Working towards precise and ambiguous targets: - the challenge for Health Extension Workers of Ethiopia

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Abstract. Immunization is one of the strategies designed to reduce mortality and morbidity of children. The health care system of Ethiopia concentrates its effort in order to ensure full immunization of all eligible children with national goal of 90% coverage. However, the planning system for immunization has drawbacks because of the ambiguity arising from the targets. Drawing from the institutional theory, we studied the problem associated with target setting. The plan of district health offices depend on the population data projected from census. Health extension workers, on the other hand, enumerate the number of population in their respective localities. Subsequently, the ambiguity occurs from mismatch between the target from census and the number of eligible children counted by health workers. In practice, they are expected to follow the target given from district health offices, which is high in most cases. Thus, we found that most peripheral health workers considered as the inflated target given from their higher level lowers their achievements. This in turn affects the incentive given, thus, has implication on job satisfaction and performance. The need of considering the reality at the ground, rather than following only the formal institutional rules is emphasised in order to address the identified impediments.

Introduction

The health care systems constitute institutional logics that embody the organising principles: and complex web of services, supplies and information related to the health of an individual and society. To understand the institutional environment, therefore, it is important to adopt a multi-level analysis that considers how societal, inter-organisational and individual factors influence, both directly and indirectly (Currie, 2007). Institutions operate at different levels of jurisdiction, from the world system to localized interpersonal relationships, through the formal rules and informal constraints (Jepperson, 1991). The actor plays no independent role in maintaining these institutions; rather they serve to constrain his behaviour

(Scott, 2001). In our study, the formal rule, which is formulated in the health care system of Ethiopia in order to deliver immunization to all eligible children, has faced informal constraint from the peripheral health workers due to the confusion arising from following uncertain precise target setting.

Fulfilling the Millennium Development Goals is one of the top global agenda. Millennium Development Goals constitute a multi-dimensional goal structure, including decreasing the death of children by two-third. As Ethiopia has high infant mortality rate (77 deaths/1,000 live births) and most of these deaths occur from few preventable and curable diseases and conditions, substantial efforts are being undertaken to minimize the problem (FMOH, 2005). Immunizing of all eligible children is one of the strategies designed to accelerate the achievement of these goals. An ambitious plan (90% coverage of immunization for all antigens) is formulated nationally, and implementation is taking place.

The major problem is the issue associated with the targeting mechanism. In tracking the implementation of immunization in each kebele, there are two types of targets in most cases. The ambiguity in relation to targeting emanated due to the fact that the district (wereda)[1] health offices provide the target for each health facilities using the census data. The Ethiopian housing and population census was conducted in 1995 by Statistical Authority, and the health care system formulates its plan for different health services based on the projected population from the census. Accordingly, the target for immunization is set from the projected population data. On the other side, the health extension workers (HEWs) are supposed to enumerate eligible children from their respective assignment localities (Kebeles)[2]. Thus, the periphery level health workers complain that the target so as to they are getting from the wereda health office is erroneous. The practical experience of health workers showed that the target figure is doubtful. Hence, as they mentioned, it was difficult for them to reach to the designed goal mainly due to the inflated target provided from wereda health offices.

Health workers are trapped by getting more children for immunization; nonetheless, their achievement tends to be low while comparing with the census target. Target is an essential element of planning as it allows health workers to be responsive to the endeavour expected from them so as to organize their efforts for the accomplishment of the intended outcome. However, target setting in practice depends on the national level regulations, with limited consideration of the grass root level health workers endorsement. Setting target for immunization and other health services needs to be the reflection of different factors- such as the previous year performance and other local realities, Neverthless, the studies conducted in Ethiopia and Mozambique showed that it is rarely effectively realized in practice (Mengistu, 2005, Mavimbe et al, 2006).

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[1] Wereda is a synonym for districts of Ethiopia

[2] Kebele is the smallest administratice unit of ethiopia

Decentralization of health systems focuses on the transfer of decision-making, planning, budgeting, management and resource allocation of health care from the national to district and sub-district levels (Litvack et al, 1998). The essence of health extension program orginated from the need for health services to be managed in a smaller community (kebele) by developing local understanding of health problems, and acting upon them in a participatory and locally relevant manner (FMOH, 2005). By devolving power, authority, services and resources to local levels and involving local community in planning, more sustainable health systems can be established (World Bank 1993). The health delivery system in developing countires are in the process of being decentralized, however, the extent of decentralization is quite modest, restricted to only a few administrive functions (Hutchinson and LaFond, 2004). Distributing power to the lower levels is rarely practiced in real context, and communication barrier at every level is another impediment. For example, Kimaro and Sahay (2006) argued that decentralization of health information system is problematic to achieve because of the complex interlinking of various administrative, political and fiscal processes (Kimaro and Sahay, 2006).

