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ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

COMMUNITY PARTICIPATION
AND THE EFFECT OF
PARTICIPATORY RESEARCH
IN
SOUTH-WESTERN ETHIOPIA

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Community Participation and the Effect of Participatory Research

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LIST OF ABBREVIATIONS

AAU	Addis Abeba University
CHA	Community Health Agent
CHF	Community Health Foreman
CHW	community health worker
CP	community participation
FGD	focus group discussion
IDRC	International Development Research Center
MCH	maternal and child health
MOH	Ministry of Health
PA	peasant association
PHC	Primary Health Care
PR	participatory research
SHP	Shebe Health Project
TTBA	Trained Traditional Birth Attendant
UNICEF	United Nations Children's Fund
WHO	World Health Organization

ABSTRACT

A descriptive study was conducted from October 1994 to March 1995 to document the patterns and determinants of community participation (CP) in 25 peasant associations in Seka Chekorsa Woreda. An experimental component of the study tested the effect of participatory research (PR) on the measurement and promotion of CP.

The study address the barriers to fuller communities participation in health development activities despite the high demand from the health sector.

Over half (52.5%) of community members reported participation in health activities within the preceding month. Most common forms of participation reported were contribution of labor (31.2%) or materials (11.9%) and attending meetings regarding health development (29.9%). Communities were most likely to identify more passive forms of CP, including service utilization (60.9%), attending meetings (44.8%), and contribution of material or labor (33.9%). Few (11.2%) indicated that CP implied involvement in decision making and planning. Key barriers to promotion of CP in health included poor community awareness of roles and responsibilities, lack of technical and financial resources, and lack of strategies and organizational structures to promote CP.

PR was effective in increasing community awareness of CP, and in increasing rates of participation, including through attending meetings and through decision making and planning. Strengthening CP through the development of clear strategies and policies and decentralization of financial and technical resources together with utilization of existing mutual self help societies such as funeral societies (*Edir*) were recommended in order to improve health development programs.

INTRODUCTION

The importance of community participation (CP) has been recognized since the foundation of human society. Historical records witness communities' support to traditional healers in the past centuries, and it remains a feature of traditional societies today (1).

The recognition of the importance of CP in public health activities was not, however, given due attention until the 19th century. United Nations agencies have addressed the need for CP in development programs since the early 1950's. During the 1970's, the World Health Organization (WHO) strongly emphasized CP as an essential aspect of Primary Health Care (PHC), as affirmed in the 1978 Alma-Ata declaration by the representatives of 134 nations (2). Since then, CP has been widely recognized as an important strategy to improve health status, particularly among the poor and underserved populations in developing countries (1).

There have, however, been conceptual differences among health professionals and communities as to what is meant by CP, why it is needed, who should participate and how it should be promoted. Many health planners and professionals consider CP as a means of resolving problems in service delivery and a means of mobilizing resources for health programs (3).

The Alma-Ata declaration defined CP as "a social process in which specific groups with shared needs living in a defined geographical area actively pursue identification of their needs and take decisions and establish mechanisms to meet them" (1). CP is also often defined as a process by which community members take part in programmes or activities that are being conducted in the community's interest.

Although health professionals and communities agree on the importance of CP in health, many programs in many countries have encountered barriers in its promotion (4). The Shebe Health Project (SHP), in Seka Chekorsa *Woreda* of Jimma Zone (Oromia Region), is among the programs which have encountered such barriers to the promotion of CP (5). This area was, therefore, selected for this study of the patterns and perceptions of CP in order to assist these program planners in identifying and addressing the barriers to its promotion.

The total population of the *Woreda* for the year 1994 is estimated to be 258,654, with a male to female ratio of 1:1.06 for urban and 1:1.02 for rural populations. Approximately 3.2 % of the total population lives in the two semi-urban areas of the *Woreda* (Seka and Shebe). There are nine functional health posts, five health stations and one health

center in the *Woreda*. The health center is located in Shebe town, 50 kilometers from Jimma. The five health stations are located within a range of 17 to 100 kilometers from the health center (5).

The deterioration of health infrastructure which has accompanied the recent political and social upheaval has been reflected in a high rate of attrition among community health workers (CHWs) throughout Jimma Zone. For example, the *Seka Chekorsa Woreda* has only 9 of the 38 community health posts which were functioning three years ago, 16 of the 61 community health agents (CHAs), and 22 of the 62 trained traditional birth attendants (TTBAs) (5).

To help address this problem, the SHP trained a new type of CHW called Community Health Foremen (CHF) to assist in implementation of the community-based health programs. The 38 CHF trained to date are voluntary workers chosen by their communities, each serving 25 to 50 households in four peasant associations (PAs). Traditional categories of CHWs, including CHAs and TTBAs serve much larger populations of up to 1000.

All these CHWs, including CHFs, CHAs, and TTBAs, are trained to identify and refer patients with clinical signs and symptoms of common diseases, to provide health education, to motivate those eligible to

seek preventive services, and to promote CP in the identification of community health problems, prioritization of needs and development of action plans to be implemented in collaboration with the SHP and the MOH. The CHF's, however, have received some additional and intensive training in these areas through the SHP.

LITERATURE REVIEW

The need for CP in health is globally acknowledged by governments, international organizations, health professionals and communities. Proponents of CP point out three major reasons to promote CP in health programs: 1) its relative cost effectiveness compared to alternative approaches, 2) the enhanced success and sustainability of development efforts which incorporate CP, and 3) the improved equity in development activities which rely on empowerment through participation (6). However, problems have arisen in its implementation because of varying interpretations of CP and approaches to its promotion.

Rifkin and associates (7) have developed a pentagram model, grading community participation from the minimal and passive forms of participation, such as utilization of services, to the highest and most active forms, such as beneficiaries involvement in identification of needs, mobilization of resources and management of health activities. Agudelo (8) emphasized the importance of communities' involvement in the administration and financing of health services, implying that CP should include communities' involvement "... in the planning, organization, operation, and control of PHC..." Alvaro and Bermejo

(9) define CP as a social process of taking part, voluntarily, in either formal or informal activities, or discussions to bring about a planned change or improvement in community life, service or resources.

