in every six month. Supervision ususally preferd to be given by the one who is near to the profesionals beacuse it may be simple to give technical support and feedback.
8. All of the respondents 28 (100 %) of the health extension workers didn't have any access to printed recording formats to accomplishments in line with HMIS formats. In addition, it was disclosed that 42,85% of the HEWs hadn't any any planning habits.
9. Concerning the salary and per-diem of HEWs, 25 (89.28%) them believed that the payment was not enough compared to the work they carry out and the higher costs of living in the City.
10. With regard to assessment of incentives, it was found out that there was shortage or and lack of incentive, motivation, training and refresher training, non-monitory remuneration. On the FDG the officials gave their idea ,

    Actually incentive has motivational capacity to encourage for best performance for any one, thus according the budget capacity it is tried to provide available incentive for HEPs even if it was not satisfactory.

5.2 Conclusion

Based on the major findings, the following conclusions were drawn:

1. The findings indicated that educational backgrounds of HEPs were below first Degree level. Hence, it could concluded that the HEPs would have strong limitations in the identification of dieases, diseases manifestations and also in providing basic and essential types of treatment while they are doing home to home visit.
2. The findings indicated that the level of supervision was low as the majority of the HEWs asserted that it was conducted either once in a month or in a six months. In addition, it was revealed that supervisors failed to provide written feedback. Hence, lack of written feedback might lead to the fact that the Health Extension Professionals might overlook their own weaknesses.
3. The study indicated that the perception of the majority of the community members towards towards health extension workers in Yeka sub-city was negative. Hence, this situation might discourage the Health Extension Workers.
4. Since there is no incentive like up grading, refresher course and per-diem for daily activity, this situation might negatively affect the motivational level of HEPs.

On the whole, it could be safely concluded that training-related, supervisory support-related and logistic related factors have strongly influenced the proper implementation of health extension package in Yeka Sub-city.

5.3 Recommendations

Based on the finding of the research the following recommenadtions have been forwarded:

1. The Ministry of Health is advised to revisit the courses provided for HEPs in order to make them more practical rather than fully involved in the theortical assumptions.
2. Woreda health centers have to consider provision of short-term trainings and experience sharing events for HEPs report writing and data recording skills.
3. Since it is directly related with the best record of performance of Health extension package, Yeka sub city health office is advised to organize refresher short term trainings for HEPs in collaboration with diverse stakeholders.
4. Yeka sub-city health office should strengthen the necessary follow ups and technical support for HEPs timely based on the feedback obtained from HEPs and the community.
5. Since commitment of HEPs and full participation of community in health packages play crucial role in performing all activities as scheduled and to achieve best performance. Yeka sub-city should conduct continuous awareness creation program to change the preception of the community on HEP role and responsibility;
6. Fair and competent working environment is the driving factor for the professionals to stay on job safely; hence, the MOH is advised to develop incentives schemes to encourage better performing and committed HEPs.

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Appendices

Focus Group Discussion (FGD)

Instructions to facilitators:

- Before you start anything, greet the participants sincerely and respectfully and thank them for coming.
- Introduce yourself and quickly brief the group members the whole objective of the study and how useful the outcome of the result from the discussion. And assure them that any information from the discussion will be kept confidential and will strictly be used only for the purpose of this study.
- Let the FG participants introduce themselves by presenting the general background information about them.
- You are required to complete the FGD within a maximum of 1:30 hours and need to utilize the time wisely by systematically and diplomatically guiding the discussion through only the relevant topics.
- At the end of the session, thank them gratefully for their participation and say good-bye.

Focus Group Discussion Guide for District Health Officials (FGD)

1) How are you supporting the Health Extension Professionals in their respective sites?
2) For whom the Health Extension Professionals reporting? Why?
3) What determinants are affecting the roles of health extension factors in Yeka sub city, Addis Ababa? Which are the most important ones?
4) What incentives does your office render to the Health Extension Professionals with the aim to motivate them to enable them discharge their responsibilities at the utmost standard? In your opinion does it have an impact on their role?
5) In your opinion what is the perception of the community towards Health Extension Professionals? Are they considering and respecting them like health professionals working in clinics and hospitals with White Uniforms?
6) In your opinion is the current amount of the population a Health Extension Professionals serve could be a burden for her?
7) How the Health Extension Professionals logistics and supplies managed? Is it availed on time in abundant?
8) How can you control the quality of the services delivered by the Health Extension Professionals to the community?

