Addis Ababa University

College of Development Studies

School of Graduate Studies

Institute of Regional and Local Development Studies (IRLDS)

Factors Affecting the Human Resource Development in Health: The case of Health Extension Program in Eastern Showa

A Thesis Submitted to the School of Graduate Studies of Addis Ababa University

Thesis Advisor: Yemane Berhane (MD, MPH, PHD)

In Partial Fulfillment of Requirements for the Degree of Masters of Art in Regional and Local Development Studies

By Adey Araya

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LIST OF ACRONYMS

CNHDE: Center for National Health Development in Ethiopia

EFY: Ethiopian Fiscal Year

E.C. Ethiopian Calendar

ESHE: Essential Service for Health in Ethiopia

FMoH: Federal Ministry of Health

HC: Health Center

HEP: Health Extension Program

HEW: Health Extension Worker

HP: Health Post

HRD: Human Resource Development

HRH: Human Resource for Health

HRM: Human Resource Management

HS: Health Station

HSDP: Health Sector Development Program

HSEP: Health Service Extension Program

MDGs: Millennium Development Goals

MoH: Federal Ministry of Health

NGO: Non-Governmental organization

PHC: Primary Health Care

TVET: Technical and Vocational Education and Training

WHO: World Health Organization

WorHO: Wereda Health Office

WorHC: Wereda Health Center

UNICEF: United Nations International Children Emergency Fund

VCHW: Voluntary Community Health Workers

ABSTRACT

Ethiopia is among the least developed countries where basic health has not yet accessible for the majority of its people. Common fatal health problems in the country are those diseases that can be prevented easily. Hence, the Ethiopian government with the aim of reaching health services to all planned Health Extension Program (HEP). This study was made to asses the Human Resource Development (HRD) in Health in the HEP in Oromia Regional State, East Showa Zone, Boset and Lume Weredas.

The study was intended to assess the general situation of the Human resource development in the HEP in the specified study areas. It has also tried to assess the working environment of Health Extension Workers (HEWs) in relation to Human Resource Management (HRM) components.

This was a census study conducted by interviewing HEWs using questionnaire and supported by in-depth interview of the concerned Wereda, Zonal and Regional officials.

The results illustrate that proper functioning of HEP requires provision of essential education and training that are the main inputs followed by continuous technical and administrative support from the Health system. Besides this, construction of Health Posts (HPs), availability of adequate working materials, supported follow-ups should be aggravated to serve the purpose of the program. It further highlighted that mobilization of volunteer community health workers function as a support and serve as a link between the broad governmental efforts and the communities at the grassroot level.

In general, the health sector development of the HEP should be considered as the focal point and efforts should be strengthened by all concerned inorder to integrate health activities with the overall development endeavor and accomplish the goal.

I. CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Recent years have witnessed stiff competition towards development among countries inorder to make their country a better place to live and in a broader spectrum to make the world better place for people. On the other hand, it is the people who are responsible for a county's development. It is also true that a country with healthy and skilled human resource is certainly more developed as it is able to use other resources in a most creative, effective and efficient manner.

Furthermore, development is all about creating a healthy and favorable environment for people. Producing healthy society and creating healthy environment for them is thus one of the crucial goals of development. This implies that development is by the people through the people for the people. Developing human resources is also an important factor towards creating sustainable development efforts. Moreover, it would be a paradox to be concerned about development without making human development the nucleolus and without making public health the focal point of the human development strategy (World Health Report [WHO], 2000).

Yet in developing countries like Ethiopia, there are lots of people who are deprived of basic health services. The situation is calling for an immediate action as the main health problems are those that can be easily prevented. Hence, the Ethiopian government under the broader framework of reaching "health services to all" and in response to the country's development goal as well as the Millennium Development Goals (MDGs) has given its attention for this sector (The New Partnership for Afirca's Development [NEPAD], 2003).

More often than not in most developing countries, urban areas have better access to basic public services such as health and education. Likewise, in the case of Ethiopia the rural mass is relatively disadvantaged mainly due to the natural topography and

lack of resources. Therefore, the HEP has come into existence focusing on provision of health services to the rural people.

HEP, therefore, deals with Primary Health Care (PHC) service at the community level giving special attention for mothers and children who are most vulnerable. The program was started in 2004 and full deployment of the HEWs will be on 2009 (Center for National Health Development in Ethiopia [CNHDE], 2006).

Ethiopia has extremely poor health status even compared to other low income countries. Preventable infectious diseases and nutritional deficiencies take the highest portion of the diseases that cause loss of its nation. The country has also high rate of population growth of which many are destitute of sufficient access to clean water and hygiene facilities, poor access to health services and low education levels. Moreover, Action Plan for the Health Sector Development Program stressed that problems are observed in the health service delivery as it suffers from the shortage, poor distribution and inadequate mix and training of its health personnel (Ministry of Health [MoH], 2005 & Sahlu, 2003).

The health status of the country is still among the poorest similar to its economic situation. There are different factors that contribute to the prevalence of common diseases. Among these, the environmental factors such as the desert and semi-desert conditions result about 75% of malaria infection and the river basins and lakes where irrigated farms are common cause of infection of shistosma; the low lands of the country mainly those neighboring the Sudan and Kenya suffer from Lishmaniasis cutanea and Kalaazar. And the highlands are also liable for acute febrile illness such as relapsing fever, typhus etc (MoH, 1978).

In response to these, The Country has its on going efforts in the provision of equitable health services access since the 1970s. Previously, attempts had been made to increase as many Health Stations (HSs), Health Centers (HCs) and hospitals as possible to rural

and remote areas in spite of the economic constraints that emphasis on preventive aspects (MoH, 1978).

Furthermore, similar to other developing countries, health professionals in developing countries are scarce. The condition is further aggravated by high level of health professionals' migration both to urban areas as well as overseas. And recently to tackle the stated problems and to provide equitable health service, the country has employed a 20-year Health Sector Development Plan (HSDP) that is segmented into different plans ranging from three to five years. As described in the Health and Health Related Indicators 2005/06), HSDP deals with effective planning, Implementation and monitoring of the health sector development activities. Health Service extension Program (HSEP) is one of the major innovative efforts included in the HSDP. It is the recent community based health care delivery system intended to create healthy atmosphere as well as healthy living. The major purpose of HSEP is to enhance access and equality to preventive vital health intervention provided at household levels that focus on continued preventive health undertakings and increased health awareness creation (Federal Ministry of Health [FMoH], 2005/06)

Nonetheless, compared to the efforts that have been made to have equitable health services access since the 1970s, attainments seen so far are generally gradual and restricted which require concerted effort. Better management and changes in the role of the government, such as more responsibility at lower levels through decentralization are among the requirements. To have a well-functioning system, well-motivated workforce is also a prerequisite. In response to this, HSDP 2001/02 - 2002/03) depicted that efforts are being made to strengthen capacity building in planning and management, especially at wereda levels that includes the staff of the Wereda Health Office (WorHO) and the members of the wereda Council. In addition, developing managerial capacity of the wereda administration and empower them on public health issues is given the main concern (FMoH, 2003).

In general, Ethiopia's existing health concern seems improving. Nonetheless, the Human Resource Development (HRD) particularly the rural workforce needs further attention. Creating qualified and motivated human resources for the health sector is amongst the most important elements towards creating healthy and productive nation.

1.2 STATEMENT OF PROBLEM

The health extension is given priority by the Ethiopian government in the overall health policy to increase the coverage of health services and meet the needs of millions of rural people residing in the regional states of the country. Ethiopia could be severely disadvantaged in achieving the MDGs as a result of scarcity of Human Resource for Health (HRH). Currently though, it is acknowledged that HRH plays a major role for achieving the development agenda including the MDGs and the Plan for Accelerated Sustainable Development to End Poverty (CNHDE, 2006).

As a subset of this endeavor, HRD and other efforts to improve access and quality of health services are among the seven core processes of Business Process Reengineering (BPR). As per the Health Sector Strategic Plan 2005/6 - 2009/10, one of the vital strategies of HRD deals with accelerated production of key health professionals in bigger quantity: "flooding". This strategy has been made by the training of HEWs and health officers. The redesign is assumed to sufficiently forward both the training and retention of the health work force of the country (FMoH, 2005).

Even though designing the program is the first and most important component, it has to be followed by proper performance to make it well functioning and target oriented. Moreover, health systems are in general labor intensive that requires the greatest concern for its manpower development and management. The system is dependent upon effective and efficient utilization of this resource. Ensuring its practicability and sustainability needs examination of factors that affect both the HEWs' and the government's interest towards achieving a common goal. These factors then help in

identifying suitable approach that influence the workers willingness towards achieving the predetermined goals.

> *"The performance of health care systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering the service"* (The World Health Report, 2000)

This report further stressed that human resource is the most important input of the health system. And their motivation depends on working conditions, financial incentives and compensation along with overall personnel management and the potential for professional advancement. Moreover, the Human Resource Management (HRM) has impact on other resources.

In Ethiopia yet, there has been scarce researches carried out so far that have dealt with the general assessment of the HEP giving limited concern to HRD which is the backbone of the program. Furthermore, the program is in its early stage and there are no particular experiences from other countries.

Hence, the main inquiry of this study focuses on how well the HEP has gone towards the development of its human resource, whether essential HRM components affecting HEWs development are being put into operation and if there are continuous assessment and examination to cure the drawbacks with regards to the human resource component.

1.3 OBJECTIVES

1.3.1 General Objectives

Generally, the objective of the study is to assess factors affecting human resource development in the health extension program in Eastern Showa Zone, Oromia Regional State.

1.3.2 Specific Objectives

1. to assess the Education and Training given to HEWs
2. to assess the Working Environment of the HEWs
3. to evaluate the Attitude of HEWs towards their job
4. to review the presence of components of Human Resource Management

1.4 STRENGTH AND LIMITATION OF THE STUDY

1.4.1. Strength of the study

The study used both structured and non-structured questions to complement the results. Despite the fact that the HEP is at its early stage, the study integrated all important HRM components inorder to give insight for decision makers which further contributes for the efforts that have been done for the program's sustainability.

1.4.2. Limitation of the Study

In addition to the resource constraint, topographical setting of the area was difficult to enlarge the study areas beyond the two Weredas. Moreover, 17 HEWs from each Wereda (n=34) were about two months after they were deployed while conducting the study whom were not capable to respond to most of the questions. This group accounts more than half of the total study population (56.67%), which considerably affects the result and it was also difficult to enhance each variables and outcome via associating variables.

II. CHAPTER TWO

REVIEW OF RELATED LITERATURE

This section tries to signify relevant facts about the main concepts, definitions of key terminologies, and the components of HRD written by different authors. In this respect, it attempts to go through the reasons for focusing on human resource aspects of the health sector, HRM practices that are practical for any organization, give their definition and argue the importance of each practice for achieving the objective.

2.1. HUMAN RESOURCE IN HEALTH (HRH)

Health organizations depend on their labor force. These labor forces take a high share of budgets allocated to the health sector; most significantly the economic and human costs of poor HRH management are particularly high. HRH is concerned with two functions, the resource production and service provision (WHO, 2002).

Moreover, the quality of health services, their effectiveness, efficiency, accessibility and viability depend mainly on the human resources that deliver the service. (Dussault G, Dubois CH (2002) cited in WHO, 2002).

Human resources policies, besides reducing the constraints that are common in health delivery, they are vital to achieve developmental goals. The World Development Report of 2004 stated that the health related MDGs can not be attained unless and otherwise the human resource of the sector is not given full consideration (Mathauer and Imhoff, 2006).

The resource production function of HRD includes *investment cost* and *maintenance cost.*

Investment cost refers to their education and *maintenance cost* for sustaining their quality and productivity via continuous education and training for short and long

range future support. It also involves activities related to planning the size and composition of the workforce at the national, regional and local level and investment in the creation of knowledge and skills. Salaries and other benefits paid or offered to health professionals are also costs that are parts of the development of human resource (Cassels & Janovsky, 1991 and Dahlen & Balmsjo 1996, cited in WHO, 2002).

2.2. HUMAN RESOURCES MANAGEMENT (HRM)

If human resource is the most imperative resource of any organization, there has to be proper way of handling the resource. HRM is then the one that deals with managing people at work. It also involves studying what can be done to increase employees' production and satisfaction with their work life (Ivancevich & Glueck 1989 cited in Eskezia et.al, 2003).

