A Study of Health Communication Practice to Reduce Maternal and Child Mortality in the rural areas of the Amhara Region: Baso liben Woreda in Focus

Haimanot Getachew

A Thesis Submitted to
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Addis Ababa University

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This is to certify that the thesis prepared by **Haimanot Getachew** entitled: **A Study of Health Communication Practice to Reduce Maternal and Child Mortality in the rural areas of the Amhara Region: Baso liben Woreda in Focus** and submitted in partial fulfillment of the requirement for the Degree of Master of Arts Journalism and Communications complies with the regulations of the university and meets the accepted standards with respect to originality and quality.

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Abstract

A Study of Health Communication Practice to Reduce Maternal and Child Mortality in the rural areas of the Amhara Region: Baso liben Woreda in Focus

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As a core component of the broader health system, Health Extension Program (HEP) focuses on the household and community that calls for coordinated action at all levels (FMOH, 2007). This study focused on the health communication strategies used by health extension program workers to reduce maternal and child mortality rate in the rural areas, with an emphasis on whether these strategies were effective in promoting participation and creating awareness among the rural communities in the Baso liben Woreda. This was chosen purposively as case study area because it is one of the woredas with high child and maternal mortality rate. Six kebeles (three out of 12 'Weyina Dega' kebeles) and three of 11 'Qola' kebeles) were purposively selected for the study. Qualitative methods were used for data collection. Accordingly, from the selected kebeles, in-depth interviews were conducted with 13 women from the FGD, six HEWs and three key informants and six FGD sessions of the health army group (one-to-five), one in each kebele. All the data were transcribed.

Based on the participatory communication model as a theoretical framework, the data was analyzed. The analysis indicated health extension program depended on interpersonal communication, team communication, and door to door communication and team communication strategies. Among those methods of communications, interpersonal communication had a better acceptance by the community and the health extension practitioners. In the case of community participation even through the Ministry of Health Bureau implemented a participatory development process as set out in the policy documents participation of the community horizontal communication. However, it was found out that in the study area, the top down communication was more predominantly used. Men were not included in the communication. Finally, it was recommended that gender based health army group should be restructured including both men and women in order to help raise men's awareness.

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List of acronyms

CDC – Centers for Disease Control and prevention

CSA – Central Statistical Agency

FGD – Focus Group Discussion

FMoH – Federal Ministry of Health

GTP – Growth and Transformation Plan

HEP – Health Extension Program

HEW – Health Extension Workers

MCH – Mother and Child Healthcare

MDG – Millennium Development Goal

NGO – Non Governmental Organization
PHC – Primary Health Care

UN – United Nation

UNDP – United Nation Development Project

USAID – United States' Agency for International Development

VCHWs – Voluntary Community Health Workers

WHO – World Health Organization

Table of Contents **page**

Chapter One

1. Introduction

1.1 Background of the Study

This study focuses on six *Kebeles* in the *Baso liben Woreda* of the Amhara Region of Ethiopia. A triangular-shaped district at the southern-most end of the *Misraq Gojjam* Zone, *Baso liben* is bordered on the south by a bend of the *Abay* river which separates it from the Oromia region, on the northwest by *Guzamn*, and on the northeast by *Aneded*; the *Chamwaga* river defines part of its western border. The major town in *Baso liben* is *Yejube*. Rivers in this *woreda* include the *Yada* and the *Sens*, a tributary of the *Chamwaga*. Several fords have been used from time immemorial to cross the *Abay* from *Baso liben* to *Guduru* and *Cheliya woredas* in the Oromia region. The fords are, in downriver order, the *Balanti*, *Malka*, *Malka Kuki*, *Malka Fursi*, and Malka Yekatel. (See Fig. 1 in the Appendix)

According to the 2007 National Census conducted by the Central Statistical Agency of Ethiopia (CSA), the *Woreda* had a total population of 138,332: 68,034 male and 70,298 female; 6,439 urban and 131,893 rural. The population of the *Woreda* had increased by 19,625 from the 1994 Population and Housing Census of Ethiopia. The largest ethnic group reported in *Baso liben* was the Amhara (99.91%). Slightly over ninety-eight percent (98.59%) reported as followers of the Ethiopian Orthodox Church, while 1.33% followed the Muslim religion. Charles Beke, who travelled through this area in 1842, states that groups of Oromos had settled in this part of Gojjam, the names of their tribes becoming the names of these districts (Gebru Tareke, 1996).

Baso liben *Woreda* is chosen as a case for the study because:

- Maternal and child mortality is a well-known serious problem and has attracted policy attention over the years and the researcher is very knowledgeable of the study area.
- The widespread culture of traditional medication and witchcraft encourages people to prefer traditional healers rather than staff at health posts when get sick; and finally
- In addition, due to various factors, Baso liben *woreda* is the most known *woreda* with its high maternal and child mortality, on the contrary, different international media, governmental and non-governmental organizations reported that Ethiopia has registered a dramatic maternal and child mortality reduction in health extension program. As a result, the researcher's attention has been drawn to evaluate how HEPs engage the community at the grassroots in general and women in particular.

In May 2002, world leaders adopted the Millennium Declaration at the General Assembly of the United Nations. Recognizing the urgent need to reduce poverty and address development challenges for long-lasting peace and security, time-bound development goals, coined the "Millennium Development Goals" were established with specific targets and indicators (WHO, 2005).

In line with this, our country Ethiopia established its own strategy the Growth and Transformation Plan (GTP) in 2010. The GTP is directed towards achieving Ethiopia's long-term vision and sustaining rapid and broad-based economic growth anchored on Ethiopian's experience with implementing development policies. The overriding development agenda of GTP is to sustain rapid and broad-based growth and eventually end poverty **(**GTP 2010/11-2014/15).

An important element of the GTP, the Health Sector Development Plan, aimed at ensuring community ownership and empowerment through effective social mobilization, enhanced and sustained awareness creation, and created a conducive environment and supporting community organizations. The Health Extension Program (HEP) was to serve as a primary vehicle for prevention, health promotion, behavioral change communication and basic curative care through effective implementation of sixteen health packages. Among these packages, reducing child and maternal mortality is given special emphasis.

Despite global and national efforts to improve women's health, death of women during child birth remains an unresolved challenge in many developing countries, including Ethiopia. With slight improvement in maternal and newborn morbidity, Ethiopia still registers one of the highest mortality rates in the world. Current estimates of maternal mortality stand at 871 deaths per 100,000 live births. This translates into twenty-five thousand (25,000) maternal deaths per year (CSA, 2001: 110).

In recent years, global leaders have made significant international commitments to women's health. The Millennium Development Goal 5 aims to reduce maternal mortality and improve maternal health. Global health experts have reached consensus on what must be done to achieve these goals. However, even with the knowledge and commitment in place to save the lives of mothers and children, targets fail to be met. Long-term conditions disable women who survive delivery-related complications. These include fistula, chronic pelvic pain, depression and exhaustion. Fistula is especially common in Ethiopia, primarily due to the frequency of adolescent pregnancy combined with neglected prolonged labor.

A key factor contributing to both high maternal and newborn mortality is the lack of skilled care, in the community, during pregnancy and delivery. To tackle this problem, the Federal Ministry of Health initiated the Health Extension Program, one of the most innovative community-based health programs in Ethiopia. It is based on the assumption that access to and quality of primary health care in rural communities can be improved through transfer of health knowledge and skills to households.

Research demonstrates that participatory health communication strategies are important for empowering women, men, families, and communities to recognize preventive health-related risks, and to take responsibility for developing and implementing appropriate responses. Increased knowledge and awareness is essential for reducing delays in seeking health care and in reaching a health facility. Communities and individuals must be empowered not only to recognize pregnancy-related risks, but they must also have the capacity to react quickly and effectively once such problems arise.

1.2. Statement of the problem

Health communication is the art and technique of informing, influencing, and motivating individuals, institutions, and large public audiences about important health issues based on sound scientific and ethical considerations (Tufts University Student Services, 2006).

An effective health communication strategy is indispensable, because it equips the public with the tools and knowledge to respond appropriately to health crises such as flu outbreaks, maternal and child mortality. Government agencies and technology corporations should collaborate together to bring healthy society and address as many households as possible. For the benefit of people with marginal literacy skills, pertinent health information should be provided at their level

of understanding. Health communication professionals should offer continuing education and incorporate appropriate learning. Professionals need to be able to identify the contexts, channels, messages and reasons that will motivate individuals to heed and use health information – whether designing health communication programs for vulnerable populations, framing a health policy issue for legislators, or educating patients on medications.

In order to promote the adoption of health communication strategies and practices in health care, disease prevention, and health promotion initiatives, the Ministry of Health designed the National Health Extension Program.

In spite of the past efforts and gains registered in maternal and child mortality programs, it is realized that essential health services have not reached the grass-roots, as can observed in *Baso liben Woreda*. Maternal and child mortality indicators show a slight decrease but in *Baso liben Woreda* reports indicate maternal and child mortality is still high at nine child and mothers out of thousands. This is probably made worse by the prevalence of violence against women, use of harmful traditional practices like early marriage and community attitudes towards such serious problems.

There has been no research to comprehensively examine the communication strategies of the Health Extension Program in rural areas. There is one unpublished Master's Thesis by Hiwote Derbew (July, 2007) on family planning communication in rural parts of Ethiopia: the case of Basona *Woreda* found in North Shewa. In her thesis, she focused on the informal, interpersonal and indigenous communication used by the community and finally concluded indigenous ways of information exchange and informal interpersonal networks were useful in communicating family planning.