Focus Group Discussion Guide for community members/model families (FGD)

1) In your opinion is the community considered and respect Health Extension Professionals as other health professionals working in clinics and hospitals? If no why?
2) In your opinion are the services from Health Extension Professionals based on your needs and relevant to you? If no why?
3) How and what services are the Health Extension Professionals delivered for the community?
4) Why the community is happy or not happy with the service provided to the community by the Health Extension Professionals?
5) How are you discharging your roles in relation to the health extension program as part of the community or model mothers?
6) How are you working in collaboration with the Health Extension Professionals to address the health needs of other members of the community?
7) How the Health Extension Professionals are supervising and providing technical support in the process of addressing the health needs of the community?

Structure Questionnaire

Consent:

We are conducting a survey on the determinants of the role of Health Extension Professionals in Addis Ababa, Yeka Sub-City. We would like to ask you some questions about yourself. The questioner to complete or filling the questions completely will take about 45 minutes. Any information that you provide will be kept strictly confidential and will not be shown to other people.

Are you willing to Participate?____Yes, _____No

ADDIS ABEBA UNIVERSITY

College of education and behavioural studies

Department of curriculum and teacher

Professional development studies

Annex I. Questioner for:-

Factors Affecting the Role of Health Extension Professionals in the Implementation of Health Packages in Yeka Sub-city, Addis Ababa

Dear respondent I am conducting a survey on the determinants of "Factors Affecting the Role of Health Extension Professionals in the Implementation of Health Packages in Addis Ababa, Yeka Sub city .

The main purpose of the survey is that, to assess the extent of functionality of HEPs trained and deployed in Addis Ababa Yeka sub city.

To explore the correlates associated with the roles of HEPs in the implementation of health packages in the sub city to collect information necessary for developing appropriate Strategies and programs to Health Extension Professionals in the Implementation. To attain this purpose your honest and genuine participation is very important and highly appreciable.

I, therefore, kindly request you to fill this questionnaire as accurately and carefully as possible. Please be assured that all the information gathered will be kept strictly confidential and you do not need to write your name on any of the questionnaire page. Only the researcher has the access of the information and used it for the study purpose only. You have a full right and decision to not respond all the questions or partly.

Thank you in advance for your cooperation!

Individual Questionnaire Identification_____

S/No	Question	Answer	Code	Skip
001	Date of data collection	dd/mm/yy_____		
002	Questionnaire number			
003	Code of data collector			
004	Name of the Sub-City			
005	Name of the Woreda			

Part-I General information

1. Background information

S/No	Question	Answer	Code	Skip
1	Sex	Male Female	1 2	
2	Age			
3	What is your educational status	9-12 10/12 + Certificate Diploma Degree Degree and above	1 2 3 4 5	
4	What is your religion	Orthodox Christian Muslim Protestant Others (specify)	1 2 3 9	
5	What is your marital status	Single Married Divorced Widowed	1 2 3 4	

2.1. Assessment of Supplies

S/No	Questions	Answers	Code	Skip
2.1.1	Accessibility of Health Center/ Health Post?	Highly accessible Accessible Less accessible Not accessible	1 2 3 4	
2.1.2	Do you get drugs supply consistently?	Very high High Medium Low	1 2 3 4	
2.1.3	Are medical equipment's available in your Health Center / Health Post?	Very high High Medium Low	1 2 3 4	
2.1.4	Do you have registration book?	Yes No	1 2	
2.1.5	Do you have communication Facilities?	Very high High Medium Low	1 2 3 4	