People work to support themselves and their families, to create and accomplish, to get appreciation and position or to look into and enlarge their aptitude. Consequently, people and organization are two partners working together to reach their goals. Nonetheless, there are challenges that they face while working to achieve these goals. Inorder to come across these challenges, organizations use a device called HRM (Ivancevich & Glueck 1989 cited in Eskezia et.al, 2003).

HRM further deals with its four components to fully-operate. These are environment, organization, job and individual.

- Environment: social, economic, political and technological
- Organizational : size, structure, HR policies, culture
- Job: challenge , variety, autonomy
- Individual: abilities, knowledge, personality, values, expectation

HRM therefore can be seen as the process of integrating these components in harmonious and productive fashion (Hall & Goodale, 1986).

HRM process contains a wide variety of activities; as an organization is formed and jobs are created, personnel are recruited and selected to fill those jobs. Employees are then oriented to the organization, their section and specific responsibility followed by job assignment. Job assignment will empower them with salary and benefit payments. Training is often the subsequent step followed by job assignment. Then employee performance is monitored and reviewed. Results are examined and efforts are made to increase employees' performance. And salaries and benefits are paid, various health and safety programs are established, unions representing employee groups are formed. And side by side, employee concerns related to motivation, personal and organizational problems are assessed and addressed and future achievements and their plans are made (Hall & Goodale, 1986).

Despite the fact that these steps are not firmly mandatory, they are often workable to most organization. Hence, believing that they will contribute to HRM in health, the next part of the study talks about the HRM components vis-à-vis the HEP.

2.2.1. *Recruitment and Selection*

Recruitment is a step that comes first before the selection process. It paves the way for selection as it facilitates the production of smaller number of candidates that are ideal and skilled applicants for performing the expected tasks. It is the process of producing a group of competent candidates for organizational jobs (Mailer and Cowling, 1998 cited in Eskezia et.al, 2003 and Mathis & Jackson, 1997).

Similar to other HRM activities, recruiting is done at the present time to affect future performance. People that are recruited are those that are assumed to perform best. However, it is really difficult to know how well the new recruits will do until they actually execute the job; hence how well they will do is predicted at the time of selection (Baird, 1992).

Selection is a sequential step that assists choice of applicants with relevant qualification for hiring. It is a process of selecting individuals who have pertinent credentials to fill jobs in an organization. The selection process begins when candidates apply for employment and ends with hiring decision (Mailer and Cowling, 1998 cited in Eskezia & et.al, 2003).

2.2.2. *Training and Development*

Training is one way of investing in human capital needed for strategic advantage. It is a learning practice whereby people get skills or knowledge to help in the attainment of goals. It also provides employees with particular knowledge and skills for use on their present jobs. Training is a planned exertion by an organization to assist the learning of job-related knowledge and skills by its employees to improve employees' performance and further organizational goals (Mathis & Jackson, 1997).

Training could be done on the job or off the job. Economist Lester Thurow argue that on-job training provides the bulk of skills used on the job while formal education serves a signaling function of communicating to employers the trainability of job applicants (Baird, 1992).

The most suitable form of training program which provides an employee with on-the job training is apprenticeship. Proper mix of theoretical and practical experience is helpful to enable students learn by doing. Hence, practical experience should be inter-spread with periods of theoretical training. It provides skill under guidance of a skilled and certified worker (Mathis & Jackson, 1997).

Development on the other hand is a process of improving an employees' present and future success. The goal of development is its four results which determine careers effectiveness (in the context of the employees' carrier), performance, attitudes, identity and adoptability (Hall & Goodale, 1986).

Though they are not synonymous training and development are often used together. Gomez-Mejia and others (1995) defined training as a process that focused providing employees with specific skills that are useful to make improvements on ineffectiveness seen in their performance. And development deals with the employees' skills and the organizations' attempt to provide employees with present and forthcoming requirement of the organization (Eskezia et.al, 2003).

One of the most common problems with regard to training and development is, managers invest significant amount of resources to train and develop their employees, but they hardly inspect the result obtained from it. They lack to examine how training and development can well support organizational goal or how development actions should be adjusted along with the goal of the organization (Hall & Goodale, 1986).

Furthermore, employees' skill should be upgraded overtime to enhance their performance at present and to equip them with skills needed in the future. Hence, career development is required. And career development must also be coupled with continuing education. But mostly, managers overlook the prospective role of continuing education for motivating employees. Continuing education may be in the form of refresher courses, workshops or seminars, or other kinds of in-service training. It can also be helpful to enable employees fill the skill gap, to qualify current skill or future promotion (Homby et al. 1980).

In a broader way, ensuring effective communication between the health and education sectors in planning and developing manpower and health services is often disregarded. However, in many health educational programs, training is mostly inclined towards theory; and practical field work is given little attention which is a disagreement between training service functions. This further makes trainees feel embarrassed as they are assigned to their jobs. The health service and its manpower development are inseparable (Homby et al. 1980).

2.2.3. *Performance evaluation*

Performance evaluation is a formal system of regular appraisal of an employees' job performance. What is really done, whether it contributes to the set objective is known through evaluation. The overall objective of performance appraisal systems is to evaluate and give feedback to employees that will advance the organization's effectiveness. Moreover, it is important for improvement, adjustments on merit pay increase, feedback, employee management and future human resource planning. Knowing what has been accomplished against performance goals is also useful to identify training and development need. It helps to indicate how future performance be managed (Baird, 1992).

It is also a process of determining how well employees do their job. It has mostly two roles; to assess presentation for the function of rewarding and for making administrative decisions about employees (Mathis & Jackson, 1997).

2.2.4. *Motivation and Reward*

It is defined as the willingness of individuals to exercise an effort towards achieving determined goals. Staff motivation is critical to performance; attitudes of decision makers need to change if staff motivation is to change. Problems of attitude and motivation are the most difficult, but also are among the most important in determining staff performance. Among the numerous reasons, lack of career development and adequate incentives reduces staff motivation (Homby et al. 1980).

Motivation could be financial and non-financial. A study made in selected African countries by German Technical Cooperation (GTZ) showed that health workers in rural areas who are exposed to hard working conditions had high level of motivation due to good leadership and supportive management. On the other hand, more money does not always entail high motivation thus comprehensive strategy that take advantage of health worker motivation should merge both financial and non-financial motivation tools (Mathauer and Imhoff, 2006).

2.2.5. *Career Development*

Career planning is a process whereby an individual sets career goals and identifies the means to achieve them. Individual and organizational careers are not separate and distinct. Career development is an effort made to match individual career plan with the organizational plan. A person whose individual career plan can not be followed within the organizational plan will probably leave the firm sooner or later. Thus, organizations should assist employees in career planning so that both can satisfy their needs (Mathauer and Imhoff, 2006).

2.2.6. *Health and Safety*

Top management frequently takes the lead by setting health and safety objectives and developing plans to achieve those objectives. Retribution and compensation is the first approach used to compensate employees for job-related injuries or illnesses - Insurance program that compensates employees or their survivors in the case of work-related injury or death. Compensation is given for lost income, medical expenses, disability or death. These offer advantages to employees as well as employers (Homby et al. 1980).

Prevention is another approach to employ health and safety. The efforts are to prevent work-related injuries and illnesses - using safety equipment and devices, control work environment such as standards for environmental control, medical records. Physical examinations, workers' compensation investigation to determine causes of accidents and injuries and means of prevention, energy treatment, and professional nursing service (Homby & et al. 1980).

2.2.7. *Salary and Benefits*

Fair compensation is important for employee retention. Increased retention also occurs with performance based compensation, incentives, and other benefits that are valued by employees. Pay is the basic compensation employee receives, usually as a

wage or salary. Incentives are on the other hand payment that rewards workers for their endeavor ahead of the normal performance expectation. They are most valuable as employees can notice that additional efforts direct to improved performance and desirable rewards (Baird, 1992).

2.3. HEALTH SECTOR AND DEVELOPMENT IN ETHIOPIA

The land area of Ethiopia is estimated to be 1.1 million square km. with a total population of approximately 77 million. Among these people, about 84% live in rural areas. The Federal Democratic Republic composed of nine National regional states with two administrative cities of which are further divided into 600 Weredas and about 15,000 kebeles (5000 urban and 10,000 rural) (FMoH 2006/07).

Along with the poverty reduction program, the government has taken steps to improve the poor health status in all these kebeles. Among the efforts, one of them is the introduction of HSDP for a total of 20 yrs period with Five-year rolling program. It was established within the framework of a well-built government dedication to democracy and decentralization, and was planned to react to the health care needs of the rural inhabitants who comprise the majority of the entire population (MoFED, 2002).

The linkage between improved health and general developmental activities are progressively being recognized. Their alliance was well articulated in the HSDP I through the link between enhanced health condition and productivity of population, reduced household expenditures on health hence releasing resources for other productive uses, and the resulting contribution to reduced poverty and contribution to the overall socio-economic development of the country (MoFED, 2002).

The efforts stated are essential both for poverty reduction and health sector development as intended. The commission on Macro-economics and health report (2001) concluded that health and development are intertwined; health is the main concern in its own sense and it is also a focal point into economic development and

poverty reduction. The report further stressed that governments of developing countries and international donor organizations need not under-evaluate the combined outcome of the two. High investment in the health sector would mean hundreds of billions of dollars per year of increased income in the low income countries. In addition to this, there will be large social benefits owed which are resulted from improved health coverage such as spillovers to wealthier members of the society (MoFED, 2002).

As per the final evaluation report on HSDP II [2002/03- 2004/05], the overall goal of the HSDP is to improve the health status of the people of Ethiopia. The main objectives of HSEP include:

- Build of basic infrastructure
- Provide standard facilities and supplies and
- Develop and deploy appropriate human resource for realistic and equitable health care delivery at the grass-root level.

Parallel to this concept, the total budget for HSDP was estimated to be 20 Billion Birr for the 20years period. Five Billion Birr is for the first five year plan. Fund that is required for the HEWs (salaries and training) and for the construction and upgrading of HPs and Health centers (HCs) (FMoH, 2006).

The following table is to indicate the total number of HEWs, HPs construction and HCs construction and their upgrading of the first two HSDPs.

Table 2.1. HEWs Training and Infrastructure Development

Phase	HEWs training	HP construction	HC construction	Upgrading
HSDP II - 1995-1997	9,827	1,460	143	29
HSDP III - 1998-2002	20,962	12,249	563	2,167
Total	**30,799**	**13,709**	**706**	**2,196**

Source: HSEP coordination office (Feb 2006) and Accelerated Expansion of Primary Health Care coverage (AEPHCC) booklet, 2004 cited in Report of the Final Evaluation of HSDP II (2006)

The evaluation report further revealed that the government has estimated a total investment of 1.69 billion USD for the period 2005-2010 (total investment and recurrent costs). This comes down to 4.63 USD per capita per year. This estimation however, excludes the community contributions towards the construction of HPs (FMoH, 2006).

Table 2.2. Estimated Annual Costs of HSEP

Costs center per HP per yr (excludes HCs, training HEWs and supervision)	Annual costs (USD)	Annual HP requirements in 2001 (EC) (USD)
Annual Salary of HEW	540	16,643,340
Annual operational costs per HP	670	9,135,450
Annual preventive maintenance	290	3,951,250
Annual amount for essential drugs and consumable Kits per HP	548	7,366,500
Total Estimated per year	**2,048**	**37,096,540**

Source: UNICEF proposal 2005 and Accelerated Expansion of Primary Health Care coverage (AEPHCC) booklet 2004 based on rate USD ($1=8.68 Birr) cited in Report of the Final Evaluation of HSDP II (2006)

Note: This estimates on the other hand excludes the costs for construction, upgrading and equipping health facilities and TVET centers, refresher courses for Tutors and HEWs, apprenticeship HEWs, minimum equipment requirement, Wereda capacity development, transport and monitoring and evaluation.

For the above table: estimated requirement of 13,625 HPs and monthly salaries of Br. 400.00 is considered. The report further stated that though the estimation might not be exact, it provides insight for knowing the minimum annual running costs per HPs and these costs will need to be secured at regional level.

To convert all this expenditure into productive results, the HRD component of HSDP is the most precious resource of a country. HSDP II stresses that without trained manpower, other resources can not be properly used and this is even more accurate in the health sector than in many other sectors. HSDP III (2005/6-2009/10) discloses that training and supplying relevant and qualified health workers of different categories is the main aim of the program. The specific objectives are

- Supply skilled HR in adequate number to new health facilities
- Improve the capacity of the existing health human resource working at various levels
- Initiating and strengthening continuing education and in-service training
- Review and improve the curricula of some categories of health workers
- Rationalize the categories of personnel (FMoH 2005)

The NEPAD Health Strategy (2003) affirms that advancing HRD is one of the most dominant challenges for most developing countries like Ethiopia. It emphasized that whether it is primary or any other health care system, HRD is the basic step towards the goal. This document further states that;

> *"The slow pace of sustainable human development in Africa has impacted greatly on health development efforts in the region. Health is a resource and an outcome of development.*

Poor health can not be effectively addressed without sustainable human development in Africa. Similarly poverty can not be eradicated as long as the high burden of disease continued to plague the continent."