Even though the Federal Ministry of Health establishes sufficient infrastructure like health posts and the professional manpower called health extension workers, it is observed that health extension workers seem to lack skills to effectively communicate with the target community. This study explores the health communication strategies used by health extension program workers to reduce maternal and child mortality in rural areas, with an emphasis on whether these strategies are effective in promoting participation and creating awareness among the rural communities in the Baso liben *Woreda.*

1.3. The Purpose of the Study

The main purpose of this study is to explore the role of communication strategy and community participation in the health extension program, focusing on the reduction of maternal and child mortality.

1.4. Research Questions

In order to understand the communicative nature of health extension program, this study will address the following questions:

1. What communications strategies' and campaign components are used to reduce maternal and child mortality in the health extension program?
2. What are the factors that affect the practitioners and the target community to address the health communication strategies in maternal and child mortality package?
3. Based on the requirements set out in the national and regional and maternal and child mortality reducing policies, what sort of communication strategies are practiced at the local level?

4. Are communication strategies employed by the health extension workers participatory?

1.5. Significance of the study

This study analyses the practice of health communication strategies with relation to reducing child and maternal mortality rate at the local community. The study benefits the society in helping find out effective strategies and channels of communication to build capacity at the grassroots level. It also may assist policy makers; college students, as well as other influential bodies like the mass media in indicating how the health extension program design the communication strategies to produce skilled community and confident individuals who work for sustainable development. Findings will interest stakeholders and practitioners in the health extension program.

1.6. Scope of the study

This study focuses on health communication strategies of health extension program used by the health extension workers in rural areas. The research includes guidelines and recommendations for improvement in the process, objective, implementation of future programs. This study is limited to exploring the communication strategies of health extension program and communities participation on it in reducing the maternal and child mortality in *Bao liben Woreda*.

1.7. Organization of the thesis

This thesis has five chapters. The first chapter gives an introduction which incorporates the background of the research area, statement of the problem, objectives and major research questions. The second chapter deals with the review of literature which focuses on the theoretical framework of participatory communication model, the health communication strategies and briefly the health extension program in Ethiopia. This is followed by chapters three and four which deal with the research methodology and data presentation and analysis respectively. Conclusion and recommendations constitute the last part of the thesis.

Chapter Two

2. Literature Review

2.1 Introduction

This chapter reviews literature encompassing the developmental communication paradigm and participatory health communication model, strategies and theories. Moreover, it presents an overview of the Health Extension Program (HEP) and its practices.

Maternal and child mortality reducing strategies are strongly emphasized in the Millennium Development Goals. The Growth and Transformation Plan (GTP) of Ethiopia focuses on community awareness raising, birth preparedness, and Health Extension Workers (HEWs). Increasing transport options between communities and health facilities is a priority, including better roads, ambulances and local transport, making costs of transport affordable, and use of tricycle ambulances. Both programs share the view that community awareness is the best solution to reducing child and maternal mortality.

Development is a concept which is contested both theoretically and politically, and is inherently complex and ambiguous. Recently, it has taken on the limited meaning of the practice of development agencies, especially in aiming at reducing poverty and the Millennium Development Goals (Thomas, 2004: 1-2).

Development efforts should be anchored in faith of the people's capacity to discern what is best done as they seek their liberation and to participate actively in the task of transforming society. The people are intelligent and have centuries of experience. Draw out their strength and listen to them (Servaes, 1995).

When development comes to our mind, there is an active community creating awareness and communication amongst the people to empower themselves.

2.2 Development communication

Development communication is using communication to change or improve the way of living of the citizen of a country. The messages in development communication are designed to transform the behavior of people or to improve their quality of life (Servaes, 1999).

This is Servaes definition:

> Development Communication refers to a spectrum of communication processes, strategies and principles within the field of international development, aimed at improving the conditions and quality of life of people struggling with underdevelopment and marginalization (p. 17).

This definition of development communication draws attention to the fact that the objective of development communication is to get higher the quality of life as soon as possible.

Development is all about causing sustainable development in the community. This is based on the definition of development as a process of social change which has its own goal as the improvement of the quality of life of all or majority of the people without doing violence to the natural resources or cultural environment in which they exist.

Everett M. Rogers (1983) defines development communication as the uses to which communication is put in order to further development. Such applications are intended to either further develop in a general way, such as by increasing the level of the mass media exposure among the nation's citizen, in order to create a favorable climate for development, or to support a

specific definite program or project. In the above mentioned definition, Rogers (1983) says that for the development of any aspect, the community will create an environment or climate for development.

According to Narula Uma (1994), development communication has two primary roles: a transforming role, as it seeks social changes for a higher quality of life and a socializing role, by seeking to maintain some of the established values of the society.

Development communication is used for transforming role by bringing in social change in a way that will bring a higher quality of life. Here communication acts as an instrument to achieve these objectives. On the other hand it also tries to maintain the established values of the society by playing a socializing role. In playing these roles, development communication seeks to create an atmosphere for change as well as providing innovation through which society may change.

In history, development communication has been perceived in many ways: from the dominant era to the grassroots. Scholars like Sarvaes, argue that development communication can be attained through multiplicity paradigms via grassroots participation. The discourse later shifted to the 'other development' option, commonly known as the multiplicity paradigm.

2.3. Multiplicity or participatory communication

Paradigms in development theory according to Pieterse (2002), Sarvaes, etal, (1996) include those of modernization, multiplicity, dependency and alternative development. This study is based on the multiplicity paradigm of developmental communication that the theoretical frame majorly on participatory communication model.

According to Pieterse (2002) multiplicity paradigm aims at satisfaction of basic needs, material development of cultures and indigenous culture and effective utilization of natural resources, which are all embedded in participatory paradigm of development communication.

According to the paradigm, Sarvaes and Jacobson (1996) indicated that individuals and communities become empowered by gaining knowledge about specific issues, communicating about issues of common concern, making decisions for themselves and negotiating power relations. A bottom-up communication approach is emphasized here. Communicators work with the community. Communication according to Waisbord (2005: 79) is from 'bottom to up' it starts right from the local people grassroots. The practitioner uses communication as a tool to smooth improvement of participation in development.

Waisbord (2005) argues that, practitioners have recognized the need for a multiplicity of communication strategies to improve the quality of life in communities. Different techniques in different contexts might be necessary to deal with specific problems and priorities. This represents participatory development communication as a deliberate activity based on mass media and interpersonal communication and other participatory processes which makes possible a dialogue among different stakeholders in the region of a common development problem.

On the other hand Melkot and Steeves (2001), understood multiplicity paradigm in the sense of horizontal communication and culture specific meaning;

> Multiplicity paradigm makes it necessary horizontal communication that includes all stakeholders and to relay on a mix, the modern and traditional communication channels. Moreover, development praxis and advances in communication theory

> suggest that communication be culture-specific and provide a platform for community discussion and dialogue (p. 25).

Melkot and Steeves call such dialogue and horizontal communication "communicators' communication" that results in creating and sustaining a community. The participatory approach to communication is a distinctive outcome of the alternative paradigm.

Although the new paradigm has been introduced, the older approaches to development are still practiced widely, resulting in an overlap of different communication and development approaches (Mody, 2002).

The participatory model stresses the importance of cultural identity of local communities and of democratization and participation at all levels international/national, local and individual. It points to a strategy, not merely inclusive of, but largely emanating from, the traditional receivers (Servaes, 1995). Freire (1983:76) refers to this as the right of all people individually and collectively to speak their word. This is not the privilege of some few men, but the right of every man.

To share information, knowledge, trust, commitment, and a right attitude in development projects, participation is very important in any decision-making process for development. This calls for new attitudes for overcoming stereotyped thinking and to promote more understanding of diversity and plurality, with full respect for the dignity and equality of people living in different conditions and acting in different ways (International Commission for the Study of Communication, 1980:254).

This model stresses reciprocal collaboration throughout all levels of participation. Listening to what the others say, respecting the counterpart's attitude, and having mutual trust are needed.

Participation supporters do not underestimate the ability of the masses to develop themselves and their environment (Servaes, 1995).

In terms of the specific concept of participatory communication, scholars give different points of view about how it developed after it was conceived more than two decades ago (Midgley, 1986:13). According to Freire (1983:22) and Yoon (2000, cited in Servaes, 2008) the participatory approach is related to post-modernism:

> Participatory approach is the overall approach to modernizing; the developing world eventually ran into problems. Development experts found out that development was not limited merely to social practices of building roads, piping water, and distributing electricity (Yoon 2000).

Furthermore many of the agricultural extension projects failed because farmers were reluctant to abandon their time-tested ways for strange new methods of farming from foreign countries. The farmers were not comfortable in planting the new exotic crops which they could not eat but had to sell for money with which to buy food from the market. When piped water arrived, it was frequently used for washing rather than drinking and cooking because the people disliked its taste (p. 52).

Ownership of local development plans was diminished by central planning. People had no ownership of the development plans that affected them personally. In other words, development became a government responsibility. While in the past, farmers could collectively maintain the long-established water sharing systems that they collectively owned, workers of irrigation establishment found in the governments, now built the new channels and dictated the discharge and cessation of the water supply. As the irrigation waterways broke down, farmers just waited

for these irrigation workers to repair them rather than repair the problem, deeming that the system did not belong to them. If the workers failed to arrive and solve the problems, the system was simply abandoned (Yoon, 2000).

The failures of the top-down strategies were noticed more and more in cities. Supplementary activists began to criticize the top down, mechanistic approach loudly as merely focused on the symptoms and not the causes of deficiency in social standards.

