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Analysis of the Core Functions, Issues, and Challenges of Human Resource Management for Urban Health Extension Professionals

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ANALYSIS OF THE CORE FUNCTIONS, ISSUES, AND CHALLENGES OF HUMAN RESOURCE MANAGEMENT FOR URBAN HEALTH EXTENSION PROFESSIONALS

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Addis Continental Institute of Public Health

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ACROMNYMS

ACIPH	Addis Continental Institute of Public Health
BSC	Balance Score Card
C/THO	City / Town Health Office
FGD	Focus group discussion
FMOH	Federal Ministry of Health
GDP	Gross domestic product
GHWA	Global Health Workforce Alliance
HEP	Health extension program
HEW	Health extension worker
HIV	Human immunodeficiency virus
HRH	Human resource for health
HRM	Human resource management
HSDP-IV	Health Sector Development Program
MDG	Millennium Development Goal
NCDs	Non-communicable diseases
PHCU	Primary health care unit
RHB	Regional Health Bureau
SEUHP	Strengthening Ethiopia's Urban Health Program
TB	Tuberculosis
UHE-p	Urban Health Extension Professional
US	United States
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Background: Ethiopia has a critical health workforce shortage. On top of that, studies indicate that there are no human resource health development policies, such as retention strategies or mechanisms to manage the existing health workforce, including urban health extension professionals (UHE-ps). Human resource management (HRM) functions and responsibilities are generally fragmented across a broad range of key stakeholders, which limits access to quality health care, attainment of the health-related MDGs, and improved health outcomes.

Adequate human resources for health (HRH) are the heart of a country's health care system and are critical for achieving the health-related Millennium Development Goals (3, 4, and 5). Strong HRM is required for the sustainable health development of a nation. HRM focuses on people and describes where they fit and how they are utilized and can be most effective within the health system.

Understanding core human resource functions, challenges, service-quality gaps, workload, activities, and performance management related to assigned duties/job description (including job satisfaction, level of motivation, work environment, supervision system, reporting lines, recognition, incentive schemes, training and professional development among UHE-ps and their supervisors), could help government and relevant stakeholders overcome the HRH shortage.

Objectives: The purpose of this assessment is to describe the core functions of HRM for UHE-ps and their supervisors, best practices for HRM, HRM challenges and gaps, and to prioritize improvements to HRM processes and UHE-p systems in Ethiopia.

Methods: A cross-sectional study design with both quantitative and qualitative approaches was employed in 28 towns/cities in seven regions. Quantitative data were collected from 590 UHE-ps and 119 supervisors using structured questionnaires, with 58 in-depth interviews (IDIs) (seven with health center heads, 28 with the town/city health offices, and 14 with dropouts) and seven focus group discussions (FGDs) for qualitative data. UHE-ps and their supervisors were selected by simple random sampling for quantitative study and the key informants at various levels were selected purposively for the IDIs. UHE-ps who did not take part in the quantitative study were recruited for FGDs. Descriptive and multivariate analyses were used to analyze the quantitative data. Odds ratio with 95% confidence level in binary logistic regression was used to identify factors associated with job satisfaction of UHE-ps and their supervisors. The qualitative data were coded using Open Code version 4.02 software, and thematic analysis was utilized to summarize the data.

Results: According to key informants, the regional health bureau is responsible for planning and deployment of the workforce for the urban health extension program, and 58% of UHE-ps and 64.8% of UHE-p supervisors were aware of the HRM recruitment and deployment function. UHE-ps and supervisors are hired based on a pre-set criteria developed by FMOH that is modified to accommodate regional-level context.

Although there is no standard retention policy or strategy at federal and regional level, higher-level government officials reported that they are using variety of mechanisms to retain UHE-ps and their supervisors. Most UHE-ps (78.2%) and supervisors (74.5%) said that the HRM did not have a retention function. There is high rate of UHE attrition, especially in major cities, and more than half (57.4% UHE-ps and 55.8% supervisors) do not intend to stay in the Urban Health Extension Program.

The reasons that UHE-ps drop out include dissatisfaction with salary and financial incentive schemes; management and supervision; the nature of the job; workplace-related issues; and community-related issues. Dissatisfaction with salary is the most common reason that UHE-ps to drop out: 91.4% UHE-s and 84.7% UHE-p supervisors did not believe that they are adequately paid for the activities they undertook; 92.2% of UHE-ps and 88.1% of UHE-p supervisors reported salary dissatisfaction. They strongly argued that their salary doesn't match the amount of work they are obliged to do. In general, the dropouts were not satisfied with the management and administration of UHEP, although 57.3% UHE-ps and 72.7% UHE-ps supervisors who are currently working believed they were fairly treated by supervisors.

Regional health bureaus, city health offices, and the kebele administrations are directly involved in the implementation of UHEP. These organizations are expected to support UHE-ps in their day-to-day activities. However, most dropouts reported minimal support.

More than half of the UHE-ps (76.8%) and UHE-p supervisors (69.2%) expressed dissatisfaction with their job, while 80.9% UHE-ps and 74.6% UHE-p supervisors thought their workload was beyond what is written on their job description. Overall, 69.6% UHE-ps and 62.3.5% UHE-p supervisors are not happy with their work environment in general and more than half (66.4%) UHE-ps and 74.1% UHE-p supervisors were not comfortable with the physical working environment. 76.3% UHE-ps and 72.6% UHE-ps supervisors responded that they did not have necessary equipment or resources to conduct their work. There are no provisions in the constitution to protect the rights of health professionals, nor are there documents with specific reference to UHE-ps except manuals, as is common for other health professionals. Accordingly, 75.6% UHE-ps and 74.6% UHE-ps supervisors were unhappy with workplace safety conditions. In addition to the physical environment, 43.5% of UHE-ps and 81% of supervisors confirmed the presence of any form of physical harassment during household visits. However, there are no clear procedures to report or solve such encounters, and 65% of UHE-ps and supervisors confirmed the lack of such formal procedures.

Overall, 81.3% UHE-ps and 75.6% UHE-p supervisors believed there was no career development structure; specifically, 78% of UHE-ps and 68% of the supervisors didn't think their current job would lead to higher-level jobs. Similarly, 87.7 % UHE-ps and 86.3% UHE-p supervisors were unsatisfied with workplace training and education opportunities.

More than half of the study participants (55.2% UHE-ps and 59.3% UHE-p supervisors) were comfortable with the overall situation of the performance management. More than 90% of UHE-ps (93.4%) and UHE-p supervisors (93.1%) said that they had annual work plans. On the contrary, 75.3% UHE-ps and 80.2% UHE-p supervisors did not know of any performance-based reward system.

Almost every respondent reported using paper-based human resource information system (HRIS), and almost all respondents from the city/town health offices reported no HRIS expert to manage the office systems. Varieties of officials handle the HRIS but most considered this as an additional job. The collected data are mostly used for monitoring and evaluation, and to conduct workforce budget allocation.

Conclusion: All core functions of the human resource management were available and have been used in the management of the UHE-ps and their supervisors. However, there are discrepancies in the roll-out of these functions at all levels. The main challenge of the HRM system was the absence of standard across the country and in some places it was not clear whose was responsible for managing these professionals. There were also problems related to the work environment and conditions, retention mechanisms, and performance appraisals. Moreover, respondents showed clear dissatisfaction with the system, specifically regarding job description, workload, work environment, supervision, and management. This may explain the high attrition reported in this assessment.

Recommendations: Establish or revise the existing HRM manual and adhere to it uniformly at all levels. The manual should indicate who is responsible for the professionals; proper and clear line of command; clear job description and expected outcomes for the jobs; as well as responsibilities, rights, and obligations. The manual should also consider the possible carrier structure, incentive mechanism, and workplace policies.

1. INTRODUCTION

1.1 Background of the study

With an estimated total population of 82 million, Ethiopia is the second most-populous country in sub-Saharan Africa (SSA). Its population is projected to reach 170.2 million in 2050, which will make Ethiopia the tenth-largest nation in the world. Eighty-four percent of Ethiopians live in rural areas. With only 16% (13 million people) living in urban areas, Ethiopia is one of the least urbanized countries in the world, although this proportion living in urban areas is estimated to grow to 27% by 2030. Of the urban dwellers, around 23.4% are women of childbearing age and 45% are younger than 15 years. The male-to-female ratio is almost 1:1 (1-3).

The country has a total surface area of about 1.1 million square kilometers and great geographical diversity. Mean daily temperatures vary with topography, from as high as 47 degrees Celsius in the Afar Depression, to as low as 10 degrees Celsius in the highlands. There are three principal climates in the country: tropical rainy, dry, and warm temperate. It is an agrarian country in which agriculture accounts for 43% of the gross domestic product (GDP), enabling the country to register 11.4% real GDP growth rate (3, 4).

The current Ethiopian health policy was launched in 1993 and focuses on the health of the poor and rendering basic health services (5). The introduction of a 20-year Health Sector Development Program (HSDP) in 1996/97 established framework for preventive and curative components of health care; ensuring accessibility of health care for all segments of the population; and promotion of public-private partnership in the health sector. The health extension program (HEP) was endorsed in 2004 to expand the national health program. It include community-based interventions as a primary component of the HSDP, with a package of 17 basic and essential promotive, preventive, and high-impact curative health services. The HEP targets rural households to improve their health status and achieve the Millennium Development Goals (MDGs) within a context of limited resources through frontline community health workers, who are the primary agents of prevention, health promotion, behavioral change communication, and basic curative care in the country (6-8). In 2009 the urban health extension program was implemented to enable the extension workers to render 15 essential health extension packages. While many of the interventions are similar to the rural program, prevention and control of non-communicable diseases (NCDs), mental health, and violence and injury prevention are included in the urban packages because of their significant impact on the urban population (8).

The country also adopted the Millennium Development Goals (MDGs) to attain its MDG targets by 2015 (3, 4). Likewise, HRH are recognized as critical in achieving the MDGs (9) and require strong human resource management (HRM) and integrated use of systems, policies, and practices needed to plan, produce, deploy, manage, train, support, and sustain the workforce. HRM focuses on people and describes how they fit, are utilized, and how they can be most effective within a health system. A sound HRM system is central to the provision of an effective, enabled, and functional health system. It is also a necessary aspect of an environment in which the health workforce—including health extension workers—can be deployed effectively (9, 10).

John Snow, Inc. (JSI's) Strengthening Ethiopia's Urban Health Program (SEUHP), which is supported by the U.S. Agency for International Development (USAID), is striving to improve the health status of the urban population in Ethiopia by reducing HIV/TB-related and maternal, neonatal, and child morbidity and mortality. It is also helping the Ethiopian government reduce the incidence of communicable and non-communicable diseases by improving community–level health services; strengthening referral linkages; building the institutional and technical capacity of regional health bureaus (RHBs); and promoting intersectoral collaboration and public-private partnerships (PPPs) (11).

1.2 Statement of the problem

Human resources for health (HRH) have been described as the heart of a health care system in any country and a critical component in health policies. A well-trained, motivated, and functioning health workforce must be produced, deployed, maintained, and appropriately utilized for the goal of improving the health of the population. However, despite its importance the health workforce has been a neglected component of health care system development in low-income countries due to poor HRM (12, 13).

Globally, an estimated shortfall of 4.3 million health care workers (HCWs) has had a negative effect on access to quality health care, attainment of the health-related Millennium Development Goals, and health outcomes (10). Many low-income countries are struggling to mitigate health workforce shortages, which inhibit access to health care and are a result of insufficient numbers and unequal distribution of health workers. Ethiopia is one the sub-Saharan African countries most affected by high disease burden, as reflected by the high rates of maternal and child mortality and aggravated by the shortage and imbalance of HRH, geographical distance, and socio-economic factors. This has led the government search for ways to improve health system equity, efficiency, effectiveness, and responsiveness to health outcomes of its population (8, 13, 14).

To improve the health status of a given society, the quality of health services at all levels of the nation to curb must be scaled up. Health service quality is multidimensional and can be measured in terms of structural, process, and outcome quality. Studies in Ethiopia indicate a lack of policies specific to human resource development for health, retention, and proper mechanisms to manage the existing health workforce, including urban health extension professionals (UHE-ps), to create a culture of quality in the health care system. Moreover, health worker performance problems such as absenteeism, dissatisfaction, insufficient knowledge or skills about HRM functions, and poor handling of patients are among the many challenges to HRM (15, 16).

In the same line, there are often no clear guidelines on the relationship between HEWs and other community-level health workers, career structure, transfer, or leave of absences. Moreover, HRM functions and responsibilities are generally fragmented across a broad range of key stakeholders, which limits access to quality health care, attainment of the health-related MDGs, and improved health outcomes (9).

Understanding core human resource functions, challenges, service-quality gaps, workload, activities, and performance management related to assigned duties/job description (including job satisfaction, level of motivation, work environment, supervision system, reporting lines, recognition, incentive schemes, training and professional development among UHE-ps and their supervisors), could help government and relevant stakeholders overcome the HRH shortage.

Please see the Human Resource for Health (HRH) action framework indicated below and developed by the Global Health Workforce Alliance (GHWA) and in collaboration with USAID and the WHO) (10).