One of the main concerns of HEP is the supply of more than 30,000 health extension workforce that is meant to serve the community at each corner of the country. This study, therefore, supposes that it is worth having a glance over the broader concept of extension followed by its alliance with the health sector.

2.4. WHAT IS EXTENSION?

The word "extension" was first introduced in England. Extension education was first concept pioneered in 1873 by Cambridge University to describe a particular educational innovation. The aim was to win the educational benefit of the universities to the ordinary nation (Farquhar, 1962 cited in Maunder, 1972).

Agricultural extension was later developed in agricultural education, advice and demonstration. The objectives are focused on finding ways of using indigenous national programs that combines inter-national ideas tailored to meet the local conditions. Furthermore, all forms of extension are related to the provision of education to the people. Thus, extension and extension educations are tantamount (Farquhar, 1962 cited in Maunder, 1972).

As per R.N Farquhar (1962), extension in its wider sense is defined as

"The extending of, or a service or system which extends the educational advantages of an institution to persons unable to avail themselves of them in a normal manner".

According to Savile, the desire of every extension work is to educate people living in rural areas on how to increase their standard of living, by their own performances, using their own assets of human resources and supplies, with the smallest assistance from governments. It intends to induce local leadership and stamina of self-help

which then develops community satisfaction and their progressive growth (Maunder, 1972).

Extension in the health sector is related to delivering health care for rural people inorder to improve their life standards. In that, it is related to the delivery of PHC. PHC has been given the highest attention as it contributes for development of a country as well as for creating social justice. Promotion and securing health of the people is assumed to be vital for continued economic and social development. It also adds to improved feature of life and helps stabilize the world. Considering this importance, governments as well as the global nation are responsible for producing a socially and economically productive nation (WHO, 1978).

In PHC program, a great deal of time, manpower and material resources in the training of mid-level health workers. It also requires trainings inorder to upgrade the service delivery by advancing their knowledge and skills. However, these trainings if not supported by supervision, support and follow-up, it will deteriorate. A continuing education program can assure that the workers not only maintain their knowledge and skills, but also improve and expend upon them to maintain meeting community health needs (John, 1983).

2.5. HEALTH EXTENSION PROGRAM (HEP) IN ETHIOPIA

One of the main activities of the Ethiopian government priority areas in the health sector is extending basic health services coverage through HEP. The government introduced an innovative community-based approach aimed at improving equitable access to preventive essential health intervention. To implement this, HEWs are trained and deployed in each kebele. The HSEP workers are all females who have completed 10th grade, recruited from Kebeles where they will work and trained for one year on 16 different packages. The main duty of these workers is to develop the spirit of wellness/healthiness through prevention of diseases (Health Extension Program Implementation guideline [Amharic version], 2006/07).

The HEWs are expected to deliver a package of essential PHC and promotion services at the community level. They pursue outreach services that are different to that of the tradition of expecting the community to come to the health service provider (Health Extension Program Implementation guideline [Amharic version], 2006/07).

Their duties and responsibilities are mainly labeled into four kinds;

- Administrative Duties,
- Improving Health Status and Activities Related with Disease Prevention,
- Providing Primarily Health Services and Referral Services,
- Utilizing Different Communication Methods and Skills. Each category has its own sub-components (Health Extension Program Implementation guideline [Amharic version], 2006/07).

Some of the challenges observed by the Health Sector Human Resource Development Strategy 2005 (September 1997 E.C) were;

Weak management capacity at all levels of the health system stands out as a key constraint to governance in the sector. Even though vacancies exist at all levels, the Wereda level is the worst affected followed by the zones and regions in the rural and deprived areas. The strong and open leadership aimed at mobilizing stakeholders in support of the sector priorities - is very commendable but needs to be completed by effective leadership at Wereda level (FMoH, 2005).

The HSDP III plan disclosed that the major challenges of the HRD in general are the poor deployment and retention of all health professional, poor HRM irregularities of continuing education and on the job training (FMoH, 2005).

According to the study made by CNHDE, introduction of HEWs at community level is creditable except the fact that provision of suitable working conditions are the most central difficulty in addition to long distances, poor transportation and communication facilities. Matching staffing pattern at the HP level, direct time-use,

work schedule and relationship with the community (leadership) is one challenge. There was also lack of clear guidelines on relationship with other health workers at the community level, on career structure, transfer, leave absences etc. Reporting and health information system is weak. Community request for curative health care delivery is also another challenge (CNHDE, 2006).

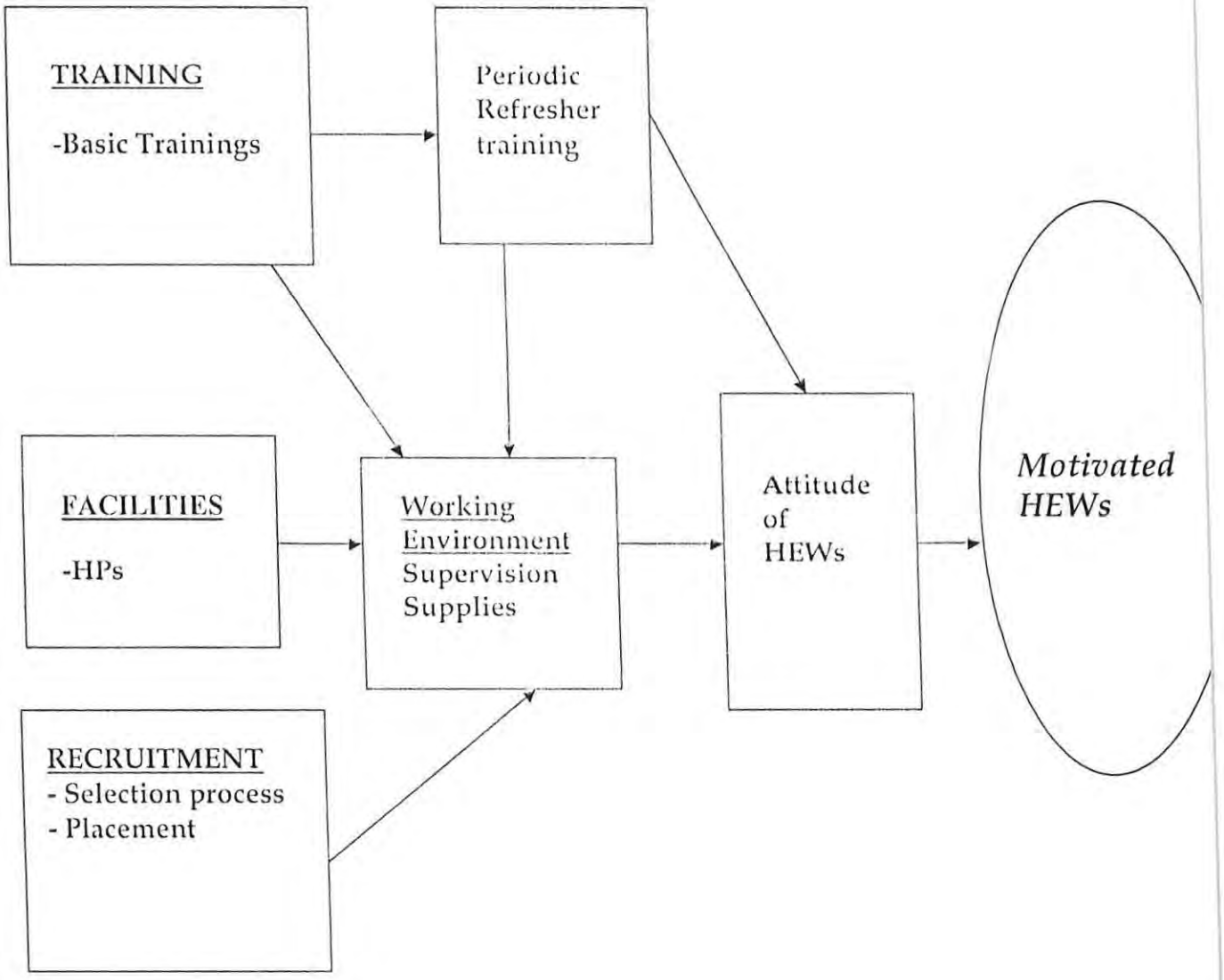
It is obvious that there is staffing shortage of trained skilled health personnel at all kebeles. Final report of HSDP II stressed that the challenges in the area of HRD is not only limited to the training of adequate staff, but also to attracting and retaining them. This is particularly applicable in harsh rural areas and Weredas (FMoH, 2006).

It also reported that often no text books or reference material was provided to trainees. The quality of training in practical skills (practical and apprenticeship) appears low and needs reinforcing by systematic in service training (continuing education) (FMoH, 2006).

A study made by Oromia Regional Health Bureau (ORHB), TVET Commission and Essential Services for Health in Ethiopia (ESHE) [2005] revealed that there was shortage of demonstration materials.

The progress of HSEP is clearly visible in the regional reports of HSDP II evaluation mission and in the documents prepared by the FMoH. It's evident that the key strategies and core activities have been achieved a very large extent; outreach Program, community sensitization and promotion program, training program, construction and upgrading of health facilities (FMoH, 2006).

CONCEPTUAL FRAMEWORK



III. CHAPTER THREE

METHODOLOGY

3.1 STUDY DESIGN

The study design involved a cross-sectional descriptive survey of HEWs in selected weredas of Oromia region supported by in-depth interview with wereda, zonal and regional officials. In addition to these primary sources, the information is reinforced by document review. The study units are HEWs of Boset and Lume Weredas and their respective officials, concerned officials from East Showa Zone and Oromia Regional Health Bureau (ORHB).

3.2 STUDY AREA

This study was made in Oromia regional state which is the home of 27 million people among which 85% reside in rural areas. There are 16 zones and six special urban zones. A total of 246 rural districts and 36 towns with respective district governance and 6,500 rural kebeles and 564 urban kebeles exist in the region. The total health infrastructures of the region up until 2006 were: 29 Hospitals (21 governmental and eight non-governmental), 186 HCs, 884 HSs, 921 HPs, two regional laboratories and Seven Health Science Colleges (Assessment of the implementation of HSEP in Oromia, Oromia Health Bureau, 2006).

Eastern Showa Zone is one of the zones in Oromia regional state comprising 14 weredas; three of them are towns and 11 are rural weredas. This zone was selected as it is one of the districts that are in closer proximity to Addis Ababa. Among the 11 rural weredas of the zone, two of them were selected randomly as a study area. These weredas are namely Boset and Lume. Though, the HEP has planned to accommodate one Health Post (HP) in each kebele with two HEWs, most HPs haven't yet coincided to this plan; Boset has 33 kebeles, 11 of them are completed and has two HEWs each. Four HPs do not have HEWs. And Lume has 38 kebeles (out of which three are urban

kebeles and are not included in the study), 13 are completed and have two HEWs each and two of the total kebeles do not have HEWs.

3.3 STUDY POPULATION

The study population comprised of HEWs in the selected study areas and their respective wereda, zonal and regional officials were also interviewed. Thirty kebeles from each wereda were eligible out of the 62 kebeles that for the study (two HEWs were not willing to participate in the study). One HEW from each HP is incorporated in the study.

3.4 DATA COLLECTION

The data collection comprised of both primary and secondary sources. Primary data was collected from HEWs and supported by concerned Wereda, zonal and regional officials. For secondary sources, publications of the Federal Ministry of Health (FMoH), previous researches made in the area both from governmental and non-governmental organizations, books and internet sources were used. The total duration of the data collection was made from March 15 to April 30, 2008.

Data from Wereda, zonal and regional officials were collected through in-depth interview using interview guide. It was made at the officials respective offices at the time suitable for them. The data were recorded by tape and transcribed after the data collection process is over. The data collection was made in Amharic and later was translated into English afterwards. Finally, it was summarized under the different themes and sub-themes respectively.

Structured questionnaire was used as a tool from the data collected from HEWs. Questionnaire was produced in English and then translated to Amharic. Four data collectors from the region with past experience in data collection were recruited for the field survey. The data from HEWs was collected at their respective HPs, Wereda

offices (when they come to submit their performance report) and as some HEWs in Lume Wereda were celebrating International Women's Day.