> The top down communication of the modernization approach tended to fracture the delicate developing community by undermining indigenous knowledge, beliefs, and social systems. In addition the activists were also displeased with the way the development plans centered more around the interested of the high powered in the developed communities, rather than catering for the issues at hand in the developing communities (Servaes, 1995).

Meanwhile, other activists started to question the basis of the modernization approach. According to the activist of the participatory approach, the solution to underdevelopment does not pivot around the adoption of Western technologies; it however needs to come from the tried practices of the developing countries. Instead, it rested on the way the whole world was structured, which saw the developed countries (also the former imperial powers) progress and benefit at the expense of the poorer countries (also the former colonies). The developed countries were more powerful than the developing countries, and the latter had to depend on the former for their well-being (Narula Uma, 1994).

Nevertheless, the extent of participation varies within different operational levels. Moreover, it can be abused. When initiating a development project or program, it is useful to clarify what

perception of participation will guide the strategy conceptually. Stretching the concept, perceptions can be identified. The following sub-section presents these varieties in detail.

2.3.1 Levels of participation

Community participation can be classified into a variety of typologies suggested by international development scholars. These typologies rank participation according to levels of influence that the communities have the power to exert on the development projects. In participatory learning for sustainable agriculture Jules Pretty (1995) suggested one of the most widely used typologies, which subdivides participation into seven levels based on the activities and public's engagement within the development project as given.

Passive Participation: People participate by being told what is going to happen or has already happened. It is a unilateral announcement by an administration or project management without listening to people's responses. The information being shared belongs only to external professionals.

Participation in Information Giving: People participate by answering questions posed by extractive researchers using questionnaire surveys or similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared nor checked for accuracy.

Participation by Consultation: People participate by being consulted, and external people listen to views. These external professionals define both problems and solutions, and may modify these in the light of people's responses. Such a consultative process does not concede any share in decision-making, and professionals are under no obligation to take on board people's views.

Participation for Material Incentives: People participate by providing resources, for example labor, in return for food, cash or other material incentives. Much on-farm research falls into this category, as farmers provide the fields but are not involved in the experimentation of the process of learning. It is very common to see this called participation; people have no stake in prolonging activities when the incentives end.

Functional Participation: People participate by forming groups to meet predetermined objectives related to the project, which can involve the development or promotion of externally initiated social organization. Such involvement does not tend to be at early stages of project cycles or planning, but rather after major decisions have been made. These institutions tend to be dependent on external initiators and facilitators, but may become self dependent.

Interactive Participation: People participate in joint analysis, which leads to action plans and formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systematic and structured learning processes. These groups take control over local decisions, and so people have a stake in maintaining structures or practices.

Self-Mobilization: People participate by taking initiatives independently of external institutions to change systems. They develop contacts with external institutions for resources and technical advice they need, but retain control over how resources are used. Such self-initiated mobilization and collective action may or may not challenge existing inequitable distribution of wealth and power.

True participation, specifically participatory communication beyond the grounds of pseudo-participation, begins on level six where the participants are seen as integral equal partners in the bilateral dialogue. This level of participation then creates further empowerment and cooperation among the stakeholders through active citizen control, delegated power and partnerships (Deshler and Sock, 1985). It is the level of participation where platforms begin to play an important role.

On the other hand Mefalopulos and Tufte (2005) suggest a similar, yet shorter typology of participation:

Passive Participation: The least participatory of the four approaches. Primary stakeholders of a project participate by being informed about what is going to happen or has already happened. People's feedback is minimal or non-existent, and their participation is assessed through methods like head counting and contribution to the discussion (sometimes referred to as participation by information).

Participation by Consultation: An extractive process, whereby stakeholders provide answers to questions posed by outside researchers or experts. Input is not limited to meetings but can be provided at different points in time. In the final analysis, however, this consultative process keeps all the decision-making power in the hands of external professionals who are under no obligation to incorporate stakeholders' input.

Participation by Collaboration: Forms groups of primary stakeholders to participate in the discussion and analysis of predetermined objectives set by the project. This level of participation does not usually result in dramatic changes in what should be accomplished, which is often already determined. It does, however, require an active involvement in the

decision-making process about how to achieve it. This incorporates a component of horizontal communication and capacity building among all stakeholders a joint collaborative effort. Even if initially dependent on outside facilitators and experts, with time collaborative participation has the potential to evolve into an independent form of participation.

Empowerment Participation: Where primary stakeholders are capable and willing to initiate the process and take part in the analysis. This leads to joint decision making about what should be achieved and how. While outsiders are equal partners in the development effort, the primary stakeholders are primus inter pares, i.e., they are equal partners with a significant say in decisions concerning their lives. Dialogue identifies and analyzes critical issues and an exchange of knowledge and experiences leads to solutions. Ownership and control of the process rest in the hands of the primary stakeholders.

2.3.2 Ascendancy of participatory approaches

In reaction to modernization and to a degree the realization of global structural imbalances gave birth to the rise of the various participatory approaches.

> These new participatory processes shared the intent of actively involving the people who were the subjects of development in the developing countries, in shaping the process for their own needs. In most cases, however, the similarity ends and endless differences begin to show. People participation became defined in many different ways, and this in turn led to numerous unresolved disagreements (Korten, 1986:481; UNDP, 1998).

Four different levels of participation can be distinguished in development projects claiming to be participative (Jones &Wiggle, 1987:111):

- **Participation in implementation**- People are actively encouraged and mobilized to take part in the actualization of projects. They are given certain responsibilities and set certain tasks or required to contribute specified resources;
- **Participation in evaluation** - Upon completion of a project, people are invited to critique its success or failure, they are invited to give examples of success and state how thing can be improved on also on where things have gone wrong;
- **Participation in benefit** - People in the community participate in the benefits of the development initiative. This might include such benefits such as the ability of pumping water from a hand pump, medical care in the form of mobile clinics, a truck to transport produce to market, or community meetings in the new community hall; and
- **Participation in decision-making** - People initiate, discuss, and plan activities as a community. These decision making activities may be related to more common development areas such as building schools or applying for land possession. Others may be more political, such as removing officials, supporting parliamentary candidates, or electoral education activities. Many other activities may be cultural or religious in nature organizing a traditional festival, marriage ceremonies, big parties, or just to have a good time.

Therefore, allowing people to participate in the implementation, evaluation and decision-making process, concerning the health communication strategy, will empower them to benefit from in the development process, enabling sustainable outcomes.

LoZare (1989) pointed out the mutualism between communication and participation:

> Communication and participation are actually two words sharing the same concept. Etymologically the Latin communion relates to participation and sharing. Modem languages have given different meanings to the word communication: it is very often considered synonymous with the word information. There is confusion, mostly by English speakers, between communications: the act or process of communicating, and communications with the means of sending messages, orders, etc (p. 4).

According to Yoon (2000), when trying to design a profile of participatory communication, it is important to be conscious about the political implications of participation in development. Participation can be seen as an issue of power. The democratization of communication cuts through the issue of power. Participatory approaches contribute to put decision-making in the hands of the people. It also consolidates the capability of communities to confront their own ideas about development with development planners and technical staff. Within the community itself, it favors the strengthening of an internal democratic process (p.3) And an issue of identity**:** Especially in communities that have been marginalized, repressed or simply neglected over decades, participatory communication contributes to install cultural pride and self-esteem. It reinforces the social issue through the strengthening of local and indigenous forms of organization. It protects tradition and cultural values, while facilitating the integration of new elements (p.35).

The most important rudiments that characterize participatory communication are related to its capacity to involve the human subjects of social change in the process of communicating.

The following are some of the issues that distinguish participatory communication from other development communication strategies in search of social changes (Servaes, 1995; Veneklassen, 1990:130-132):

Horizontal vs. Vertical: People are dynamic actors, actively participating in the process of social change and in control of the communication tools and contents; rather than people perceived as passive receivers of information and behavioral instructions, while others make decisions on their lives.

Process vs. Campaign: People taking in hand their own future through a process of dialogue and democratic participation in planning communication activities; rather than expensive unsustainable top down campaigns that help to mobilize but not to build a capacity to respond from the community level to the needs of change.

Long-term vs. Short-term: Communication and development in general is conceived as a long-term process which needs time to be appropriated by the people; rather than short- term planning, which is seldom sensitive to the cultural environment and mostly concerned with showing results for evaluations external to the community.

Collective vs. Individual: Urban or rural communities acting collectively in the interest of the majority, preventing the risk of losing power to a few; rather than people targeted individually, detached from their community and from the communal forms of decision-making.

With vs. For: Researching, designing and disseminating messages with participation; rather than designing, pre-testing, launching and evaluating messages that were conceived for the community, and remain external to it.

Specific vs. Massive: The communication process adapted to each community or social group in terms of content, language, culture and media; rather than the tendency to use the same techniques, the same media and the same messages in diverse cultural settings and for different social sectors of society.

People's needs vs. Donors' musts: Community-based dialogue and communication tools to help identify, define and discriminate between the felt needs and the real needs; rather than donor-driven communication initiatives Based on donor needs (family planning, for example).

Ownership vs. Access: A communication process that is owned by the people to provide equal opportunities to the community; rather than access that is conditioned by social, political or religious factors.

Consciousness vs. Persuasion: A process of raising consciousness and deep understanding about social reality, problems and solutions; rather than persuasion for short-term behavioral changes those are only sustainable with continuous campaigns.