In this paper, we analyze the two types of target setting processes for immunization; these include the target given to health facilities by the wereda health offices and the number of eligible children enumerated by health workers, with a particular focus on the peripheral level health workers (HEWs). This study aims at explaining how the precise and ambiguous target influences the health workers effort in fulfilling the intended goal for immunization, and discusses the peripheral health workers attitude and perception towards the ambiguity. Ways for the organisation to release the pressure from the ambiguity and the relevance of having common single target in order to achieve the intended goal have also been considered.

The theoretical basis for the paper is institutional theory, specifically taking the concepts of institution, formal rules and informal constraints. That is the institutional rules formulated within the health system formally, faces informal constraint from the health staff. Taking this theoretical perspective as analytical tool, we seek to understand the views of health workers and health managers on the existing target setting mechanism, and how they deal with the ambiguity that may contribute to shape the present routine and initiate institutional change.

The rest of the paper is organized as follow. In the next section, we discuss some relevant literatures and key concepts from institutional theory which helps to understand the dilemma taking place in formulation of planning and target setting.. In Section 3, the research setting and methods are described followed by the research findings in section 4. Section 5 presents discussions, and finally, we provide a concluding remark.

2. Literature review and theoretical perspective

2.1. Health Extension Programme

Although the majority of Ethiopian population reside in rural areas, most of the health facilities were concentrated in cities that result in unequal access for essential health services. In order to minimize this, a truly community-based approach to primary health care delivery is needed to address the vast majority of the population. The Government of Ethiopia, therefore, has launched a new program for the "Accelerated Expansion of Primary Health care Coverage" with the health extension program (FMOH, 2005).

Health extension program is an innovative community-based approach aimed at creating healthy environment as well as healthful living by introducing sixteen health Packages at community and household/families level. The main objective of this program is to improve access and equity to preventive essential health interventions provided at kebele and household levels with focus on sustained preventive health actions and increased health awareness (CNHDE, 2007). HEWs that are selected from respective kebeles, trained for one year and deployed at each health post/kebele. HEWs provide basic care and advices for many aspects of health actions mainly maternal and child health, major communicable diseases and, basic sanitation and hygiene practices. They are also supposed to record local health data including death and birth. Health extension program is considered to be a major vehicle to improve maternal, neonatal, and child health. It is assumed that about 60 to 70% of the health problems at community level could be averted by effective intervention at grass-root level through health extension program. Therefore, it could be considered as the most important institutional framework for achieving the Millennium Development Goals (FMOH, 2005).

In Amhara region, as to 2007 Regional Health Bureau reports, near to 97% of rural kebeles are covered by HEWs. Two female HEWs are responsible for population of each kebele, which is equivalent with 1000 households. The average household size is estimated to be five, and the total population of one kebele is near to 5,000. Thus, each HEW is accountable to give service for 500 households or 2,500 populations. Their first task is to collect the baseline data in their respective kebele's that includes number of total population, children, hygiene and environmental health facilities (Amhara region health bureau, 2007). They maintain their kebele data with them, and they also send monthly reports to wereda health offices and/or cluster health centres. One cluster health centre used as a referral link for five health posts and wereda health offices are responsible for administrative issues (FMOH, 2005). HEWs perform their activities in collaboration with voluntary community health workers.

Volunteer community health workers are members of the community who are early adapters of health actions and volunteer to practice do-able health actions to them and show to their relatives, friends and neighbours. They act as a mediator and collaborate with HEWs in providing health promotion and disease prevention activities, and mobilizing the villagers for all types of health actions with in the kebele (Amhara region health bureau, 2007). Community health work needs to be well coordinated and harmonized. In this aspect HEWs would play the role of trainer, supervisor and coordinator of the volunteer community health workers and other community resource persons.

2.2. Working under ambiguous conditions

Organization is stifled by rules. If things are out of control, then the system needs clearer rules and procedures. Rules inhibit freedom and flexibility, stifle initiative, and generate oceans of red tape. Organizations will be more effective when goals and policies are clear (but not excessively restrictive), jobs are well defined (but not too limiting), control systems are in place (but not oppressive), and employees behave reasonably and prudently (Bolman and Deal, 2003). Absence of clear regulation and working procedure can result in role ambiguity, this in turn result in job dissatisfaction (Abramis, 1994).