2.2. Assessment of logistics for HEP.

S/No	Questions	Answers	Co	Skip
2.2.1	Do you have vehicle in your office for your work?	Very HighHighMedium Low	1 2 3	
2.2.2	Do you have a taxi fare from your office if you are not using office vehicle for transportation?	Very high High Medium Low	1 2 3 4	
2.2.3	Do you have enough stationery for your work?	Very high High Medium Low	1 2 3 4	

2.3. Assessment of Perception of the Community Towards HEPs

S/No	Questions	Answers	Code	Skip
2.3.1	Did the community understand your professional as a Nurse like those who are working in Clinics/Hospitals	Very high High Medium Low	12 3 4	
2.3.2	Is the commitment of the community/model mothers compromised by some materials benefit such as allowance for partaking in trainings	Yes No	1 2	
2.3.3	If yes, have you ever been developed sense of frustration because of the perception of the community?	Yes No	1 2	
2.3.4	Is the community happy and accept the HEP roles?	Yes No	1 2	
2.3.5	Is the community considered & respect the HEPs like the Health Professionals working in Hospitals /Clinics?	Yes No	1 2	
2.3.6	Is the community utilizing the Health Centers/Post services?	Yes No	1 2	
2.3.7	If yes what services are most Preferably utilized?	MCH Environmental Health Diseases Prevention &Control	1 2 3	

2.4 Job Satisfaction and Future Aspiration

S/No	Questions	Answers	Code	Skip
2.4.1	Are you doing your work Independently?	Yes, Always Yes, often Yes, some times No	1 2 3 4	
2.4.2	Are you satisfied on what you are doing?	Yes, Always Yes, often Yes, some times No	1 2 3 4	
2.4.3	For question number 2.4.2 above, your response is “Yes sometimes” and “No” “Why?”	Lack of community support Lack of office support Lack ofself-interest Lack of supplies Others(specify)	1 2 3 4 9	
2.4.4	Are you satisfied by yourprofession?	Yes No	1 2	
2.4.5	If no, Why?	Lack of upgrading chance Lack of refresher course Lack of incentives In sufficient salary Uncomfortable working environment Other(specify)	1 2 3 4 5 9	
2.4.6	What is your future aspiration?	Stay as health extension worker Upgrading Moving to privet/NGO Stopping employed work Other(specify)	1 2 3 4 9	
2.4.7	If you aspire to stay as HEPfor how many years?	<4 years 4-5 years >5 years	1 2 3	
2.4.8	If you aspire to upgrade towhat profession?	Nurse Environmental Health Officer Pharmacy Technician Administration Public Health Officer Other(specify)	1 2 3 4 5 9	

2.4. Assessment of Training Adequacy

S/No	Questions	Answers	Code	Skip
2.5.1	Have you trained on HEP packages before you commenced your job?	Yes No	1 2	
2.5.2	Was the training adequate for your work?	Strongly agree Partially agree Disagree	1 2 3	
2.5.3	If not What do you think is that lacking?	Theoretical part Practical part Both Neither Other(specify)	1 2 3 4 9	
2.5.4	Have you been given a refresher Course or on job training?	Yes No	1 2	
2.5.5	If yes how frequent is it?	Every 3 months Every 6 months Every year	1 2 3	
2.5.6	What is your field of study / profession?	Public nurse Clinical nurse Nurse Pharmacy technician Laboratory technician Other Specify	1 2 3 4 5 9	

2.6. Assessment of the status of Supportive Supervision

S/No	Questions	Answers	Code	Skip
2.6.1	Have you been supervised by Supervision team?	Yes, Always Yes, often Yes, some times No	1 2	
2.6.2	How, often are you supervised?	Every Day Every month Every 6 months Every year Other(specify)	1 2 3 4 9	
2.6.3	Who is your immediate supervisor/s?	Health Center /Post Head Worada Health office	1 2	
2.6.4	Are you regularly receiving written feed back from your immediate supervisor/team?	Yes No	1 2	
2.6.5	Do you have annual, quarterly and monthly work plans?	Yes No	1 2	
2.6.6	Do you have tailored printed formats to record your accomplishments in line with HMIS?	Yes No	1 2	
2.6.7	Are you reporting your accomplishments in line with your respective plan?	Yes No	1 2	