2.3.3 Cultural identity, empowerment and participatory communication

According to Servaes (1995) authentic participation directly addresses power and its distribution in society. Participation 'may not sit well with those who favor the status quo and thus they may be expected to resist such efforts of reallocating more power to the people (Lozare, 1989:2). Therefore, development and participation are inextricably linked. Participation involves the more equitable sharing of both political and economic power, which often decreases the advantage of certain groups. Structural change involves the redistribution of power. Many

communication experts agree that structural change should occur first in order to establish participatory communication policies. Mowlana and Wilson (1990) for instance state:

> Communication policies are basically derivatives of the political, cultural and economic conditions and institutions under which they operate. They tend to legitimize the existing power relations in society, and therefore, they cannot be substantially changed unless there are fundamental structural changes in society that can alter these power relationships themselves (p. l43).

The UNDP (1998) and Servaes, (1995:17-18) note that; participation is commonly seen either as an end or as a means to an end. In participation as a means, communication is seen as a process where local people co-ordinate or collaborate with externally introduced development programs or projects. The term participatory development is more commonly used to describe the participatory communication approach. Chitnis, Ketan S. (2005) says the approach to participation as a means is most recommended by advocates and practitioners of participatory rural appraisal who see it as empowerment of those in need of development.

2.3.4 Guidelines for participatory communication at community level

Some of the most successful participatory communication program was tested at the village/community level. The small size of the community permitted the intensive use of interpersonal channels, as well as other folk and traditional media (UNDP, 1998; The Communication Initiative Partnership, 2002). These are the steps followed by many NGOs in implementing their programs. These steps have drawn ideas not only from development communication methodologies, but also from participatory development, and non-formal education.

2.3.4.1 Entering the community

The first step of any participative communication project is the identification of a community partner through which the development can take place by means of a partnership. This is achieved by identifying communities that the NGOs have worked with in the past, or are currently working in. The advantages of approaching the development process in this fashion are two-fold. There is a working relationship in place and secondly the relationship has already established a feel for what the community requires with regards to developmental projects.

2.3.4.2 Preparing to plan action

Initial periods of listening and getting-to-know-each-other should in essence lead to a decision to collaborate, yet in many instances this is not the case and the decision is made not to collaborate. In the case of the former, the next step is often planning the extent of the collaboration. Communication plays a vital role at this stage. Meetings with the community are good starting points, this allows for as many people as possible from within the community to be involved with the opportunity to participate in the planning process. During this meeting the purpose of the planning exercise can be explained and debated, the people can be involved, introduced to each other, and the process for development can be decided upon (Yoon, 2000).

2.3.4.3 Planning what to do

According to Yoon (2000) the first step is a reflection upon the current conditions, problems, aspirations and resources faced by the community. Media can and must play a catalytic role in this phase. Traditional and folk media should be targeted as the media types that can be used effectively to gauge these conditions in the community. In many communities the

members or the local theatre group prepare and present to the community, a play about a fictitious place where conditions are similar to those in the village. The performance that follows does not have any conclusions. During the performance the members of the community act out the ending or suggest what the ending should be. What makes this medium so effective is the fact that it is entertaining and easy to participate in partly because of the indigenous setting. It also acts as a non- threatening and minimally belligerent situation as the issues that may be prevailing in the community are being dealt with through a proxy that is offered by the fantasy characters in the performance.

2.3.4.4 Supporting action

As the development phase evolves, there would be a likelihood that the community has advanced to the stage of action, a group would've evolved that would ensure that the communication activities of the community would be taken care of. According to Narula Uma (1994), it would probably comprise of the opinion leaders like religious and traditional leaders, teachers, folk musicians, actors, and others involved with the interaction between the community members. The village communicators may be offered training in communication methods by the NGOs. Such training should emphasize the principles of participation and the supportive role of communication in triggering participative development within the community (Yoon, 2000; USAID, 2002).

2.3.4.5 Withdrawing from the community

According to Yoon (2000), NGO workers who help set up participatory communication projects should plan their withdrawal from the communities as soon as the people indicate their readiness to take complete charge. The groundwork for withdrawal should be started on and included in

the initial meetings and planning preparations between the community and the NGO, so that the people can prepare for it while the development process is on the go. In addition the withdrawal phase signals to the community that the ultimate goal is for them to take control over the development and actions that affect them.

Beside interpersonal communication guidelines of participatory communication, mass media have an immense contribution for development. The media content might be designed with diverse platforms and tools. Among the tools, entertainment-education, information dissemination and participation are vital.

2.4 Mass media in development communication

Mass media should be extensively and tactfully used for development. It should be kept in mind that it is a weapon in the hands of the government for positive developmental purpose. When the media are used for developmental purposes, the development communicator has to keep in mind that the usage should be extensive. The mass media structure should be planned and efforts should be made to reach out to the maximum number of people every time. Daniel Lerner in (1958), while discussing the relation of development with that of any mass media said that: the greater the communication facilities, the greater or even faster is modernization.

According to Wilbur Schramm (1988), the role of media in development can be divided into three parts i.e. to inform, to instruct and to participate.

To Inform: for the development of the society, correct social, political and economic influence is the main criteria. This information should be both national and international. People should be aware of the areas or facts which hamper the development process.

To Instruct: Mass literacy is an essential tool to development. This is possible by spreading basic skills among the people. Mass media plays an important role in this. Mass media can instruct people and educate them.

To Participate: Voluntary and steady participation of the citizens of the country is necessary for its overall development. Such participation is possible in a liberal society. Such awareness is possible through debate, conflict and discussion. Discussions and debate helps people to know current issues, participate in developmental programs and bring a change in the standard of living of the society.

To sum up, employing an integrated approach, both interpersonal and mass communication fosters development. Specifically, when the issue comes to community health, communication is perhaps the hub. To change the behavior of a certain community regarding health beliefs, health communication is the fundamental tool for progress. Following is an elaboration of nature and practices.

2.5 What is health communication?

An understanding of health communication theory and practice requires reflection on the literal meaning of the word communication;

> Communication is: 1). Exchange of information, between individuals, for example, by means of speaking, writing, or using a common system of signs and behaviors; 2.) Message—a spoken or written message; 3.) Act of communicating; 4.) Rapport—a sense of mutual understanding and sympathy; 5.) Access—a means of access or communication, for example, a connecting door (Renata Schiavo, 2007:5).

One of the key objectives of health communication is to influence individuals and communities. The goal is admirable since health communication aims to improve health outcomes by sharing health-related information. In fact, the Centers for Disease Control and Prevention define health communication as the study and use of communication strategies to inform and, influence individual and community decisions that enhance health, (U.S. Department of Health and Human Services, 2005). The word influence is also included in the Healthy People 2010 definition of health communication as the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues (U.S. Department of Health and Human Services, 2005: 11-12).

On the other hand Renata Schiavo (2007) emphasizes health communication with supporting individuals;

> Health communication is a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt, or sustain a behavior, practice, or policy that will ultimately improve health outcomes (p. 7).

Similarly Piotrow (1997) agreed that effective strategies in health communication identify and prioritize key behaviors, segment audiences, design messages based on scientific evidence and research, and reach audiences through key channels, while mobilizing communities to become involved in this processes.

> Health communication is generally conceived as a strategic process aimed at achieving a rational use of health services, and improving the efficiency and effectiveness of programs directed at disease prevention and health promotion. Research has shown that health communication programs based on solid theory may bring health to the forefront of the public agenda, reinforce sanitary messages, stimulate people to seek more and better information, and in some cases lead towards healthier lifestyles four key elements of the communication process are typically used in health communication: source, message, channel, and audience, increasingly coupled with social mobilization and participation components and with rigorous research (Piotrow, 1997).

Another important role of communication is to create a receptive and favorable environment in which information can be shared, understood, absorbed, and discussed by the program's intended audiences. This requires an in-depth understanding of the needs, beliefs, taboos, attitudes, lifestyle, and social norms of all key communication audiences. It also demands that communication is based on messages that are easily understood.

Health communication differs by context, like information flow through individual influence, disease prevention through behavior modification, is exchange, interchange information, two-way dialogue, scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable.

To inform and influence (individual and community) decisions. Moreover, health communication is a key strategy to inform the public about health concerns and to maintain

important health issues on the public agenda (New South Wales Department of Health, Australia, 2006).

The study or use of communication strategies is to inform and influence individual and community decisions that enhance health (CDC, 2001; U.S. Department of Health and Human Services, 2005).

Health communication is a means to disease prevention through behavior modification (Freimuth, Linnan, and Potter, 2000: 337). It has been defined as the study and use of methods to inform and influence individual and community decisions that enhance health (Ibid).

Health communication is a process for the development and diffusion of messages to specific audiences in order to influence their knowledge, attitudes and beliefs in favor of healthy behavioral choices (Hansen, A., *et al.* (1998).

Health communication is the use of communication techniques and technologies to (positively) influence individuals, populations, and organizations for the purpose of promoting conditions conducive to human and environmental health (Maibach and Holtgrave, 1995: 219–220). It may include diverse activities such as clinician-patient interactions, classes, self-help groups, mailings, hot lines, mass media campaigns, and events, (Health Communication Unit, 2006).

Ratzan and others (1994) understood health communication as motivating individuals:

> The art and technique of informing, institutional and audiences about important health issues is scope includes disease prevention, health promotion, health care policy, and business, as well as enhancement of the quality of life and health of individuals within the community (p. 361).

Effective health communication is the art and technique of informing, influencing, and motivating individuals, institutions, and large public audiences about important health issues based on sound scientific and ethical considerations (Tufts University Student Services, 2006).

Clift and Freimuth (1995) understand health communication is Change behaviors. Health communication, like health education, is an approach which attempts to change a set of behaviors in a large-scale target audience regarding a specific problem in a predefined period of time (p.68).

The goal of health communication is to increase knowledge and understanding of health related issues and to improve the health status of the intended audience (Muturi, 2005: 78). Communication means a process of creating understanding as the basis for development. It places emphasis on people interaction (Agunga, 1997: 225).