3.5 DATA QUALITY

To ensure the data quality, enumerators were given trainings on purpose of the study, data collection procedures, ways of maintaining good data quality and ethical issues. The training further incorporated objective of the study vis-à-vis their duties and responsibilities. Questionnaires were edited and cleaned on daily basis; missing values, irregularities, inconsistencies, or suspicious responses is checked accordingly. Moreover, the principal investigator was supervising randomly while the data was collected.

3.6 DATA ANALYSIS

Qualitative data analysis (responses for open ended questions of the structured questionnaire and the interview guideline for the Wereda, zone and regional officials) was carried out simultaneously with the data collection.

The quantitative data were arranged and edited after the data collection. It was then organized and entered into SPSS version 11 for statistical analysis; simple quantitative tools like percentage and proportions were used.

3.7 ETHICAL CONSIDERATIONS

Letter was written from Oromia Regional Bureau (ORHB) to Eastern Showa Zone. Wereda were then communicated inorder to enhance their respective cooperation.

Verbal consent was also requested from each respondent to confirm willingness and those not willing were given the rights to do so. Moreover to ensure confidentiality, interviews were held on private basis and it was made on unnamed basis; this was ensured throughout the process.

3.8 OPERATIONAL DEFINITION

Education and Training: background schooling for HEWs as a fundamental education conveyed by the TVET centers with the apprenticeship given by the WorHCs for a total of one year.

Refresher Trainings: different update trainings, seminars and workshops that are given to upgrade the knowledge and skill of HEWs subsequent to the HEWs assignment.

Working Environment: These include areas within which HEWs execute their jobs and the people they serve. These are: HPs, the kebele district and the community, other community health workers and officials that HEWs are accountable to.

Human Resource Management: The process, by which HEWs are selected, placed, administered and maintained within the health service delivery system.

Attitude of HEWs: the feeling of HEWs about carrying out their job at present and their forthcoming interest towards continuing community health service delivery.

IV. CHAPTER FOUR

RESULTS

This chapter presents the findings and illustrates under the different themes and sub-themes of the study.

4.1 SOCIO DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Data were collected from a total of 60 HEWs. Two of the respondent refused to participate in the study out of the total HEWs that are eligible for the study.

All HEWs (100%) were female.

Most of the respondents 96.7% (n=58) were between age range 19 to 23.

The majority of the respondents 85% (n=51) of them was Christians. 93.3% (n=56) of them were single and 6.7% (n=4) were married.

All respondents attended secondary school and above.

Except for two, all said that they had interest to be engaged in health service delivery before they were recruited.

Table 4.1. Socio-Demographic Characteristics of HEWs in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Age:		
19-23	58	96.7
24-28	2	3.3
Religion:		
Christian	51	85
Muslim	3	5
Others	6	10
Marital status		
Single	56	93.3
Married	4	6.7
Level of education		
Elementary	-	-
Secondary	60	100
Year(s) of service as HEW		
< 6 months	34	56.7
6 months - 3yrs	8	13.3
> 3yrs	18	30
Occupation before the health extension training		
Student	58	96.7
Other	2	3.3
Reside in this Wereda		
1yr - 3yrs	2	3.3
3yrs - 5yrs	58	96.7
Reside in this kebele		
< 6 months	6	10
6 months to 1yr	10	16.7
1yr - 3yrs	17	28.3
3yrs - 5yrs	14	23.3
> 5yrs	13	21.7

4.2 RECRUITMENT AND SELECTION

All the respondents said that they heard about the health extension training through advertising and the general criteria for being selected as HEW were the following;

- being female
- Language: who can speak and write Oromiffa,
- 10^{th} grade complete
- Healthy: physically and mentally healthy
- Who is a member of the community in which they are going to serve

All the HEWs claimed that they fulfill the above requirements. Zonal and Wereda officials further stated that their political ideology is also one of the criterion; those who supports and the view points of the existing political ideology will be preferred to secure the peace and stability of the people they serve. As per the officials, candidates should be open to accept the political ideology of the government towards the country's developmental efforts.

Moreover, 10^{th} grade completes who if possible scored greater than or equal to two points (≥ 2) and those with score above "C" in Oromiffa are given priority. Besides being in good health condition, they should not be pregnant during selection period so as they won't withdraw from the training.

One of the criteria as seen previously is their ability to read and write Oromiffa fluently. However, some did not have the said knowledge. The Wereda officials in Boset said that they saw the problem and tried to prepare the reporting formats in English, which was also a problem.

During the first years of the program, the recruitment and selection criteria were not strictly followed and most of them were from urban areas; they didn't have the readiness to work in rural areas. However, recently the officials revealed that criteria

are strictly followed by the selection team and then documents are verified and approved by zonal offices.

In addition to this, after recruitment, at least one of the two HEWs in each HP has to be kebele cabinet; this is intended to empower them to make health as one part of the agenda of discussion in the kebele.

4.3 EDUCATION AND TRAINING

More than 88% of the respondents were satisfied with the class-room training and others said it is not as much as necessary. Regarding the practical training/apprenticeship, 95% (n=57) of them articulated that the training was not enough. The zonal officials said that it was planned to incorporate 25-30% theory and 70-75% practice. However, HEWs tell that the theory session is by far greater than that of the practical training.

Table 4.2. Attitude of towards education and training in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Satisfied with the inside class room training		
Yes	53	88.3
No	7	11.7
Satisfied with Practical training		
Yes	3	5
No	57	95

Inorder to compensate the gap between the needed skill and the actual skill of HEWs, integrated refresher trainings have been prepared. HEWs declared that though refresher trainings are very important, except that they are provided for a short period of time and they lack the practical part which was also seen in the trainings provided first.

Table 4.3. Updates/ refreshment trainings/ seminars of HEWs in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Availability of updates/ refreshment trainings/ seminars		
Yes	31	51.7
No	-	-
D. K.	29	48.3
Adequacy of updates/ refreshment trainings/ seminars (out of the 31 respondents)		
Yes	2	6.5
No	29	93.6

The HEWs complained about their relatively poor knowledge in providing delivery service. They said that there have been increased anti- and post- natal health services delivered which obviously contributed a lot for the health conditions of infant and mothers. Nevertheless, as most HEWs declared, they haven't even encountered case of delivery during their apprenticeship.

The HEWs clearly disclosed that they do not have confidence and the practical ability to attend delivery. Some of them said that they will call the TTBA in case of delivery. One HEW said,

> *"While the TTBAs face difficulties, they look for our help but we have little know-how than the TTBA. We feel embarrassed when mothers are referred to us".*

Having seen the problem with regards to delivery, ORHB has been giving one-month training for five to ten HEWs from each weredas. The wereda officials further articulated that this training is the practical one, and each HEW is expected to make a specified number of deliveries by herself. They said that it is expected that the training will reach all HEWs progressively.

As per the Wereda officials, the apprenticeship program of HEWs at first lack enough preparations by the WorHCs but as time goes on, there has been improvement. Some of the existing problems stated are the greater number of HEWs assigned at one place which is difficult for mentorship. And there were times where the Wereda health professionals were not informed about the objective of the HEP and about what kind of guidance they had to give. Students were not also oriented about the basics that they are expected to gain from the apprenticeship. The Wereda officials, however, stated that recently, HEP is one of the key assignments and HCs are also fully aware of this initiative.

Moreover, as per Boset Wereda official, the Wereda officials and TVET centers sometimes exchange information and discuss the gaps seen after HEWs are deployed.

In addition to this, the study has found out that ESHE have been giving considerable technical assistance in many aspects in Boset wereda. Besides providing trainings for voluntary health workers, they have been giving trainings for HEWs. In the said wereda, it has provided trainings for about 546 community members on basic health concepts; one from each "Gere" (a group containing 30 households). They have also given trainings to the Wereda levels with particular attention on reproductive health and child health, said Boset wereda official.

The "Tolay" Training (-training given at place called "Tolay") was amongst the trainings that HEWs regarded as a good opportunity to acquire important information affecting their job. The training, besides its main objective, gave the HEWs a chance to meet together and exchange ideas with higher officials. The training mainly aimed at equipping HEWs with good governance, Democracy, Health policy, HIV, Environmental Health and Agriculture giving special attention for good governance and Health policy. HEWs said that higher officials from the

FMoH and ORHB were there to discuss the issues regarding HEWs; those points that are beyond the capacity of the WorHCs were discussed. The training, however, has not yet incorporated all the HEWs. Both in Lume and Boset weredas, 17 HEWs each have taken this training - (Seven in the first and ten in the second round). Officials said that it was difficult not to get their service during the training period especially in places where there is only one HEW. In the 11 HPs that have two HEWs, one from each took the training. Those that have not yet taken the training are expecting that there will be a third round.

Table 4.4. Access to publication and practice of HEWs in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Access to publications related to public health issues		
Yes	35	58.3
No	-	-
D. K	25	41.7
Reading habit		
When I face with things that I don't know	3	5
When I have time	57	95
Commitment for service after training as HEW		
Yes	56	93.3
No	-	-
D. K.	4	6.7

Fifty Seven of the respondents (95%) said that they read the publications when they have time; only 5% of them said that they will read them when they face difficulties practically.

Majority of the HEWs (n=56) said that they are expected to serve for two years period as a commitment.

4.4 JOB ASSIGNMENT AND DESCRIPTION

More than 63% of the respondents said that they have a job description. They consider the 16 HEP packages as their job description. And the rest do not know their specific job description.

Table 4.5. Job description and attendance in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Availability of job description		
Yes	38	63.3
No	10	16.7
D. K	12	20
Availability of attendance		
Yes	11	18.3
No	49	81.7
Frequency of signing attendance (out of the 11)		
Once	8	72.7
Twice	3	27.7

As per the regional bureau, the first task of HEWs is collecting and documenting of basic data on the Kebele community to have full knowledge of what kind of community they are going to serve. Though they are expected to address the entire community later on their service, they have to select model households which will work with them. These families are those community members that are considered to be pioneer, open to accept new ideas and influential community members. Each HEW gives trainings on the packages for up to 60 members and graduates them when they are convinced and well informed of the health intervention. These graduates are then expected to demonstrate practical changes in the use of health agenda, personal and environmental sanitation and serve as and example to other community members. This is expected to expand gradually until it covers the whole kebele.

HEWs have also the responsibility to visit communities house to house. Doing this they teach families especially female/mothers who are the base for a family. Along with this, they also coordinate community for participatory health plans and ways to implement them.

They are also expected to bring together other voluntary health workers which are also tools for community acceptance and recognition of set goals.

Most of the HEWs (81.7%) do not have attendance to sign. They start and end their daily routine depending on specific conditions. They also said that they do not have fixed time therefore; they eat their lunch anywhere convenient.

Twenty Nine of them said that they go for outreach three times a week and others said that they do it more than three times a week. Most (2/3) said that they visit 11-15 houses per day depending on the distance between the houses.

4.5 WORKING CONDITION

The working base for HEWs is the HP; which is the lowest governmental health unit. HP construction of the region has lagged behind compared to other regions said regional bureau officials. As per the information from the Weredas, the total HPs needed are 33 and 38 for Boset and Lume respectively.

In Lume wereda, there are 38 kebeles containing 35 rural kebeles and three urban kebeles. 13 HPs are constructed and furnished. And out of the three urban kebeles, two have HCs under construction and one is planned to have a HP. The 13 HPs have two HEWs each. Kebeles that are distant and those having high population are given priority to have two HEWs said the Wereda officials. And four HPs do not have HEWs.

In Boset Wereda, the total number of HPs required for the Wereda is 33. Recently, 11 HPs are functional and 22 are under construction. That means 2/3 of the HPs are not yet ready. Though the 22 HPs are currently under construction, there are one HEW assigned for each and are currently serving the community on outreach basis. The 11 HPs have two HEWs each. Out of the total 33 kebeles, two HPs do not have HEWs yet.

Table 4.6. HPs in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Residential conditions		
In the house accommodated by the HP	24	40
In a personal residence	8	13.3
In a rented house	11	18.3
Others	17	28.3

About 40% of the respondents live in the house accommodated by the HP. HEWs whom HPs are not yet ready, live in temporarily given kebele offices, with their Development Agents (DAs), teacher associates, rented house or with their family if their service area is near.