Despite these conceptual differences among those who advocate CP, there are groups of researchers and social scientists who are critics of these ideas. These groups question, for example, whether rural communities are so homogeneous as to share common interests or to elicit universal cooperation (7). Such critics also point out that CP may be used as a means of shifting government responsibilities to communities or to cover inequities in health status and social or political power that exist at regional, national, and international levels (10). These critics of the traditional CP literature also underline the importance of local differences in communities' capacity for and interest in participation.

Other researchers in CP believe that participating communities are "made not born". Madan (11) argued that it is unrealistic to expect local people in the developing countries to have the power, expertise, resources, or organizational structure to take the kind of actions expected for CP in health. Brownlea (10) has also emphasized the need for "resourcing" communities (with power, knowledge and skills) in order

to make CP feasible. Bermejo and Bekut (12) have suggested the need for political support from governments to successfully promote CP using "grass roots" organizations through which people can influence decisions. They also point out the need to decentralize power and resources to local people to make CP relevant.

Other determinants of community participation which have been identified include the communities' characteristics (such as community segmentation and social environment), the managerial capacity of the providers, and the commitment of health authorities to PHC. Intersectional coordination, training of human resources, and task characteristics also influence the likelihood and quality of CP in specific health development activities (12).

In order to address the conceptual differences in defining and promoting CP, WHO has made efforts to define participation through one of its study groups (13). This group suggested that participation may be interpreted in three ways, including: 1) contribution (of cash, labor or material), 2) organization (through selection of community health workers and formation of social structures to facilitate participation), and 3) empowerment (through management decision making). Though many health professionals consider CP to be a

means of mobilizing resources for health programs (3), those most aware of the complex issues prefer to emphasize community empowerment rather than exploitation.

A study in Saudi Arabia (14) of attitudes of decision-makers towards community involvement in health development documented that 96% of 29 planners, decision-makers and community leaders understood community involvement in health to be the participation of communities in implementation of health programs, while 93% considered it to be a means of mobilizing locally available resources to support government programs. Most (93%) also believed that community participation helped them to identify community needs and to make their plans more realistic and responsive. Most (95%) of the 2417 community respondents also strongly affirmed the importance of community participation in health.

The PHC review of the Ministry Of Health of Ethiopia in 1985 (15) showed that 50% of the local communities had been involved in identifying health problems, 28% in priority setting, 60% in mobilizing local financial resources and 66% in decision making. In 1990, the mid-term review of UNICEF programs in Ethiopia reported (16) that only 35% of CHAs and 45% of TTBAAs were providing services; implying a decline of CP

in health. It was documented that the government's top-down approach and perceived disregard for the real needs and priorities of the population by the government were the major factors explaining this low level of CP in health development activities.

One of the only other studies on CP in Ethiopia was that conducted by Mathewos in 1988 (17). His comparative investigation of community involvement in urban and rural districts showed greater CP in rural communities, particularly in planning and decision-making processes. Among the 900 households in 30 communities (15 each rural and urban) included in his study, 38% of the rural participants were involved during the planning phase, 10% in decision-making, and 64% in the implementation of immunization programs. Overall, 75% of the heads of households participated in at least one of these three aspects of the program. On the other hand, only 12% of urban heads of households were involved in planning, 15% in decision-making, and 22% in implementation. The study also showed that community involvement and immunization coverage were greater in communities with active community health workers.

WHO's Seventh Report on the World Health Situation for 1978 to 1984 (18) has pointed out that 133 countries (out of 166) had mechanisms for promotion of

CP. A few of those countries reported having difficulty in mobilizing communities due to centralization in the control of resources and in decision-making, and the lack of a clear policy for involving the communities in health care. Other factors cited as barriers to CP included poor education, traditional customs or beliefs concerning the causes and nature of ill health, and dependency on government which created a passive attitude on the part of the population.

Case studies of eight selected countries by the Pan American Health Organization in 1984 (19) suggested that effective CP requires a mechanism for continuous participation which is recognized as legitimate by the community and appropriate to local conditions. Additional factors identified which influence CP in these countries were: the attitude of health personnel, the understanding of CP objectives by the health committee, the availability of adequate personnel and resources, the community's recognition of its rights and responsibilities, and the presence of dynamic leadership. Countries with a greater degree of community involvement reported improved coverage, increased program effectiveness, and increased utilization, mainly as a result of new facilities built with community help.

Over the last decade, experience has led social scientists and researchers to promote the use of participatory research. Participatory research (PR) has been defined as "a people-centered learning process that can transform local patterns of awareness, equalize distributions of power and resources, and increase participation in development activity" (21).

PR and use of information can help to empower communities through involvement of the entire community (including historically powerless groups such as the poor, the oppressed, and the marginalized) in the identification of a research problem as well as its analysis and solution. PR is also thought to create a greater awareness by the people of their own resources and mobilize them for self-reliant development (22,23).

It is further suggested that participatory research is a more scientific method of research in that the participation of the community in the research process facilitates a more accurate and authentic analysis of social reality. The ultimate goal of PR is generally the radical transformation of social reality and improvement of the lives of the people involved.

Since 1976, Ethiopian national health policy (24) has embodied the PHC philosophy. It emphasizes the promotion of self-reliance and community involvement in health activities. The new health policy of the

Transitional Government of Ethiopia (25) also proposes decentralization as a principal strategy for promotion of CP in identifying major health problems and managing health activities. There is, therefore, a need to investigate these issues within Ethiopia to develop innovative ways of promoting CP, democratization and equity.

This study was designed to address these needs, by gathering information regarding CP (including the nature and level of participation, perceptions of community participation, and barriers to fuller community participation in health development) and by exploring the effect of PR on patterns of CP in support of PHC.