According to Renata Schiavo (2007), health communication is exchange, interchange information, two-way dialogue. A process for partnership and participation of that is based on two-way dialogue, where there is an interactive interchange of information, ideas, techniques and knowledge between senders and receivers of information on an equal footing, leading to improved understanding, shared knowledge, greater consensus, and identification of possible effective action.

Health communication is the scientific development, strategic dissemination, and critical evaluation of relevant, accurate, accessible, and understandable health information communicated to and from intended audiences to advance the health of the public (Bernhardt, 2004: 51 cited by Renata Schiavo).

Therefore, health communication, as an area of practice, uses various channels to reach the intended audience, share health related information and engage stakeholders**.**

2.6 Health communication channels

Channels and Tools, provides a guide for selecting the channels team will use to convey the message to the intended audience. The focus here is on identifying and assessing potential resources that can help you carry out a communication program. Health communicators define communication channels broadly as a delivery system for messages to reach intended audiences. According to Piotrow & Kincaid (2001) health communication channels are categorized as follows:

- **Interpersonal channels:** Focus on either one-to-one or one-to-group communication. One-to-one channels include peer to peer, spouse to spouse, and health clinic worker to client. An example of one-to-group communication may be a community-based outreach worker meeting with a women's cooperative. Interpersonal channels use verbal and nonverbal communication (p. 25).
- **Community-oriented channels** focus on spreading information through existing social networks, such as a family or a community group. This channel is effective when dealing with community norms and offers the opportunity for audience members to reinforce one another's behavior (p. 26).
- **Mass-media channels** reach large audiences. They are particularly effective at agenda setting and contributing to the establishment of new social norms. Formats range from educational to entertainment and advertising, and include television, radio, and print media,

such as magazines, newspapers, outdoor and transit boards, the Internet, and direct mail (p. 26).

However, selecting the appropriate channels and integrating them might be essential, but designing effective message is the underscoring issue.

2.7 Designing effective theory based health messages

Health behavior and health communication scholars study messages and interventions that encourage patients to be active participants in health communication contexts. In addition to designing mediated health messages, we need to focus on effective interpersonal message strategies that will prove effective with the unique complexities and barriers patients and their family members often face (Rubin, etal, 1988).

They argued that, such a goal must be pursued by paying attention to the unique cognitive and emotional processes different populations often deal with, followed by tailored interpersonal message framing that will be more likely reach such specific populations one patient and one family at a time.

Nearly all health-related information can be construed in terms of either gains (benefits) or losses (costs). But which frame works better? The answer depends on whether the target health behavior is an illness-detection behavior or an illness protection behavior (Andersen, M. R., and Lobel, M., 1995). Protection behaviors (e.g., using sunscreen) typically lead to relatively certain outcomes. Prospect Theory predicts that loss-framed information leads to preference for uncertainty, whereas gain-framed information leads to preference for certainty. Research findings indicate that loss-framed messages were effective in promoting mammography, breast

self-examinations, and HIV testing. Gain-framed messages were effective in promoting infant car restraints, physical exercise, smoking cessation, and sunscreen.

To sum up, to communicate health-related messages in a community, a system that facilitates dialogue among groups and the community in general seems logical. Health systems need to encourage households in health development. As an example, the Ethiopian health promotion strategy through health extension program can be referred to.

2.8 Health extension program in Ethiopia

Ethiopia is one of the countries with high disease burden. Mortality and morbidity of mothers and children is said to be one of the highest in Africa. According to FMOH (2007) Ethiopia introduced a health policy and health development program that targets disease prevention. Both the health policy and program give due emphasis to mother and child healthcare.

> Federal Ministry of Health indicates that it has introduced a four tier system: the Federal specialized referral hospitals, the regional specialized referral hospitals, the district hospital and the primary health care with a health center and satellite health posts. The four tier system is designed to make health service delivery at each level accessible (p. 12).

The target of the health policy and program is disease prevention. The primary health care system focuses mainly on disease prevention and health promotion. Curative services are given at nucleus health centers.

The Health Extension Program (HEP) is a strategy on disease prevention and health promotion implemented at village level. It was launched in 2004 with 16 packages to be implemented in rural Ethiopia.

They argued that, such a goal must be pursued by paying attention to the unique cognitive and emotional processes different populations often deal with, followed by tailored interpersonal message framing that will be more likely reach such specific populations one patient and one family at a time.

The main approach of Health Extension Program is transferring skills and knowledge in health to households and communities as a mechanism of improving community and household health outcomes.

> Two female Health Extension Workers (HEWs) are assigned at each health post and each village. They are regular employees and salaried. Health extension workers are selected from the villages that they are supposed to serve. They have to be grade ten complete and speak the language of the communities they would be serving. They are trained for a year in the sixteen packages (FMOH, 2007:14)

The HEP is designed to collaborate with all government sectors, local leaders and communities in the implementation of the health extension packages (FMOH, 2007).

The communities and local leadership participate in many ways to make the implementation smooth especially in the construction of the health post, the selection of voluntary community health workers (VCHWs) and model families. HEP takes vs. CHWs and model families as key components in the transfer of skills and knowledge in health to households and

communities. HEP is a household and community based health intervention. It believes that communities can take care of their health if they are helped to build their capacities and skills in disease prevention and health management. According to HEP, the communities and households have to 'own health.' Every household should be producer and multiplier of health, (Ibid). HEP takes access, equity, quality and safety of mothers and children as indicators of effective community health care.

HEWs train VCHWs and supervise their activities. Both HEWs and VCHWs work in collaboration in the training and graduation of model families. HEWs take the responsibility of training model families in the sixteen packages whereas VCHWs facilitate the process and assist HEWs. It is believed that VCHWs have better opportunity to reinforce health behavior since they live close to the community members and interact more.

The assumption behind the idea of model families is that such families would influence their nextdoor households and friends to promote practices and positive attitude towards disease prevention and better quality of life.

The whole idea of voluntarism in health and model families is to make every household a volunteer and model in health. At the initial stage of implementation, it is assumed that there would be one VCHW for 10-20 households (p. 28).

The HEP recognizes the potential roles that community structures could play in the implementation process. Community structures are social capital with a lot of influence on households. Thus, HEP has a community package that HEWs implement. HEP also recognizes the roles that could be played by sector structures such as schools or agriculture extension agents.

According to the health extension guide (FMOH, 2007):

> Structures such as *Idir, Equib,* religious institutions, and government structure at community such as schools, community based association such as women association, youth association, and farmers association… are expected to be active in health promotion and enabling the community to own health and produce and multiply health (p.17).

As the Health Extension and Education Center of the Federal Ministry of Health (June 2007) indicates HEWs are required to spend 75% of their time conducting outreach activities by going from house to house. During these visits, HEWs are expected to teach by example (like helping mothers care for newborns, cooking nutritious meals, of latrines and disposal of pits).

HEWs utilize the following three approaches:

Model families- HEWs identify and train model families that are involved in other development work, and /or that have acceptance and credibility by the community, as early adopters of desirable health practices to become role models in line with heath extension packages. Model families help diffuse health messages leading to the adoption of the desired practices and behaviors by the community.

Community based health packages- HEWs communicate health messages by involving the community from the planning stage all the way through evaluation. HEWs utilize Women and Youth Associations, Schools and Traditional Associations such as *idir, Mehaber, ekub,* to coordinate and organize events where the community participate by providing money, raw materials and labor.

Health posts- At the Health Post HEWs provide antenatal care, delivery, immunization, growth monitoring, nutritional advice, family planning and referral services to the general population of the *Kebele.*

2.9 Health extension program and millennium development goals

From the Millennium Development Goals (MGDs), those stated under MDG 4 and 5 are directly related to the Ethiopia's Health Extension Program. MDG 4 – Child survival: Health workers are the bridge between children and the well known, often simple interventions such as immunizations and oral rehydration therapy for diarrhea that will save their lives. Accordingly World Health Report (WHR, 2005) emphasizes the need for more health workers, estimating that 4.6 million community health workers and the equivalent of 100,000 – and possibly many more additional health professionals are required to scale up global child health activities.

Regarding MDG 5 – Maternal health, the WHR (2005) stated that putting in place the health workforce needed for scaling up maternal, newborn and child health services towards universal access is the first and most pressing task. To reduce maternal mortality, properly trained midwives and other skilled personnel who can assist with childbirth are needed.

Deploying higher level health professionals in to all rural area is difficult for poor countries like Ethiopia. That is why HEWs are being appointed as alternative health work force and are now participating in the delivery of health care.

> Although different degrees of emphasis may be placed on different levels of the system for different purposes, reaching the goals for both child health and maternal health requires strengthening all of the following. Due attention is required in

household prevention and care-seeking behaviors; the delivery of services within the community by healthcare workers trained to perform a few specific tasks; and a competently staffed and adequately supplied clinic that provides outpatient care. In addition, a first-level referral hospital where severe, life-threatening conditions can be managed by health professionals trained to do so and strengthening other related areas need to be emphasized (WHO, 2011).

As far as addressing shortage of health workers in maternal and child health is concerned, the role VHWs is considered very important. VHWs are useful in sensitizing community members to the importance of pre and postnatal care. Using such insiders helps in improving access to family planning information and commodities, providing insecticide-treated bed nets, and recognizing and managing anemia.