The disparity between HPs and deployed HEWs is the first and foremost challenge of the region regarding the HEP. The Zonal officials said that there were six-tiers in health sector in the previous regime and it has now decreased to four. And previous clinics have to be either downsized to HPs or else they have to be upgraded to HCs. But, both the downsizing and upgrading were very difficult. The downsizing obviously creates dissatisfaction of the community who were at an infant stage to change their well-rooted recognition of curative health service delivery. Upgrading them was also difficult as it needed considerable budget.

Normally, HP construction was the responsibility of the government and the community. But, NGOs working in the region support the construction. For example, in Boset Wereda, World Vision has built and furnished five HPs and Support Africa constructed one HP.

Though the HP construction does not have specific standard, those HPs constructed by NGOs have adequate rooms (n≈5) and are constructed by hollow-block. Nevertheless, others constructed by the community are relatively smaller, with fewer numbers of rooms (n≈3) and are normally made of "chika" said the wereda officials. The HPs constructed by the community do not have room assigned as a bedroom for HEWs; most use the store as their bed room. They said it creates unfavorable working condition and it might have health hazards as some medicines have evaporation.

The problem of housing was an issue of discussion at the "Tolay Training" and the problem was noticed by concerned officials and thus, ORHB has promised to do what it can to construct houses for HEWs as per the Wereda officials.

In addition to this, most HEWs have problem with regards to working in remote areas. The wereda officials disclosed that some of the HEWs aspired to work in urban areas. Because of this, their practical motivation to go to remote areas is not enough.

4.6 SUPPLIES AND EQUIPMENTS

Among the common important items that are needed in the HP, 40% of the HEWs said that they have shortage of gloves; thus, sometimes they buy from their own pocket and sometimes they use ordinary plastic bags for protecting themselves in case of contact with blood. The problem of gloves seems to be dominant in Boset

(n=20/30) compared to Lume (n=4/30). The wereda official in Boset wereda also confirmed that they do not have supply of gloves.

On the other hand, in Lume wereda, about 93% of the HEWs said that they have shortage of stationery items. Correspondingly, the wereda officials also confirmed that in the budget year, they have shortage of stationery items. Nevertheless, the officials said that they give priority to HEWs than their wereda office as their working bases are in distant/rural places. Contraceptives, Oral Rehydration Salt (ORS) and malaria drugs (except for malaria free areas) are mostly available for all.

In addition to this, the Wereda officials have also stated that even if HEWs were able to perform delivery, there would have been shortage of delivery kits (except for some which UNICEF provided). UNICEF supplied the necessary medical supplies for three HPs in Boset and seven HPs in Lume Wereda. As per the information gathered from the wereda officials, at "Tolay" Training, number of functional HPs with and without delivery kits was registered. The wereda officials expect that it is to make arrangements for continued provision.

Respondents stressed the problem of transportation especially at times of immunization; they take the vaccines from the WorHCs. But, they have to return the vaccines to the Wereda at the end of each day because they do not have refrigerator for preserving, which they said is among the most challenging task. The Wereda officials on the other hand said that this problem arises when HEWs do not have proper record of their communities; if they have the record they can take the exact number and they won't be expected to return the rest.

Given a difficult topographical condition of the country, the other major problem is means of transportation. One of the respondents said, pointing to a mountain opposite to the HP,

"You see that mountain? Behind it there are communities of this Kebele; there were times that I spend nights there".

Almost all HPs (except three or four in Lume Wereda) do not have electricity. They said they buy kerosene/candle from their own pocket. But HEWs that have refrigerators are provided with kerosene and they use it for illumination as well. According to the Wereda officials, they know that kerosene is only provided for refrigerator not for illumination.

All said that they are not provided with raincoats or umbrella and majority of the respondents (n=56) do have personal mobiles as a communication media.

4.7 RELATIONSHIP WITH OTHER COMMUNITY HEALTH WORKERS AND THE COMMUNITY

4.7.1. Relationship with other Community Health Workers

When asked about the relationship with other Voluntary Community Health Workers (VCHWs), HEWs stressed that they are grateful of the support they get from other voluntary health workers. They said that communities have positive attitude towards VCHWs as their relationship with the community in other day to day activities and their relatively older ages makes them influential to mobilize community participation.

All the respondents have affirmative attitude towards other community health workers. Some of them confirmed that their job would have been handicapped if the VCHWs were not with them. Some said that their performance lose-pace during agricultural times when VCHWs engage in their agricultural duties as they are not full-timer health workers. Officials have also confirmed the works of NGOs to coordinate the efforts of HEWs with that of other community health workers. To

illustrate one, the guideline of HEWs prepared by ESHE details how to train VCHWs, work together, and other important responsibilities.

4.7.2. Relationship with the Community

Most of the HEWs (except n=12 of them) believe that the community has accepted them. They said the community has changed the attitude towards HEWs overtime. At first they complained about the fact that there is no enough curative measure at HPs. This discontent was clear as the community gave little attention and support. As time passes and as their awareness increases, the community has corrected the perception about the need of HEP and preventive measures. The respondent HEWs, said that the community, especially women have made behavioral change and their relationship with HEWs is being enhanced eventually.

Respondents said that the community has now become cooperative and demanded of the services of HEWs. During the study period most visitors of HPs were women. They seem to be very open to HEWs. It was observed that the community consults them in several aspects. HEWs said that even men are positive towards the efforts of HEWs; they come with their wives and ask about family planning.

Inorder to enhance the cooperation with the community, HEWs suggested that strengthened discussions and awareness creation about preventive health care system is beneficial.

4.8 SUPERVISION AND PERFORMANCE EVALUATION

According to most respondents, they said that they are accountable to Wereda officials. HEWs disclosed that Wereda officials are positive in many regards towards supporting them in any ways. All said that in case of inquiry, they get assistance form wereda health center. Yet, they complained that in case they are not at the HP

to give community service, supervisors black list them. One of those who do not have HP said,

"we give out-reach services all the time; and in case the supervisors come and if we are not at there due to miscommunication, they will report as if we were not on duty"

On the other hand, the Wereda officials said that they have record of all supervisions and before they black list them they advise them and then notice will be given accordingly.

Table 4.7. Supervision and performance Evaluation in Boset and Lume wereda

CHARACTERISTICS	FREQUENCY	PERCENT
Accountability		
Kebele officials	7	11.7
Wereda health officials	53	88.3
Frequency of performance evaluation		
Quarterly	32	53.3
Others	28	46.7
Responsible body to fill performance evaluation		
Wereda officials	52	86.7
Kebele officials	8	13.3
Supervision while service delivery		
Yes	51	85
No	9	15

All HEWs need to provide monthly performance report to the Wereda. The Wereda officials are also required to revise the reports, discuss them with HEWs, take actions within their scope and pass the rest to the zone. In Lume wereda however, they report twice in a month (once in 15 days). Even those that are from distant areas

either come or send it; officials confirmed that submission of report is strictly obeyed.

They all know that they have periodic performance evaluation. But the 46.7% of them do not know how many times they are evaluated.

One of the major challenges of the HEP is with regards to Wereda capacity. As per the Wereda officials, they have no enough resources (human, material and financial) for supervision. The weredas try to make it work within their capacity; but to reach all sites fairly, adequate resources are required (human resources, motorcycle/vehicle, etc.). They lack resources that are equivalent to their responsibilities. As we had a glance of budget requirement for the program in the literature review of the study, huge amount of fund is required to finance the operation. In Boset Wereda, for instance, 20 officials are required. Yet, there are about six officials working. Moreover, the Weredas are serving the duty of Nucleolus HCs besides their assigned responsibilities (Nucleolus HCs are health centers that will embrace five HPs and serve a population estimated to be 25,000). The total HCs required for the Wereda are about seven (33/5~7). Four are under construction said wereda officials. Construction of nucleolus HC is the next step after HPs are completed and until then, Weredas are busy to cover their role. These six persons at the Wereda have divided the responsibility and they are working in team. Among them one is the focal person assigned for HEP. Similarly, in Lume wereda, there are only seven personnel in the wereda serving 38 kebeles.

Moreover, wereda officials said some of the trainings are only given to the HEWs and we might not know about the full detail of the trainings and it would be difficult to evaluate the aftermath performance against the training (this was specific in Lume Wereda; Boset Wereda officials said that they participate in the trainings that were prepared by ESHE).

The Wereda officials supervise HEWs while they give service either at the HPs or outreach services. However, the study suggests that those which are relatively near to the Wereda and/or those places that are accessible are supervised often. And those at far sites and/or with difficult geographical sites have less or no supervision at all.

Feedback and discussion on the results: The Wereda officials discuss the results of reports after the periodic report and performance review. Communities are also given the chance to evaluate HEWs' performances; they express what they feel at the time of gatherings. They sometimes come to the WorHCs if they have complaints about HEWs, disclosed the wereda officials. ESHE officials have planned to undertake quarterly performance appraisal meeting with the wereda officials and HEWs, said Boset wereda official. But, they have not made it for the past three quarters this year.

4.9 MOTIVATION AND REWARDS

Most of the HEWs (90%of them) declared that outstanding performances have not been recognized. Some (10%) said that they received oral incentives/praises. When asked almost 97% of them want "Future Carrier Development" and "Training" as a reward.

All respondents said that monetary incentives, oral incentives, good leadership and supervision, adequate equipment and supplies, decision making, community acceptance, future career development opportunity and good working relationship with other health workers influence their job. Regional and Zonal officials said that the program acknowledges the need for motivation and reward system and they are working on it. Wereda officials on the other hand revealed that they recognize outstanding works of HEWs and give feedback after periodic performance reports.

As per the Wereda officials, some of the HEWs are naturally talented and have good interpersonal skills that are accepted by the community. The highest share of their job should be towards persuading and educating what is important for the community. Therefore, those stakeholders such as ESHE that support the HEP technically give trainings with regards to interpersonal skill and communication to increase their influential power which in-turn grants community acceptance as a reward.

4.10 OTHER HRM COMPONENTS

Annual leave: All except for three of the respondents know they are entitled to annual leaves of 20 days. All of them know that they are entitled to sick leave.

Transfer: Respondents also disclosed that they can apply for transfer within the Wereda and not otherwise. On the other hand, the officials said that transferring from place to place might not be applicable always; especially after all kebeles are accommodated by two HEWs. During the first phase of HEP, it was sometimes difficult to have female member of the kebele having the set criteria, therefore, member of the wereda community was selected even if she is not the kebele member. If currently there is HEWs of that kebele, transfer might be made. Otherwise, the request might not be acceptable as being part of the kebeles community is one qualification for HEWs.

Maternity leave: The respondents know that they have maternity leave of 90 days. And as per the officials only three have utilized it and fortunately these were from those areas having two HEWs.

Medical coverage for illness: HEWs do not have benefit of free medication for illness. The Wereda officials said that they are not the only ones that do not have this privilege; this is true for all the personnel in health delivery at present.

Human resource guidelines and procedures: The wereda officials when asked if they have clear human resource guidelines and procedures for implementing with regards to the HEWs, they said they do not have clearly specified procedures.

In Lume Wereda, one HEW (who previous had disciplinary records and warning letters) requested resignation and the request is delayed as there are no clear procedures to handle this type of cases. The case is being reviewed by the zonal officials.

In Boset wereda, two of them left the job before they serve their two years of service after the HEWs training; one after one month and the other after one year of service. The wereda officials said that they could not trace them. They finally disclosed the case to the zone.

Professional Association: HEWs of the study area do not have professional association yet. In Lume Wereda, however, they said that we heard about it as we were celebrating International Women's Day of the year 2000 E.C. Others said that they have discussed this issue at the "Tolay" Training. Lume wereda officials also revealed that after the discussion at the training, some HEWs came to the wereda to ask for assistance in organizing a meeting to form the association. And the wereda officials confirmed that they had met once till the time of wereda officials' interview.

4.11 INFORMATION MANAGEMENT

The study revealed that though it is not regular, HEWs have meetings with the community and other community health workers. HEWs have meeting with

community health workers when needed. Only 25% of the HEWs said that they recorded meeting minute for themselves. None of them record their daily routine. They all said that they have performance review with Wereda officials regularly; in Boset wereda, they submit the report monthly between 10th till 15th of the calendar month. And in Lume wereda they present their report twice in a month (per 15 days). They also have pre-printed format for reporting. In case there is a shortage of the pre-printed format, they use ordinary white paper for reporting.

4.12 ATTITUDE OF HEWS TOWARDS THEIR JOB

More than 98% of the respondents like their job and they want to develop their carrier within the health sector.