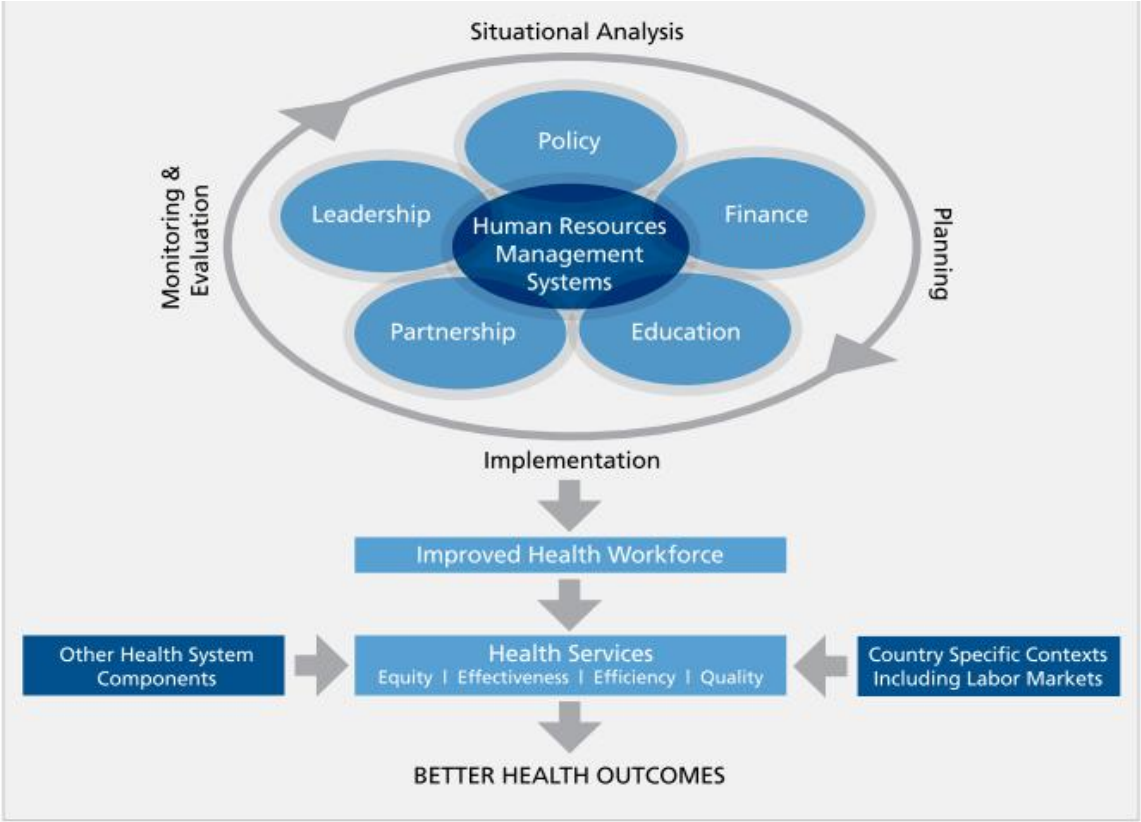

Figure 1: HRH action framework

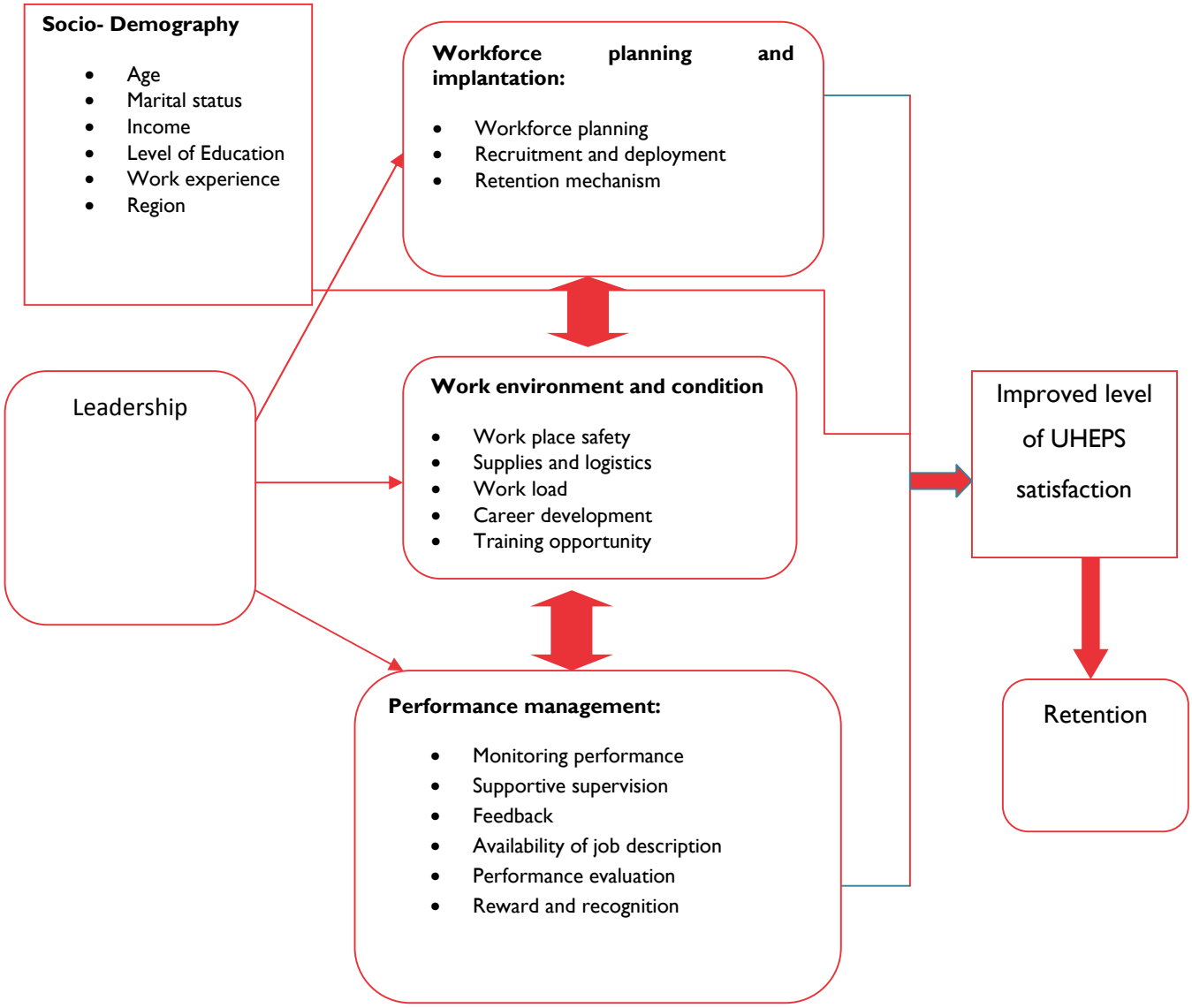

Figure 2: HRH action conceptual framework, 2014

2. ASSESSMENT PURPOSE AND KEY QUESTIONS

The purpose of this assessment is to use the following key study questions to analyze the core functions, issues, and challenges of human resource management (HRM) for urban health extension professionals and their supervisors.

2.1 Key study questions

1. What are the core functions of the HRM for urban health extension professionals (UHE-ps) (may include but not limited to UHE-p workforce planning and implementation, work environment and conditions, HR information systems, and performance management) and how do they operate?

2. Which gaps and deficiencies in the HRM for UHE-ps could be overcome by strengthening Ethiopia's Urban Health Program (SEUHP) in conjunction with UHEP program managers and leadership? Which areas require major change in systems and functions, or major policy or programmatic shifts by the government?

3. How do the UHE-ps' workload, activities, and performance compare to assigned duties/job description (including areas such as job satisfaction, level of motivation, work environment, supervision system, reporting lines, recognition and incentive schemes, performance management, training, and professional development)?

2.2 Objectives of the study

General objective

- Describe the core functions of the human resources management for urban health extension professionals (UHE-ps), best practices within the HRM, challenges and gaps of HRM, and prioritize improvements in the HRM processes and systems for UHE-ps.

Specific objectives

- Describe the core functions of the HRM for UHE-ps and evaluate how these functions operate.
- Explore the gaps, deficiencies, and challenges of HRM and prioritize improvements in the HRM processes and systems for UHE-ps.
- Explore UHE-p and supervisor perceptions of assigned duties, job descriptions, job satisfaction, work environment, supervision system, recognition and incentive schemes, performance management, and training and professional development.

3. METHODS

Both quantitative and qualitative study approach was employed to complete this assessment in 28 towns selected for the project.

The details of the methods used are described below for each component.

3.1 Qualitative method

Design and sampling procedure: A qualitative study approach was used to collect information from various respondents. A purposive sampling procedure was used to identify and recruit individuals who could provide rich information on the study matter because of either their position or their experience in the health extension program at various levels. UHE-ps who were not selected for the quantitative study were recruited for the FGDs.

Study participants and sample size: A predefined number of participants were recruited for this study: two experts from the FMOH; seven from RHBs; seven from HCs at the main town of each region; and 28 from /city health office (one from each town/city). In addition, 14 (two from each main town of the study regions) in-depth interviews (IDIs) were conducted with UHE-ps who dropped out of the UHEP. Seven focus group discussions (FGDs) were conducted with UHE-ps in the main towns of the region.

Data collection tool and procedure: In-depth interview and FGD guides were developed for each target population of the qualitative study. Data were collected by trained research assistants who had a minimum of second degrees and previous experience in qualitative data collection. The research assistants were given two days training on the purpose, procedures, and data collection tools. The questions included were mostly open-ended and included thematic issues. Interviews and FGDs were conducted with participants after obtaining their informed consent. The IDIs and the FGDs were tape recorded with permission from participants. The IDIs were conducted in offices where respondents felt comfortable and privacy was assured. Two research assistants conducted the FGDs, one serving as a moderator and the other as note-taker. One research assistant conducted the IDI. During the qualitative interviews, participants were asked for any supporting document available and these documents were collected by the research assistants.

Data management and analysis: The qualitative data were transcribed verbatim from the recorded tapes. Codes and categories were given by using Open Code version 4.02. Any emerging themes were also integrated in the analysis. The thematic analysis identified themes and summarized data.

3.2 Quantitative method

Study design and participants: The assessment used a cross-sectional study to address key issues relevant to human resource management of urban health extension professionals. The study participants were urban health extension professionals and their supervisors in 28 selected towns.

Sample size and sampling procedure: The sample size was calculated using the single population proportion formula based on the following assumptions: proportion of UHE-ps who received any form of promotion after performance evaluation by their immediate supervisors to be 32.8% (18) (this indicator was selected from the list of 11 related indicators on performance evaluation, professional development, incentive, and supervision); the two-sided alpha level 5%, margin of error 3%, and 10% for non-response. The total sample size was 795; included 618 UHE-ps and 177 supervisors in the 28 towns. The estimated sample size for UHE-ps was allocated using probability proportional to the population size of all 28 cities /towns. The study participants were selected randomly from each town list by simple lottery. In addition, all supervisors in the respective city/town were considered for the survey.

Data collection tools and procedures: The data collection tools were developed based on the key study questions after reviewing pertinent literature in the area. Then, experts reviewed and provided feedback to fine tune the questionnaire. The questionnaire was initially prepared in English and later translated into the national language (Amharic), which the research team cross-checked with the English version for consistency. Data collectors used to facilitate the study had at least first degree in health or social science fields and previous experience in similar field research. The data collectors were given two days training on the purpose, procedures, and data collection tools. The study tools were pre-tested before the actual dates of data collection. The randomly selected UHE-ps and all supervisors in the study towns were invited to the nearby health center or Kebele to complete a self-administered questionnaire, for which they first gave informed consent. Data collectors were monitored throughout the training period and those who were not suitable for the job were excluded from the actual task of data collection.

Data management and analysis: Double data entry and cleaning was done using the EPi-Info version 3.5.1 software and exported to SPSS version 16 for further cleaning and analysis. Quantitative data were presented using descriptive statistics including frequencies, proportions, and numerical summary measures. All human resources management activities (recruitment and deployment, retention, work environment, workplace conditions, workplace safety, career development, performance management, and organizational constraints) were considered as explanatory variables. Job satisfaction was considered an outcome variable. In the descriptive tables, the human resource management activities were presented in two ways. First, each component of the core function was presented as percentage and then the overall score was calculated for the core activities and presented as overall percentage.

Explanatory variables were dichotomized in to 0 (disagree) and 1 (agree); and outcome variable (job satisfaction) was dichotomized in to 0 (dissatisfied) and 1 (satisfied). The Likert responses 1 (strongly disagreed), 2 (disagreed), and 3 (neutral) were coded as disagreed (0); 4 (agreed) and 5 (strongly agreed) were coded as agreed (1) for explanatory variables. The Likert responses 1 (strongly dissatisfied), 2 (dissatisfied), and 3 (neutral) were coded as dissatisfied (0); 4 (satisfied) and 5 (strongly satisfied) were coded as satisfied (1) for outcome variables. Binary logistic regression was used to see the association of job satisfaction of UHE-ps and their supervisors and the independent variables (recruitment and deployment, retention, work environment, workplace conditions, workplace safety, career development, performance management, and organizational constraints).

3.3 Ethical considerations

Ethical clearance for this study was obtained from ACIPH institutional review board. Letters of support were secured from the Federal Ministry of Health and permission to conduct the study was secured from the respective regional health bureaus. All participants were informed about the purpose of the study and gave informed and written consent before taking part in the study. Privacy and confidentiality of the study participants were maintained by not collecting personal identifying information. Respondents were informed of their full right either to take part in the study or not.

4. RESULTS

4.1 Socio-demographic and work-related characteristics of UHE-ps and their supervisors

Seven-hundred-and-nine study participants (590 UHE-ps and 119 UHE-p supervisors) completed the questionnaire with the overall response rate of 89.18% (95.47% for UHE-ps and 67.23% for supervisors). All 590 UHE-ps were females from seven regions (Tigray = 60, Amhara = 96, Oromia = 107, SNNPR = 100, Dire Dawa = 50, Harar = 32, and Addis Ababa = 145). The 119 UHE-p supervisors were also drawn from the same regions (Tigray = 15, Amhara = 24, Oromia = 21, SNNPR = 21, Dire Dawa = 6, Harar = 6, and Addis Ababa = 26).

The age of UHE-ps ranged from 18-50, with the mean age of 26.91 + 5.01 years, while the age of supervisors ranged from 21-56 years, with the mean age of 31.79 + 7.95 years. About 47.9% of UHE-ps and 65.5% of UHE-p supervisors were married; 49.1 % UHE-ps and 32.8% of supervisors were single. The majority (94.4%) of the UHE-ps were diploma nurses. The total years of work experiences of UHE-ps ranged from less than 1 to 7 years. UHE-p study participants worked for 3.46+1.64 years on average. Details of UHE-ps' and their supervisors' demographic and work-related characteristics are shown in Table 1.