2.7. Assessment of Salary and Per-diem of HEP

S/No	Questions	Answers	Code	Skip
2.7.1	Do you think your salary is a fair for your work?	Yes No	1 2	
2.7.2	Are you receiving your salary/any payment timely?	Yes No	1 2	
2.7.3	Do you have any form of per-diem?	Yes No	1 2	
2.7.4	Are you satisfied with the per-diem you are receiving?	Yes No	1 2	
2.7.5	Have you promoted and upraised based upon the results of your performance evaluation?	Yes No	1 2	

2.8. Assessment of Incentives

S/No	Questions	Answers	Code	Skip
2.8.1	Do you have any sort of benefits or incentives because of the present position?	Yes No	1 2	
2.8.2	Have you ever received motivation either from the family, community, or health office?	Yes No	1 2	
2.8.3	Have you received capacity development supports like training, supportive supervision and refresher courses?	Yes No	1 2	
2.8.4	Have you received non-monetary remunerations such as back bags, gumboots, umbrellas and t-shirts?	Yes No	1 2	
2.8.5	If yes, how often you are receiving incentives?	Quarterly Biannually Annually	1 2 3	

2.9. Assessment of Program Relevance to Beneficiaries

S/No	Questions	Answers	Code	Skip
2.9.1	From your experience do the community interested with Health Awareness programs in the absence of practical assistance for their impoverished situation?	Yes No	1 2	
2.9.2	Do you think the community perceived Health not just as a change in Health Seeking Behavior but mainly as change in troubled livelihood?	Yes No	1 2	

2.10. Assessment of the Population Size HEPs Served

S/No	Questions	Answers	Code	Skip
2.10.1	For how many House Holds are you responsible to address the health needs through the HEP?	<500 500 >500	1 2 3	
2.10.2	Is this number of House Hold manageable for efficient & effective Health Service Provision or it's a burden for you?	Yes No	1 2	
2.10.3	If no, how many House Hold would be manageable for one HEP to serve efficiently and effectively?	<200 200-300 300-400 400-500 >500	1 2 3 4 5	
2.10.4	Are you providing all the HEP services for the entire house Hold you are responsible for?	Yes No	1 2	
2.10.5	Do you think that you are overload from your tasks?	Yes No	1 2	
2.10.6	If no, among the four main components of the HEP how many of them are you delivering? Hygiene &Environmental Sanitation, Family Health Service, Disease Prevention and Control, Health Education & Communication	one two three	1 2 3	

2.11 Assessment of the status of the roles of HEPs

S/No	Questions	Answers	Code	Skip
2.11.1	Do you think this all factors affect your roles or performance?	Yes No	1 2	
2.11.2	Do you think that you are performing your roles efficiently and effectively in the utmost standard with this situation?	Yes No	1 2	

በግል የሚሞላ ቃለ-መጠይቅ **መለያ ቁጥር----------**

ተ.ቁ	ጥያቄ	መልስ	ሚስጢር ቁጥር	ይታለፍ
1	መረጃ የተሰበሰበት ቀን			
2	የመጠይቁ ቅፅ ቁጥር			
3	የመረጃ ሰብሳቢው የሚስጢር ቁጥር			
4	ክፍለ ከተማ			
5	ወረዳ			

ክፍል 1-የግለሰቡ ጠቅላላ መረጃ

ተ.ቁ	ጥያቄ	መልስ	ሚስጢር ቁጥር	ይታለፍ
1	ፆታ	ወንድ ሴት	1 2	
2	እድሜ			
3	የትምህርት ደረጃ			
4	ሀይማኖት	ኦርቶዶክስ ተዋህዶ ሙስሊም ፕሮቴስታንት ሌላ ካለ ይገለፅ	1 2 3 9	
5	የጋብቻ ሁኔታ	ያላገባ ያገባ የፈታ የትዳር አጋርየሞተበት/ባት	1 2 3 4	

.