OBJECTIVES

General Objective: To describe community participation and to explore the effect of participatory research on patterns of community participation in Seka Chekorsa Woreda.

Specific Objectives:

- 1) To describe the nature and level of community participation.
- 2) To assess the communities' and health workers' perceptions of community participation, including barriers to fuller participation in health development activities.
- 3) To assess the effect of participatory research in changing the pattern of community participation.

METHODS

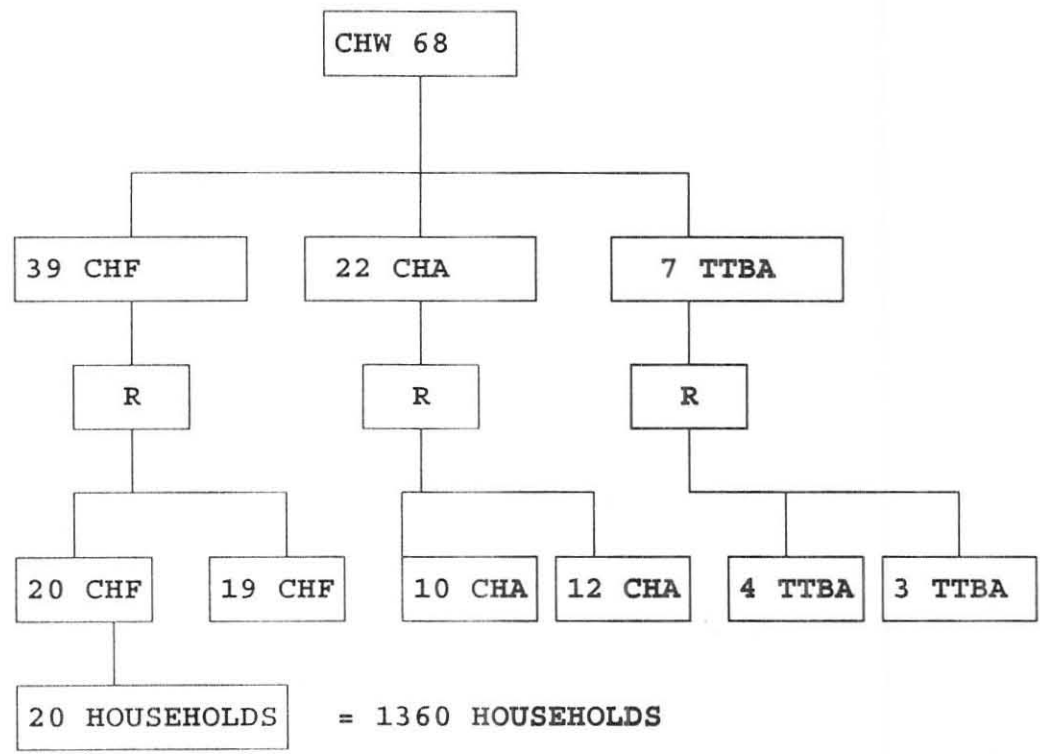
Study Design

A descriptive study was conducted to elucidate the patterns and determinants of CP in 25 peasant associations in Seka Chekorsa Woreda from Oct. 15, 1994 to March 15, 1995. The study also included an experimental component designed to test the effect of PR in measurement and promotion of CP through a randomized controlled trial using the catchment areas served by 68 community health workers (CHWs).

Study population and Sampling procedures

The source population for both components of the study included all 258,000 community members in Seka Chekorsa Woreda. Although sample size required for the descriptive component of the study was calculated assuming a reported participation rate of 50%, 95% confidence level and a difference of no more than 4% from the actual figures for source population, and the required sample size was 600 households. However, the selection of the study population was guided by the requirements of the experimental component of the study for practical reasons. Hence, the study population was obtained by selecting every *n*th household within each community health workers catchment area in order to

obtain 20 households from each of the 68 areas served CHWs, yielding a total of 1360 households. For the experimental component of the study, the households served by all 68 CHWs were randomly allocated using a table of random numbers to either the intervention or the control group (Sampling Scheme 1).



Data Collection and Management

Data for the descriptive component of the study were collected through both structured interviews and focus group discussions (FGDs). Structured interviews were conducted by 15 twelfth grade graduates who were locally recruited and trained for four days in interviewing and data recording skills. Pretesting was conducted before data collection by the interviewers in areas not selected for the study. Interviewers were supervised by a sanitarian who was specially trained by the principal investigator to monitor data quality. The format for the structured interviews is presented in annexes A and B. The interview was conducted with both a male and a female head of each household if both were present. Interviewers returned to households up to three times until both heads of each household had been interviewed, except in single-headed households.

FGDs were conducted among community members, community leaders, community health workers and facility-based health workers. A total of four FGDs were conducted by the investigator with each of the four categories of participants. Topics discussed during FGDs included: 1) the major health problems of the area, 2) whether the community could play a role in solving health problems, 3) whether the community

should play a role in solving health problems, 4) barriers to community participation in health activities, and 5) strategies for promotion of community participation.

The experimental component of the study used the data obtained during both the initial and a follow-up structured interview. The intervention began with the initial survey in experimental areas where data were collected by a research team composed of community health workers, community leaders and interviewers. The research team discussed the major findings of the survey at the end of each day of data collection. Data were collected by the interviewers alone in the control areas. After the initial "participatory assessment", community members from intervention (participatory research) areas were invited to 16 feedback sessions to discuss and interpret the findings. During these sessions, all community members were briefed regarding survey results (knowledge, attitude and practice of CP and factors determining levels of participation) and encouraged to analyze their situation and select among alternatives for action.