Table 1: Demographic and work-related characteristics of UHE-ps and their supervisors, 2014

Variable		Study participants			
		UHE-ps		UHE-ps' supervisor	
		No.	%	No.	%
Sex					
	Male	-	-	83	70.3
	Female	590	100	35	29.7
	Total	590	590	118	100
Age					
	Less than 25 years				
	25-29years	181	32.1	9	7.6
	30-34 years	291	51.7	58	49.2
	35-39 years	42	7.5	18	15.3
	More than 39 years	25	4.4	12	10.2
	Total	24	43.3	21	17.8
		563	100	118	100

Variable	Study participants			
	UHE-ps		UHE-ps' supervisor	
	No.	%	No.	%
PMarital status				
Single	287	49.1	39	32.8
Married	280	47.9	78	65.5
Divorced	12	2.1	-	-
Widowed	5	0.9	2	1.7
Separated	1	0.2	-	-
Total	585	100	119	100
Educational status				
Nurse diploma	554	94.4	33	27.7
Nurse degree	20	3.4	18	15.1
Diploma environmental health	-	-	2	1.7
Degree environmental health	-	-	39	32.8
Degree health officer	-	-	12	10.1
Degree health education	-	-	2	1.7
Degree food technology	-	-	2	1.7
MPH or MSc	-	-	2	1.7
Other	13	2.2	9	7.5
Total	587	100	119	100
Years of experience as UHE-p or supervisor				
0-2 years	142	24.2	43	37.7
3-4 years	318	54.3	43	37.7
5 or more years	126	21.5	28	25.6
Total	586	100	114	100
Monthly income (ETB)				
1000 - 1500	445	77.8	9	7.8
1501 - 2000	90	15.7	18	15.5
2001-2500	34	6.0	29	25.0
2501 -3000	3	0.5	40	34.5
3001 and above	-	-	20	17.2
Total	572	100	116	100

Variable	Study participants			
	UHE-ps		UHE-ps' supervisor	
	No.	%	No.	%
Do you supervise any other worker?				
No	497	85.2	-	-
Yes	86	14.8	119	100
Total	583	100	119	100
Whom do you supervise?				
Urban health extension professionals				
Development group	-	-	119	100
Health extension workers	42	50.0	-	-
Supervisor	12	14.3	-	-
Volunteers	10	11.9	-	-
Health center and kebele	3	3.6	-	-
Other	4	4.8	-	-
Total	13	15.4	-	-
	84	100	119	100
Staff under supervision				
1-10	45	54,2	75	64.7
11-20	14	16.9	34	29.3
21-50	14	16.9	5	4.3
51 and above	10	12.0	2	1.7
Total	83	100	116	100

4.2 Description of the core functions of the HRM of UHE-ps and their supervisors

The study measured the core functions of HRM of UHE-ps and supervisors, and the perceptions of UHE-ps and supervisors on assigned duties, job descriptions, job satisfaction, work environment, supervision system, recognition and incentive schemes, performance management, and professional development under the following thematic areas.

4.2.1 4.2.1 Workforce planning and implementation

Key findings:

- There is limited competence and skill in the workforce planning and implementation for UHE-ps and their supervisors at all level including the FMOH but more pronounced at the woreda and kebele levels.

- There is no separate workforce planning at the FMOH but regions are mandated to have their own workforce plan for UHE-ps and their supervisors.

- No standardization of workforce planning and implementation at any level. In some places there is no standard UHEP implementation manual revised for these professionals.

- It is not clear who is responsible for recruitment and deployment of UHE-ps and their supervisors. Though recruitment is assumed to be done according to pre-set criteria by managers at different levels, not all UHE-ps or their supervisors were aware of the presence of such pre-set criteria.

- The experts at C/THOs, RHB and FMoH, and UHE-ps agreed that UHE-p deployment is not always responsive to demand.

4.2.1.1 Current status of workforce planning and implementation at different levels

Currently there are limited skills and several gaps in UHE-p management competence at the FMOH and various levels down to the kebele. Regarding the skill at the FMOH a respondent said, "Because of the newness of the Directorate (i.e., Primary Health Care and Health Extension Program) and newly organized and structured Directorate, there could be a gap and shortage of skills and competencies in all level in relation to UHE-ps." The limited number of professionals assigned to HEP in general leads to limited performance at the Ministry level. The other respondent from the FMOH also mentioned that managing the UHE-ps is the responsibility of the respective region. This respondent noted that there is a possible gap in competence and managing and implementing the program at the regional and lower management levels. Moreover, the Ministry provides regional support only to narrow the gap in skill and competence in human resource management.

Although not consistent in all regions, respondents at the region agreed the presence of such gaps in skill but assume that this is the result of lack of clear structure as to how and who should manage UHE-ps . The respondent from Harar explained the moderate level of competence at the regional health office and said that UHE-ps are managed by the Health Promotion and Extension Case Team at the region. Similarly, the respondent from the Addis Ababa City Health Bureau acknowledged adequate skills at his/her office level but indicated possible limitations in skill and competence at the lower management level.

The lack of competence and skill is prominent at the woreda level and/or kebeles. For instance, one participant said, "There are some problems at woreda level, such as giving priorities for personal interest, unable to provide convenient working environment (unfurnished offices), problems attached to administration, and mild technical incompetency on the management of UHE-ps." Another participant from Dire Dawa stated that "... kebeles don't have the capacity to manage the UHE-ps therefore; we tried the health centers to directly control the urban health extension program."

At the FMOH, UHE-p and supervisor workforce planning is part of the overall human resource planning for health for the nation. The regions do their own workforce planning based on the FMOH plan and their regional context. The respondent from the FMOH acknowledged gaps because there was no guideline at the region level and said that the Ministry is designing planning documents for the regions.

Although there are some variations in implementation, the regions plan their workforce according to the standard that assigns 1 UHE-p to 500 households. At the beginning, the regional offices are responsible for the planning; later in the process, demand may come from the woreda to replace the dropouts. For instance, in Mekelle when UHE-ps resign, the city administrator reports to regional health bureau for re-recruitment of UHE-ps, but sometimes health centers under subcities undertake the recruitment of UHE-ps because they have the mandate. Then sub-cities report to regional health bureau and the human resource department is informed to facilitate issues related to training and other HR matters. Others also mentioned that there is a chain of direction from the regional health bureau down to kebeles; the health centers take major roles in the process of workforce planning of UHE-ps and their supervisors.

There is no clear approach to HRM standardization for the UHE-ps and their supervisors at any level or among partners. For example, there is no up-to-date guideline on urban health extension program.

The FMOH is revising implementation manual for the program, but because regions are autonomous, it is working on documents relevant to training and activities instead of standardizing the system. The ministry is employing information technology to avail information on human resource anywhere in the country.

Attempts to standardize HRM systems are not uniform across the regions but most acknowledge challenges with HRM system standardization. Participants in Hawassa and Dire Dawa are currently using the HRM manual developed for GOE Rural Health Extension Program and have implementation challenges. For instance in Hawassa the manual is not even revised for the UHE-ps in the UHEP context so they are using a manual designed for the rural health extension workers. In Dire-Dawa they have used a manual from the FMOH. This has created conflict between the keble and health center management because according to this manual, the health center is responsible for technical support and management, while the kebele shoulders administrative responsibilities related to these professionals. As a result, half of the UHE-ps are managed by the kebele and the rest by different health centers.

One of the regions is now revising the manual to standardize the HRM system according to their context. This is motivated by the variation in the implementation of the program in the same region across towns. The participant explained that "The challenge is the existing difference from town to town in the implementation of UHEP because it is not standardized. The difference is not only in the salary, there is also a difference in their tasks as some towns add jobs while the others do not. The other challenge is related to the absence of equal understanding of UHEP at each level including zone and woreda. For instance, when it comes to vaccination, the role of UHE-ps is to raise awareness about it in the community but in some towns, UHE-ps are obliged to give the vaccination to the children. They push the work of the health center to them and some health centers prevent them from doing such kind of tasks."

4.2.1.2 Recruitment and deployment

According to participants from the city/town health offices, recruitment of the UHE-ps and their supervisors is based on a set of criteria set by either the woreda/town health office or regional health bureau. This varies from place to place; for instance respondents from Assela, Oromia mentioned that only the town health office can request professionals while the regional office conducts the actual recruitment. Contrary to this, in the same region, a participant from Bishoftu mentioned that the UHE-ps are recruited by the town health office, but only the supervisors are recruited by the RHB. In addition, in some places the civil service office takes part in recruiting the professionals.

Criteria for recruiting the professionals vary but include place of residence, sex, and educational background. Females who are living in the same community and have the required educational background are preferred. The required educational background for UHE-ps is diploma nurses who passed the Centre of Competency (COC) exam; those with a bachelor of science (B.Sc.) are hired as supervisors. Fluency in the local language is a criterion in some places. Open advertisements listing the criteria are posted, calling for people to apply. Those who qualify are recruited and deployed after three months pre-service trainings. Respondents from the FMOH mentioned that the recruitment is conducted by the respective regional health bureaus based on a set of criteria that are can change depending on the regional context. Not all supervisors and UHE-ps agreed that there is pre-set criteria to recruit UHE-ps and their supervisors; more than half (55.5%) of the UHE-ps and (56.8%) UHE-p supervisors didn't think the recruitment of UHE-ps is based on pre-set criteria.

Following recruitment, UHE-ps and supervisors reflected on deployment; 65.5% UHE-ps and 59.0% UHE-p supervisors did not think that an orientation program exists for all newly deployed UHE-ps and UHE-p supervisors. And while all UHE-ps acknowledge being trained for three months before their deployment, they did not consider that as orientation. One FGD participant said that as a result of no orientation before deployment, "When we started our work we were just sent to the community and no one introduced us to the community and that created a big challenge for us." Participants from the regional office also mentioned that professionals were deployed without proper training, as when someone drops out and must be replaced but it's too costly to train one or two people so they aren't trained.

Table 2: Distribution of recruitment and deployment function components by UHE-ps and their supervisors, 2014

Recruitment and deployment variables	Study participants							
	UHE-ps				UHE-p' supervisors			
	Disagree		Agree		Disagree		Agree	
	No.	%	No.	%	No.	%	No.	%
Our staff establishment is current/updated					44	37.3	74	62.7
Our staff establishment is approved					31	27.2	83	72.8
The recruitment process has a short turn-around time of 4 months or less	316	**55.5**	253	44.5	67	**56.8**	51	43.2
The recruitment process is fair	182	31.2	402	**68.8**	44	37.3	74	**62.7**
The recruitment is based on a pre-set criteria	145	24.8	440	**75.2**	50	42.7	67	57.3
An orientation program exists for all new employees	376	**64.5**	207	35.5	69	**59.0**	48	41.0
I am happy with the existing recruitment process	280	47.7	307	52.3	58	50.4	57	49.6
Overall Score	***237***	***42.5***	***320***	***57.5***	***38***	***35.2***	***70***	***64.8***

The existing UHE-ps and supervisor workforce recruitment and deployment processes and practice do not always respond to service demand. The participants from FMOH explained that it is up to the respective region to know the population to be served by these professionals and respond to the service demanded. However, they suggested that scientific evidence (research) is required to know whether UHE-ps and supervisor workforce recruitment and deployment processes and practices respond to existing service demands.

Although the recruitment process is based on the assumption that every UHE-p serves 500 households and must visit 8 households every day, participants thought that the demand is not being met. The number of employed UHE-ps was reported to be generally inadequate, although in most places the number of supervisors was reported to be adequate. Budget constraints are a reason for not responding to the demand when it comes to these professionals' recruitment process. As noted in Nekemte, Oromia, the number of supervisors in some study towns is not enough for proper UHE- p supervision.

4.2.1.3 Retention

Currently there is no stand-alone retention strategy for keeping UHE-ps and their supervisors on the job. However, fragmented strategies and mechanisms are listed in different documents. According to a respondent from FMOH, the consequence of no strategy for retention is noted and felt, and FMOH is developing a UHE-ps motivation and retention package. The absence of a standard and national retention strategy leads RHBs and C/THOs to devise their own mechanisms to address the problem of UHE-p retention in the health workforce. Suggested methods included providing educational opportunities, short-term refreshment training with certification, supplies such as umbrellas, bags, and stationery materials, recognition of good performance, and incentives like mobile card. However, respondents acknowledged that such measures would be unlikely to remedy problems related to attrition.

The participants at the regional health bureaus also confirmed the lack of standard retention strategy. Respondents from Mekelle, Tigray, and Addis Ababa talked about their attempts to provide incentives. "In order to retain UHE-ps, we have tried different mechanisms like refreshment training, and provision of 50 birr for mobile card and material like bags, umbrellas, and bicycles for transportation."

"UHE-ps are given 100 birr for mobile card and 243 birr for transportation allowance monthly, and offering them different refreshment trainings to upgrade their capacity ... moreover a ceremonial event is organized to acknowledge and award those performing better every 6 months to motivate these professionals and the city administration provides a telephone card worth of 343 birr as an incentive."

However, not all regions employ incentive mechanism and few of the respondents replied that they don't have any incentive mechanisms at all. According to some respondents, new strategies have been finalized to facilitate retention and will be in place as of the coming Ethiopian year, but they were not willing to disclose details of this strategy.

In the quantitative survey, UHE-ps and their supervisors were asked questions related to the existence of retention mechanisms and their intention and willingness to stay at work. The overall score indicates that most of the UHE-ps and their supervisors (78.2% UHE-ps and 74.5% UHE-p supervisors) disagreed with the existing retention function of HRM. The majority of respondents (85.8% UHE-ps and 87.3% UHE-p supervisors) did not agree that retention strategies are developed or revised periodically. In line with this, a huge portion of UHE-ps and their supervisors believe that attrition rate is high, and more than half do not intend to stay in their job (56.1% UHE-ps and 51.8% supervisors) (Table 3).

Table 3: UHE-p and supervisor perceptions of retention mechanisms, 2014

Retention variables	Study participants							
	UHE-ps				Supervisors			
	Disagree		Agree		Disagree		Agree	
	No.	%	No.	%	No.	%	No.	%
Attrition rates are low	470	80.2	116	19.8	85	72.0	33	28.0
Retention strategies are developed and revised periodically	501	85.8	83	14.2	103	87.3	15	12.7
I have an intention to stay in my job	335	57.4	249	42.6	63	55.8	50	44.2
I am willing to stay in my job	321	56.1	251	43.9	57	51.8	53	48.2
Overall score	***440***	***78.2***	***123***	***21.8***	***82***	***74.5***	***28***	***25.5***

4.2.1.4 The status of attrition among UHE-ps and supervisors

Almost all participants reported that attrition is more common among the UHE-ps as compared to supervisors. Respondents from two towns (Jimma from Oromia, and Dilla from SNNP) reported attrition rates of 11% to 15% among the UHE-ps in 2006 Ethiopian calendar (EC). In Akakki-kaliti subcity of Addis Ababa alone, 20 UHE-ps left their job for different reasons this year. The problem seems common in other cities as well; a respondent from Hossana, SNNP said the following: "… UHE-ps usually leave their jobs, on average three per year because in a day a simple street coffee shop can earn by far more than what UHE-ps get as a salary and other incentives per month. Therefore, UHE-ps don't want to be abused."

In contrast, according to respondents from Debre Birehan, Amhara; Maychew, Tigray; Dessie, Amhara; Bishoftu, Oromia, and Arbaminch, SNNPR there are few reports on attrition. One of the participants from these study sites said that these towns are surrounded by smaller and suburban areas and seem to have less attrition. One participant said, "We didn't face many problems in this case, sometimes UHEPs leave their jobs because of marriage and getting better jobs but not related with desperation on their jobs. Since Arbaminch is a town usually other people from the rural would want to come here but those working in the town have no intention to leave their job." One interesting point raised by the participant from Bishoftu was that, "The attrition is almost null here because there are more trainings, incentives, and even close supervision for the professionals. Besides, there is also clear career structure like any other workers."