One of the HEWs said

"I never expected that giving community health service is this much interesting. Even though there are lots of challenges working as HEW, I am very satisfied"

Another respondent said

"I am from this same Wereda and I thought that I knew how the community in this wereda lives but I was wrong; there were many things that I didn't know. I now am able to see the problems of the community clearly and I consider myself as lucky to be able to help them"

Future Career: One of the biggest questions of HEWs is the issue of career path. They said that they have heard that they would be promoted and will have educational opportunity but they are not sure about it. When asked about what they would prefer for outstanding performance, they preferred to have educational opportunity.

4.13 SAFETY AND PROTECTION

Respondents were inquired if they have free medical service in case of work-related accidents and none of them have this service. They said that they used to have it before but recently, they were told that they are no more entitled to this service. Officials on the other hand said that if they have accident while they are on duty the policy allows them to get medical service.

Likewise, when asked about their use of gloves in case of contact with a bleeding patient only 2/3 of them use it at all the time. Others say that they don't have contact with a blood often and in case they encounter, they use plastic bags or gloves that they buy out of their own pocket.

With regards to harassments encountered during working hours, 5% of them revealed that they previously faced it. When asked if they had reported it, none of them did. Some said they know that there are difficult incidents regarding the issue therefore, they go longer distances and places for the first time with VCHWs. VCHWs are often older and familiar to the community and HEWs feel comfortable to do outreach services with them.

In addition to this, HEWs have stressed the problem of security guard for the HPs. This problem is not specific to distant areas. Some have security guards hired by the community but they are not responsible to do their job regularly; they complain about their salary. They unveil that there are cases where a person with mental problem come to the HP and when they go outreach, they find the wall of the HPs damaged by inks.

4.14 SALARY AND BENEFITS

Respondents said that they have a salary of Birr 658 which they said is not enough compared to their assignment. They do not work during the weekends except on

some Sundays when they have meetings with the community. They are not paid for overtimes. More than 80% said that they are paid perdiems for campaigns and quarterly evaluations. They all said that they have pension.

V. CHAPTER FIVE

DISCUSSION

This section of the study deals with discussion of the major findings of the results and what they mean for this study.

5.1 RECRUITMENT AND SELECTION

This study agrees with the Program's intent to recruit female which is important as women/mothers often take the primary role to care of their children as well as the family in general. Moreover, female population has key role for health and education of children and economic welfare of Households as well as for the women themselves. Furthermore, during the study time the number of women visiting HPs indicates that women/mothers are the primary users of the service. The study takes this as a success of the design of the program.

Moreover, in rural areas where female are burdened with different roles at home and in the field, they often do not have time to go to schools or other places to acquire important information for themselves. Hence, this program's intent to provide outreach services is appropriate and it seems that it is the most workable solution as most HEWs affirmed.

HEWs are also required to come from the locality that they are going to work. Applicants should bring letter from the kebele/peasant association which assures that they live in the said kebele/peasant association. People who have traditional beliefs and practices tend to preserve them. Resistance of change is a common characteristic of human beings. Change to a new belief or practice may take away the feeling of security; unless the new knowledge or practice has acceptance and approval by the group. Therefore, community endorsements are gained by those people who understand the organization of the community and share the beliefs and culture. HEWs of the same origin can talk the same language, live together and

therefore are the preferred candidates. Corresponding to this, the program opts for applicants who are a member of the community.

As seen in the Table 1 the result section, most HEWs are at their young working age (19 to 23); this is also useful in some way as young people are receptive, energetic and open to new ideas. Moreover, they have longer probable time to serve the community.

Regarding the political background, the study has found out that HEWs who correspond to the government political ideology are given priority so that they would have political commitment towards their job. This would obviously endow the HEWs with additional commitment to their personal commitment towards performing their jobs. However, similar to any other health professionals, HEWs should be valued by their professional interest and quality, rather than political belief. HEWs are there to implement the policies of the government and for that, required training would make them understand and implement them.

Furthermore, at least one of the two HEWs has to be kebele cabinet after they are assigned to their job. This would help the HEWs to allow them to integrate health issue as part of every activity within the kebele. It would also be a tool to incorporate health issues with other social, political and economical concerns. It further let them work on health awareness among other kebele officials. This also gives them a chance to integrate plans and their implementations to achieve common goal of the kebele which in turn is also the subset of broader developmental goals.

5.2 EDUCATION AND TRAINING

The results disclosed that majority are satisfied by the inside-classroom training and not satisfied by the practical training. Apprenticeship takes place in WorHCs. Each

WorHCs functions as "Nucleus Health Station" as well. During apprenticeship, students will be exposed to common health problems of the community and to the common treatments that are given. But this is not problem-free; it was also shown that the WorHCs were not fully aware of the objectives of HEP during the first years of the program. This result was also supported by the study made by ESHE and ORHB TVET Commission which stated that due to lack of awareness of health professionals at the wereda, HEWs were not able to get the necessary support during their apparentichip. Though the wereda officials said that awareness has increased at present, it has to be continually guaranteed.

It was also learnt that particularly skill based training is deficient to furnish them with adequate delivery care. And on the other hand, delivery care from qualified health professionals is recognized as a key point for lessening of maternal and neonatal mortality. The proportion of births that took place in health facilities referring a five years data is 5% (CSA, 2005). Knowing this, the probability that they encounter cases of delivery during their apprenticeship is rare. And, in a country where mothers and child death is among the highest, HEWs' insufficient knowledge means a major handicap to them. Moreover, having adverse topography and scattered settlement, those mothers with delivery complications and/or in cases where it is beyond the aptitude of TTBAs, most are likely to die before they reach the WorHC.

To fill the skill gaps observed, refresher trainings have been prepared by different stakeholders. The skill-based refresher training on delivery that has been provided by ORHB should be continued until the training reach to all HEWs. Moreover, it also requires continuous supportive supervision and follow-ups to realize the outcome.

ESHE's effort in awareness creation among the smallest section of the community members in Boset wereda is very commendable. Moreover; this organization has given health trainings for WorHCs. As WorHCs are responsible to manage, supervise and support HEWs, they should also have to have proper knowledge and information about the program.

Assessing the general conditions of the HEP, the time given for the theoretical and practical training is nearly one year. This is enough to acquire the necessary knowledge said Regional Bureau officials. However, the quality with regards to the students' readiness, teachers' skill, and proportion given to the theoretical and practical training are compulsory. Generally, the cumulative opinion of both the HEWs and the officials suggest that the overall important points for educational opportunities in the HEP shall sum up the following;

- Formalized classroom teaching equipped with demonstration techniques
- Supervised apprenticeship with oriented tutor
- Orientation of new staff to other community health workers, kebele officials and to the community which they will serve.
- Encourage team work among the stakeholders for achieving predetermined goals
- Proper coaching , supporting supervision and evaluation
- Training workshops/working conferences/Refresher courses
- Preparing means of advanced study for future career path

Distribution of publications related to public health is also considered important to develop both the quality and interest of HEWs. They have to be encouraged to develop the habit of reading them.

It was disclosed that two-year commitment is required after HEWs receive a one-year education and training. Moreover, it helps them pass the challenges of emotional breakdowns due to lack of exposure and experience during the earliest times of placement. It will also urge applicants of HEP to think twice before deciding to be engaged in the program. This in turn saves the government from losing its personnel before they serve the community.

5.3 JOB ASSIGNMENT AND DESCRIPTION

HEWs data collection and documentation of basic socio-demographic data on the Kebele community is considered as the first and most important element of their job. In addition, as HEWs are also closer to the community to give door to door health service, it is easier to access this information and to have understanding of the composition of the community. This in turn is useful to inject health or any other community interventions. Coordinating VCHWs and the community will help them build a team-spirit for a common goal.

Furthermore, HEWs should be well-informed on what job description means in general and their job description in particular so as to make them responsible and accountable to it.

Most HEWs said that they don't sign attendance. The nature of their job is not convenient to control them using attendance; they do outreach services and they are supposed to live in the HPs. Having daily performance reports, written confirmation of where HEWs are while they do outreach services along with reports from supervisors could be used as controlling mechanism.

5.4 WORKING ENVIRONMENT

As discussed in the literature review part, HP is a small clinic-like place staffed with two HEWs that are expected to serve a population of about 5,000 people in a kebele.

The fact that the community has been involved in the construction of HPs helps to develop a sense of acceptance and belongingness. However, the disproportional distribution of HPs and HEWs is the most difficult gap in the region that needed to be given the principal attention and construction of HPs should be strengthened. Moreover, the construction should consider bed room for the HEWs as it is one of their main concerns.

5.5 SUPPLIES AND EQUIPMENTS

In most of the cases, they said, reaching the community as well as the WorHO is so difficult. Means of transportation which is affordable should be considered. Though it may call for further assessment, pack animals could be one alternative. Otherwise the complaint might be reflected on their motivation towards serving distant communities as well as towards their job in general. The principal investigator herself has witnessed the difficulty of transportation in the area, during her assessment. Some places are very far and not accessible and some are not even convenient to use a motor cycle. The problem will obviously be aggravated in rainy seasons.

In addition to this, inaccessibility of places and poor transportation will also contribute for the shortage of supplies and smooth operation. The fact that most HEWs have personal mobile is helpful, principally in those areas where transportation is inaccessible.

Implementation guideline of 2005 listed the commodities and logistics those are required for full-functioning of the program (See Annex Three). Common complaints of HEWs during this study were also part of this list; Kerosene lamps, fuel (kerosene) and female bicycle.

Proper supply of materials and equipments, besides assisting proper functioning of the program, helps to enhance their morale and influential capacity of HEWs over the community. Hence, efforts should be made to find means of obtaining supplies and equipments required for the job by all concerned.

5.6 RELATIONSHIP WITH OTHER COMMUNITY HEALTH WORKERS AND THE COMMUNITY

5.6.1 Relationship with other Community Health Workers

Harmonized efforts by different community health workers are believed to be important for full and facilitated achievement of the desired goals. Their coordination besides helping as a pillar for HEWs, they help to incorporate health activities with the overall development and also to promote united participation.

The harmonization of the two at the lower level is pinpointing of the coordination of the NGOs working in the area and the government; it is very essential for the productivity of the program to meet short-term objectives and long-term sustainability; the government gain assistance for the implementation of its strategies and the NGOs will be in better position to notice the outcomes and make it sustainable if they coordinate their effort with a relatively permanent governmental structure.

5.6.2 Relationship with the Community

As per the respondents, community involvement has increased in many ways; the community has been involved in the construction of HPs, it has developed a sense of belongingness as well. The study shows that the community has started to insist the service from the HEWs. This is considered as a huge step towards the behavioral change vis-à-vis this strategy.

5.7 SUPERVISION AND PERFORMANCE EVALUATION

Proper and regular supervision of HEWs is believed to help HEWs encourage the team spirit and also to encourage and strengthen the coordination of HEWs and Wereda officials. Hence, the Wereda officials (or other supervisory body) shall have a constructive communication with HEWs inorder to make them consider the leadership side of the supervision positively. Otherwise, negative feeling towards the officials will create a bad influence on the works of the HEWs.

Furthermore, HEP in general is close to the community at grassroot. The program supports the contemporary and workable philosophies, "people's participation and Decentralization", as its focal point. They have become the core point to coordinate construction HPs, recruitment, selection and placement, and then coordination, guidance and supervision of HEWs along the established HEP set by the FMoH. Hence, their capacity in-terms of quality and quantity of human resource assigned for the HEP is has to be comparable to the responsibility they bear. Strengthening the Wereda capacity appears to be the best solution to create improved environment for HEP.

Feedback and discussion on the results: feedback on the results of supervisions and evaluations serve as a base for transparent communication and improvement of drawbacks observed; therefore, the discussion of the results of evaluations should be enhanced.

5.8 MOTIVATION AND REWARDS

Human resource is the most significant and valuable resources of all other resources (human, material and financial etc) for any organization. Especially, in community health service delivery where human resources play significant role, exceptional attention has to be given for their well-being and well-functioning. This resource,

unlike other resources, has both physical and psychological being which entail for both concerns to acquire their output out of their full potential.

According to this study, as HEWs are front line service deliverers to the community, they have the capacity to mobilize the community and work in them and if they are provided with proper education, training, and enabling environment (which one of them is motivation and reward for superior performance). Moreover, it is clear that motivational tools are used as a sign of go-ahead for successful results and better performances. As discussed previously, motivation could be both financial, non-financial and combination of the two. Cost-effective and accepted motivational tools shall be considered following due assessment. And in this case, where the weredas do not have enough financial resource, good leadership and supportive management could be used as a motivational tool until defined motivational system is developed.