The two groups (PR and control) were compared through a follow-up data collection three months after the initial data collection to assess whether initial

differences were sustained. The same structured instrument was used for follow-up data collection, which was conducted in both intervention and control areas by the interviewers alone (without community leaders and CHWs). The same households were visited as during the initial survey. Data entry, cleaning, and analysis were conducted using EPI INFO (version 5.0)) and SAS software packages (26). Analysis was completed through calculation of frequencies, crude and adjusted odds ratios, and confidence intervals as appropriate.

RESULTSSample Characteristics

A total of 2435 participants (1200 males and 1235 females) from 1324 households were included in the study. Fewer than 20 households were identified in the catchment areas for a few CHWs (all of whom were CHFs), in which case all households in the catchment area were selected. None of the selected households refused to participate in the study.

For the experimental component of the study, 34 CHWs were randomly assigned to each of the intervention and control groups. The CHWs in the intervention areas included 20 CHFs, 10 CHAs and four TTBAAs serving in 16 of the 24 peasant associations. The CHWs in the control areas included 19 CHFs, 12 CHAs, and three TTBAAs serving in 16 peasant associations. The socio-demographic characteristics of the study participants, including both community members and CHWs, are summarized in tables 1 and 2.

Table 1: Socio-demographic characteristics of the community study participants, Seka Chekorsa Woreda, 1994/95.

Variable (N=2345)	#	%
Sex		
Male	1200	49.3
Female	1235	50.7
Age		
15 - 30	968	39.8
31 - 45	974	40.0
46 - 60	393	16.1
61 - 75	81	3.3
76 - 90	19	0.8
Religion		
Muslim	1766	72.5
Christian	669	27.5
Ethnic group		
Oromo	1564	66.7
Keffa	108	4.6
Amahara	79	3.4
Others	594	25.3
Marital status		
Married	2222	91.3
Single	75	3.1
Divorced	29	1.2
Widowed	109	4.5
Education		
Literate	405	16.6
Non-literate	2030	83.4
Occupation		
Farmer	1489	61.1
Merchant	62	2.5
Others	884	36.3
Cattle ownership		
None	908	37.3
One	522	21.4
Two	649	26.7
Three or more	356	14.6

Table 2: Socio-demographic characteristics of the community health workers, Seka Chekorsa Woreda, 1994/95

Variable (N=65)	#	%
Sex		
Male	52	80.0
Female	13	20.0
Age		
15 - 29	28	43.1
30 - 44	33	50.7
45 - 59	4	6.2
Religion		
Muslim	43	66.2
Christian	22	33.8
Ethnic group		
Oromo	37	56.9
Kulo	6	9.2
Amahara	5	7.7
Others	17	26.2
Marital status		
Married	57	87.7
Single	2	3.1
Divorced	3	4.6
Widowed	3	4.6
Education		
Literate	41	63.1
Non-literate	24	36.9
Occupation		
Farmer	57	87.7
Others	8	12.3

Nature and Level of Community Participation

Community organizations which could provide a mechanism for CP in development activities were found in all participating communities. Most (97.5%) of the respondents were members of community groups, including funeral societies (*Edir*) (86.1%) and religious associations (13.7%). Among *Edir* members, 66.8% (1366) responded that their association had contributed to health activities by providing money to the poor for medical treatment and for transportation of patients and laboring mothers to health institutions.

More than a third (39.4%) of the respondents reported that they or their family members had used health services within the previous month. Of these, only 24.7% (237) used these services at the community level, whether through CHAs (at health posts), TTBA's, or CHF's. The remainder (75.3%) of those using health services obtained them at other health facilities, such as private pharmacies, clinics, health centers, and hospitals.

Over half (52.5%) of participants reported that they had personally participated (beyond simply using health services) in health development activities during the previous month. Contribution of labor was the most common form of participation reported, with

31.2% of the respondents indicating that they had assisted health development activities through provision of labor within the last month. 29.9% indicated they had attended meetings and 11.9% had contributed materials to health development activities within their communities. None of the respondents had contributed money. Among those who reported contribution of labor or materials, 1.8% (44) indicated that their contribution had been used to support their CHWs. Only 29 (1.2%) of the respondents reported they had participated in decision making and planning, while 24 (1.0%) had taken part in evaluation or supervision of health development activities.

Almost all (99.1%) of the interviewed households knew their CHW by name and 62.3% (1517) indicated that they had been visited by their CHW at least once within the previous month. 41.9% of respondents reported that their CHW had tried to motivate them to participate in community health service activities within the last month. Those who were motivated by their CHW to participate in health development activities were significantly more likely to report some kind of participation (OR=10.10, 95% CI=8.25-12.37). Those who were contacted by other community members and invited to participate were also more likely to report some kind of participation within the previous month

(OR=9.19, 95% CI=3.47-26.50). Table 3 summarizes the reported rates of participation among respondents by the frequency of household visits by CHWs.

Table 3: Frequency of report of any participation within the previous month by the number of CHW home visits, Seka Chekorsa Woreda, 1995

Number of CHW visits (N)	Number Participating (%)	Odds Ratio (OR)	95% Confidence Interval (CI)
None (918)	421 (45.9%)	1.00	--
Once (109)	37 (34.0%)	0.61	0.39-0.94
Twice (431)	120 (28.0%)	0.46	0.35-0.59
Three times (455)	279 (61.3%)	1.87	1.48-2.37
More than three times (522)	421 (80.7%)	4.92	3.79-6.39

Rates of participation were significantly higher among lower socio-economic groups (as reflected by cattle ownership), Christians, and merchants, as summarized in table 4.

All CHWs indicated that they had participated in some way in health development activities within the previous month. Most CHWs (90.8%) are members of a community organization, of whom 78.0% reported that these organizations deal with matters of health development. The majority of CHWs reported that they had participated within the previous month in attending meetings (72.3%), mobilizing communities to participate (67.7%), planning and decision making (64.6%), and in supervision or evaluation of health development activities (55.4%). Only 15 (23.1%) of the CHWs indicated that their communities had participated in supporting them through contributions of labor, materials, or cash.