Problems related to attracting and retaining UHE-ps

The above findings indicated that UHEP has challenges retaining UHE-ps and supervisors. Details of the problems are as follows:

1. **Dissatisfaction with salary**: Participants claimed that UHE-ps salary is not comparable with the type and volume of work they supposed to undertake. The UHE-ps get the same amount of salary as nurses who deliver services at the health center. Participants from Adigrat said the following: "The UHE-ps who are also nurses by profession are getting the same salary as those who are working in the health center and compared to UHE-ps workload, UHE-ps need to be paid more. ."

2. **Lack of training and career structure:** According to the participants, the UHE-ps want to pursue their education at some point. However, participants know of no such structures that would allow UHE-ps to pursue further education. In addition, unlike the rural health extension professionals and nurses who are working at the health centers, the UHE-ps do not get frequent refresher trainings. One participant from Addis Ababa said that there is no organizational structure that indicates career ladder of UHE-ps." One participant from Wolkite, SNNP claimed that "Urban health extension packages did not get adequate government attention like that of Rural Health Extension Program in many ways, lack of refreshment training is one among the others."

3. **Workload:** This is the most commonly mentioned problem by the participants, who said that since the UHE-ps are working at the community level, the work is very tiresome. They would prefer to work at the health centers instead because they need transportation to visit households and none is available at this moment.

4. **Budget constraints:** According to participants there is no budget allocated for the program which makes it difficult to provide transportation, refresher training, or incentives to existing professionals and to attract other professionals to the program. A participant from Axum said that "there is no budget even to buy umbrellas, bicycles, or coffee and tea for UHE-ps."

5. **The type of service UHE-ps provide:** It is clear that the UHE-ps compare themselves with the rural health extension workers (HEWs). One area of difference is the type of services provide to the community. The UHE-ps are supposed to provide mostly health promotion work, providing information and education on key health-related issues. They believed that the service they provide is inferior to their rural health extension counterparts because they don't provide clinical services such as delivery and ANC, which rural HEWs do. One participant from Arbaminch, SNNP said, "When we compare the type of service the UHE-ps provide with that of the RHEW it is very limited, as rural HEWs provide services such as ANC, family planning and sometimes delivery and postnatal services. The UHE-ps, who are nurses by profession, provide only immunization. This creates dissatisfaction with their job."

Less frequently mentioned reasons were living away from family, poor leadership, and lack of permanent stations. For example, rural HEWs have health posts but the UHE-ps do not have offices where they can compile their reports. In some places lower acceptance by the community was mentioned as barrier to attracting other people to the profession. A respondent from Nekemte said "Construction of seepage pit is interrupted by lack of materials in the region, which has resulted in poor attitude of the community toward these professionals as they could not demonstrate the construction of seepage pit for the community. It was mentioned that those UHE-ps from Hawassa did it for their community using red clay soil… which could have increased their acceptance by the community."

Reasons for dropout (former UHE-p perspective)

To further understand why UHE-ps leave their job, we interviewed 14 nurses who dropped out of the urban health extension program. They were selected from seven major cities throughout the country. The dropouts served from six months to four-and-a-half years before they left the job. A dropout from Mekelle city served the longest while a nurse from Harar city gives the shortest service. Most of the respondents worked more than one year, which seems enough to understand the program.

The main reasons that UHE-ps leave their job are categorized in four areas: 1) dissatisfaction with salary and financial incentive schemes; 2) dissatisfaction with management and supervision; 3) dissatisfaction with nature of job/workplace; and 4) problems with the community.

Dissatisfaction with salary seems the most common reason that UHE-ps drop out of the program. The salary was considered very low compared to their professional status and workload. The participants describe the tasks of UHE-ps as very tough and physically demanding. As one respondent said, "I am not as such comfortable with the salary.... I spent three years in college and graduated after a lot of hard work but after that the salary that is paid for us is very…very small. You know…the last hard work in the world is the work of health extension. Going door-to-door, with lots of fatigue, through the burning sun and the chilly weather sometimes, hence, comparing to this, the salary is not satisfactory."

Dissatisfaction with salary also comes by comparing the salary of UHE-ps with that of nurses working in hospitals and health centers. UHE-ps believe that they work harder and assume more challenging duties but get less salary. One participant said, "It would be better if they are provided with additional salary to help them get them on the same level with the nurses in the other health facilities. The work is basically harder isn't it? The work is not just what you perform sitting in hospital or health center, rather by going home to home in every residence with how many people, how many behaviors you face. There are so many people who may pick a fight with you; they may strike you and these challenges should be considered."

Participants reported an absence of other financial incentive mechanisms regardless of their unreserved effort to get things done. They reported that they used to work extra time to visit households that are closed during normal working hours, but never get over time payment. They also complained about the absence of other allowances like transportation and hardship.

The general management and administration of urban health extension program did not satisfy the dropouts. Regional health bureaus, city health offices, and kebeles are government bodies directly involved in the implementation of UHEP. They are expected to support urban health extension professionals in their day-to-day activities. However, most of the dropouts reported that the support they got from these organizations was minimal. Health officials only visit during reporting periods and when there are visitors from higher government bodies. As a result health extension professionals feel they are working alone, which creates stress and dissatisfaction. Dropouts also said that supervisors and managers only looked for mistakes and never acknowledged their efforts. This dissatisfaction with management and supervision is another reason for leaving the program. A participant said, "They don't even consider our effort. They only need a report. They came once in a while or when something comes up from the higher officials. They will only collect a report in a hurry otherwise they never ask if we have any problem. When we face a problem they are not with us."

The participants seem to be denied basic work-related rights. They repeatedly reported that they did not get annual or sick leaves from their supervisors and managers. They reported that they are denied their civil rights despite efforts to accomplish their duties. So they felt abused and some of them resign from their job. One participant said, "The workload is too difficult, and no one understands that. For example when you are sick you do not get sick leave. Extension means a worker with no right in which civil service does not concern. We have many problems. Even housemaids are much better than us. When you ask your right, you are not granted, even if you fulfill your duties. For instance we work in emergencies, be it immunization or epidemics, but the right of the health extension is not respected as other governmental workers. That is one of the reasons to leave my work; the work is full of stress."

The other common reason leading to resignation is the unclear line of command in the urban health extension program. According to the participants, they receive orders from city health offices, RHB, health center, and kebele. They feel like they have many bosses. One participant asked, "To whom are we accountable? That is what I can't understand now; it is not clear for me. As a tradition, it is the health center; as the beginning what they told us was we would work in the health center but mainly the kebele would monitor our job. I told you it is not only the kebele coordinator that shouts at us but also those at lower level." Another participant said, "The health extension professionals are in trouble they don't know to whom they are accountable: kebele or woreda office or health center. At one time, we were supposed to be under the kebele. When we are under the kebele, we have work burdens. While we work with kebeles, we are nurses, at the same time we work in the community, and the cabinet /local politicians make us their messengers."

Another reason that pushes UHE-ps to resign is the nature of the work itself. The UHE-ps are expected to travel house-to-house and educate the community. Almost all respondents considered the work to be very tiresome and physically demanding, and for some it was tiresome enough to lead to resignation. A participant said, "The main reason that forced me to leave the job was that I was tired because we did not have transportation. During household visits I walk 40 minutes to my work area, four times 40 minutes a day to travel from house-to-house; this is the main reason which forced me to leave my job. I got only 115 birr addition to my salary in my new work but at least I sit the whole day without any exposure to sun."

Beyond being tiresome, the tasks of UHE-ps are generally considered unrelated to what they studied in nursing school. According to them, a nurse is expected to provide clinical services in hospitals and health centers. Working in a community giving health education house-to-house is considered unrelated to their profession and adds no value to their career prospects. We interviewed a dropout who now works at a private hospital. She worked as UHE-ps for 3 years. However, these years of experience did not add any value for her current professional practice. Even she regrets the time she spent as UHE-p. As one participant said, "The other thing is...the work experience of health extension is valueless. You work for 3, 4, or 5 years. What does this means if it has no value for your work experience? Now I if I left and compete to be employed for a referral hospital, my work experience has no value. That is why most of them [stay as a UHE-ps], due to lack of other opportunity [not a single health extension workers feeling happy in her work]… we are nurses plus health extension but we are not treated as a professional. And when you compete as a health extension [worker] it is difficult as the work experience is valueless to health center and hospitals, so you are working for nothing."

Moreover, not able to see change in the community and not being accepted by the community were mentioned by few as reasons for leaving their job. A participant said, "I have worked for two years, starting from data collection up to implementation of the 15 packages. The package has to be performed by the house heads but the peoples do not give attention to what we teach them and they do not implement the packages. So why do I suffer? This is for them. They should do it happily and effectively. However, I see no changes year after year. This makes me stressed. This is the other reason why I left the job."

4.2.2 Work environment and condition

Key findings:

- More than half of the UHE-ps (66.4%) and their supervisors (74.1%) were not comfortable with their working environment. On the contrary, the respondents from the C/THOs consider the environment conducive to working.
- The supervision at the workplace is not regular or supportive.
- 91.4% UHE-s and 84.7% UHE-p supervisors did not agree that their job offers them adequate pay compared with the job requirements.
- About 80.9% UHE-ps and 74.6% UHE-p supervisors did not agree that their work load is in line with the job description.
- 43.5% of UHE-ps and 81% of the supervisors had experienced any form of physical harassment during household visits.
- More than 65% of UHE-ps and supervisors don't think there is clear procedure to report and solve harassment encounters.
- 76.8% of UHE-ps and 69.2% UHE-p supervisors expressed dissatisfaction with their job. For the UHE-ps who were satisfied with their job, satisfaction came from working in the community.
- 78% of UHE-ps and 68% of the supervisors don't think their job provides opportunity for advancement.

4.2.2.1 Work environment

Overall, 69.6% UHE-ps and 62.3.5% UHE-p supervisors responded negatively to the work environment variables. More than half of the UHE-ps (66.4%) and 74.1% UHE-p supervisors were not comfortable with the physical working environment. More than two-thirds (76.3%) of UHE-ps and 72.6% UHE-p supervisors responded that they did not have necessary equipment and resources. However, more than half (57.3%) of UHE-ps and 72.7% UHE-p supervisors believed that they get fair treatment by their supervisors (Table 4a). Unlike the negative perspective of the professionals and their supervisors toward their workplace environment, most respondents in the qualitative interview at the town health office claimed that there were no marked problems regarding required materials for the work of UHE-ps (drugs, guidelines and standard procedures, registers, posters, charts, manuals, guidelines, documents, etc.). One of the main reasons for the absence of problems was that UHE-ps are not supposed to provide medical services because they focus on rendering preventive services to the community. Besides, materials for their work are supplied by the respective city/town health offices and health centers. An interviewee from Arbaminch, for instance, said that up to 80-90% of these materials are supplied by respective C/THO and HCs and to some extent a budget from the FMOH Maternal and Child Health (MCH) program is used for this purpose. An interviewee from Shashmane corroborated this, saying that they have never faced a stock out of or these materials.

On the contrary, the interviewees from Shire, Adigrat, Wolkite, and Jimma confirmed the professionals' negative attitude toward their working environment. They consider the absence of separate kebele offices for UHE-ps a basic problem that has resulted in difficulty organizing their data. A respondent from Hossana said that UHE-ps are facing huge problems such as a lack of stationery materials, budget, and responsible body for the Urban Health Extension Program (UHEP) in the zone. He claimed that the government has left the issue for nongovernmental organizations (NGOs), which are busy with their own matters. The issue of budget was also claimed by a respondent from Harar, who mentioned that there was no budget for the program since the last three years, when JSI has provided materials like umbrellas and first aid kits. An interviewee from Akaki Kaliti subcity in Addis Ababa complained that UHE-ps lack gowns and that stationery materials are in short supply. Other sites also reported similar problems with the availability of equipment.

Heads of health centers were also asked about the conduciveness of working environments for UHE-ps and supervisors; not all agreed. For instance, interviewees from Dire Dawa, Harar, and Adama responded "no" to conduciveness, while those from Addis Ababa, Hawassa, and Mekelle stated that it was. Others claim that it is improving. Among the reasons that working environment was not conducive were challenging topography and poor infrastructure of certain areas. Places with hot climates were also considered problematic for UHEPs because the heat makes it is very difficult to travel on foot and perform tasks during the day time.

On the contrary, respondents from the above-mentioned towns who felt that work environment was conducive explained that UHE-ps hardly face ups or downs in working environment, especially compared to rural HEWs. "These professionals," they claimed, 'are like any employee in urban areas with field duties. Their allocation takes into consideration their residence areas and therefore transportation as well as other supply shortages are not worth mentioning."

UHE-p FGD participants reported that they were challenged by an environment that was not conducive to their work. Some had to share an office at the Kebele or the health center when they conduct their weekly or monthly report; others report in the field. A few had offices but said they were not clean and did not have the necessary office furniture (table, chair, or filing cabinet). One participant said, "We have no office. We just sign the attendance sheet and go back home. Sometimes we write reports in one of the households."

Some see their work environment as the community home visit. Compared to the community, their office is the worst. It seems that they don't have much expectation in terms of office environment. The participants are responding to the questions knowing that nothing good will come of it. It seems they are tired of their environment and promises to improve it so they make jokes when they are asked about their work environment.

Table 4: UHE-ps and supervisor perceptions of work environment, 2014

Work environment variables	Study participants							
	UHE-ps				UHE-p' supervisors			
	Disagree		*Agree*		*Disagree*		*Agree*	
	No.	%	No.	%	No.	%	No.	%
The physical working environment is good for me (space, lighting, ventilation)	389	66.4	197	33.6	86	74.1	30	25.9
I have necessary equipment and resources available	447	76.3	139	23.7	85	72.6	32	27.4
I get regular management and leadership	378	64.5	206	35.5	65	57.0	49	43.0
I get supportive management and leadership	358	61.2	227	38.8	55	47.8	60	52.2
I get fair (equal) treatment by my supervisors	250	42.7	336	57.3	30	27.3	80	72.7
Overall score	***400***	***69.6***	***175***	***30.4***	***66***	***62.3***	***40***	***37.7***

4.2.2.2 Supervision at workplace

In general supervision from place to place varies in terms of regularity and the person providing the supervision. Supervision may take place every 15 days or every three months or be random. Supervision may be from the woreda office or health center. One participant said "Supervision is done only when someone with a guest come to visit us." The participants' perception of supervision is not uniform but the majority has negative perception of management and supervision. One participant said "the supervision is not supportive at all," which was supported by the quantitative result that 61.2% of the UHE-ps and 60% of their supervisors think there is a lack of supportive management and leadership.