2.1. የአቅርቦት ሁኔታ መገምገሚያ

2.1.1.	በአቅራቢያዎ የጤና ጣቢያ/የጤና ኬላ አለ?	የለም አለ	1 2	
2.1.2.	መድሀኒት በቋሚነት ያገኛሉ?	የለም አለ	1 2	
2.1.3.	በጤና ተቋሙ/የጤና ኬላው ውስጥ ምን አይነት የህክምና መገልገያ መሳሪያዎች አሉ? የሚያገኙበት ጤና ተቋም	የለም አለ	1 2	
2.1.4.	የመመዝገቢያ ዶሴ/ቅፅ አላችሁ?	የለም አለ	1 2	
2.1.5.	ምቹ መወያያ ስፍራ አለ?	የለም አለ	1 2	

2.2. **ለጤና ኤክስቴንሽን ባለሙያዎች የአስተዳደራዊ እገዛ ግምገማ**

2.2.1.	የመንገዣ/መኪና አቅርቦት አለ?	የለም አለ	1 2	
2.2.2.	የመኪና አቅርቦት ከሌለ የትራንስፖርት ክፍያ አለ?	የለም አለ	1 2	
2.2.3.	በቂ መገልገያ የፅህፈት መሳሪያ አላችሁ?	የለም አለ	1 2	

2.3.ለጤና ኤክስቴንሽን ባለሙያ የማህበረሰቡ አመለካከትን መገምገም

ተ.ቁ	ጥያቄ	መልስ	ሚስጢር	ይታለፍ
2.3.1.	ማህበረሰቡ የእርስዎን የሥራ ድርሻ ልክ እንደሌሎች የጤና ተቋም ነርሶች ተረድተዋችኋል?	የለም አለ	1 2	
2.3.2.	ከማህበረሰቡ/ከሞዴል እናቶች የድጋፍና የቁሳቁስ ድጋፍ ይደረግላችኋል?	የለም አለ	1 2	
2.3.3.	አዎ ከሆነ መልስዎ በማህበረሰቡ አመለካከት ምክንያት ስጋት አድሮቦዎት ያውቃል?	የለም አለ	1 2	
2.3.4.	ማህበረሰቡ በጤና ኤክስቴንሽን ባለሙያዎችና አገልግሎታቸው ደስተኛ ሆኖ ተቀብሎታል ነው?	አዎ አይደለም	1 2	
2.3.5.	ማህበረሰቡ ለጤና ኤክስቴንሽን ባለሙያዎች እንደ ሌሎች የጤና ተቋም ጤና ባለሙያዎች አክብሮት	አዎ አይደለም	1 2	
2.3.6.	ማህበረሰቡ የጤና ጣቢያና የጤና ኬላ አገልግሎቶችን ይጠቀማል	አዎ አይደለም	1 2	
2.3.7.	የሚጠቀም ከሆነ በብልጫ የትኞቹን አገልግሎቶችን ይጠቀማል	እናቶች ህፃናት የአካባቢ ጤናአጠባበቅ የጤና ትምህርት	1 2 3	

2.4.የሥራ እርካታና የወደፊት ራዕይ

ተ.ቁ	ጥያቄ	መልስ	ሚስጢር	ይታለፍ
2.4.1.	ሥራዎትን የሚሰሩት ብቻዎትን ነው?	አዎ አይደለም	1 2	
2.4.2.	በሚሰሩት ስራ ደስተኛ ነዎት?	አዎ አይደለም	1 2	
2.4.3.	መልስዎ አይደለም ከሆነ ለምን?	ከማህበረሰቡ ድጋፍ በማጣት ከጤና ተቋም ድጋፍ በማጣት የግል ተነሳሽነት አለመኖር የአቅርቦት ችግር ሌላ ካለ ይገለፅ	1 2 3 4 9	
2.4.4.	በሞያዎት ደስተኛ ነዎት?	አዎ አይደለም	1 2	
2.4.5.	መልስዎ አይደለም ከሆነ ለምን?	እድገት የማግኘት እድል ስለሌለ የማሻሻያ ሥልጠና ስለሌለ ማበረታቻ ስለሌለ በቂ ደምወዝ ስለሌለ ምቹ የሥራ ሁኔታ ስለሌለ ሌላ ካለ ይገለፅ	1 2 3 4 5 9	
2.4.6.	የወደፊት ራዕይዎት ምንድነው?	ባለቡት ቦታ መስራት ካሉበት ቦታ ማደግ ወደግል/ግብረሰናይ ድርጅት መዛወር ሥራን ማቆም ሌላ ካለ ይገለፅ	1 2 3 4 9	