Ambiguity originates from a number of sources, sometimes information is incomplete, unreliable or vague; the same information may be interpreted in a variety of ways. At another times, ambiguity is deliberately created to hide problems or avoid confusion (Clegg, 2006). Some events are so clear and unambiguous that it is easy for people to agree on what is happening, so it is possible to give a straight forward suggestion. However, solid facts and simple problems in every day life at work are hard to find. In a survey of 570 public managers in the US, ambiguity factors at the political, organisational and individual levels were investigated (Pandey and Rainey, 2006). The result of the survey showed that political support, internal communication and role ambiguity at the same three levels came out as the three main predictors of overall ambiguity. Again, this conclusion pointed that improved internal communication will reduce the ambiguity that managers experience.

The relation between role ambiguity and job satisfaction is significantly reduced under conditions in which communication in organization is clear; but problems of communication may lead to an increase in ambiguity which then reduces job satisfaction (Abramis, 1994). Organization needs to get relevant information from its environment and respond to it adequately. All downward, upward, and horizontal communication is required for proper functioning of organization. Upward communication includes employees' feedback concerning rules, strategies and implementations. Employees often know more about services, customers and products, as they are in daily contact with them (Clegg, 2006).

The meta-analysis conducted by Abramis (1994) also reported that social support from supervisors and co-workers has reduced the negative correlation of role ambiguity with job satisfaction (Abramis, 1994). Providing appropriate response, by taking in to consideration the suggestions given by employees, would be one incentive and increase work initiative. Motivation is necessary whether you are a leader yourself, lead others, or to be lead by others. Motivation can be intrinsic or extrinsic. Intrinsic motivation refers to internal factors, such as interest and enjoyment. While extrinsic motivation can result from extrinsic factors, such as reward or punishment (Dierkes, 2003). Provision of the right incentive can motivate or initiate the performer's inner drive to accomplish a task.

2.3. Institutional Theory

The institutional perspective is relevant to this paper as we seek to analyze how the formal rules and informal constraints are institutionalized in a particular setting, and to investigate mechanisms to narrow the gap between them. The basic building block of institutional theory is the concept of institutions. Scott (2001) mention as there is no single and universally agreed definition of an 'institution' in the institutional school of thought (Scott, 2001). North (1990), on the other hand, emphasizes the distinction between organizations and institutions, arguing "If institutions are the rules of the game, organizations are the players". Standard operating procedures and similar pattered activities are the central features of institutions. Institutions are socially constructed, routinely reproduced, rule systems in the organization representing patterned way of doing things and acting (Jepperson, 1991). Thus, institutions do not emerge in vacuum; they always challenge, borrow from, and, to varying degrees, displace prior institutions.

Institutions play three interconnected roles: helping to frame the behaviour of individuals by structuring incentives they face in their everyday activities, facilitating social action, and reducing the uncertainty of social interaction by providing a structure where people can act and be understood (Scott, 2001). Institutions can be formal and explicit, such as a national constitution, political rules, economic rules, and contracts, and informal rules that include taboos, customs, traditions, perceptions and myths (Jepperson, 1991). Formal rules may sometimes complement and increase the effectiveness of informal constraints by lowering the information needs and enforcement costs. Typically, laws to enforce informal constraints are costlier than the formal rules, but the latter does not always imply efficiency.

The formal rules and informal constraints constituted by the various entities comprising the organizational field create multiple institutional influences in the operation of health information system (Currie, 2007). Apart from the material exchanges amongst these entities, such as informational reports, plans or financial disbursements and drug supplies, they also exert other normative or cognitive influences. These influences are exerted at the same level of the health structure

or between levels, shaping the activities, such as the development of health plans (Kimaro and sahay, 2006). Moreover, the rules and the regulations formulated by the governing body and allied organizations has an important part.,In our study, for example, the population data given by the Bureau of Finance and Economy to Bureau of Health have great impact in shaping the target to each wereda health office and then the health facilities.

As mentioned by North (1990), institutions are social structures that have attained a high degree of resilience. An existing set of beliefs, norms, and practices comes under attach, or falls into disuse, to be replaced by new rules, forms and scripts. Although change is a difficult process as Walsham, (1993), organizational change will be enabled more easily with greater overlap between formal and informal institutions (Pioti et al, 2006). Thus, the health delivery system of Ethiopia needs to take in to consideration the informal constraints arise while formulating the plan following the formal rule. Based on the perspectives of different social science researchers, institutional theory will allow us to understand the formal and informal institutions arising from the target setting in the organizational field of the health care.