5.9 OTHER HRM COMPONENTS

HEWs are supposed to know their benefits with regard to their leaves and transfers. Having a civil service manual and HEP implantation guideline at hand might be useful to aware HEWs about their rights and obligations. Both the wereda officials and the HEWs should be aware of the rules, regulations and policies with regard to the human resource. Moreover, unless and otherwise there is reserve human resource pool, the program would be disadvantaged in cases of leave of absences, death, permanent illnesses etc. Moreover, it would make the program inflexible with regards to inquiries of transfer due to different reasons.

Professional Association: The idea of forming professional association might be too early for the program. The wereda officials in Lume deserve appreciation for playing their role in supporting the HEWs to form HEWs association. It is also one step up in the direction to exploiting the benefits from professional association.

This study also advocates the advantages of forming professional association plus the formation will have positive contributions;

- ✓ To create a stage of experience sharing among them,
- ✓ To boost HEWs self-esteem that they are part of professional association,
- ✓ To create conducive environment for those researchers that have interest to work in the area,
- ✓ To create opportunity for organized voices which would help them feel sense of ownership as they feel that their voices will be heard.

If conditions are difficult for the association to stand by its own, the possibility of embarrassing it under experienced professional associations in the field (such as Ethiopian Public Health Association) could be one alternative. Moreover, HEWs are the backbone of public health in the country as the majority of the population is rural and HEWs' contribution for the health of the rural community is very significant. Hence, this has to be taken into consideration and these personnel, HEWs, need to be the nucleolus of all public health concerns.

5.10 INFORMATION MANAGEMENT

The HEP implementation guideline is the principal information device to create comprehensive understanding about the program; The Health Extension Implementation Guideline (February, 2007) appear to be inclusive of all the important components of the program including the responsibilities of stakeholders. This guideline is the latest version of the previous implementation guideline (2005). Amendment of the guideline indicates availability of continuous assessment towards disseminating information. The manual is prepared in Amharic which is easier to be comprehended by both the officials as well as most HEWs. It would also be easier to translate the Amharic version to respective local languages than to do it from the English version. To serve its purpose though, it would be more suitable if

all HPs and all stakeholders have the guideline so that each of them knows their responsibilities.

Furthermore, communication network from top officials at the national level to lower ones along the ladder has to be improved. This would help HEWs to have a larger scope of the program out of their Wereda (to regional and then nation-wide plan and its implementation); this in turn would make them feel a sense of ownership. Moreover, the information network among Wereda officials/to be assigned supervisors/ and the higher levels have to be strengthened as the former are the ones to witness the result - practical service delivery to the community.

Furthermore, as HEWs are the front liners, they are the base of the bridge that connects the grass-root at the lower edge and the decision makers at higher levels. Hence, information to and from them should be documented, organized and then disseminated to the concerned which is also one factor towards the programs achievement.

5.11 ATTITUDE OF HEWS TOWARDS THEIR JOB

One of the most appealing findings for the program is that they have positive attitude towards engaging in health service delivery to the community; virtually, all are willing to make their carrier in the health sector. This definitely is the biggest input for the program's success at present and its potential sustainability. To develop this inspiration, the program shall have its HRM strategy with well defined career plan for them.

Future Career: Designing further trainings and preparation for future career may not be easy for this program which is very young and has a long way to meet objectives. Yet, balancing the interest of both sides would be supportive to make HEWs understand the status of the program compared to the set goals. Informing

about the planned career structure would neutralize the situation. Moreover, HEWs should be informed about the factors that are planned to influence their future carrier (e.g. performance appraisal, time of service etc).

Inorder to harmonize the organizational and individual part of HRM, the program have to have clear HR procedures and policies. The wereda officials should have also the confidence to do their job formally and according to the set principles.

5.12 SAFETY AND PROTECTION

The well-being of the HEWs is highly mandatory for the well-being of service delivered by them. Particular policies with this regard should be informed to the HEWs. Problem of security guards should also be given due concern.

5.13 SALARY AND BENEFITS

HEWs contend their salary is not enough compared to what they do. They further stressed that this is due to the fact that they use it for communication, transportation and other miscellaneous costs from their own pocket. Though it needs further study, either arranging transportation and communication allowance or reimbursement of costs might be taken as an option.

VI. CHAPTER SIX

CONCLUSION AND RECOMMENDATION

Human resource is the most significant and valuable resources of all other resources (human, material and financial etc) for any organization. Especially, in community health service delivery where it plays significant role, exceptional attention has to be given for their well-being and well-functioning. This resource, unlike other resources, has both physical and psychological being which entail for both concerns to acquire their output out of their full potential. The study has also based this concept and tried to give an overall scene of the HEP in the study areas. And this chapter in particular presents the final say of the study corresponding to the objectives specified in the first chapter.

1. Results reveal that majority of the HEWs are satisfied by theoretical part of the schooling however, they were not fulfilled by the skill based trainings. Therefore, skill based trainings particularly on delivery should be continued to reach all HEWs. Moreover, proper follow-ups and appraisals of trainings have to be made to acknowledge the outcomes.
2. One of the major problems of the HEP in the study area is the disproportional distribution of HEWs and HPs. As HPs are the working base for HEWs, concerted effort of all concerned shall support the construction of HPs.

- The relationship between HEWs and VCHWs is much appreciated; the coordination and support should be motivated for further reinforced affiliation.
- The community has increased their awareness about the health service delivery and has started to claim their rights. However, further studies which integrate communities' direct response with regard to the service rendered by

HEWs and the changes seen and the potential progress on them would be complementary to the results of this study.

3. Majority of the respondents have positive attitude towards engaging in health service delivery to the community; most of them are willing to make their carrier in the health sector. This would be one input for the program's sustainability. Hence, the program shall have its HRM strategy with well defined career plan for them.

4. Human resource procedures are not well-defined and communicated to the wereda level. Concerned parties should have and then communicate Human resource procedures and guidelines along the different levels.

- The weredas do not have proportional capacity as to their assigned responsibility. This further has been affecting the human resource function. Hence, further studies comprising ways of acquiring resources (Human, material, financial) that are comparable to the jobs assigned have to be considered.
- Comprehensive researches on the determinants of human resource development for health (at all levels) are suggested to support the HRD of the sector.
- Though training of HEWs is nearly in its last phase, there has to be due consideration for reserve human resource pool for future requirement in case of attrition, leave of absence, death etc.

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ANNEX. I. Questionnaire for Health Extension Workers

Identifying information- Address: Wereda: _____ Kebele: _____		
	interview 1	interview 2 (if there is rescheduling)
interview date(dd/mm/yyyy) interview start time	___/___/____ ____ to ____	___/___/____ ____ to ____
interviewer number & name	No. _____ Name:_____	No. _____ Name:_____
Results	*Completed*..... 1 *Postponed/rescheduled*..... 2 *Refused*..... 3 *other (specify)* _____	
<u>Note</u>: if the interview is Postponed/rescheduled, write the rescheduled date___/___/____ & time (___:___)		

A. CONSENT STATEMENT

"My name is _____. I represent a student from Addis Ababa University (AAU), Regional and Local Development Studies (RLDS). Currently, she is working her masters on Human Development in Health, the case of Health Extension Workers in Eastern Showa.

I would like to ask you some questions regarding the working condition in the HEP. You have been selected as your Wereda is randomly chosen to be included as a study area. Your participation will be very much appreciated as it contributes towards the efforts made to enhance the working conditions of the HEP.

Your participation in this study is absolutely voluntary; you have the right to refuse answering to any of the questions as well as to refuse participating in the study in general. All your answers will be treated with the highest confidentiality. Your responses to any of the questionnaire will not be given to anyone else and no reports of the study will ever identify you. I would appreciate if you could allow me 30 mins of your time.

In case you have any questions or concerns about this study or your rights as a study participant you may contact Adey Araya at the following telephone number: _____.

Are you willing to participate in this study?
Answer: Yes =1 |__|..... (Continue to the question part)
No= 0 |__|..... (Skip to the next participant)

A. IDENTIFICATION OF THE RESPONDENT

A1	Sex	Male ..... 1 Female..... 2	
A2	Age	Years..... |_____| D.K. 99	
A3	Religion	Orthodox..... 1 Muslim..... 2 Catholic ..... 3 Protestant ..... 4 Other(specify)_____ _____	
A4	Marital status	Never married ..... 1 Married ..... 2 Separated..... 3 Divorced..... 4 Widowed 5	
A5	Educational status before joining HEP training	Elementary..... 1 Secondary..... 2 Other(specify)_____ _____	
A6	Year(s) of service as HEW	< 6 months..... 1 6 months to 3yr..... 2 > 3yrs..... 3 Other (specify)_____	
A7	What was your occupation before the health extension training? *Instruction: if the respondent does not know his/her occupation ask him/her to choose among the alternatives*	Student..... 1 Housewife..... 2 Retired..... 3 No work..... 4 Other(Specify)_____ _____	
A8	A8a when do you start living in this Wereda?	< 6 months..... 1 6 months to 1yr..... 2 1yr – 3yrs..... 3 3yr – 5 yr..... 4 > 5yrs..... 5	
	A8b when do you start living in this kebeles?	< 6 months..... 1 6 months to 1yr..... 2 1yr – 3yrs..... 3 3yr – 5 yr..... 4 > 5yrs..... 5	

B. Recruitment and Selection

B1	Who told you that there is a training of HEWs?	Announcement..... 1 Selected from school..... 2 Someone recommended you in person..... 3 Other(Specify)_____ _____	

B2	At what time of joining the HEW training; which one of the following was true about you HEW? *Note: the answer could be more than one.*	10th grade completion.....1 Being the member of the community..... 2 Other(specify)_____ _____	
B3	Did you have the interest in health service delivery before this training?	Yes..... 1 No 0	

C. Education and Training

C1	What was the total duration of the inside- training?	No. of months..... |___|	
C2	Do they think that the classroom training is enough to prepare you for the job of HEW?	Yes..... 1 No ..... 0 D.K..... 99	
C3	What was the total duration of practical training?	No. of months..... |___|	
C4	Do they think the practical experience was enough to prepare you for the job of HEW?	Yes..... 1 No ..... 0 D.K..... 99	
C5	What were the major problems that you face during your training?	No problem..... 0 Teachers..... 1 Text Books..... 2 Reference books..... 3 Class rooms..... 4 Other(specify) _____ _____	
C6	Do you have access to publications related to public health issues?	Yes..... 1 No 0	
C7	C7a Which of the following are available at your HP? Note: the answer could be more than one	MoH publications..... 1 Journals..... 2 Newspapers..... 3 Newsletter ..... 4 Reference books..... 5	
	C7b Do you read them?	Yes..... 1 No 0	**-> C8**
	C7c When do you read them?	Regularly..... 1 Sometimes..... 2 When I face with things that I don't know..... 3 When I have time..... 4	
C8	C8a Do you get updates/refreshment trainings/seminars?	Yes..... 1 No 0	**-> C9**
	C8b what is the approximate interval between the update trainings/seminars?	No. of months..... |___| No specified interval. 9	
	C8c what is the approximate duration for the update trainings/seminars in each interval?	No. of days..... |___| No. of months..... |___| No specified duration..... 9	
	C9d Do you think the duration of the trainings/seminars is adequate?	Yes..... 1 No 0	
C9	Have you been comfortable with the way the trainings are delivered?	Yes..... 1 No 0	

C10	C10a Have you entered in a commitment to serve for a specified period of time, after the Health extension training?	Yes..... 1 No ..... 0 D.K 99	 -> D1 -> D1
	C10b For how long?	No. of month/s..... |____|	

D. Job Assignment and description

D1	D1a Do you have job description?	Yes..... 1 No ..... 0 D.K. 99	 -> D2 -> D2
	D1b Is the daily routine similar to the specified job description?	Yes..... 1 No..... 0	
D2	At what time do you start your daily routine?	|__:__| No fixed time 0	
D3	At what time do you finish your daily routine?	|__:__| No fixed time 0	
D4	Do you have fixed lunch time?	Yes..... 1 No 0	
D5	Where do you eat your lunch?	At my residence..... 1 At the HP..... 2 In the field..... 3 Anywhere convenient ..... 4 Other(specify) _____	
D6	D6a Do you have attendance to sign?	Yes..... 1 No 0	 -> D7
D7	How many days do you go outreach per week?	Three days a week ..... 1 > than three days..... 2 Other(specify) _____	
D8	How many homes do you visit per week on average?	>5..... 1 5-10..... 2 11-15..... 3 > 16..... 4	