The participants believed that their supervisors did not have skills to do their job. The UHE-ps don't consider supervision to be supportive and say that the feedback they get is demoralizing. According to the participants, the source of this conflict between the UHE-ps and their supervisors is that the supervisors are not aware of the program or the work to be done. So they sometimes provide feedback that is not acceptable to the UHE-ps or related to what they set out to do. As one respondent said, "All the packages may not concern a given mother. For example, a household may not be a candidate for family planning for obvious reason but the supervisors think all the fifteen packages should be applied to a single family but that is not the case. We select and use [relevant] packages for each household. That is how we were trained. But because of their wrong understanding of the program, they send us feedback that demoralizes us. Sometimes, those who know about the profession explain and send us feedback, which help us improve and educate."

The participants complained about the lack of clarity and often contradictory nature of the feedback given by immediate supervisors and the other officials.

4.2.2.3 Workplace conditions: salary, job description, and workload

Overall, 62.2% UHE-ps and 68.0% UHE-p supervisors reported that they were happy with the workplace conditions. Though the overall score is good, 91.4% UHE-ps and 84.7% UHE-p supervisors did not agree that their job offers them adequate pay compared with the job requirements. About 80.9% UHE-ps and 74.6% UHE-p supervisors did not agree that their workload is in line with the job description (Table 5).

Similar with the quantitative result, the UHE-ps are unhappy with their monthly salary. They strongly argued that their salary is not fair compensation for the amount work they are obliged to do. When it comes to salary they compare themselves to nurses who work at a health center, whom they said work only 8 hours in a comfortable environment and are paid for extra hours. But the UHE-ps, who spend the whole day walking and working extra hours including weekends, get only their monthly salary, which is the same as the nurses in the health facility. One participant said "What I am satisfied about is that before I started working in health extension I was unable to express my mind. But now I talk very eloquently. After thirty days of tiresome work and moving around in the community, we receive our salary and that is the day I get dissatisfied because the salary is not worth our efforts."

Table 5: UHE-p and supervisor perceptions of workplace conditions, 2014

Workplace conditions variables	Study participants							
	UHE-ps				UHE-p supervisors			
	Disagree		Agree		Disagree		Agree	
	No.	%	No.	%	No.	%	No.	%
My managers provide me regular feedback about the effectiveness of my performance.	205	34.7	385	65.3	52	44.1	66	55.9
My co-workers provide me regular feedback about the effectiveness of my performance.	171	29.0	419	71.0	43	36.8	74	63.2
Teamwork is commonly practiced with the co-workers	140	23.8	449	76.2	29	24.6	89	75.4
I get professional assistance from my supervisors,	224	38.2	363	61.8	45	39.1	70	60.9
My job gives me the opportunity to participate in decisions that affect my job.	147	25.4	432	74.6	35	30.4	80	69.6
My job offers me adequate pay compared with the job requirements.	523	91.4	49	8.6	100	84.7	18	15.3
My job offers me adequate pay compared with the pay in similar jobs.	529	90.6	55	9.4	87	76.3	27	23.7
My workload is in line with the job description.	469	80.9	111	19.1	88	74.6	30	25.4
I am able to do my job independently of others.	259	44.4	324	55.6	45	38.5	72	61.5
I know to whom I report.	67	11.5	518	88.5	6	5.1	112	94.9
I report only to my immediate supervisor.	316	54.8	261	45.2	70	59.3	48	40.7
I have control over the pace of my work.	178	30.4	407	69.6	31	26.3	87	73.7
I usually have the opportunity to complete the work I start.	180	30.8	404	69.2	45	38.1	73	61.9
My job offers me job security as long as I perform well.	176	30.2	406	69.8	33	32.0	70	68.0
There is much variety in my job.	63	10.8	518	89.2	9	8.8	93	91.2
Overall score	***196***	***37.8***	***322***	***62.2***	***31***	***32.0***	***66***	***68.0***

All respondents agreed that they have a heavy workload. They said they do everything they are asked by whoever is in charge in the government office. In addition to their house-to-house visits, they work with various stakeholders and there are no official hours so they often work nights and weekends. One participant said that UHE-ps aren't paid anything when they work extra hours while others with the same qualifications at the health facilities earn extra hour payment.

The participants believe that their job description is to carry out the 15 packages. However, they spend most of their time working on unrelated issues, which they are not happy about. This created a lot of burden on them and obscures their image in the community. One participant said, "Health extension means, simply a lot of burden. The only organizations that have not benefited from us are telecommunications, electric power, and Ministry of Transportation. When teachers are asked about the number of children, they refer the question to us. There were times when we were told to register

people who are in the small and medium-scale business and the unemployed and we did it." Another participant said "There are other things that we do but are not part of the list of work we are supposed to do. This [extra] work has nothing to do with the services we are supposed to give. As a result the community does not have a good attitude toward us. When we go ask them about something, they are not cooperative ... we are in real trouble."

According to participants, there are no specific job descriptions. They spend most of their time working on agriculture, education, and even political activities. They did ask the officials about their job and the response from the officials was not positive. According to the respondents, the UHE-ps who asked these questions were penalized. Their salary was cut and some were forced to resign. Some are not totally against the additional activities, but they want additional training if they have to conduct them. The official responded to this request by saying "Even the 8th grader can do the job without training but you are diploma nurses trained to be extension worker so this shouldn't be a problem."

4.2.2.4 Workplace safety

Although there are provisions in the constitution and health sector safety rules that protect the rights of health professionals, there is no explicit document with specific reference to UHE-ps except manuals that apply to other health professionals as well.

Almost all of the interviewees indicated that there are no any special workplace policies or practices to protect UHE-ps and supervisors. However, the kebele administrators and police work in collaboration to ensure the security of the UHE-ps across the study regions. Some kebele administrators occasionally assign security personnel to travel with the professionals to safeguard them. One respondent from Wolaita replied that "there was a conflict between the UHE-ps and a household head on the liquid waste management of the household and the kebele administrators soon arrived upon the call from the professional to resolve the conflict. It was mentioned that the professional was so happy with the intervention taken by the kebele leaders at the spot." A respondent from Mekele said that "even the high level administrators are not involved in such matters, in some cases police and women's development association is engaged in maintaining the security of the UHE-ps." A respondent from Shire emphasized that "no special attention was given to UHE-ps by civil service policy. In most of the cases crimes to UHE-ps are managed like any regular crime." Respondents from Akaki and Yeka subcities of Addis Ababa indicated that "there is no policy with regard to the safety of UHE-ps; however, their problems are resolved by the woreda management."

As reported above, there is no clear procedure to solve abuse. The UHE-ps also mentioned that the kebele tries to solve the issue whenever conflicts are reported but there are no measures to prevent them. In addition, the kebele and other responsible officials do not interfere unless there is a big commotion, because incidents and minor abuse are usually endured by these workers and go unnoticed.

UHE-p and their supervisor's perception of workplace safety

Overall, 75.6% UHE-ps and 74.6% UHE-p supervisors seemed unhappy with the workplace safety conditions. Around 43.5% of UHE-ps and 81% of the supervisors acknowledged the presence of any form of physical harassment during household visits. More than 65% of UHE-ps and supervisors don't think there is clear procedure to report and solve such encounters (Table 6). The qualitative assessment of UHE-ps also supports this finding. Participants have been verbally harassed by household members, physically abused by mentally ill people, and even bitten by dogs, especially at the beginning of their posts, although this diminishes if they are able to gain the trust of the community.

At times, physical harassment escalates to sexual harassment. One participant described experience. "I had to graduate a model household so I told them dig a garbage hole. The woman's son was in the house. He said that I was abusing his mother and he grabbed me by the neck. Some people pulled him away from me. I reported this to the woreda but it did nothing and did not even consider it as a problem." Another participant said "I was working in the neighborhood one day when a man came to beat me. I had been trained in martial art. So I struck him first and defended myself."

There is clear discrepancy between the UHE-p and the supervisor report on harassment and the people from town health office. The latter do not agree completely on the presence of such harassment. They said that it is not a major problem due to the support the program has from key stakeholders including professionals, kebele administrators, community, police, and women's associations. As one respondent said, "as the UHE-ps and their supervisors themselves are "Cabine," [indicating a member of the political structure] the professionals are not prone to any form of harassment." However, as indicated below, there are very few reports on the issue of harassment. A respondent from Harar indicated that UHE-ps have been subjected to sexual abuse, insults, etc., and a case of rape was reported from Hossana. Moreover minor quarrels, letting dogs bite the UHE-ps, and closing doors in an attempt not to talk with them were also reported. All the problems have been resolved by discussion with the community and legal actions were taken like any other crime. Some respondents said that they plan to control harassment by creating community awareness and collaborating with kebele administrators, police, and social workers to safeguard the UHE-ps.

Table 6: UHE-p and supervisor perceptions of workplace safety, 2014

Workplace safety variables	Study participants							
	UHE-ps				UHE-p supervisors			
	Disagree		*Agree*		*Disagree*		*Agree*	
	No.	%	No.	%	No.	%	No.	%
My workplace complies with safety procedures.	407	69.1	182	30.9	78	66.1	40	33.9
I am provided with safety training.	455	77.5	132	22.5	95	80.5	23	19.5
I am provided with safety equipment.	491	84.2	92	15.8	92	78.6	25	21.4
I do not encounter physical harassment when I visit households in the community.	256	43.5	333	56.5	94	81.0	22	19.0
Clear procedures are in place for reporting accidents.	389	67.0	192	33.0	79	68.1	37	31.9
Overall score	***430***	***75.6***	***139***	***25.4***	***85***	***74.6***	***29***	***25.4***

4.2.2.5 Employee satisfaction

Despite the challenges UHE-ps encounter every day, some managed to have some level of satisfaction with their job. Their satisfaction comes from their work. Knowing that mothers are delivering at health facilities, children are getting immunized properly, and people are actually listening to what they say and begin cleaning their environment. But a few were never satisfied with their job. One participant said, "I liked my job better when I was working at the health center as a clinical nurse."

The participants also mentioned the sources of dissatisfaction on their job. The UHE-ps are dissatisfied when the community fails to take their advice and does not support them. The participants think that the support from the officials is not continuous and felt that they are alone. In addition, the workload and the salary that is not comparable with their work are sources of dissatisfaction. This was supported by the quantitative result, where more than three-quarters of UHE-ps (76.8%) and UHE-p supervisors (69.2%) expressed dissatisfaction with their job, and 92.2% of UHE-ps and 88.1% of UHE-p supervisors reported their dissatisfaction with their salary (compensation). Similarly, 87.7% UHE-ps and 86.3% UHE-p supervisors were dissatisfied with the existing training/education opportunities (Table 7).

Factors motivating the UHE-ps and their supervisors

The most commonly mentioned motivating factors were increase in salary; creating conducive working environments by availing means of transportation such as bicycles; and provision of further educational opportunities. The supervisors suggested the need for professional career development, regular refreshment training, and improved flow of work supplies, supportive supervision, and timely resolution of problem to keep UHE-ps in the program.

Some UHE-ps said the positive comments and feedback from the community about their professional skills is motivational. The ability to work with other teams and the presence of fair leadership are also good motivational factors. However, negative feedback from the community and the people in the woreda outweigh the positive and negatively affect their motivation. Similarly, in the quantitative result, the 64.1% of the UHE-ps and 65.2% of their supervisors reported dissatisfaction with current management.

Moreover, these professionals strongly suggest that the health extension manual consider the urban context and their service rendering modality be extended like that of rural health extension workers so they can work beyond preventive services. Other respondents strongly argue that the UHE-ps need to have a permanent workstation (again, as have the rural HEWs) to keep them motivated and work to their best.

Table 7: UHE-p and supervisor satisfaction levels, 2014

Employee satisfaction variables	Study participants							
	UHE-ps				UHE-p supervisors			
	Disagree		*Agree*		*Disagree*		*Agree*	
	No.	%	No.	%	No.	%	No.	%
I have been given regular opportunities to express my views.	369	62.6	220	37.4	49	43.8	63	56.2
I have given regular opportunities to contribute to joint problem-solving exercises.	372	63.1	218	36.9	53	44.9	65	55.1
Mechanisms are in place to deal with grievance.	499	84.9	89	15.1	70	60.3	46	39.7
Incentive schemes are available.	511	86.8	78	13.2	94	79.7	24	20.3
Incentive schemes are affected.	484	85.1	85	14.9	97	82.2	21	17.8
I am satisfied with my job.	286	49.8	288	50.2	73	65.2	39	34.8
I am satisfied with current compensation (salary).	533	92.2	45	7.8	104	88.1	14	11.9
I am satisfied with the existing management and leadership.	370	64.1	207	35.9	77	65.8	40	34.2
My job gives me a feeling of achievement and accomplishment.	230	40.4	340	59.6	56	47.9	61	52.1
I am satisfied with my relations with co-workers.	84	14.6	491	85.4	30	25.6	87	74.4
I am satisfied with my supervisor support.	254	44.3	320	55.7	61	52.1	56	47.9
I am satisfied with the training/education opportunities exist.	505	87.7	71	12.3	101	86.3	16	13.7
Overall score	***413***	***76.8***	***125***	***23.2***	***72***	***69.2***	***32***	***30.8***

4.2.2.6 Career development

Overall, 81.3% UHE-ps and 75.6% UHE-ps supervisors did not think they had career development opportunities. More than half of the study participants (both UHE-s and UHE-p supervisors) did not think that existing career development opportunities are adequate (Table 8). Similarly when the UHE-ps were asked about career opportunities, they started to talk about getting additional training and leaving their job. They even laughed when they were asked about it. Some don't see any prospect in being health extension professional. This is strongly supported by the fact that 78% of UHE-ps and 68% of the supervisors don't think their job provide opportunity for advancement to higher level jobs.

Instead, the participants said that there were few training opportunities after their initial health extension worker training. They need refresher training because the field is constantly changing. This is also supported by the quantitative result where 70.9% of UHE-ps and 60.3% of the supervisors do not think there is any inservice training opportunity. In addition, 69% of UHE-ps and 74% supervisors don't think the training they had addresses their current gaps in knowledge, attitude, or skills.

The participants also claimed that the people in the woreda office deny them training by sending someone who is not the right candidate or decline any training offer coming from an organization. One participant said "… what they say nowadays is that if an individual or an institution wants to give us training, the institution will be told by the health office to stay on the queue for four or five months. When they are asked the reason they do this, they reply if they are given a lot of trainings, they will not do good on their job.' There is a condition where training has come to cease. We haven't been given any training this year."

The response from the town health respondents supports the lack of career development path reported by the UHE-ps and their supervisors. Although the concept of career pathways is vague for most of the respondents at the city/town health offices, most said that there is no clear career pathway for these professionals. 'Career pathway' was understood by most of the respondents as an increase in salary of UHE-ps and supervisors, so they are not sure about it. For instance, an interviewee from Debremarkos said, "Their salary is increased every two years; to the best of my understanding this is not professional career." Another respondent from Wolkite described the same in different way. "There is no vertical career referring to educational opportunity for these professionals, but there is horizontal career referring to an increase in salary every two years." However, some respondents said that there is an education opportunity beyond an increase in the rate of their salary every two years. According to one respondent from Addis Ababa, unlike other health professionals, determination of the career pathways of these professionals requires further study.