2.10 Maternal and child health in developing countries

Despite the overall decline in global maternal and infant mortality rates, the situation in developing countries remains troubling. According to the World Bank (2006), malnutrition is most damaging during pregnancy and in the first two years of life, and the effects of this early damage on health, brain development, intelligence, educability and productivity are largely irreversible (p. 10). Therefore, interventions must focus on this window. Specific MDGs have aimed to halve the proportion of people who suffer from hunger, reduce the under-five mortality rate by two-thirds and reduce the maternal mortality rate by three-quarters by 2015 (UN, 2009).

Investing in nutrition is critical to achieving the MDGs. For instance, MDG Goal 4 is to reduce child mortality, and malnutrition is directly or indirectly associated with most child deaths and it

is the main contributor to the burden of disease in the developing world, (World Bank, 2006 b, p. 15).

Additionally, MDG Goal 5 is to improve maternal health, but "maternal health is compromised by malnutrition, which is associated with most major risk factors for maternal mortality" (World Bank, 2006, p. 15). However, five years away from this target year, statistics do not look promising, especially in developing countries. The trend of declining rates of undernourishment in developing countries reversed in 2008, rising by one percentage point, most likely due to increasing food prices (UN, 2009).

> Child mortality rates have declined steadily in the past decade; however, many developing countries are still far from reaching target numbers set by the MDGs. The UN reports that approximately 536,000 women die each year from complications during pregnancy and childbirth, and the majority of these deaths are in developing countries (p. 21).

As a result, more action is required to reach targets by 2015, such as increased attention given to health programming involving women and children, those most in need related to the aforementioned MDGs. In addition, larger-scale actions related to policy change must be advocated for in those countries with the most need for MCH protection.

2.11 Maternal and child mortality in Ethiopia

Globally, over 500,000 women and girls die of complications related to pregnancy and childbirth each year (WHO, 2011). Over 99 percent of those deaths occur in developing countries such as Ethiopia. But maternal deaths only tell part of the story. For every woman or girl who dies as a

result of pregnancy-related causes, between 20 and 30 more will develop short- and long-term disabilities, such as obstetric fistula, a ruptured uterus, or pelvic inflammatory disease

Sub-Saharan Africa accounts for around half of all deaths of children under five in the developing world, while African women face a one in 22 chance of dying in pregnancy or childbirth. Ethiopia, however, has made substantial improvements in the health sector and is now on track to meet its MDG targets for child health. A report of the 2011 independent Ethiopia Demographic and Health Survey (DHS) shows infant deaths have decreased by 23 per cent, under-five deaths have decreased by 28 per cent and the number of women using contraceptives has doubled.

> Even though the report shows improvement in the child and maternal mortality, Ethiopia's maternal mortality rate continues at an unacceptably high level. While maternal mortality figures vary widely by source and are highly controversial, the best estimates for Ethiopia suggest that over 25,000 women and girls die each year due to pregnancy-related complications. Additionally, more than 500,000 Ethiopian women and girls will suffer from disabilities caused by complications during pregnancy and childbirth each year (WHO, 2011).

2.12 Theoretical Framework of the Study

This research is based on the Community-based Participatory Model. The participatory model advocates equal participation of individuals and each and every part of the society in development projects. In addition, communication agents are only facilitators. Moreover, the model emphasizes the cultural identity of the target community. The other important thing in the participatory model of communication is participatory evaluation or research. The theory insists

local health workers should find out the problem in a local area and the communication medium and message that can best suit the situation (Servaes, 1995: 88- 93).

Servaes also added that in participatory communication, the communicator's role is to facilitate instead of influence or persuade society. The process takes fair and active involvement of all parties while simultaneously aiming to improve the participation process. Lastly, there is an unlimited potential for social change, so participatory communication continues to grow in quality through learning and practice.

Thus, the participatory communication model promotes communication as a dialog with the community rather than the mere transmission of information from experts to the community members.

Additionally, the argument of Merino Ulteras (1988), used for supporting of the theoretical framework of measurement whether there is a poplar participation in the area or not. As indicated by Jorge Merino Utreras, popular participation consisting the following.

The production level: In this case, participation is possible in the production of message and programs. It involves access to professional help, technical facilities and production process.

The decision making level: This involves the management of the medium itself and it implies the participation of the community in deciding the program (content, time, schedule etc.), and in controlling the administration and financing.

The planning level: This refers to the right of the people to participate in formulating plans, policies, objective, management principles, way of financing, etc., as well as establishing plans for local, regional and national communication (pp, 28-29).

Chapter Three

3.1 Research Methodology

This chapter gives an idea about the methods and techniques of data collection, which the researcher employed to achieve the purpose of the study stated in chapter one. This research is intended to explore health communication strategies that were used by health extension program in Baso liben Woreda to reduce the rate of maternal and child mortality.

To answer the major research questions such as what kind of communication strategies and campaign components have been used to reduce maternal and child mortality in the health extension program, and are those communication strategies employed by the health extension workers participatory, the researcher used qualitative research methodology.

Qualitative research methodology is employed due to the fact that this research approach claims to describe life world 'from the inside out', from the point of view of people who participate and the research focuses on the practice rather than showing the seriousness of the problem in numbers. It is appropriate to use qualitative methods in communication research when the goal of the research is to gain insights into an intended audience's lifestyle, culture, motivations, behaviors, and preferences (Mack et al.,2005). Additionally this research uses series scrappy facts to reach a general conclusion, therefore qualitative research seems pertinent. Qualitative research, with its precise and thick description, does not simply depict reality, nor does it practice exoticism for its own sake. It rather makes use the unusual or the deviant and unexpected as a source of insight and a mirror whose reflection makes the unknown perceptible in the known and the known perceptible in the unknown, thereby opening up further possibilities for self-recognition (Strauss, etal, 1998). Gerson and Horowitz (2002) also define qualitative research

methods as an inquiry process of understanding a social or human problem (discovering something that was previously not documented, or to prove certain ideas and hypotheses in order to give them substance), based on the complex building of a holistic picture by means of words, of the informants in a natural setting.

This is an advantageous method when striving for deeper understanding of a specific phenomenon in the society. Through a qualitative approach it is also possible to map and evaluate processes and find information that otherwise would be less possible to find. The strength and major contribution of qualitative approach is the fact that it generates in a holistic and deep understanding of the process that is in focus of the study (Reinard, 1994). The goal of such qualitative approach can be used to develop principles about a specific phenomenon, in this case the external communication works in the health extension program. Identifying underlying factors, exploring decision processes, mapping a range of contributory elements are diagnostic of qualitative research**.** Processes of a phenomenon such as communication works in organization health extension can be evaluated by this research method. These characteristics of qualitative research enable the researcher to scrutinize communication approach of health extension program.

Hence, the research aims at exploring the communication strategies used by health extension program workers to reduce maternal and child mortality in the rural areas. The emphasis here is whether these strategies are effective in promoting participation and creating awareness among the rural communities. Thus, qualitative methods are used purposively.

The data collection methods include document analysis, focus group discussions, and in-depth interviews with key informants and participant observation.

3.2. Population of the study

The researcher used *Baso liben wereda* of *Misrak Gojjam* Zone in Amhara regional state as a subject of study because of policy intervention, magnitude of the maternal and child mortality case and widespread culture of using traditional medication like witchcraft which encourages people to prefer in those traditional healers.

3.3 Sample size and sample technique

The case study area, *Baso liben woreda,* has 22 rural and one semi-urban *kebeles*. Of these 23 kebeles, the researcher selected six *kebeles*: three *kebeles* from *Weyina Dega* and another three from *Qola* considering the balance between the agro-ecological zones. According to Van Mere (1978), the agro-ecological zones will bring differences on community behaviors. This helped the research to obtain cross-sectional data from different communities with diverse settings. The research believed that it would have been better to include more sample, however, due to time, finance and manageability of data, the research limited itself to six *kebeles* only.

To pick the three kebeles in each category, the researcher selected those kebeles which have a high maternal and child mortality rate based on the Woreda's annual health report. Moreover, to elicit adequate data, six FGDs were formed by taking participants from the group formally called one-to-five. Every one-to-five group was nominated for FGD participation for their relative engagement in health extension program.

3.4 Data collection method

In this research, the researcher used document analysis, participant observation, in-depth interviews and focus group discussion (FDG). The researcher has tried to closely study the

materials (magazines, brochures, posters, and annual reports) and methods like practical demonstrations that the HEWs and the *Woreda* Health Bureau use to pass on messages aimed at changing the behavior of their target audience to save the children and the mothers' lives. In addition to this, in-depth individual interviews were carried out with experts like HEWs, and officials who are appointed in the health *Woreda* office. Moreover, the researcher has attempted to visit and make a participant observation while moving each *kebeles* that are selected for this study.

3.4.1 Document analysis

Document analysis is a form of qualitative research in which documents are interpreted by the researcher to give voice and meaning to the topic (Hansen, A., *et al*., 1998). Analyzing documents incorporates content into themes similar to how focus group or interview transcripts are analyzed. So, the researcher critically examined the *Woreda* documents to study how effective their communication strategy was.

These documents were public records and physical evidences: in public recodes, official, ongoing records of health extension program, activities mission statements, annual reports of Baso liben Woreda, manuals of FMOH (2007) at the Federal level, handbooks and strategic plans, were included. Whereas, physical evidence were physical objects found within the health post centers.

3.4.2 Focus groups discussion (FDG)

FDGs involved small groups selected from a wider population and sampled through open discussion. These are employed to collect data from the health 'army' group structures, which

are called One-to-Five groups. The aim here is to gather information about the perception on the structure and to see its functionality**.**

The researcher took with the discussion guides that contained already prepared open-ended questions. In the discussions, the researcher worked as a facilitator to help participants of the group (One to Five) when they were expressing their ideas.