E. Working condition

E1	Where do you live?	In the house accommodated by the HP..... 1 Personal residence/ with my family..... 2 In a rented house..... 3 Other(specify) _____	 -> F1 -> F1 -> F1
E2	When do you visit your home/family?	Once a week..... 1 Once in two weeks..... 2 When I have free time..... 3 I live with them ..... 4 Other(specify) _____	

F. Supplies and Equipments of the HPs

F1	F1a Which of the items are necessary at the HPs? Note: the question might have more than one answer.	Stationeries..... 1 (Pen, pencil, paper etc.) Gloves..... 2 Raincoat..... 3 Umbrella..... 4 Hat ..... 5 Motorcycle..... 6 Bicycle..... 7 Other(specify) _____ _____	
	F1b Which of the items are available at the HPs?	Stationeries..... 1 (Pen, pencil, paper etc.) Gloves..... 2 Raincoat..... 3 Umbrella..... 4 Hat ..... 5 Motorcycle..... 6 Bicycle..... 7 Other(specify) _____ _____	
F2	F2a Which of the items/drugs are necessary at the HPs?	Contraceptives..... 1 Oral rehydration salt (ORS)..... 2 Anti-malarial drug..... 3 Other(specify) _____ _____	
	F2b Which of the items/drugs are available at the HPs?	Contraceptives..... 1 Oral rehydration salt (ORS)..... 2 Anti-malarial drug..... 3 Other(specify) _____ _____	
F3	What kind of communication and media facility are available at your HP?	Office telephone..... 1 Personal mobile..... 2 Other (specify)_____ _____	

G. Relationship with other community health workers and the community

G1	Who is/are other community health workers in your community? Note: **TBA**: Traditional Birth Attendants, **CHA**: Community Health Agents	TBA..... 1 CHA..... 2 Other (specify)_____ _____	
G2	Do you think you have good working relationship with other community health workers?	Yes..... 1 No 0	
G3	Do you think the community has acknowledged your effort?	Yes..... 1 No 0	

H. Performance Evaluation

H1	To whom are you accountable to?	Kebele officials..... 1 Wereda health officials..... 2 Nucleolus Health center..... 3 Other (specify)_____ _____	
H2	H2a Do you have periodic performance evaluation?	Yes..... 1 No ..... 0 D.K 0	 -> **H3** -> **H3**
	H2b How many times a year are you evaluated in a year?	Per 3 months..... 1 Per 4 months..... 2 Per 6 months..... 3 Once a year..... 4 Other (specify)_____ _____	
	H2c Who is responsible to fill your performance evaluation?	Kebele officials..... 1 Wereda health officials..... 2 Other (specify)_____ _____	
	H2d Do you get feedbacks about the results of the performance evaluation?	Yes..... 1 No 0	
	H2e What is the basis for performance evaluation? Note: the question might have more than one answer.	Attendance..... 1 Qty of model family..... 2 Community evaluation..... 3 Cumulative performance report.....4 Other (specify)_____ _____	
H3	Have you been supervised while you give service to the community?	Yes..... 1 No 0	

I. Motivation and Rewards

I1	Do you like your job?	Yes..... 1 No 0	
I2	What do you think are the things that influence your work? Note: *the answer could be more than one.*	Financial incentive..... 1 Verbal incentives..... 2 Good leadership and supervision..... 3 Adequate working equipment & supplies..... 4 Decision making and participation..... 5 Community acceptance..... 6 Future carrier dev't possibility..... 7 Communication with other community health workers..... 8 Other (specify) _____ _____	

I3	Which one of the following is/are available for outstanding HEWs in your Wereda?	No thing..... 0 Certificates..... 1 Praise Letters..... 2 Financial incentives..... 3 Possibility of education..... 4 Other (specify) _____ _____	

J. Personnel management

J1	J1a Do you have annual leave?	Yes..... 1 No .....0 D.K..... 99	**-> J2** **-> J2**
	J1b How many days a year?	_____ days	
J2	Are you entitled for sick leaves?	Yes..... 1 No 0	
J3	J3a Are you entitled for maternity leave?	N.A.....0 Yes..... 1 No..... 0 D.K..... 99	**-> J4** **-> J4** **-> J4**
	J3b How many days?	_____ days	
J4	Do you have access to free medication in case of illness?	Yes..... 1 No..... 0 D.K..... 99	
J5	J5a Are there possibilities for transfer in case you want to work in another area?	Yes..... 1 No..... 0 D.K..... 99	
	J5b Have you ever requested for transfer?	Yes..... 1 No 0	**-> J6**
	J5c Why?	In/accessibility of roads..... .....1 Working conditions..... 2 Leadership style..... 3 Community acceptance..... 4 other (specify)_____ _____	
J6	Is there a civil service manual in your HP?	Yes..... 1 No.....0 D.K..... 99	
J7	What do you want to be your future carrier?	In health profession..... 1 (Nurse, environmental science etc.) Other than health profession..... 2	
J8	J8a Are you member of any professional association?	Yes..... 1 No 0	
	J8b Have you ever discussed about forming association for HEWs?	Yes..... 1 No 0	

K. Safety and protection

K1	Do you have medical expense coverage for accidents during working hours?	Yes..... 1 No 0	
K2	Do you use gloves while there is a need to contact with other persons blood?	Yes ..... 1 Sometimes..... 2 No..... 0	

K3	K3a Have you ever faced with any sexual harassment while you do your job?	Yes..... 1 No 0	-> L1
	K3b Have you reported this?	Yes..... 1 No 0	
	K3c Were there legal actions taken?	Yes..... 1 No 0	

L. Health Information Management

L1	Do you keep records of your daily activities?	Yes..... 1 No 0	
L2	L2a Do you have regular meetings with Wereda health officials?	Yes ..... 1 It is not regular but we have..... 2 No..... 0	-> L3
	L2b Do you keep record of the agenda discussed?	Yes..... 1 No 0	
L3	L3a Do you have regular meetings with other community health workers?	Yes..... 1 It isn't regular but we've..... 2 No..... 0	-> L4
	L3b Do you keep record of the agenda discussed?	Yes..... 1 No 0	
L4	Do you have regular reports to Wereda Health Office?	Yes ..... 1 It isn't regular but we've.....2 No..... 0	-> M1
L5	Do you have format for reporting?	Yes..... 1 No 0	

M. Salary and other benefits

M1	How much is your salary?	____ Birr	
M2	Do you think your salary is enough in proportion to what you do?	Yes..... 1 No 0	
M3	M3a Do you work on weekends/holidays?	Yes..... 1 No..... 0	-> M4
	M3b Do you get payment for that?	Yes..... 1 No..... 0	
M4	M4a Do you work overtime?	Yes..... 1 No..... 0	-> M5
	M4b Do you get overtime payments for extra hours on job?	Yes..... 1 No..... 0	
M5	M5a Have you ever get per-diem?	Yes..... 1 No..... 0	-> M6
	M5b When do you get per-diem? Answer: [I get per-diem when I participate in .....] Note: the answer could be more than one	Workshops..... 1 Different campaigns..... 2 Meetings..... 3 Other (specify)_____ _____	
M6	To which of these benefits are you entitled?	Pension..... 1 provident fund..... 0 Other (specify)_____	

N. Opinion, Recommendation or Suggestion

N1. What are the most significant challenges that you face as HEW?

_____

_____

_____

N2. What would you like to improve to make your job as HEW more effective/successful?

_____

_____

_____

N3. What would you suggest are important things inorder to enhance cooperation with the community?

_____

_____

N4. What would you suggest to be rewarded for those HEWs who have outstanding performance?

_____

_____

"Now I have almost finished my questions but before we wind up, may you have anything you want to tell me...

_____

_____

END OF INTERVIEW: THANK THE RESPONDENT FOR THEIR COOPERATION!

Interview End time	___:___
Interviewer remarks regarding the interview:	_____ _____
To be filled by the researcher	
Date of checking(dd/mm/yyyy)	___/___/___
Date of data entry (dd/mm/yyyy)	___/___/___
Researcher's remarks:	_____

ANNEX II. Checklist for Oromia Regional Health Bureau/ Eastern Showa Zone

- How do you see the HEP development? (When did it start? How is it going up to now?)
- What are your responsibilities during HEWs recruitment and selection?
- What are the criteria for being selected as HEW?
- Where does the training take place? How many trainings centers are there in your area? What are the weaknesses and strengths of the education and trainings delivered to HEWs?
- What do you think are important factors to have valuable HEWs education and training program?
- What are the responsibilities of HEWs after they are assigned to their jobs?
- How do you evaluate the working conditions of HEWs?
  - health post construction
  - supplies and equipment
  - leadership and supervision
  - safety and health policies
  - performance evaluation
  - future carrier development
- What do you suggest to make the best out of the HEP?
- What are the strength and weaknesses observed in the program in general?
- What do you suggest to further reinforce the strengths and to improve the weakness?
- Is there is any other thing you to include?

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ANNEX III. Checklist for Wereda Officials

General conditions of HEP:

- When was HEP started in your region?
- How many Kebeles are there in your Wereda?
- How many o f them have HEWs? How many do they have one/two?

Recruitment and selection:

- What are the recruitment and selection criteria for HEWs?

Education and Training:

- How do you evaluate the training of HEWs?
- Do they get refreshment trainings?
- What are the problems seen after HEWs are assigned to their job?
- What shall be done to improve the situation?
- What kind of trainings have they taken so far?

Job assignment and responsibilities:

- What are the responsibilities of HEWs?
- What are the challenges for your weredas with regards to the HEP? What measures have you taken so far?

Living and working conditions:

- How many of HPs/HCs are there in your wereda?
- Who is responsible to construct HP?
- What are the efforts being made in response to the problems with regards to HP construction?

Performance appraisal:

- Is there job evaluation? Who does the performance appraisal?
- Do they get feedback after evaluation?

Motivation and reward:

- What kind of motivational mechanisms do you use to reward outstanding performance?

Cooperation with NGOs:

- Are there NGOs working in your wereda? If yes, who are them and what kind of assistance have they provided so far?

Equipments and supplies:

- What are the wereda responsibility with regards to supplies and equipments needed for HEP?

Relationship with the community and other community health workers:

- How do you evaluate the relationship of HEWs with the community and with other community health workers?

Professional Association:

- Do HEWs have professional association?
- Have there been efforts to establish?

Human resource policies and procedures:

- Do you have human resource policies and procedures to be implemented for the HEWs?
- Have you ever faced difficulties of implementing them?

Suggestion and Recommendation:

- What are the strength and weaknesses observed in the program in general?
- What do you suggest to further reinforce the strengths and to improve the weakness?
- Is there is any other thing you to include?

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ANNEX IV. List of Commodities Logistic Supplies for HEWs

- Contraceptives (oral and injectables), condoms and penis models,
- Disposable/reusable syringes and needles,
- Child and adult scales, Salter scale/hanging scale/,
- Vaccines, ice boxes, kerosene refrigerators: AD syringes,
- ORS, ergometreine tables, oral malaria drugs,
- Blood pressure apparatus,
- **First Aid kits, delivery kits,**
- Examination Tables, chairs, and stretchers, benches for patients,
- Filing cabinets, shelves, notice board and dustbins,
- Educational material/kits
- Thermometers and tongue depressors,
- Dishes of different sizes, forceps and scissors,
- Female gowns,
- Stationeries (pencils and pens, registration books, folders, antenatal and family planning cards, inventory cards, referral forms, report formats, writing pads, duplicating papers, staplers, staples, pins, graph papers, poster size butcher paper for graphic presentations,
- Sanitation tools,
- Dry batteries and megaphones,
- **Kerosene lamps, fuel (kerosene),**
- Alcohol, savlon, and other detergents,
- Cotton, bandage and plasters,
- **Female bicycles**
- Stethoscope, sterilizer/pressure cooker, delivery bed, hand reflector/torch,
- Dressing instrument set, tape measure, spoon, glass for drinking, graduated measuring jar of one liter, screen two fold, coat and umbrella hanger, office desk, stool, chair, working counter, book case, ladder, refuse lane, store shelf, bench for waiting area, cotton waste bin, candle filter, notice board, Growth monitoring card/EPI cards, health extension packages books, reference books.

Source: Health Service Extension Implementation Guideline, 2005.

DECLARATION

I declare that this thesis is my original work and has not been presented for a degree in any university and all the source materials used for the thesis are dully acknowledged.

Name: Adey Araya

Signature: _____

Date: 29/7/08

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Signature: _____

Date: 29-07-08