Table 8: UHE-p and supervisor perceptions of career development, 2014

Career development variables	Study participants							
	UHE-ps				UHE-p supervisors			
	Disagree		Agree		Disagree		Agree	
	No.	%	No.	%	No.	%	No.	%
There is a career development plan for skill requirements.	484	83.7	94	16.3	103	88.0	14	12.0
There is adequate development of skills.	402	70.2	171	29.8	91	79.8	23	20.2
There is adequate utilization of skills.	314	54.5	262	45.5	70	60.3	46	39.7
Training addresses current gaps in knowledge, attitude, and skills.	399	69.2	178	30.8	86	73.5	31	26.5
Training addresses future career needs.	409	70.6	170	29.4	91	78.4	25	21.6
Career ladders and succession plans exist.	402	70.2	171	29.8	84	71.8	33	28.2
Career ladders and succession plans are used.	411	71.4	165	28.6	83	70.9	34	29.1
Career plans take into account their service year and performance.	446	77.6	129	22.4	90	78.3	25	21.7
In-service training opportunities exist.	409	70.9	168	29.1	70	60.3	46	39.7
My job provides opportunities for advancement to higher level jobs.	446	78.0	126	22.0	80	68.4	37	31.6
Overall score	***447***	***81.3***	***103***	***18.7***	***85***	***75.9***	***27***	***24.1***

4.2.3 Performance management

More than half of the study participants (55.2% UHE-ps and 59.3% UHE-p supervisors) supported the overall situation of performance management. About 93.4% UHE-ps and 93.1% UHE-' supervisors said that annual work plan is available, but 75.3% UHE-s and 80.2% UHE-p supervisors did not think that reward systems based on the performance appraisal are in place (Table 9).

Table 9: Mean scores by UHE-ps and their supervisors on performance management, 2014

Performance management variables	Study participants							
	UHE-ps				UHE-p supervisors			
	Disagree		Agree		Disagree		Agree	
	No.	%	No.	%	No.	%	No.	%
Effective workflow systems are in place.	357	61.9	220	38.1	74	63.8	42	36.2
Effective supply management systems are in place.	409	70.9	168	29.1	79	68.1	37	31.9
Annual work plan is available.	38	6.6	538	93.4	8	6.9	108	93.1
Clear job descriptions exist.	167	29.0	408	71.0	31	27.0	84	73.0
Clear standards of performance exist.	188	32.5	390	67.5	41	35.3	75	64.7
Clear standards of performance are readily available.	148	25.7	428	74.3	26	22.4	90	77.6
Periodic supportive supervision is practiced by supervisors.	286	49.4	293	50.6	44	38.3	71	61.7
Periodic performance evaluations are carried out by supervisors.	177	30.2	409	69.8	39	33.9	76	66.1
Performance appraisal methods are clear.	259	44.3	326	55.7	45	38.8	71	61.2
Performance appraisal methods are fair.	302	51.7	282	48.3	53	45.7	63	54.3
Performance appraisal methods are transparent.	290	50.0	290	50.0	58	50.0	58	50.0
Performance appraisal is used for training need assessment.	409	70.4	172	29.6	88	75.9	28	24.1
Reward systems are in place and based on the performance appraisal.	439	75.3	144	24.7	93	80.2	23	19.8
Overall score	***243***	***44.8***	***300***	***55.2***	***46***	***40.7***	***67***	***59.3***

4.2.3.1 Current standards and approaches for UHE-p performance appraisal

One of the respondents from FMOH said that performance evaluation of UHE-ps is conducted on monthly basis by the head of the health center, while supervisors are evaluated by the woreda health office experts. It was also mentioned that there are evaluation criteria for both UHE-ps and supervisors that are based on annual planning specific to the program. The federal health extension directorate develops annual plans that cascade to the regions, zones, and woredas. These plans are evaluated twice a year.

Performance appraisal is based on a checklist on monthly and quarterly basis. The checklists have varying criteria depending on which of the 15 packages have been implemented per each UHE-p's plan, as well as her competency. In some cases the performance evaluation is based on Balanced Scored Card (BSC) and conducted twice a year by health extension case team members from the health center. Yet a UHE-p from Harar said that "they do not have periodic performance evaluation system at their level and at Woreda level specifically implemented for the UHE-ps and supervisors, since there is no standard format for performance appraisals."

The UHE-ps also acknowledged that there is some form of performance evaluation conducted by people coming from the woreda health office or health center. The evaluation is done regularly but the timing varies place to place. For instance in Harar it is done every two weeks while in Hawassa it is done quarterly. The purpose of the evaluation is to give incentive to the employees. According to the participants, they receive training opportunities or any form of recognition based on their evaluation result; but this is not practiced everywhere.

Not all participants believe that the criteria for evaluation and award is fair, because people who win are not those who do the job; it's those who eavesdrop on everybody's business and report to the authority. Furthermore, the criteria is not based on what UHE-p's advancement of the 15 packages, it is based on their involvement in the politics/party activities.

One participant said, "We think there is discrimination. They give the awards to those who kiss their boots. I mean there are some who don't really do their jobs but talk about what somebody is doing or not doing." Another respondent told of an unannounced evaluation. "There was also a time where unfairness had happened. We had asked our privileges on some issues. We, all extension professionals, made a petition asking for annual leave. I… have never taken annual leave yet. I have been working for three years and eight months. It is not that I don't want the leave, but I was not allowed. Others have this same problem. By the time we asked for our annual and maternity leave, they call for an urgent assessment. We were classified as 'rebels'. The evaluators were political leaders. Everybody was asked from which subcity she came and name. Then they cross-check each name with the paper they have in their pocket. Then she will be asked to confess. After that, the co-workers would ask her few questions. That was all if her name is not in the list. But if her name is on the list, the evaluation would turn to harassing. There were such terrible things. That action alone has resulted in the resignation of many." The respondent went on to say that the evaluation was followed by massive verbal abuse.

4.2.3.2 Utilization of a functional performance management system for all UHE-ps and their supervisors at all levels

The interviewees indicated the presence of implementation manuals for functional performance management systems—such as performance standards and job descriptions—from federal to lower levels. They also acknowledged that there are documents on job specification, work plans, etc. The daily job specification is developed based on the interest of the local community. Some respondents said that BSC is applied. And respondent from Mekele indicated that UHE-ps have job descriptions, manuals for graduate households, and action plan issued by the health bureau.

Similarly, the participants from FMOH indicated that the BSC has been implemented and helps monitor the jobs of UHE-ps and their supervisors. It was also mentioned that there is feedback system on the performance and improvement areas of these professionals, from federal down to regional, zonal, and woreda levels. Most of the respondents replied that supportive supervision, review meetings, and feedback are used to discuss the performance of UHE-ps and their supervisors. Provision of training and discussions with UHE-ps was also mentioned as means to improve performance of these professionals.

4.2.3.3 Level of supervision and readiness to support UHE-ps and their supervisors

Most of the respondents rated the readiness level to support UHE-ps and overall UHEP as "high." Subcities and kebeles/woredas are also involved in the support system of UHE-ps and UHEP in general, mainly providing administrative support, while health centers provide technical and logistic support. Other material support such as gowns, stationary, phone cards, and soap is also given to the UHE-ps.

Respondents were nearly equally divided on this issue, with about half claiming adequate human resources to support the supervision process of UHE-ps, and the other half claimed inadequate. The big issue is that although every region has its own scheduled supportive supervision plan, the frequency of supervision was not uniform across the studied regions. For instance, a respondent from Asella said "supervision is made every 2 weeks by experts from town health office and every week from health centers," while a respondent from Arbaminch said "supervision is carried out once per month by experts from town health office and 3 times per week by those from health centers."

According to a respondent from Adigrat, supervision is conducted every three months by experts from the health center, while in Shire it is every two months, indicating lack of uniformity even within the same region. Meanwhile, some have annual, quarterly, and monthly plans to support UHE-ps and their supervisors. In a few cases, these professionals meet with town health office heads on a quarterly basis to discuss matters related to the UHEP. This implies that the frequency and modality of supervision of UHE-ps and their supervisors is inconsistent across the nation. Zonal experts rarely visit these professionals. Another reported problem was the inconsistency in the ratio of supervisor to UHE-ps, which varies and affects the supervision process at each level. Checklists and feedback mechanism are also rarely used in the process of supervision.

4.2.3.4 Current practice in support and management of UHE-ps and their supervisors at Woreda and/or city/town level

Most of the respondents from respective regions thought that there are encouraging practices to support and manage UHEP at woreda and/or city/town levels. Practices mentioned included use of standardized supportive supervision developed by FMOH; in-service trainings; use of model families to enhance community awareness about the UHEP by constructing household latrines, peer-to-peer experience sharing**,** and fuel-saving wood stoves; and linking health center activities to health extension packages. In the same line a respondent from Debre Markos, Amhara indicated that "a group of experts from the town health office, health center, and UHE-ps and their supervisors sometimes work together in the field." Interestingly, an interviewee from Harar said "mobile card, gown, gloves, and recognition (certificate) are provided to keep UHE-ps motivated." Moreover, respondents identified various bodies that are responsible both for administrative and technical issue of the UHE-ps. In most of the cases, health extension program coordinators at the town health office, management bodies at the health center, kebele administrators, subcity steering committees, as well as disease prevention and health promotion core process are responsible for administrative issues of the UHE-ps. For instance, according to a respondent from Akaki Kaliti subcity, "There is an organized committee comprised of members from different sectors, including women's affairs, education, and health offices, working to support UHE-ps in this particular subcity, where an individual from women's affair serves as a chairperson and the one-room subcity health office administrator serves as vice chairperson and secretary." Similarly, health extension work process and case team members at the subcity level like in Addis Ababa, and experts from the town health office and health centers are mainly responsible for technical support of these professionals.

4.2.3.5 Planned capacity-building strategies for UHE-ps and their supervisors

Most of the interviewees responded that they have various plans to give refreshment training to UHE-ps. Some mentioned that will plan trainings in collaboration with NGOs and health bureaus after conducting a training needs assessment. Some of the training components include training supervisors on supervisory process, immunization, environmental activities, and other packages for UHE-ps. A respondent from Shire said there is a plan to offer on-the-job training. Peer-to-peer experience sharing, strong supportive supervision, and building offices for UHE-ps were mentioned by other respondents. Surprisingly, a respondent from Axum said, "UHE-ps have case presentation among themselves, which enriches their professional knowledge." However, most of the respondents claimed that there is not enough money at town health offices or health center to pay for training. Interviewees from Wolkite and Wolayta suggested that the government and NGOs should support the training and capacity-building of UHE-ps and supervisors.

4.2.3.6 Existing mechanisms to ensure that supervision is truly supportive for UHE-ps and their supervisors

Most of the city/town health offices and health centers use checklists and field supervision to ascertain whether UHE-ps are truly supervised. Feedback from kebele administrators, community, the UHE-ps themselves are among the other mechanisms to ensure the supervision. A few respondents replied that they have a registration book in which the supervisors write comments during supervision and their signature so it can be approved by the town health offices.

Most interviewees said that there has to be sound incentive mechanisms in place. For instance, they mentioned experience sharing visit for UHE-ps to cities/towns which have been identified for their best experience and performance, on-the-job training, feedback from all levels of management bodies, and support from different stakeholders as additional ways to monitor and improve service quality. A few respondents mentioned improving human resource workforce at woreda level, strengthening the capacity of kebele administrators, and integrating supportive monitoring of UHE-ps and their supervisors with NGOs and women's development teams to improve the quality of services rendered by UHE-ps.

4.3 Organizational constraints

Key findings:

- 80.7% of UHE-ps and 79.3% of their supervisors believe that there are organizational constraints.
- 80.4% of UHE-ps and 81.0% of their supervisors acknowledged the lack of necessary materials and supplies and equipment to do a good job.
- 63.9% of UHE-ps and 62.1% of their supervisors agreed bureaucracy and unneeded process disrupt work.

More than three-fourth of the study participants (80.7% UHE-ps and 79.3% UHE-p supervisors) think there are organizational constraints. 63.9% of UHE-ps and 62.1% of their supervisors agreed that bureaucracy and unneeded processes disrupt work (Table 10). According to the qualitative participants, a major organizational constraint was human resource planning and implementation. One respondent said, "There is a five-year strategic plan in all programs of Health Sector Development program (HSDP) at national level. This plan goes down to regional, zonal, and woreda levels with respect to human resource planning. However, there is no separate planning for UHE-ps and supervisors. It is simply managed by the respective human resource department based on health sector structures."

4.3.1 Adequacy of logistics and incentives to pursue organizational goals

About 80.4% of UHE-ps and 81.0% of their supervisors acknowledged the lack of necessary materials and supplies and equipment to do a good job. Similarly, the qualitative respondents were hesitant to say that UHE-ps and supervisors have adequate logistics and incentives. As also described above, logistics support is provided by the health centers but doesn't always satisfy the demand. This is due to flexibility of plans, extensiveness of tasks, and lack of separate transportation for UHE-ps. The health centers have to make arrangements to share vehicles with the UHE program and their own work. With the exception of Addis Ababa, all health center heads felt that UHE-p and supervisor incentives are inadequate to meet organizational goals. According to theses respondents, UHE services are much more intensive that other health services. These professionals have a heavy workload because community work involves community mobilization in the formation of one-to-five and one-to-thirty organized armies or teams and it's a struggle to achieve the program objectives with limited budget. These informants acknowledge that the UHE-ps and their supervisors deserve additional incentives and motivational benefit packages since they do not have the time to take part-time work as do professionals who are working in health centers or hospitals. The heads also revealed that there is no separate budget for UHE-ps and supervisors to accommodate the necessary financial support.

While most acknowledge the hardships of the UHE-p and supervisor duties, they described them as manageable compared to their rural counterparts. A respondent from Addis Ababa said, "No special logistics are needed for urban health extension workers as [they are for] rural health extension workers. Regarding incentives, their net salary is better than diploma nurses in the health center. They have pocket money, refreshment training, rewards for better performance etc., so it is enough to motivate them."