3. Research context and Methods

The case study presented in this paper is based in Ethiopia, a developing country located in the horn of Africa. The total area of the country is about 1.1 million square kilometres and its population is around 80 million, where about 85% of the population live in rural areas (MOFED 2007). Like other developing countries, Ethiopia faces serious constraints related to poor physical and communication infrastructure, including the health service facilities. Besides, researches conducted on health information system status of the country showed that the health data being reported are not optimal enough to support informed decision-making (Abera, 2005, Mengistu, 2005). Ethiopia has implemented health extension program since 2005 in order to address the health demand of the rural population. The organizational structure of the health care system of Ethiopia comprises of the Federal Ministry of Health, Regional Health Bureaus, Zonal Health Departments, and Wereda Health Offices, with their respective health facilities – Central referral (Specialized) hospitals at the federal level, other hospitals at regional, zonal or district levels, and health centres, and health posts (health extension program) at the wereda levels.

For this research, we followed a case study approach and broadly interpretive methods. Our study was multilevel in that data gathering was carried out at the regional, zonal, wereda, and community levels. This approach was required to gain insight from different perspectives into issues of target setting for immunization. We have tried to understand the institutional pressure to implement the ambiguous precise immunization plan and concern of health workers through the conceptual tools of institutional theory.

Three methods of data collection were adopted. First, document analysis was done on various sources such as official reports, the immunization registers and forms used to collect, analyze, and transmit data from one administrative level to another. The Third Health Sector Development Plan (HSDP III) of Amhara region was examined in order to develop understanding of the health extension program and five year strategic plan of the region. Second, we attended two meetings organized by wereda health offices, and participants were health managers, experts and HEWs. Those meetings were focused on general topics, and the issue of target setting was one of the top agendas. Focus group discussion was also conducted.

Third, we engaged in primary data collection, where 47 interviews were carried out with a range of constituents. The majority of interviews were with HEWs. The rationale for the selection of these respondents was the reason that they are the one who engaged in the implementation of the primary health activity, including immunization at the grass root level. A semi-structured interview schedule was used to enable interviewees to elucidate their answers. Interviews were mostly conducted on the working places of the respondents. This method of data collection was critical for allowing interviewees to raise additional themes, issues and concerns that they felt were important to the research study.

All interviews were conducted in Amharic and subsequently translated into English. In addition to these notes, various photographs were taken (after gaining prior approval) to strengthen the interpretive analysis. Table I below provides a summary of the interviews conducted at different organizational levels. The questions for the health facility staffs mainly focused on their work practice of immunization, their participation on target setting and how they were influenced by the higher levels. The respondents at the district and above levels were asked questions related to the systems they used for planning, the incentive mechanism for health workers and their reaction for enquiries about the target setting.

Organizational level	Respondents	Number of respondents
Regional health Bureau	Department head	2
	Immunization program Expert	1
Zonal Health Department	Head of the Zonal Health department	2
	Team leader	2
	Immunization program Expert	2
	Other health managers	2
Wereda Health Office	Head of the Wereda Health Office	2
	Team leader	2
	Extension program coordinators	2
Health Facility	Nurses	4
	Health extension workers	23
	others	3
	Total	47

Table I. Type and number of respondents interviewed

Data was gathered through field work within a focused period in between December 2007 to February 2008. A research diary was maintained through out to document memo from meetings, interview notes and observations, and some notes were also cross-checked with the concerned respondents.

Our study presents the data from twelve health posts, five health centres, three wereda health offices, two zonal health departments and the regional health bureau. Amhara region was taken for the reason that one of the investigators has a long time work experience at different levels in the health care system of the region, and the region is recognized by its effort to implement health extension program extensively.

The interpretive approach was adopted in this study that help to analyze factors related to target setting from the perspectives of different actors involved. This perspective helped us to develop deep insights into the phenomena. The analysis of data took place through a continuous process of data collection in the field to identify important themes and relate them to theory. Based on the data we had, we identified relevant literatures and suitable theory that correspond with our findings. MS Excel was used in order to facilitate the creation of tables and graphs. Citations from answers given by interviewees are provided in italic under quotation. The analysis continued to evolve through an ongoing review of the relevant research literature and theories, thus it helped us to develop some inferences around how the formal rule for target setting is encountered with informal constraints.. The findings were categorised and presented in to three themes in the following section.