Table 4: Rates of participation by demographic characteristics, Seka Chekorsa Woreda, 1994/95

Characteristic (N)	Number (%) Participating	Crude Analysis		Adjusted Analysis	
		Odds Ratio	95% CI	Odds Ratio	95% CI
Gender					
Male (1200)	677 (56.4)	1.00	--	1.00	--
Female (1235)	601 (48.7)	0.73	0.62-0.85	0.94	0.75-1.16
Literacy:					
Literate (405)	253 (62.5)	1.00	--	1.00	--
Non-literate (2030)	1025 (50.5)	0.61	0.49-0.76	0.68	0.54-0.86
Religion:					
Muslim (1766)	891 (50.5)	1.00	--	1.00	--
Christian (665)	385 (57.9)	1.35	1.13-1.61	3.00	2.10-4.28
Occupation:					
Farmer (1489)	828 (55.6)	1.00	--	1.00	--
Merchant (62)	45 (72.6)	2.11	1.19-3.72	1.87	1.01-3.40
Other (884)	405 (45.9)	0.67	0.57-0.79	0.70	0.55-0.88
Ethnic Group:					
Oromo (1624)	854 (52.6)	1.00	--	1.00	--
Keffa (112)	71 (63.4)	1.56	1.05-2.32	0.80	0.51-1.27
Amhara (79)	35 (44.3)	0.97	0.61-1.53	0.50	0.29-0.85
Other (560)	237 (42.3)	0.91	0.75-1.10	0.35	0.24-0.50
Cattle Owned:					
>3 (356)	176 (49.4)	1.00	--	--	--
2 (649)	327 (50.4)	1.21	0.94-1.57	1.30	0.99-1.71
1 (522)	294 (56.3)	1.52	1.16-2.00	1.67	1.26-2.22
None (908)	524 (57.7)	1.49	1.16-1.90	1.62	1.25-2.10

Communities' Perception of Community Participation

Of all respondents, 75.4% (1835) reported having heard about CP in health development activities. Literate respondents were more likely to report having heard of CP in health (OR=1.76, 95% CI=1.32-2.36). Most (93.3%) respondents indicated a willingness to participate personally, while 96.9% (2359) felt that their communities would be able to participate in health development activities.

Those who reported awareness of CP in health were more likely to report personal willingness to participate (OR=5.69, 95% CI=4.03-8.05) and community capacity to participate (OR=6.33, 95% CI=3.9-10.6). Among those who reported that they had heard about CP, most indicated that CP meant use of health services or attending meetings regarding community development for health. The types of participation cited by respondents are summarized in table 5. 34.3% (630) of respondents cited two types of participation, while 26.2% (480) cited three kinds of CP in health. Only 5.7% (105) were able to name all four types of CP.

Table 5: Perception of community participation (CP) among those who had heard of CP in health, Seka Chekorsa Woreda, 1995.

Responses (N=1835)	Number Citing (%)
Service utilization	1482 (60.9)
Attending meetings	1092 (44.8)
Contribution (money, material & labor)	826 (33.9)
Participation in decision and in planning	273 (11.2)
No clear idea	135 (5.5)

Those respondents who were aware of CP in health were also more likely to have actually participated in health development activities within the previous month. Table 6 summarizes the relationship between awareness and practice of community participation.

Table 6: Awareness of community participation by type of participation behaviour, Seka Chekorsa Woreda, 1995

Type of participation (N)	Number (%)	Odds Ratio	95% Confidence Interval
Contribution of Labor (760)			
Don't know cp	60 (7.9)	1.00	--
Aware cp	700 (92.1)	5.55	4.14-7.66
Contribution of materials (290)			
Don't know CP	3 (1.0)	1.00	—
Aware CP	287 (99.0)	36.89	11.33-145.93
Attending meetings (729)			
Don't know CP	44 (6.0)	—	—
Aware CP	685 (94.0)	7.53	5.38-10.58
Planning, decision making (29)			
Don't know CP	--	--	--
Know CP	29 (100.0)	--	--
Evaluation (24)			
Don't know CP	--	--	--
Know CP	24 (100.0)	--	--

(N
P)

FGDs conducted with representatives of 30 peasant associations in three sessions were attended by 34 community members. The major health problems identified during the sessions were epidemic diseases (especially malaria and diarrhoeal diseases), under-nutrition among children, poor access to safe water, shortage of drugs, poor access to health facilities, and lack of transportation, particularly for obstetric emergencies.

During the FGDs, almost all participants agreed that the local community and its organizations should participate in health development activities, although most pointed out that financial contributions should not be expected from these poor communities. Barriers to improved CP cited during the FGDs included the absence of health posts, many of which were looted or destroyed during recent conflicts, the absence of an organization to coordinate and promote participation, poor community awareness of health and disease and resource constraints, exacerbated by periodic famine within the area.

Strategies cited by FGD discussants to promote CP included community involvement in establishment of health posts, increasing community awareness through health education, and financial support to CHWs by the government.

Additional FGDs with community leaders elicited a similar list of priority health problems and affirmation of the importance of CP. The community leaders identified three additional barriers to fuller CP, including a history of theft of community development funds by some elected and appointed leaders, the resulting loss of trust in community leadership, and limited efforts by health professionals in promotion of CP.

CHWs' perceptions of CP were assessed through both the structured instrument and FGDs. All of the CHWs interviewed indicated that they were aware of CP, that they felt their communities were capable of participation, and that they, personally, could participate in health development activities. Most commonly cited among the types of CP were attending meetings (87.7%) and service utilization (78.5%). Contribution of labor, cash or materials was cited as a type of CP by more than two-thirds (67.7%) of CHWs and planning and decision making was cited by 64.6%.