Table 10: UHE-p and supervisor perception of organizational constraints/obstacles, 2014

Organizational constraint variables	Study participants							
	UHE-ps				UHE-p supervisors			
	Disagree		*Agree*		*Disagree*		*Agree*	
	No.	%	No.	%	No.	%	No.	%
My facility provides everything I need to do my job effectively.	462	78.7	125	21.3	90	77.6	26	22.4
There are necessary materials, supplies and equipment to do a good job.	472	80.4	115	19.6	94	81.0	22	19.0
Works are not disrupted due to bureaucracy and unneeded processes.	372	63.4	215	35.6	72	62.1	44	37.9
Overall score	***474***	***80.7***	***113***	***19.3***	***92***	***79.3***	***24***	***20.7***

4.4 Functions, structures, and capacity that exist at all levels for the management of UHE-p and supervisor information systems

Key findings:

- There is limited knowledge on who, how, or if HRIS data are collected.
- There is no electronic data base system for the HRIS of the UHEP however; they maintain paper- based data. These data are updated every three years and used sometimes for monitoring and evaluation of the program.
- There is no responsible person who is skilled enough to manage the HRIS at all levels.

None of the respondents could clearly describe functions, structures, and capacity exists at any level for the management of UHE-ps and their supervisors' human resources information system. However, the respondents said that training on how to gather and record data was given to UHE-ps and their supervisors. Specifically, one respondent said, "there is a standard format for reporting system. But there is a capacity problem in relation to skill of data collection and analysis." An interviewee from Addis Ababa said that "subcities are responsible for detailed information about UHE-ps. UHE-ps collect data by themselves, i.e. they develop data collection formats. JSI-supported areas have full information systems and documentation. There is no data analysis, but they are reporting data for region and federal levels." However, these professionals do not collect data for HMIS programs like family planning, even though there is a UHEP family folder like that of rural areas. Data on attrition and training of UHE-ps are also collected and analyzed.

4.4.1 Types of HRIS data and pattern of collection and use at each level of the health system regarding UHEP

Respondents at all levels indicated that an electronic data base system is not used for human resources information in the urban health extension program, although there are paper records. A respondent from Addis Ababa replied that "both computer-based, which is Microsoft office Excel, and paper-based human resource information management systems are being used and the information is collected and updated on quarterly basis."

According to one of the respondents from FMOH, data on UHE-p workforce are collected every three months. A respondent from Dire Dawa also mentioned that "activities are reported also on daily and monthly basis. The detail of the reporting format is prepared by JSI and includes households, ID card, work activity, and referral."

Overall the type of information collected included number of beneficiaries of the service in the community, type of health service packages rendered and implementation, type of organization and its structure, management style, concerns of professionals and community, challenges, and the extent of coverage of urban health extension packages.

The collected data are further categorized into three pillars: technical performance of UHE professionals (performance regarding packages implementation); ethical issues (who is performing in good and ethical manner, and adoption and exercising professional ethics and management issues). However, routinely collected data included presence or absence of UHE-ps and their supervisors from the workplace, salary, and career development, level of training, recruitment procedures, service year, other personal profiles, workplace conditions, routine activities, and future planning.

Once collected, the health extension program data will not be updated for three years after which time it will be updated based on the needs of the health centers and others interested entities. Data updating requires a computer, which is a challenges for UHE-ps.

Similarly, the interviewees at the national level indicated that the collected data are used for policy design, planning, and reporting purposes including monitoring. However, in most of the cases these data are not systematically used. Other respondents indicated that the collected data are used for monitoring and evaluation of UHEP and for different evidence-based decision making purposes at each level (information on top-ten diseases including mental illness at household level; training needs assessments of UHE-ps; quantify number of dropouts, etc.). Data are also used for performance evaluation, reward, and motivation of these professionals.

In contrast, respondents also indicated data collected and reported to FMOH is inaccurate and adequate. Moreover, one of the respondents claimed that no one is assigned to specifically look after HRM data and information related to UHE-p workforce.

4.4.2 The lack of skilled person to manage the HRIS system

Most respondents said that there is no independent expert to manage and produce reports on the human resource information system (HRIS). However, HRIS officers are assigned to every HRM issue and activity in the UHE program. These officers are not uniform in their professional background and include nurses and health care managers. In some cases human resource management and health extension case team are responsible for managing HRIS by handling workforce data and producing reports. One participant indicated that, "there is coordinator at each level to coordinate the compilation of data or information. This coordinator is often a health officer by profession but no specific person is assigned to data and information collection and compilation."

The responsibility to compile and produce reports varies by locality. At city health offices in Addis Ababa, for instance, subcity urban health extension officers and coordinators are responsible for HRIS management. In very few towns officers in Administration and Planning Department are responsible for UHE-ps HRIS management. Few C/THOs have experts for management of HRIS. These experts are graduates in the area of information technology, management, sociology, druggist, and environmental health experts.

4.5 Priority gaps, deficiencies, and challenges to HRM processes and systems for UHE-ps

4.5.1 Discharge duties challenges faced by UHE-ps and their supervisors

Among the challenges that UHE-ps face when they go to the community to teach health packages, closed doors are repeatedly mentioned. This is mainly due to two reasons. The first is that residents are not at home; the other is refusal to open their doors. The informants thought that this must be the result of lack of awareness and misperceptions of UHE-ps, who are mistakenly taken for political activists or religious missionaries. The refusal to open doors is also because the community's expectation for charity (like food, soaps, etc) from UHE-ps. Some professionals reported having community members demand that they work beyond the scope of their job, asked for example to clean waste in Dire Dawa. When they try to teach about hygiene and waste disposal, the community refused to let them in, demanding to be supplied with regular tap water supply first. In an similar instance, a household demanded professionals to remove waste containers for them. Other challenges, such as responsibility to cover kebeles with wide catchment in the provided period; challenging terrain, especially in rainy season; and dog bites are commonly reported.

4.5.2 Challenges related to human resources management

Challenges related to human resource management mentioned by respondents included:

- Lack of adequate leadership due to high turnover.
- Unsatisfactory results and unfulfilled objectives due to dissatisfaction and lack of motivation of the UHE-ps and supervisors.
- Limited budget for salary, supplies, communication, telephone cards, office furniture, stationary materials, data management, umbrellas, shoes, and bags.
- Unfavorable working schedule (not able to practice part-time like other nurses).
- Absence of clear administrative system (vague leadership between kebeles and health centers).
- Lack of professional and skills development..
- Lack of training in the UHE-program (for example in Mekelle although all are nurses, of 12 UHE-ps, 8 did not take UHE-program trainings).
- Absence of curriculum to upgrade the professionals.

4.6 Factors associated with UHE-p and supervisors job satisfaction

Key findings:

- Positive attitude toward the retention scheme, work environment, workplace conditions, workplace safety, and career development affects job satisfaction of UHE-ps.

- Retention and career development are the factors that affect the supervisors' job satisfaction.

4.6.1 Factors associated with UHE-p job satisfaction

To capture factors that contribute to job satisfaction of UHE-ps and their supervisors, we included different HRM functions in the multivariate model. From these factors retention, work environment, workplace conditions, workplace safety, and career development have shown statistically significant strong positive association with job satisfaction of UHE-ps. Accordingly, UHE-ps who agreed to stay in the program had greater probability of being satisfied with their job (AOR = 2.64; 95% CI = 1.21, 5.73) compared to UHE-ps who disagree to stay in the program. The likelihood of being satisfied with the job is much higher among participants who had a positive attitude toward their work environment than those who did not have positive view of their work environment (AOR = 5.54; 95% CI = 2.42, 12.71). Similarly, the likelihood of being satisfied with one's job was much higher among participants who had a positive attitude toward workplace safety than those who did not. (AOR=6.3(2.94, 13.55) (Table 11).

Table 11: Factors associated with UHE-p job satisfaction, 2014

Variables		Adjusted OR (95% CI)
Recruitment and deployment.	Disagreed	1
	Agreed	1.75 (0.77, 4.01)
Retention mechanism.	Disagreed	1
	Agreed	**2.64 (1.21, 5.73)***
Work environment.	Disagreed	1
	Agreed	**5.33 (2.50, 11.40)***
Workplace conditions.	Disagreed	1
	Agreed	**2.64(1.05, 6.61)***
Workplace safety.	Disagreed	1
	Agreed	**6.31 (2.94, 13.55)***
Career development.	Disagreed	1
	Agreed	**5.54 (2.42, 12.71)***
Performance management.	Disagreed	1
	Agreed	1.12 (0.06, 2.72)
Organizational constraints.	Disagreed	1
	Agreed	0.61 (0.26, 1.44)

***P-value<0.005**

4.6.2 Factors associated with UHE-p supervisor job satisfaction

Retention and career development were associated with of job satisfaction of UHE-p supervisors. UHE-p supervisors who agreed to stay in the program were more likely to be satisfied with their job (AOR = 21.59; 95% CI = 2.68, 7.73) compared to UHE-p supervisors who didn't agree to stay in the program. UHE-p supervisors who appreciated with the career development condition of their job were more likely to be satisfied with their job (AOR = 14.96; 95% CI = 1.68, 133.37) compared to UHE-p supervisors who were unsatisfied with the career development opportunities of their job (Table 12). However, the wide confidence interval indicates imprecise estimation of the odds ratio or inadequacy of the sample size to provide such estimation. Thus the results should be interpreted with caution.

Table 12: Factors associated with UHE-p supervisor job satisfaction, 2014

Variables		Adjusted OR (95% CI)
Recruitment and deployment.	Disagreed	1
	Agreed	0.349 (0.039, 3.142)
Retention mechanism.	Disagreed	1
	Agreed	**21.59 (2.678, 174.074)***
Work environment.	Disagreed	1
	Agreed	0.628 (0.085, 4.636)
Workplace conditions.	Disagreed	1
	Agreed	8.138 (0.472, 140.341)
Workplace safety.	Disagreed	1
	Agreed	4.280 (0.624, 29.381)
Career development.	Disagreed	1
	Agreed	**14.96 (1.678, 133.373)***
Performance management.	Disagreed	1
	Agreed	4.266 (0.362, 50.243)
Organizational constraints.	Disagreed	1
	Agreed	2.542 (0.296, 21.843)

*P-value <0.05

5. CONCLUSION

1. Officials agreed that there are minor setbacks in the human resource management of the UHEP at all levels, but more at the woreda and kebele administrative levels.

2. The human resource management of the HUEP is not standardized and in some places it is not clear who is responsible for this.

3. The regional bureaus and city administrations continue to use the FMOH pre-set criteria to recruit and deploy UHE-ps and their supervisors. However, the professionals repeatedly complained that the ratio of UHE-ps to the community size was below the FMOH standard.

4. The absence of a standard national retention mechanism leads to high attrition despite regional efforts to have their own attrition mechanism.

5. Attrition varies from place to place. Big towns with better opportunities seem to have higher attrition rates than small towns. Overall, the common reasons for attrition were dissatisfaction with salary, lack of training and career structure, workload, budget constraints, and the type of service UHE-ps are required to provide. Many who are currently working do not intend to stay in the profession.

6. Unlike the respondents from town/woreda health office, the UHE-ps and the health center heads agreed that the work environment is not conducive at all. However it is not clear if that perception arises from misunderstandings of the overall nature of the UHEP, which requires reaching the community physically.

7. The UHE-ps have huge workloads because they get engaged in activities beyond the 15 packages and because of staff turnover, sometimes have to cover more households than FMOH standard call for.

8. In general there is no workplace policy to protect the UHE-ps and supervisors; although traditionally the kebele administrative gave them protection. There are incidents of physical, sexual, and psychological harassment.

9. The UHE-ps are satisfied with their job only when they see changes in their community because of their efforts. Otherwise they are dissatisfied with their salary, work environment, and future prospect of being UHE-ps.

10. There is no FMOH or RHBO-defined career path for UHE-ps and the professionals themselves do not see any prospect being UHE-ps.

11. There is some form of performance management but it is not standard nor well structured. It is not regular and the criteria are not fair or supported by the UHE-ps.

12. Retention, work environment, workplace conditions, workplace safety, and career development affect UHE-p job satisfaction, while retention and career development are the two important factors for their supervisors.

REFERENCES

1 Federal Ministry of Health. Health and Health Relate Indicators: Ethiopia.". Available: http://www.moh.gov.et/English/Resources/Documents/Health%20and%20Health%20Related%20Indicators%202003%20E.C.pdf, 2011.

2 CSA, Summary and statistical report of the 2007 population and Housing Census .population size by age and sex. Addis Ababa 2008.

3 MOFED, "Federal Democratic Republic of Ethiopia: Growth and Transformation Plan (2010/11-2014/15) Annual Progress Report for F.Y. 2010/11.Addis Ababa."Available : http://www.mofed.gov.et/English/Resources/Documents/GTP%20Annual%20progress%20Report%20(2010-11).pdf. 2012.

4 EDHS, .Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International, 2012.

5 Kingu HJ, Longo-Mbenza B, Dhaffala A, Mazwai EL. Survival function and protein malnutrition in burns patients at a rural hospital in Africa. World J Surg Jul;35(7):1546-52.

6 Federal Minstry of Health .Health Extension Program in Ethiopia 2007.

7 Banteyerga H. Ethiopia's Health Extension Program: Improving Health through Community Involvement. MEDICC Review 2010; 13(3:46-9.

8 Teklehaimanot H, Teklehaimanot A. Human resource development for a community-based health extension program: a case study from Ethiopia. Human Resources for Health2013; 11:39.

9 Teklehaimanot A, Kitaw Y, G/Yohannes A, Girma S, Seyoum A, Desta H, et al. Study of the Working Conditions of Health Extension Workers in Ethiopia :. Ethiopian Journal of Health Development2007;21(3):246-59.

10 Marsden P, Caffrey M, McCaffery J. Human Resources Management Assessment Approach, Capacity Plus IntraHealth International, Washington, DC, USA 2013.

11 United Nations Population Fund ..Promoting Urban Health and Launch of the Strengthening Ethiopia's Urban Health Program (SEUHP). 2007.

12 Hongoro C, McPake B. How to bridge the gap in human resources for health. Lancet2004;364:1451-56.

13 World Health Organization .Human Resources for Health Country Profile Ethiopia. 2010.

14 Gormley W, McCaffery J. Human Resources for Health Professional Development at the District Level: Recommendations Based on the Ugandan Experience. 2013.

15 Haile mariam D. Second special issue on Human Resource for Health in Ethiopia. EJHD2013;27 (issue 1):1-48.

16 USIAD, AMREF, MSH. Competency Gaps in Human Resource Management in the Health Sector. An exploratory study of Ethiopia, Kenya, Tanzania, and Uganda. 2009.