4. Result

4.1. Immunization service and information handing activities

In all visited health posts, HEWs render immunization service 2-3 times per month based on their schedule, whereas on a daily basis in the cluster health centres. It is because of that HEWs provide health services mostly house to house. Furthermore, this approach, as mentioned by them, minimize vaccine wastage rate as they open the vaccine vials only on their immunization days. Moreover, they reconstitute the vaccines (those need reconstitution) when the eligible child is really there.

Health Extension Workers accomplish their tasks in collaboration with voluntary community health workers who have important role especially in defaulter tracing and motivating mothers of their vicinity to take their children for

immunization. While explaining how they are working together with voluntary community health workers, one of the respondents said;

> "We identify defaulters from the immunization register book, list out them and give the list for voluntary community health workers according to their vicinity; it is then easy for them to search".

Moreover, all visited health posts do not have fridges, thus voluntary community health workers bring the vaccine from the cluster health centres on the scheduled immunization days.

As we have observed, HEWs of the visited health posts try to capture information of their kebele and posted all the necessary data, including the maps of their kebele in their health posts (see picture1). Thus, it is possible to get easily or even to view the required information from the wall of the health posts. In case of immunization, they use the immunization monitoring charts that allow them to be aware of important indicators, such as drop out rate and immunization coverage for each antigen. As mentioned by them, they also follow the immunization register book to identify defaulters. On the other hand, the newly assigned staffs in the three of the visited health centres are doubtful of important information including their catchments' population, as well as, data analysis was not practiced. HEWs send their reports monthly to their respective cluster health centre and/or wereda health office. Cluster health centres then compile the report by including the health post data and send it to wereda health office.

Picture1: The kebele map and health related information in Arsa Gimbaha health post

In all visited health posts, the guideline of immunization was in place and the books for health extension packages were available. Whereas, three out of five visited health centres do not have those guidelines in their immunization room. For instance, in one of the visited health centres the responsible person went for further education 3 months ago, however, he didn't handover the immunization guideline or any reading material for the next person working there. Regarding to this, one of the interviewed wereda health manager said;

> "We have distributed protocols and guidelines to all health facilities, but health workers take them like their own property when they depart from the work place by transfer or any other reason."

From all observed health facilities, HEWs have better coordination and information of their catchments' area than the health centre staff. It is mainly because of that they are responsible for all health related activities in their respective kebeles. Cluster health centre staffs, on the other hand, can change their working area recurrently and conveying of information, as well as, the reading materials among the staff is minimal.

4.2. Target setting for immunization

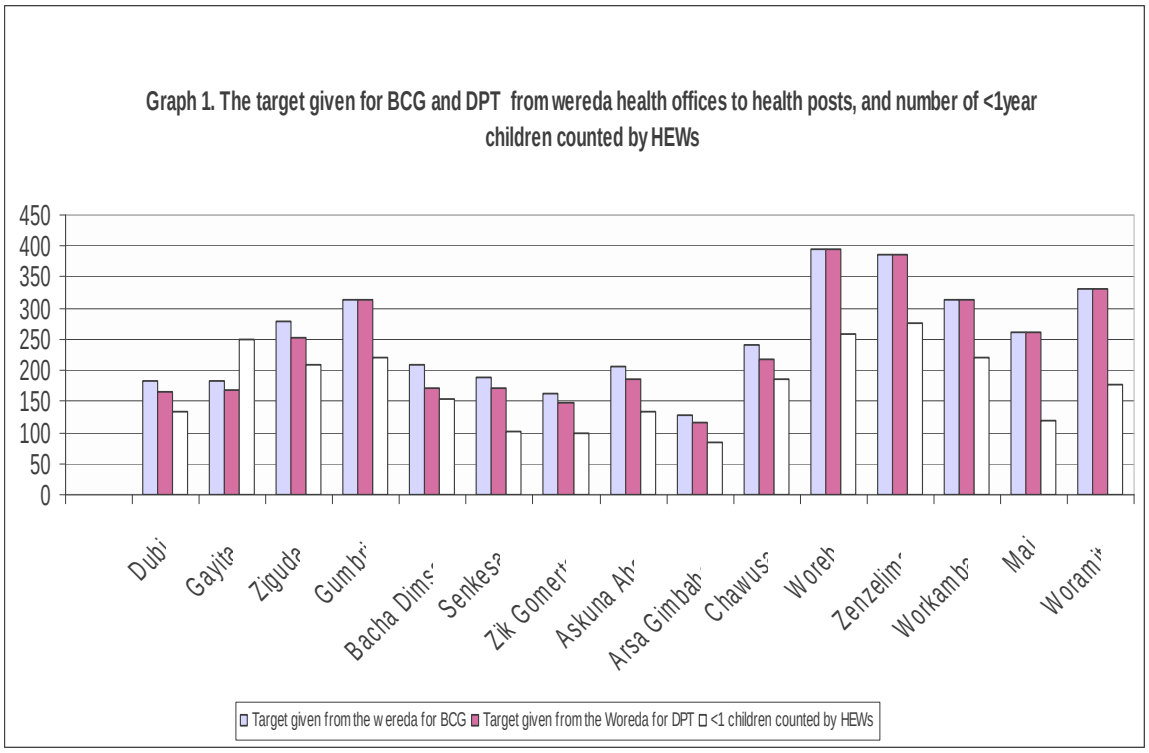
Although the target of immunization is being set by regional health bureau with the wereda responsible persons based on Reaching Every District approach, they intended to follow strictly the population data projected from census for each wereda and the value set by Federal Ministry of Health for each service. For instance, in the present year the targets for BCG and DPT are calculated using 3.73% and 3.38% of the total population respectively. While setting the target for BCG, all newborns will be considered as it is given immediately after birth whereas the target for other vaccines is being calculated from surviving infants. Moreover, according to the regional immunization responsible person, planning is done based on nationally intended coverage (goal) uniformly for all weredas. It does not consider the last year performance or other locality specific criteria. This shows that the wereda health office staffs have no mandate to make any change on the target of their own area; rather they are pressed to accept the target calculated from the projected population and the value set by Federal Ministry of Health.