During FGDs with CHWs, priority health problems identified included the lack of access to safe water, nutritional deficiencies due to famine and poor infant and child feeding practices, and respiratory diseases. All CHWs affirmed their belief that all community members, except the disabled, should participate in

health activities by contributing labor and materials. Like the other community members, the CHWs felt that cash contributions should not be expected from these communities. Barriers to fuller participation mentioned by the CHWs included the lack of support for CHWs, the lack of community knowledge of health and disease, the absence of technical support resources to promote community development, and poor communications and transportation infrastructure.

Solutions suggested by the community health workers to address these problems included development of a formal mechanism for provision of government or community support for CHWs, strengthened supervision for CHWs, reestablishment of community health posts, increased access to appropriate drugs, improved coordination with government and community organizations, and health education programs for communities, with special emphasis on latrine and spring-box construction.

FGDs with 12 facility-based health professionals (one physician, four nurses, one sanitarian and six health assistants) yielded a list of priority health problems which consisted mostly of disease intities, including malnutrition, parasitic infections, respiratory illnesses, epidemic diseases (such as malaria and diarrhoeal diseases), other tropical

diseases (such as onchocerciasis and tropical ulcer), and childhood infections (such as diarrhoea and conjunctivitis). The health personnel agreed that communities should participate in all health service activities, both individually and through community organizations, in order to achieve the objectives of health service programs. All these health service providers affirmed their belief that communities are capable of participation through contribution of labor and materials, though they emphasized the importance of a mechanism for coordination of these inputs. These participants also underlined the barriers to cash contributions by these poor communities, including the history of mis-utilization of money by community representatives. Other barriers to community participation cited by the health service providers included the dependency of communities on external assistance, failure of health personnel to promote CP, a lack of trust of CHWs by their communities, poor transportation and communications infrastructure, low levels of community awareness of the need for preventive health care and modern medicine, and a lack of budgetary support to facilitate health development activities.

Strategies to promote fuller CP which were proposed by the health service providers included

continuous and practical health education, strengthened efforts to involve communities in all aspects of management of health development activities, motivation of all health personnel to work more closely with communities, improved use of existing community organizations (such as *Edir*) to promote participation in community health development activities, provision of a budget for health institutions work in community health development, introduction of a cost recovery mechanism for health services, and improved coordination with government and community organizations.

Effect of Participatory Research

During the first survey, data obtained regarding sex and age distribution, religion and literacy rates revealed no significant differences between the intervention and control areas. Significant differences were, however, detected between the intervention and control areas in the distribution of ethnic groups. The intervention area was found to have significantly larger numbers of Oromos (OR=1.23, 95% CI=1.03-1.46) and fewer Amharas (OR=0.31, 95% CI=0.18-0.53). Socioeconomic status, as reflected by cattle ownership, was also somewhat different in the two areas, with the intervention area having a larger

proportion of the population who own no cattle (OR=1.77, 95% CI=1.50-2.10). Both perceptions and reported behaviour with regard to participation were significantly different in those areas in which CHWs and community leaders assisted in the initial survey. The types of participation specified by respondents in the two areas were virtually the same. However, in the presence of their community leaders and CHWs, community members were more likely to report having heard about CP (OR=1.93, 95% CI=1.59-2.35), that their communities could participate (OR=1.95, 95% CI=1.18-3.24), and that they could personally participate in health development activities (OR=1.39, 95% CI=1.18-1.64). The differences between the two areas in the report of participation behaviour are summarized in table 7.

Table 7: REPORTED PARTICIPATION BEHAVIOUR BY GROUP BEFORE AND AFTER INTERVENTION,
Seka chekorsa Woreda 1994/95

Types of participiation	CONTROL			INTERVENTION		
	Number	Odds Ratio	95% CI	Number	Odds Ratio	95% CI
Heared about CP	821 - 886	1.31	1.09-1.58	1014-1059	<u>1.29</u>	<u>1.04-1.60</u>
Personally participated	573 - 600	1.10	0.93-1.29	705-719	1.05	0.89-1.23
Participation by contribution of material	14-23	1.66	0.81-3.40	276-290	1.07	0.88-1.29
Participation by contribution of labor	347-374	1.05	0.58-1.26	413-446	1.12	0.95-1.33
Participation by attending meetings	277-326	1.18	0.98-1.42	452-575	<u>1.37</u>	<u>1.16-1.61</u>
Participation by decision making and planning	5-5	--	--	24-46	<u>1.95</u>	<u>1.16-3.32</u>
Participation by evaluation/ supervision	3-3	--	--	21-21	--	--

Comparison of the results of the first survey and the follow-up survey in control areas revealed no significant differences for the indicators of perception or practice of CP. For the intervention areas, on the other hand, community members were significantly more likely during the follow-up survey to report having heard about CP (OR=1.29, 95% CI=1.04-1.60), having attended meetings regarding health development issues (OR=1.37, 95% CI=1.16-1.61), and having participated in decision making and planning for health (OR=1.95, 95% CI=1.16-3.32). No other variables showed significant differences between the initial and follow-up surveys.

Differences between the initial and follow-up survey were found to be strongly associated with the type of CHW. Intervention communities with CHF's showed significant differences between the initial and follow-up survey in the frequency of report of having heard about CP (OR=13.27, 95% CI=9.38-18.84), having attended meetings regarding health development issues (OR=1.51, 95% CI=1.22-1.87) and having participated in decision making and planning for health (OR=2.21, 95% CI=1.29-3.84). No such differences were observed in communities served by CHAs or TTBA's. Table 8.

Table 8: REPORTED AWARENESS AND BEHAVIOUR OF PARTICIPATION BY TYPE OF CHW
IN THE INTERVENTION GROUP, Seka chekorsa Woreda 1994/95.