2.4.7.	ለምን ያክል ጊዜ በጤና ኤክስቴንሽን ሙያ መስራት ይፈልጋሉ?	ከ4 ዓመት በታች 4-5 ዓመት ከ5 ዓመት በላይ	1 2 3	
2.4.8.	ከጤና ኤክስቴንሽን ሰራተኝነት ማደግ ከፈለጉ የትኛውን የሥራ ዘርፍ ይመርጣሉ?	ነርስ የአካባቢ ጤና አጠባበቅ ፋርማሲስት አስተዳደር የማህበረሰብ ጤና ሌላ ካለ ይገለፅ	1 2 3 4 5	

2.5.የሥልጠና ብቃት መገምገሚያ

ተ.ቁ	ጥያቄ	መልስ	ሚስጢር ቁጥር	ይታለፍ
2.5.1.	ሥራ ከመጀመርዎ በፊት ሙሉ የጤና ኤክቴንሽን የሙያ ሥልጠና ወስደዋል?	አይደለም አዎ	1 2	
2.5.2.	ሥልጠናው ለስራው ብቁ አድርጎዎታል?	አይደለም በከፊል አዎ	1 2 3	
2.5.3.	ካልሆነ ሥልጠናው የሚጎድለው ምንድን ነው?	ትምህርት አሰጣጥ ተግባር ሁለቱም	1 2 3	
2.5.4.	የማሻሻያ/በስራ ላይ ያለ ስልጠና ወስደዋል?	አይደለም አዎ	1 2	
2.5.5.	አዎ ከሆነ መልስዎ በየምን ያክል ጊዜ?	በየ 3 ወሩ በየ 6 ወሩ በየአመቱ	1 2 3	
2.5.6.	ያጠኑት/የተማሩት የትምህርት ዘርፍ?	የማህበረሰብ ነርስ አስታማሚ ነርስ አጠቃላይ ነርስ ሌላ ካለ ይገለፅ	1 2 3 4	

2.6.የግምገማና የድጋፍ ሁኔታ

ተ.ቁ	ጥያቄ	መልስ	ሚስጢር ቁጥር	ይታለፍ
2.6.1.	በተቆጣጣሪዎች ተገምግመው ያውቃሉ?	አይደለም አዎ	1 2	
2.6.2.	በየምን ያህል ጊዜ?	በየ 3 ወሩ በየ 6 ወሩ በየአመቱ ሌላ ካለ ይገለፅ	1 2 3 9	
2.6.3.	የቅርብ ተቆጣጣሪዎ ማን ነው?	የጤና ተቋመ ኃላፊ የወረዳው ጤና ቢሮ	1 2	
2.6.4.	በዕሁፍ የተደገፈ ግብረ መልስ ከተቆጣጣሪዎ ተቀብለው ያውቃሉ?	አይደለም አዎ	1 2	
2.6.5.	የአመት ፣ የሩብ አመት፣ የወር የሥራ እቅድ አለዎት?	አይደለም አዎ	1 2	
2.6.6.	በመረጃ መረብ የተዘጋጀ ፎርም አለዎት?	አይደለም አዎ	1 2	
2.6.7.	ሥራዎትን በእቅድዎት መሰረት ነው ሪፖርት የሚያደርጉት?	አይደለም አዎ	1 2	

DECLARATION

I, the undersigned, declare that this thesis is my original work and has not been presented in other universities; all sources of materials used have been duly acknowledged.

Name: _____

Signature: _____

Date of submission _____

This thesis has been submitted for examination with my approval as university advisor.

Name: _____

Signature: _____

Date of submission _____