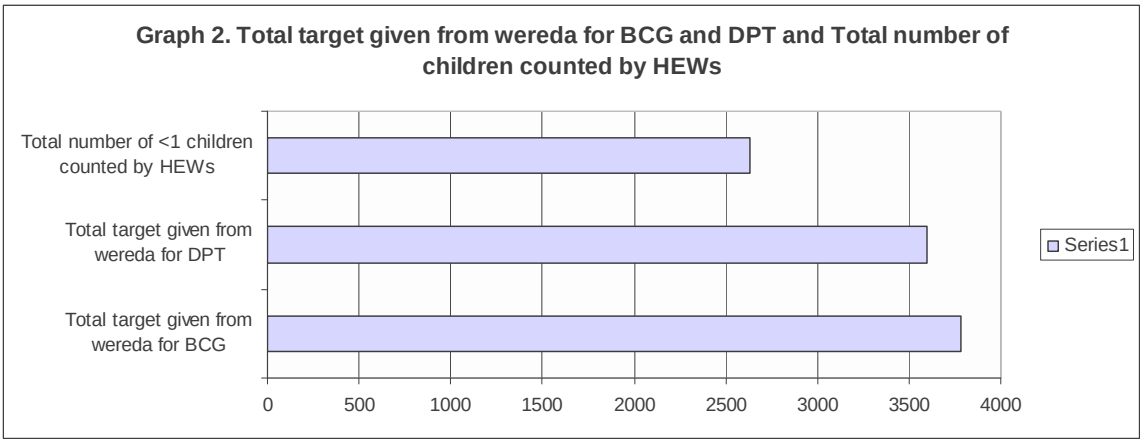
Ultimately, the wereda health office distributes the target for health posts and health centres under it. The other major problem is that the census provides data only up to the wereda level, which makes very difficult to define appropriate targets for each health facility. Basically, the census needs to be conducted every ten years (ibid), whereas the last population and housing census of Ethiopia was in 1995 (before thirteen years). Thus, using of the population data provided by this obsolete census may result in further error.

Almost all health workers in the visited health facilities mentioned the difficulty of achieving the goal (90% coverage of immunization for all antigens)

by taking the target given from the wereda health office. Especially, HEWs do not accept the population data and the target set for immunization and other health services within their kebele. As mentioned by them, they have collected baseline data and they have all information of their own kebele, thus, no one has better information in their respective kebeles than themselves. They think that they have ample opportunity to know the number of children of their catchments area as they render most of the health services house to house, as well as, voluntary community health workers provide them all the required information.

As we identified, there is enormous mismatch between the numbers of households, population and then the targets given to visited health posts by the wereda health office and the figure acquired by counting (See graph1 and 2).