Awareness and participation	Type of CHW	Number (Before and After)	Odds Ratio	95% CI
Awareness to CP	CHF	652,690	13.27	9.38-18.84
	CHA	261,268	1.10	0.78-1.55
	TTBA	101,101	--	--
Participation by attending meetings	CHF	320,399	1.51	1.22-1.87
	CHA	93,115	1.35	0.96-1.88
	TTBA	31,31	--	--
Participation by decision making and planning	CHF	22,47	2.21	1.29-3.84
	CHA	1,1	--	--
	TTBA	--	--	--

DISCUSSION

This study documents that there is general agreement, among community members, CHWs and health care providers, regarding the importance of CP for health development. Such findings are nearly universal in studies of CP in health (14,15,17,18).

Levels of CP documented in this study may not be entirely representative of the *Woreda* population, since sampling was uniform for each CHW catchment area rather than proportional to the size of the population in each catchment area. There is, therefore, some over-representation of those areas served by CHFs, who provide services for smaller populations. There are additional limitations to the generalizability of the findings due to the external inputs to the SHP, which provides resources in support of CP which are not available for most of the country. More respondents said they felt participation was important or that they would participate than admitted they knew about participation in health development activities. This difference may reflect either poor promotion of CP in the health sector or a "courtesy bias", wherein informants chose to indicate that they felt participation was important (despite not having heard about it) in order to please the interviewers.

The rate of personal participation in health activities was considerably lower than that observed by Mathewos (17). Most of this difference can probably be ascribed to differences in the time frame for the question, with Mathewos asking for any history of participation, while this study limited the reporting period to the preceding month. Other possible explanations of the observed difference include the change in the political situation since that 1988 study and the broader definition of "participation", including reported use of such preventive services as immunizations.

The higher rates of participation in planning and decision making reported in the 1985 PHC review (15) may also reflect these differences in methods and in the political context, manifest in the increased support and attention to CHWs and the health infrastructure available during that early period in the implementation of PHC. However, there was also reportedly some element of coercion in promotion of CP during that time.

There was considerable congruence in the identification of barriers to participation by community members, CHWs and health service providers. Although the absence of an organizational structure to promote CP was cited as a barrier to fuller

participation, most community members reported that they participate in health development activities through community organizations, such as the funeral associations (*Eder*). These truly "grass-roots" mechanisms for CP in health seem, however, to have not been identified as CP by the study communities. This failure to identify such participation during the survey may reflect an assumption by the respondents the survey concerned only government sponsored CP activities.

Participants were unanimous in their identification of poverty as a constraint to fuller CP. Lack of cash, materials and technical expertise in such impoverished communities has been noted by many other researchers to be a principal barrier to CP (*Bermejo, Brownlea, Madan*). The study documents that the effects of decentralization of such resources have yet to be perceived at the community level.

The involvement of only a very small portion of the community in decision making and planning may reflect a lack of commitment of health professionals to involvement of communities in such management activities in support of health development. Yet the large difference in the proportion of respondents who cited participation in decision making and planning as a form of CP when compared to the proportion who

reported they had actually participated in decision making and planning suggests that communities expect more such opportunities for CP than are currently offered to them.

On the other hand, there is evidence from FGDs that these communities still have an attitude of dependency and an expectation of government assistance and control. Other researchers have noted that such attitudes and expectations present a barrier to fuller CP. These expectations may be exacerbated in the study area by the presence of the donor-assisted SHP. Furthermore, these communities currently have a limited understanding of "democracy", particularly of its accompanying responsibilities.

Study findings regarding differences in rates of CP by occupation, income level and ethnic group suggest that segmentation of these communities may also be a barrier to increased CP. Other authors have observed such effects of segmentation or marginalization as a constraint to CP (12).

It is interesting, however, that the poor have higher rates of participation than those of higher socio-economic status. Whether the poor have a greater need to participate or sense that there is no alternative to CP, policy makers should view this finding with some alarm. Although further

investigation is needed, if CP is viewed as the province of the poor, there will be difficulty in promoting increased CP in support of health development.

Large differences were documented between intervention (PR) and control areas during the initial survey. Differences in demographic characteristics, including the distribution of ethnic and socio-economic groups, suggest that randomization did not result in two fully comparable experimental groups. Nonetheless, it is likely that most of the documented differences in reported perceptions of CP and CP behaviors were due to the presence of community leaders and CHWs in the PR group. The fact that detected differences were significant only in areas served by CHF's, who make greater efforts to promote CP, provides additional evidence that these differences were due to perceived political support for CP in the PR areas. CHF's are probably more effective in promoting CP due to the smaller populations served, because they are elected or nominated by their communities, and because they receive better training and supervision (16).

The effects of PR were limited to increases in awareness, attending meetings and participation in decision making and planning. The short interval between the initial and follow-up surveys was

undoubtedly a constraint to documenting any further impacts of PR in promoting CP. The effects that were seen were those which might be expected, however, as a first step toward fuller CP in health development activities. More fully participatory approaches, which incorporate community input into identification of research issues as well as data collection and analysis, may also result in larger impact in promotion of CP.

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CONCLUSIONS

This study has contributed to raising the consciousness of communities in Seka Chekorsa *Woreda* regarding CP and has assisted in identifying strategies for the promotion of CP. In addition, it has achieved the study objectives in providing the following information:

Nature and Level of Community Participation

Over half (52.5%) of community members report they had personally participated in health development activities within the preceding month. Most common forms of participation reported were contribution of labor (31.2%) or materials (11.9%) and attending meetings regarding health development (29.9%).

Communities' Perception of Community Participation

Investigation of community perception of CP revealed that communities were most likely to identify more passive roles for themselves, including service utilization (60.9%), attending meetings (44.8%), and contribution of material or labor (33.9%). Few (11.2%) indicated that CP implied participation in decision making and planning. Key barriers to promotion of fuller CP in health which were identified by the study

included poor community awareness of their roles and responsibilities in health development, the lack of technical and financial resources in support of health development activities, the lack of a clear strategy for promotion of CP, and the absence of an organizational structure or mechanism to promote CP which is acceptable to communities.

Effect of Participatory Research on Community Participation

PR was effective in increasing the awareness of community about CP, and increasing rates of participation in attending meetings and in decision making and planning. Other indicators of CP may have also reflected an impact of PR in promotion of CP if follow-up surveys had been conducted after a longer interval.