For this method the researcher brought together the small number of subjects who were previously formed by the health extension program which is commonly called 'one- to- five'. The group size is kept deliberately as it is, so that its members do not feel intimidated but can express opinions freely. There were six focus group discussions from the selected kebeles. A topic guide to aid discussion is prepared beforehand and the researcher usually 'chaired' the group, to ensure that a range of aspects of the topic are explored. The discussion happen with using tape-recorder then transcribed and analyzed. The researcher also used group workshops to generate data. Brainstorming techniques were used to explore the 'ideal' care giving situation. The places where the focus group discussions were conducted include the community meeting areas (shades of trees), health posts and the open areas near the homes of the leaders of the 'one-to-five'.

3.4.3 Interviewing

The qualitative technique (both semi-structured and unstructured interviewing) involved in this research gathered in-depth, detailed information from individuals who understand the phenomenon and can express from their perspectives. Lincoln and Guba (1994:245) say that qualitative research involves the production of knowledge, not its discovery.

The qualitative research interview seeks to describe and the meanings of central themes in the life world of the subjects. The main task in interviewing is to understand the meaning of what the interviewees say (Kvale, 1997).

Thus, the interviews with participants help to obtain this knowledge in combination with interviewees to produce knowledge about their communication situations in order to help gain understanding from both of our perspectives.

Therefore, the researcher used unstructured and semi-structured interviews so as to gather the data from the purposively selected population. It is proper to employ this interviewing technique to explore communication strategies' and interpersonal relationships through the perceptions of child and maternal mortality from health extension program.

Interviews use the same principle as a focus group, but subjects are interviewed individually, ideally in the patient's own home and health post. The researcher encouraged subjects to express their views. This method is particularly a useful technique for the critical incident study, in which subjects were asked to comment on real events rather than giving generalizations. This can reveal more of the beliefs, attitudes, and behavior of informants. The researcher may be able to obtain more detailed information for each subject, but loses the richness that can arise in a group in which people debate issues and exchange views.

So, for this in-depth interview, the researcher included three *Woreda* Health sector officers by taking their relevancy, six health extension workers, and Women from the FDGs. The three Woreda health officers are selected because they are the higher official working with the Woreda Health program and the researcher believed they would provide a more in-depth explanation about the area. The six particular health extension workers are selected because they are the

professionals implementing the program in that specific area. Those professionals are lastly working with the 'one-to-five' groups the researcher arranged for FGDs. The women were selected due to the reason that the selected women were active participants that the researcher believed they would express their feelings in an outgoing manner.

3.4.4 Participant observation

The data were collected by a participant observer; in the participation, the researcher immersed in or become part of the population being studied so that he could develop a detailed understanding of the values and beliefs held by members of the population.

Several occasions were observed in *Baso liben Woreda* that could enrich the data of the study. A list of observations the researcher specifically looking for is prepared before-hand. Other times, the observer makes notes about anything he observes for the analysis later.

The researcher would use observation to gather data about how value judgments made by health extension workers and the community can have an impact on decision making. In this study, the researcher acts as a participant observer and he observed health extension workers report on evaluating the performance of the annual plan within six months for about four days. There is also researcher observation in the focus group discussion how the participants express their idea freely, there was attending evaluation health extension works in six month report for about four days report.

3.5 Data presentation and analysis

The data mainly collected through qualitative data collection techniques. First all the data were transcribed since the majority of data were gathered using tape-recording and collection of written documents. After that, the relevant data were categorized so as to arrange them for analysis. The categorization is normally made based on their application to the essential ideas of the research questions raised in this study. Finally, all the data were arranged logically and according to the conceptual and theoretical framework of the study and with respect to the central research questions. The central research questions, as indicated in chapter one, are–what communication strategies are used by the health extension program to reduce child and maternal mortality and how those communication processes allow community participation.

Chapter Four

4. Data Presentation and Analysis

This chapter basically deals with the presentation and analysis of data from the perspective of health communication theories and practice at grass root level. Qualitative methodology is used in the study to analyze documents, participant observation, focus group discussions and in-depth interviews.

This chapter incorporates communication strategies employed to create awareness in the community about maternal and child mortality including interpersonal communication, group communication, and health army communication with the group one-to-five and mediated communication. It also assesses the communication between HEWs and other stakeholders, the role of the community in the communication process and cultural factors within the community that could constrain the health extension program.

4.1. Communication strategies employed to create awareness about maternal and child mortality

Communication plays a vital role in providing knowledge and changing people's attitude and also it initiates and accelerates changes that are already underway as well as in reinforcing and supporting the change that has occurred. Effective communication offers guidelines in supporting policies, positive legislation and increased resource allocation.

While the focus of this research is maternal and child mortality and the overall aim of HEP is to bring change in the whole community. This brings the fact that community based communication for the purpose of health service deliveries tends to take place in the wider community setting i.e.

in a group basis. According to FMOH (2007), health providers, HEWs communicate with community in many ways and at various levels of intensity by taking individual households as the basic area of involvement. In the documents, interviews, focus group discussions and participant observations understood that most common communication strategies that are used by extension workers are interpersonal, team education method and media communication.

4.1.1 Interpersonal Communication

The majority of the rural community has no access to the existing mass media like Television and Radio; therefore, interpersonal communication and optional kind of strategies.

Running series of trainings and administering health related consultations, the health extension workers are trained to become health facilitators in community where they are assigned. The weekly training conducted in the form of learning circles helps to raising awareness and the health army group become community-based change agents. As a result, health extension workers are health promoters and communicators. With this process chain, HEWs trained selective health army group as model families that easily understand and teach other share of the community. Such methods are done using interpersonal communication as a major tool. In relation to interpersonal communication, the health extension workers from *kebele* four stated that;

> Teaching female is considered as teaching the community, so to change each individual women's community I was obliged to communicate them separately with face to face interaction and trying to create awareness them for long life of their family, even most of the time. I was not effectively communicating the community while they are coming as group since they want to keep their

> problems secret in their cultural context. Because of this, I was trying to talk to them separately in my office and also at their home. I followed this approach hoping to keep their interest so as to get detail and extra information about their problems.

Those from the Focus group discussion in *kebele* two agree; one Participant pointed out that, communicating interpersonally had helped them to privilege the occasion to forward the questions that when something wrong in their family discussion.

This distribute the idea of Rubin, etal, (1988) when we are designing health messages, we need to focus on effective interpersonal message strategies that will prove effective with the unique complexities and barriers patients and their family members often face.

Even though there is no appropriate respect for the HEWs from the community as a beginning the health extension program, interpersonal communication appeared crystal clear that all the interviewed key informants of both community and from the health extension category were satisfied by the interpersonal type of communication channel. In the same way, the majority of FGD respondents in both groups were absorbed in interpersonal communication with health extension workers and it has been employed to promote the program of reducing maternal and child mortality.

4.1.2 Door to door communication

According to the head of woreda health officer and also the (FMOH, 2007) argued that, the basic philosophy of the HEP is to transfer ownership and responsibility for maintaining their own health to individual households by providing health knowledge and skills. Health extension workers spend 75 percent of their time visiting families in their homes and performing outreach

activities in the community. The house-to-house activity starts by identifying households that can be used as role models. These households have earned the respect and credibility of the community because of their extraordinary performance in other social and economical aspects, such as agricultural production. They are also willing to teach other communities upon completion of the training and have the capability to persuade and convince other households to adopt new and innovative health practices. The model households are considered as fast adopters of health practices in line with heath extension packages. They play a key role in diffusing health messages which in turn leads to the adoption of the desired practices and behaviors by the rest of the community.

On the other hand, from *kebele* three health extension workers pointed out that people these days look for health services during door to door orientation and they actively participate in village health promotions. If they do not manage to see them in the outreach door to door program, the observation confirms this as one health extension working formed some of them are go to their homes asking for demanding health related training and orientation. I witness a real eagerness in the people to get consulted about their health.

On the contrary, another health HEWs from kebele six argued that, their door to door movement constraint them to some problems at times of health education program.

> Visiting the door to door takes a lot of time and the problem is that, as health extension workers, we do what we can because to visit the houses, we need a lot of time and that is something we do not have. Even if we were paid as a community health worker for what we do, then we couldn't cover everything, but we don't have choice to omit any kebele (HEW, from kebele five).

Even though the motivation to serve the needs of the community exists, all health extension workers are often too limited by time in what they are able to realistically accomplish. Since the job is huge and demanding responsibility, it is also often difficult to be accomplished by one person. In this regard, they indicated that there is lack of health extension workers in the communities.

On the other hand from the community point of view, one of the interviewee who was a member of the health 'army' group traces the importance of door to door communication as follows;

> I like door to door movement of health extension workers. They explaine and tell us about HEP in relation to what we have to do during pregnancy and health 'army' group for my families especially for my husband. When health education and community conversation sessions are organized, the message is passed through me and my friends. We are representatives of people in the village. Prior communication occurs between us before any health service reaches my family, but finally those health extension workers persuade our family while they are visiting us (HEW, from kebele six).

Similarly a woman from focus group five pointed out the same idea;

> Before the health extension workers moved door to door I was doing hard work in time of my pregnancy and I was tired , but now through door to door, HEWs aware my husband how hard working during the pregnancy is harmful. As a result I am not forced to work hard as I used to.

This shows that door to door communication, getting communities' confidence by those members of health 'army' groups as a result of strong social capital owed to persuade their husbands and also their families. In addition to what has been said so far, the preference to and appreciation of health extension workers may also be related to the fact that most women prefer to give birth at home since they can't access transportation and that can't easy get medical treatment easily. But behind this the health extension workers has pessimistic attitude that they can't cover every part of the *kebele* within the given period of time.