DOCUMENT REVIEW

We used document review as part of this assessment to identify the existing policies, strategies, and manuals on the health extension program in general and Urban Health Extension Program in particular. The review found that no sufficient resources for assessing the core functions of human resources management concerning urban health extension professionals and supervisors except the Health Extension Program Implementation Manual prepared by the Federal Ministry of Health (Amharic version) were available. This forced us to use related documents such as:

- Ethiopian Food, Medicine and Healthcare Administration and Control Authority: Continuing Professional Development (CPD) Guideline For Health Professionals in Ethiopia, May 2013
- Human Resources for Health, IATT Task Team on Human Resources for Health, GSG Mid Term Review Meeting, December 6-7, 2012
- Ethiopia's Human Resources for Health Program: Case Study. GHWA Task Force on Scaling Up Education and Training for Health Workers
- Human Resources for Health – Country Profile: African Health Workforce Observatory , AHWO, 2010

1. Health Extension Program Implementation Manual, Federal Ministry of Health, May 2013

The Health Extension Program Implementation Manual describes the general and specific objectives, and the philosophy of the health extension program; defines terminologies such as health extension program, health development strategy, health development army, development team, one -to- five linkage, model family, health center and health care linkage; and implementation systems such as strengthening community participation, strengthening primary health care, planning, monitoring and evaluation, continuous on-the-job training and education, and coordination.

The manual, under the implementation of rural and urban health extension program implementation sections, illustrates the areas where the program shall be implemented, activities to be implemented at family level, at community level (outreach program), youth centers and schools, health posts; training of model family such as, training procedures, and model family graduation criteria; and structure of the rural health extension program.

The manual also describes the responsibilities of Federal Ministry of Health, regional health bureaus, zonal/special woreda/subcity health offices, woreda council, woreda health offices, health centers, Kebele

administration, HEWs/UHE-ps, development teams, one-to-five linkage, household (family), schools, women's associations, and partner organizations. The manual also shows the continuing on the job training and education, health extension program supervision and monitoring such as regular health management information system (HMIS), supportive supervision and inspection, and performance evaluation.

Key and Main Responsibilities of the Stakeholders for the Implementation of the HEP

The key responsibility of FMOH, RHBs, ZHO/special district/subcity HOs, woreda council administration, woreda HOs, health centers, kebele administration, HEWs/UHE-ps is similar i.e., focusing on the development of health development army/community mobilization for the implementation of the HEP.

The main responsibilities of the stakeholders (mentioned above under key responsibility) are described below.

Stakeholders	Main responsibilities
FMOH	▪ Strengthening primary health care ▪ Preparing manuals and documents ▪ Strengthening coordination with other federal sectors ▪ Working with, supporting, and monitoring regional command posts ▪ Conducting annual performance review meeting, and giving recognition ▪ Supervision and monitoring ▪ Devising and implementing continuing training and education mechanisms for HEWs and UHE-ps ▪ Conducting research ▪ Preparing experience sharing forum for best practices ▪ Developing reporting formants ▪ Preparing teaching aids, training manuals, and reference books
RHBs	▪ Strengthening primary health care ▪ Working with, supporting, and monitoring regional command posts ▪ Implementing FMOH policies, guidelines, and rules ▪ Strengthening coordination with other regional sectors ▪ Providing technical and administrative support for ZHD/special HOs ▪ Preparing experience sharing forum for best practices implemented in the region and other regions of the country ▪ Conducting bi-annual performance review meeting , and giving recognition ▪ Ensuring that the HEWs and UHE-ps are getting on the job training and education ▪ Training of new cadres of HEWs and UHE-ps to replace the HEWs and UHE-ps who left the program for various reasons ▪ Conducting research on the implementation of the HEP ▪ Supervision and monitoring

Stakeholders	Main responsibilities
	▪ Preparing teaching aids, training manuals, and reference books ▪ Preparing and sending reports to the FMOH regularly
ZHO/special district, subcity HOs	▪ Supporting and monitoring woreda command posts/community mobilization committee; conducting information exchange and working together ▪ Supporting and monitoring primary health care ▪ Implementing FMOH and RHB policies, guidelines and rules ▪ Collaborating with zonal council administration, sectors, woreda, and partners for the successful implementation of the HEP ▪ Providing technical and administrative support for woreda HOs ▪ Preparing experience sharing forum for best practices of the HEP ▪ Conducting quarterly performance evaluation meeting, and giving recognition ▪ Ensuring that the HEWs/UHE-ps are getting on the job training and education ▪ Supporting and coordinating the recruitment of new HEW/UHE-ps ▪ Supervision and monitoring ▪ Preparing teaching aids, training manuals, and reference books ▪ Preparing and sending reports to the RHB regularly
Woreda council	▪ Allocating sufficient budget for primary health care; and monitoring its utilization ▪ Guiding the integration of different sectors, and strengthening the support given to health sector ▪ Guiding ambulance usage, controlling other inputs utilization, and allocating sufficient human resources and budget ▪ Evaluating the implementation of HEP in the woreda

Stakeholders	Main responsibilities
Woreda HOs	▪ Supporting and monitoring kebele command posts/community mobilization committee; conducting information exchange and working together ▪ Linking, supporting and monitoring all health centers and health posts according the primary health care tier ▪ Implementing FMOH and RHB policies, guidelines and rules ▪ Collaborating with woreda council administration, sectors, woreda, and partners for the successful implementation of the HEP ▪ Providing technical and administrative support for health centers ▪ Preparing experience sharing forum for best practices of the HEP ▪ Conducting quarterly performance evaluation meeting, and giving recognition ▪ Ensuring that the HEWs/UHE-ps are getting on-the-job training and education ▪ Supporting and coordinating the recruitment of new rural HEWs/UHE-ps ▪ Supervision and monitoring, and giving feedback ▪ Performing construction and maintenance of health posts, houses for health extension workers in collaboration with the kebele ▪ Employing HEWs/UHE-ps; replacing those who left the program
Health centers	▪ Preparing primary health service plan ▪ Implementing capacity building activities by identifying attitude, skill and input supply barriers during the implementation of the program ▪ Gathering and analyzing kebele development teams and one-to-five linkage/community mobilization committee activities and information within the catchment area of the health center ▪ Providing problem solving technical and administrative support for the health posts ▪ Preparing experience sharing forum for best practices of the HEP and implementing in the kebeles under the health center ▪ Conducting monthly performance evaluation with the health posts under the health center ▪ Providing on the job training for HEWs/UHE-ps

Stakeholders	Main responsibilities
	▪ Deploying other workers temporarily while HEWs/UHE-ps are not available in the health posts ▪ Ensuring that the health center workers are supporting the health development army/community mobilization activities of the kebele by allocating the kebeles within the health center ▪ Following the implementation supervision and monitoring mechanisms in the primary health care tier ▪ Preparing and sending reports to the woreda HOs regularly
Kebele administration	▪ Establishing command post/ community mobilization to monitor and support kebele health development army/community mobilization ▪ Gathering, monitoring, supporting and evaluating development teams and one-to-five linkage/community mobilization committee members ▪ Gathering and analyzing kebele development teams and one-to-five linkage/community mobilization committee activities and information ▪ Assisting the kebele development teams and one-to-five linkage/community mobilization members while they are getting and transporting vaccines, materials, bed nets from health centers ▪ Performing construction and maintenance of health posts, houses for health extension workers, and demonstration materials ▪ Leading the health development activities of the kebele; and creating and coordinating community mobilization ▪ Monitoring the activities of the HEWs and UHE-ps on the daily basis

Stakeholders	Main responsibilities
HEWs/ UHE-ps	▪ Preparing and implementing plan in consultation with health centers, kebele administration, and other stakeholders; and evaluating the performance jointly ▪ Conducting meeting with, monitoring, supporting and evaluating development teams, and one-to-five linkage/committee of community mobilization ▪ Ensuring that the health plan is shared with or communicated to development teams, and one-to-five linkage/committee of community mobilization, and household/family level ▪ Gathering and analyzing the kebele health and health related information under the family health, and sending performance report to the health center ▪ Provide services in the health post on daily basis ▪ Conducting regular house to house visits, and outreach activities ▪ Requesting required drugs, medical instruments, equipment, and other inputs; and using according to government resource handling procedures ▪ Participating on the monthly performance evaluation meeting of the health center; and identifying and solving barriers of attitude, skill, and input in the implementation of HEP packages ▪ Training, monitoring, and supporting one-to-five linkage leaders/community mobilization members; and graduating when they fulfill the model family requirements ▪ Monitoring and supporting families followed by one-to-five linkage leaders/community mobilization members; and graduating when they fulfill the model family requirements

2. Ethiopian Food, Medicine and Healthcare Administration and Control Authority: Continuing Professional Development (CPD) Guideline for Health Professionals in Ethiopia, March 2013

This document was developed to maintain professional competence in an environment of numerous challenges, rapid organizational changes, information technology, increasing public expectations, and demand for quality and greater accountability.

The Federal Ministry of Health (FMOH) of Ethiopia is committed to ensure the quality and standards of health services in the country. One of the five strategic areas on which human resource development (HRD) should focus as identified by the health policy of Ethiopia is developing appropriate continuing education for all categories of workers in the health sector. Besides, ensuring that health science education and training is responsive to the health needs of the nation is one of the strategic objectives of the national Human Resource for Health (HRH) strategy. Moreover, initiating and strengthening continuing education including in-service training is an essential objective of the HRD component of the fourth Health Sector Development Plan (HSDP IV).

Currently, CPD activities in Ethiopia are fragmented as there are no standardization, regulation and accreditation mechanisms. Besides, CPD activities have never been linked to re-licensure of health professionals. Hence, the Ethiopian Food, Medicine, Health Care Administration and Control Authority (EFMHACA), the legally mandated agency to license and re-license federally regulated health professionals, believes that CPD should be systematically organized, tied to relicensing system and occur in concerted with other developments in health care system so as to improve the quality of health services.

EFMHACA has prepared the guideline with the technical support of HRD Directorate of FMOH, development partners, professional associations and training institutes to enhance professional competence and ensure quality health services in the country.

With the ultimate aim of improving the health status of Ethiopians through the delivery of quality health services by competent health professionals, the guideline was developed with the aim of establishing a CPD system in the country through outlining the process of accreditation of CPD courses, CPD providers and linking CPD with re-licensure that include:

- The standards of CPD
- The overall CPD accreditation of courses and providers
- Course credit designation
- Responsibilities of major stakeholder on the implementation
- Documentation and monitoring, and evaluation of CPD process

The guideline will govern all health professionals who are licensed by EFMHACA and regional health regulatory bodies.

3. Human Resources for Health, IATT Task Team on Human Resources for Health, GSG Midterm Review Meeting, December 6-7, 2012

The documents starts with a brief introduction of human resources for health crises focusing on gaps in human resources for health, including doctors, nurses, midwives, and community health care workers that are a major bottleneck in rapidly expanding HIV-prevention, treatment, and support services for mothers and children.

The document indicates that poorly functioning management systems can reduce the delivery of services; and promising practices in health workforce planning and management such as training existing workers and task shifting than to scaling up pre-service training to produce more workers. Specific constraints at facility level, supervision and management, and government structure are also described.

The document forwards several recommendations to address the human resource challenges:

- Make the necessary political and financial commitments to assess current staffing levels, determine appropriate staffing levels and take budgetary and policy action to address gaps, including establishment of adequate positions in public facilities to deliver services, filling of vacant positions, ensure that health workers are consistently paid, reviewing health worker remuneration policies and pay professionals adequately so that they remain in the public system.
- Increase the capacity of pre-service training institutions and facilitate increased enrollments to address the critical supply shortage of health professionals.
- Identify and implement policies and legal systems required to indemnify scopes of practices.

- Invest in health workforce cadres that focus on community-based efforts and human rights approaches, and work towards their formal constitution within national HRH plans.
- Strengthen management and supervision, update performance management and performance evaluation systems and reward.
- Provide decentralized authority to recruit and supervise employees, change deployment practices to match individual skills and experience to the needs of each health facility; and provide support systems for health workers that provide psychosocial support.

4. *Ethiopia's Human Resources for Health Program: Case Study. GHWA Task Force on Scaling Up Education and Training for Health Workers*

The document starts with the background of Ethiopia such as government structure, population and its distribution, common health problems, the 20-year Health Sector Development Program, the Millennium Development Goals. It also states that Ethiopia is one of 57 countries in the world with a critical shortage of health workers.

The document describes the total number of available human resources for health and availability during HSDP II and 2nd year of HSDP III in terms of absolute number and ratio to population.

The document describes the health extension program was started in 2004, developed and financed by the government of Ethiopia. The document lists the roles of health extension workers, health officers, doctors. The document highlights the early 'quick wins' such as:

- In 2003, 85 master trainers trained more than 700 faculty in regional workshops.
- Training texts (modules) for 65 diseases and health challenges and more than 100 lecture booklets have been developed.
- The first group of 2,880 started training to become HEWs in January 2004.
- Thirty-seven existing vocational institutes in seven regions are training HEWs.
- As of June 2007, more than 17,000 HEWs have been deployed and more than 8,850 health posts have been constructed.

Finally, the document forwards lessons and policy recommendations: The Health Extension Program is still in a relatively early stage and further research and evaluation is needed, but some early observations are:

- Strong leadership from the Minister of Health and the active support of the Prime Minister is a key success factor.
- The first visible result of the Health Extension Program was the speedy deployment of a massive number of HEWs, but educating and training the entire range of cadres has been the intention of HEP from the beginning.
- There are no clear guidelines on their relationship with other health workers at the community level, or on career structures, transfers, leaves of absence, etc.
- Reporting and health management information systems in general are weak; work is being done to strengthen them.
- Early success in the speedy scaling up of HEWs has made it easier to gain donor support for more costly plans to scale up doctors, nurses and midwives.

5. *Human Resources for Health – Country Profile: African Health Workforce Observatory, AHWO, 2010*

The paper documents the country context in terms of geography and demography, economy, politics, and health status; country health system in terms of governance, service provision, health care financing, and health information system; health workforce situation such as health workers stock and trends, distribution such as gender, age, occupation , region, and residence. The paper also tells about HRH production that includes pre-service education, in-service and continuing education, and health workforce requirements

According to the assessment of the country's health workforce, a total of 66,314 health workers are currently in service including 30,950 HEWs. The national ratio of health workers per 1,000 population is 0.84. This is far less than the standard set by WHO of 2.3 health workers per 1000 population. The ratio of health workers to 1,000 population also shows variation across Ethiopia's regions, with the highest ratio in Harari (2.8) and the lowest in Somali (0.47). This information on the stock of health workers relative to the population shows that there is huge gap to be filled in order to reach the critical threshold that would allow the most basic levels of health care coverage to be accessible throughout the country.

The shortage and imbalance in the supply, deployment and composition of the health workforce is an obstacle to the effectiveness of the country's core health systems and services.

Even though various endeavors have been made at national level to increase the number of physicians in the country, what has been gained over the last five years has also been lost. This affects the health system in many ways, including retraining and recruitment. This study has examined time series data to identify both gains and loss over the last three years. An overall shortfall of 29% compared with the number of physicians expected to be in service was recorded by using indirect measurement of physicians at national level. This is a concern to be considered critically at policy and program levels, perhaps reviewing the health workforce management systems in the country, in order to answer why, when, and where the attrition of health workers is taking place.