RECOMMENDATIONS

In view of the study findings, the following recommendations are made:

- Community Participation should be seen as a primary goal of development assistance.
- CP should be strengthened by developing a clear strategy and policy and through decentralization of financial and technical resources in order to improve the effectiveness of health development programs.
- Existing mutual self help societies, such as the funeral societies (*Edir*), should be exploited as mechanisms for organization and promotion of CP.
- PR should be further explored as a strategy to empower communities and promote CP, in order to involve communities in identifying, analyzing and solving their problems.

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ANNEX AHOUSEHOLD QUESTIONNAIRE FOR COMMUNITY INVOLVEMENT

1. Full Name _____ 2. Age _____
3. Sex M [] F [] Address: _____
4. Ethnicity 1. Oromo [] 2. Keffa []
 3. Amhara [] 4. Kullo []
 5. Other (specify) _____
5. Religion 1. Muslim [] 2. Orthodox Christian []
 3. Other (specify) _____
6. Marital status : 1. Married [] 2. Single []
 3. Divorced [] 4. Widowed []
7. Number of members of the household _____
8. Can you read and write? 1. Yes [] 2. No []
9. Last grade completed _____
10. Occupation 1. Farmer [] 2. Merchant []
 3. Daily laborer [] 4. Other (specify) _____
11. Number of animals owned by the household:
 1. Cows ____ 2. Oxen ____ 3. Sheep ____ 4. goats ____
 5. Other (specify) _____
12. What does community participation mean to you?
 (interviewer should categorize spontaneous
 responses as follows):
1. service utilization []
2. contribution (money, labor, materials) []
3. discussing/attending meetings []
4. planning/decision-making []

13. Has your community been represented in efforts to identify and/or address health problems within the last month?
1. Yes [] 2. No []
14. Do you think your community could play a role in identifying and/or addressing its health problems?
1. Yes [] 2. No []
15. Have you personally participated in identifying and/or addressing your community's health problems within the last month? 1. Yes [] 2. No []
16. Do you think you personally could participate in identifying and/or addressing your community's health problems?
1. Yes [] 2. No []
17. Have you or your children used health services within the last month? 1. Yes [] 2. No []
18. If yes, whom did you consult (check all applicable answers)?
1. CHW (CHA, TTBA, CHF) []
2. Health Station []
3. Health Center []
4. Hospital []
5. Others (specify) : _____

25. Do(es) your group(s) or committee(s) address health issues?
1. Yes [] 2. No []
26. Have you attended any meetings concerning health within the past month?
1. Yes [] 2. No []
27. Do you know the name of your Community Health Worker?
(specify): _____
28. Has your CHW visited you within the last month?
1. Yes [] 2. No []
29. Did your CHW encourage you to participate in any contributions, meetings, or management activities related to health within the last month?
1. Yes [] 2. No []
30. Did any other members of your community encourage you to participate in any contributions, meetings, or management activities related to health within the last month?
1. Yes [] 2. No []
31. Have you participated in evaluation of supervision of health activities within the past month?
1. Yes [] 2. No []

32. How long (in hours) does it take for you to reach the nearest:

CHW: _____

Health Post: _____

Health Center: _____

Hospital: _____

33. What health programs exist in your community?

1. Environmental health []

2. Immunization []

3. Nutrition []

4. MCH Services []

5. Health Education []

6. Family Planning []

7. Curative Services []

8. Other: (specify) _____

ANNEX BQUESTIONNAIRE FOR COMMUNITY HEALTH WORKERS

1. Full Name _____
2. Age _____
3. Sex M [] F []
4. Area Served: _____
5. Address: _____
6. Type of worker: 1. CHA [] 2. TTBA []
 3. CHF []
7. Duration of work (in years) in present job: _____
8. Ethnicity: 1. Oromo [] 2. Keffa []
 3. Amhara [] 4. Kullo []
 5. Other (specify) _____
9. Religion:
 1. Muslim [] 2. Orthodox Christian []
 3. Other (specify) _____
10. Marital status: 1. Married ([] 2. Single []
 3. Divorced [] 4. Widowed []
11. Can you read and write? 1. Yes [] 2. No []
12. Last grade completed _____
13. Occupation 1. Farmer [] 2. Merchant []
 3. Daily laborer []
 4. Other (specify) _____

14. What does community participation mean to you?
(interviewer should categorize spontaneous responses as follows):
1. service utilization []
 2. contribution (money, labor, materials)[]
 3. discussing/attending meetings []
 4. planning/decision-making []
15. Has your community been represented in efforts to identify and/or address health problems within the last month?
1. Yes [] 2. No []
16. Do you think your community could play a role in identifying and/or addressing its health problems?
1. Yes [] 2. No []
17. Have you personally participated in identifying and/or addressing your community's health problems within the last month? 1. Yes [] 2. No []
18. Do you think you personally could participate in identifying and/or addressing your community's health problems?
1. Yes [] 2. No []
19. Do you receive any support (cash, labor, or material) in compensation for your work as a health worker?
1. Yes [] 2. No []

27. Have you visited any members of your community to encourage them to participate in any contributions, meetings, or management activities related to health within the last month?

1. Yes [] 2. No []

28. Have the leaders in your community assisted you by visiting any members of your community to encourage them to participate in any (contributions, meetings, or management) activities related to health within the last month?

1. Yes [] 2. No []

29. What health programs exist in your community?

1. Environmental health []
2. Immunization []
3. Nutrition []
4. MCH Services []
5. Health Education []
6. Family Planning []
7. Curative Services []
8. Other: _____

DECLARATION

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in any other university and that all resources of material used for this thesis have been fully acknowledged.

Name : ADUGNA KEBEDE

Signature: 

Place : Addis Ababa, Ethiopia

Date of Submission : May, 1995