For instance, HEWs of Arsa Gimbaha health post reported that the wereda health office plan showed as 729 households exist in their kebele, however they actually counted only 548 households. The total population of Workamba health post was 8,222 and 5615 according to the wereda population projection and house to house counting of HEWs respectively. In all visited facilities (except one), the population and target figures given by the wereda health office are always higher than what they have got by counting. This has, therefore, an impact on the coverage of different health services including immunization.

4.3. Impact of the ambiguous target

As reported by the respondents, the plan that consists of targets from the wereda influences their achievement. For example, respondents from Chawusa health post reported that the target given last year for BCG for their kebele was 240 thus, despite their effort to immunize all eligible children in their catchments' area; their previous year achievement for BCG was only 54%. However, it would be 82% while calculating from the number of under one children counted by themselves. Respondents also complained that they lost incentives and rewards since the uncertain precise target constrain them. Concerning the issue, the following key complaints were reflected by HEWs of the visited health posts;

> "We are trying to do our bests, however, the wereda health office staff evaluated us based on their target, and we scored very low grade. It is very annoying for us"
>
> "We don't bother about the wereda target, because we know that we are right"
>
> "You can imagine that who is going to be correct, because we did house to house counting but they take the average. Sorrowfully, they are the one who evaluate and give us lower score"

In the review meetings, which are attended by the wereda health managers and HEWs, the problem which arises from target figures of immunization and other health services, was thoroughly discussed. Health managers also recognized the ambiguity occur as the result of the target. Some of them extended their efforts to clear the ambiguity. For example, the regional immunization responsible person stated how they tried to confirm the problem related with the target figure by using the survey result from the immunization campaign. He explained;

> "The convenience surveys that took place after National Immunization Days usually showed greater than 90% coverage; where as the coverage of routine immunization for every antigen is not greater than 75%. This can point out the presence of problem on the target".

It was also mentioned by immunization responsible person of Bahirdar special zone that the immunization campaign allowed them to estimate the number of less than one year children. He stated that the present year plan of their catchments' area for polio campaign was intended to immunize 46,000 children based on the target from projected population, however, according to him, they immunized only 25,000 (59%) with intensive house to house visiting. Although there are signs that showed the present immunization targeting mechanism is uncertain, it was not possible to make a change.

5. Discussion

Health organizations are rarely “standalone,” being formally and informally linked with a variety of entities, such as other governmental sectors, international agencies, non governmental organizations (NGOs), and the community (Currie, 2007). These different organizations and their linkages are creating multiple institutional influences on the rules and efforts take place to accomplish targets. Institutions consist of formal rules and informal constraints (norms of behaviour and self-imposed codes of conduct) that individuals follow in their daily lives (Jepperson, 1991). For instance, in our study, the target set for immunization according to the formal rule of the health care system of Ethiopia faced informal constraints from peripheral health workers. HEWs of the visited health posts do not accept the target set for immunization service for their catchments’ areas (kebeles’). Health workers, who are basically the core in service giving, were not practically participating in the process of target setting. They, thus, believe that the number of children counted by themselves in their respective kebele’s is more reliable than the target specified to them by the wereda health offices.

Institutional environments, which exerted in the form of societal and regulatory pressures, may influence organisations through the ‘archetypes they develop for actors, the logics they legitimate, and the governance systems and rules of social action they support’ (Scott, 2001). The health care system of Ethiopia has institutional rule for target setting and planning. HEWs of the visited facilities, on the other hand, have counted the population in their catchments’ area and they know the number of less than one year children in their kebeles. The dilemma occurs due to the disparity of the target that is designed in a top-down manner from projected population of the census and the data gathered by HEWs. In any case, the health facility staffs have to follow the plan formulated according to the rule of their organization. Hence, despite their tremendous effort to provide immunization for every child, their achievement would be lower while calculating the performance with the inflated denominator (target).

Regarding target, HEWs expressed their feeling in different ways, some of them were sad, and others do not bother. In the meetings held with their higher levels, HEWs were explaining without apprehension about the appalling effect of the ambiguous precise target. Organizations, and also individuals can react to institutional pressure in a number of ways (Scott, 2001). In the meetings held by wereda health offices, HEWs were not only resisting institutional pressure to conform but do so in a highly public manner. As stated by Scott, defiance is likely to occur when the norms and interests of focal organizations diverge subsequently from those attempting to impose requirements on them (Scott, 2001).

The study conducted in Mozambique also showed that the target figures for immunization tend to be arbitrary estimated and do not considered the previous year performance (Mavimbe et al, 2006). Likewise, in our study, the problem

associated with the target was understood at every level in the health care system. Along with the health workers, health managers from wereda health offices, zonal health departments and regional health bureau also do not disagree with this attribute. Some of the health managers extended their efforts and tried to investigate the problem associated with target setting as there was usual complain from the service givers. Accordingly, they found that the on going target setting system is far from reality. However, as the planning scheme is a regulation and working procedure formulated by the governing body, they couldn't make any change. This emphasized Walsham saying "change is not a straightforward, rational process but a complex, analytical, and political process that is historically situated" (Walsham, 1993). Nevertheless, deinstitutionalization of existing forms and their replacement by new arrangements, which, in time, undergo institutionalization, can take place in incremental rather than radical way (North, 1990). Thus, the health care system of Ethiopia needs to address the health workers concern regarding to target setting in order to reduce the gap between formal and informal institutions, and to bring organizational change as mentioned by Pioti et al (2006).

We inferred that HEWs were supported by their supervisors that may contribute to reduce the role ambiguity and job dissatisfaction (Abramis, 1994). However, in practice, the work appraisal for health workers is set using the wereda plan that may result in bias as mentioned by the respondents of the study. As to Clegg 2006, evaluation should be a tool for assessing performance, whereas if the plan is not well done, outputs are ambiguous and success is hard to measure (Clegg, 2006). We argue that offering pertinent evaluation and incentive for performance of staff, either financial or career related, can potentially improve efficiency by minimizing the gap between formal rules and informal constraints.

Communication is also very important for organizational performance. Concerning to this, Abramis (1994) mentioned that the problems of communication may lead to increase in ambiguity which then reduces job satisfaction and performance (Abramis, 1994). Pandey and Rainey (2006) else cited political support, internal communication and role ambiguity are the three main predictors of overall ambiguity. Similarly in our study, lack of effective communication and information conveying observed in the cluster health centres was the major source of doubt. Organizations will be more effective when goals and policies are clear; jobs are well defined and well communicated (Bolman and Deal, 2003, Clegg, 2006). In the nutshell, our analytical focus is to elucidate the importance of clear organizational objective, staff participation in planning, communication, apt incentive and motivation in order to raise job satisfaction and performance.

6. Concluding Remark

This research highlights at least four key issues that need to be addressed if the organizational performance is to be effective: participation, motivation, communication and ambiguity reduction. The existing plan for immunization service of Ethiopia endures from lack of alignment between the target given from census and the data gathered locally by peripheral health workers. HEWs are expected to enumerate the population and collect other relevant health data within their respective kebeles. Nevertheless, their participation in the formulation of immunization targets was practically negligible, and that lead them to ambiguity and scepticism. It is known that having one pertinent plan is decisive factor for the achievement of the intended objective. Thus, it is worthwhile to find options in order to minimize the gap between the formal rule and informal constraint. It is required to draw on local knowledge and integrate it with the more formal and scientific knowledge. Therefore, for immunization service and other tasks to be effectively implemented, there is the fundamental need to consider local work practices of health workers involved in data collection, analysis, transmission, and use of information. The formal institutions mandating improvement of the work practice tend to be mindful for local experience, work practices and recommendations of health workers.

Without any doubt, it is possible to conclude that the incentives and enforcement mechanisms are almost unreasonable within the existing institutional structures as health workers are evaluated by the performance calculated from the ambiguous target. Through appropriate enforcement mechanisms and incentives, motivation can be enhanced and thus contribute to improve performance. Bearing in mind that the main purpose of immunization is decrease child mortality by immunizing all eligible children, evaluating of performances by the achievements calculated from inflated denominator (target) is irrational. Thus, emphasis should be given for having of valid targeting system, as well as, appropriate evaluation method and incentive mechanism. Moreover, information generated in the health care system needs to be communicated and used at all level. Lack of adequate communication also contributed to magnifying the doubt especially in the visited cluster health centres. It is wise to design a mechanism of conveying information among the health staff through reports, the intended plan, guidelines and books. A key implication of our analysis is a need for change in order to reduce the ambiguity associated with target setting and information handling.

An institutional approach was used as a theoretical framework that allowed us to reach explanations about the problems associated with the target setting for immunization service from health workers and health managers' point of view. In addition, this study has allowed describing the effects of participation, motivation and communication for fruitful performance of organization. The implications of this analysis, we believe, go beyond the target setting for immunization service

and can be applied more broadly for other health services in the context of Ethiopia and other low-income countries with similar working conditions.

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