But on the contrary the researcher observes that there could be indicative of unfavorable relation of women with their husband opposing what they do with HEWs. Due to this, women need HEWs to persuade their family by moving to door to door.

4.1.3 The team education method

This communication strategy once structured the community in a group which called one-to-five having a total six women in number in a single group. The communities provide their input and the health extension workers make the final decision.

Most of the time illiteracy is one of the main problems of rural women which in turn constrain to teach and make them to understand within a short period of time, causes a huge problem to communicate by using print media and leaflets especially within the *Qola* audiences. It has an influence on women's awareness creation and to bring societal attitude change.

According to the *woreda* health officer this structure was formed, as he replied, where the minimum requirements were met such as five and thirty in number. In other words once the minimum requirements are met, the group would have one representative for each one-to-five group that are short-listed and presented to the entire community and then they vote on that.

With an attempt to know how team communication and HEWs work together, interviews with HEWs sessions revealed that there is co-working between the community and the structures. A health extension worker from *kebele* four describes the group work this way;

> We work with one-to-five group in counseling pregnant mothers. We provide them different materials that can be used for teaching- learning; we teach them if any wrong happens to discuss. We co-educate pregnant women. They are helpful in encouraging women to seek them in health posts or health centers. We do all this because there is constructive and rewarding interaction between us.

On the contrary to HEWs, from the community's perspective of FGD participants show that there is some level of cooperation and good interaction between HEWs and both the developmental health army and one to five group. Most of the participants of FGDs rejected that team communication is waste of time in attending group meeting.

But in the other case regarding team communication, one of the health extension workers puts she facing a wrong story, since vaccination helps to prevent childhood diseases or weaken their severity, children should be taken to health facilities to get their vaccination on time, and unfortunately as soon as takes vaccination one baby died for unknown problems. Starting from that time their team communication group argues that nobody is interested to her to vaccinate a child and she stays for about two months without any child vaccination. Finally she enforced to change her health post *kebele* to other to get the community credibility.

On the other hand from the discussions the researcher had with them, it was indicated that there is team graduate communication, these are persuasive communication strategies when they show celebration with certificate award for those who fulfill the package strategy and they take white

flag from the *woreda* health officers. And those who did not do their assignment given by health extension workers will get black color flag which shows them as they are doing something not satisfactory.

According to Servaes (1995) and Veneklassen (1990), in participatory communication, there should be a process of raising consciousness and deep understanding about social reality, problems and solutions; rather than persuasion for short-term behavioral changes those are only sustainable with continuous campaigns. However, in the case of Baso liben woreda the health extension workers perused the community with exclusion of their interest and agreement.

All these are solid proofs that the health extension workers are providing different information using different methods and styles which will be instrumental in getting people aware about the prevention mechanisms and on how to be treated while they are caught by diseases. In addition to creating awareness, this type of stage will play an important role in creating competition among people so as to take care of them.

4.1.4 The Mass media

According to the document written by regional bureau, there is a family planning magazine which is published in Amharic language. The magazine features Family planning services and the health of children and mothers. The objective of the magazine is intended to raise awareness about problems women are facing during pregnancy and about child issues in the society.

One of the interviewed *woreda* officer says;

> We distribute the magazine for *woreda* offices, sector offices, different women associations and gender clubs, community libraries and NGOs. The main goal is

> to raise awareness through showing stages of birth cycle by pictures and indicate ways of empowerment by presenting what women should do during pregnancy. The target group for the magazine is mostly pregnant women; however since they are illiterate most of the rural community cannot read in turn only focus on the given pictures.

Therefore, issues like illiteracy and limited accessibility adversely affect its distribution. The health extension workers use the magazine to inform opinion leaders (they called them religious leaders) and to motivate them to further communicate and channel the information in the magazine to other women. This means that the information in this case reaches the public indirectly via the opinion leaders and it shows how communication messages can travel in two ways. This is an indication of how the health extension workers are giving attention to the opinion leaders who in turn plays inevitable role in spreading information to the rest of the community. In this contemporary world especially in developing countries where the mass of the people resides in rural areas, opinion leaders are more acceptable and heard than other community manuals.

Focus group discussion from kebele six women's mentioned that;

> Family planning magazine is making women to discuss about what they see in the society and encourages them to take a look at the importance of attending health extension program through women's eyes. The magazine is considered as an empowering and eye-opening medium. Mostly, this is done through picture presenting. The females are called for social change and preaching new perspectives about women's issues in the child and maternal mortality via picture.

Even through, family magazine is an eye-opening medium for the rural community, the researcher observed that people perceived as passive receivers of information and behavioral instructions, while others make decisions on their lives.

As the woreda health office manual (2012) indicated, in addition to this, health extension program distribute different types of publications similar to brochures that are provided by different NGOs like MASH, Alma L-thinking and Entrance. Those NGOs are involved in maternal and child health program of Amhara region. The brochures have picture expressions which are represented to be easily understood by the rural community. But according to the HEWs supervisors who are assigned at Alma L-thinking, the communication strategies are not really understood by the mass public because most of the time this rural *Woreda* people are illiterate and cannot consume print media output.

Additionally, one interviewee respondent from *kebele* three added that radio is more important than other media outlets. She says that she always listens to the Ethiopian radio health program and share the ideas related to child and maternal mortality issues with her parents and community.

Fig 4.1 Pregnant women help each other by looking through the family Planning Magazine about what they should do each stage of pregnancy.

4.2 Communications between health extension workers and other stakeholders

Although the health post is the place which is considered as the center for most of the health activities, it is believed that effective service under HEP is delivered through the participation of different organizations. Accordingly, one of the points this study initially aspired to explore is to find out the nature of communication between HEWs and stakeholders of the various hierarchies (particularly with health centers, *kebele* administration, supervisors at *kebele* level and *woreda* coordinator). Some results were obtained from the interviews with HEWs and key informants which indicated that the overall interaction among these stakeholders is weak.

When the researcher asks how they describe their interaction and coordination among themselves, HEWs from *kebele* four replied that they have no strong link with health centers and woreda officer's only through their responsibility on them. Although the Woreda health officers,

the kebele leaders at large and the health system are the major stakeholders, the strategies for the success calls for coordinated action at all levels failed in supporting the HEWs.

As the community based program, HEP needs good coordination with various sectors. Most importantly, the document FMOH (2007) also emphasizes that the program needs strong partnership with local administration. The HEP brings the health sector to Kebele level, whereby the HEW represents health sector in the local administration.

Another HEW from kebele one pointed out that, elected members of the *Kebele*, agricultural development agents and teachers at the same *Kebele* constitute a *Kebele* council bringing administrators and sector specialists together. However, this was not what is witnessed in this particular study. The role of each stakeholder; the relationship of these cadres with other health workers at the community level, on career structure, transfer, and leave of absences are specifically described in the implementation guideline. In spite of all the descriptions, HEWs said that these are not applicable in the health extension program of interaction between HEWs and stakeholders found at the various hierarchies.

This was also confirmed by the woreda coordinator and kebele level supervisor when they said that their interaction with HEWs is not strong and interactive as it could be. In particular, HEWs were asked to describe their relation with *kebele* leaders and replied that *kebele* officials dictate them. They reported that k*ebele* leaders force them to disseminate political messages and other administrative duties rather than health related messages and orientations and preventive mechanisms. In principle, their major task is to create conducive environment for the rural community and providing health related trainings and consultations so as to promote preventive mechanism. HEWs complained that they are perceived not as health workers but as political

cadres by some *kebele* officials. And this leads to the community perception on us a political representative.

HEWs reported that the absence of strong bond has resulted for weak information exchange in time of reporting and health management. Further, HEWs have disclosed that visits by *woreda* coordinators and even regional level supervisors are untimely, sudden, irregular and not periodical. They said that they have no information about who comes to visit and when that visit takes place. All of them understood that this is negatively affecting their work by creating a feeling of frustration.

In general, the study shows the absence of established and coordinated interaction between HEWs and stakeholders at different levels on one hand; and the enforcement of extension workers to act in the interest of local administrators on the other hand. This recalls us that well coordinated interaction and communication among them is inevitable and significant if community health has to be addressed effectively and successfully.

But from the perspective of the Ministry of Health documents on FMOH (2007) reproductive health officers, One to five and health army is the structure that a participatory health communication strategy would greatly improve the approach towards reducing child and maternal mortality in the community and greatly improve the women's share to achieve. And this is the result of the stakeholders (the Woreda health officers and the kebele leaders) assisted the health extension worker.

The HEW from kebele four says that, health extension program should lead to the greater participation by the community in the process formed by the *woreda* health officer on health

extension program to ensure the community at grassroots level needs are truly encompassed in the child and maternal mortality package initiatives behind them.

The health extension workers argued that lateral communication should be assured between the *Woreda* health officers and the grassroots community. If people actively participate directly to the *woreda* health officer about any issues pertaining to them, frankly speaking, they will be benefited and their awareness standard will be improved. Accordingly, any communication strategy, therefore, has to be designed and implemented having in mind lateral and participatory communication.

4.3 Women's attitudes towards health 'Army' groups

The point of reference that women have put their attitude on the health army program is based on the tradition and culture of the society especially the place the women occupy in the community and women's attitude in the context of what they are thinking.

A respondent who is interviewed from FGD four health army groups says;

> In our family, men decided and, every activity is not done without their consent. If I try to hide something from him, he feels as if I am not real wife. But if you see the health extension program doesn't include men's participation in this group. Because of this always quarrel with him when we want to share ideas that we discussed in the group.

On the other hand, in the focus group discussion from group kebele three respondent expresses her attitude on health army group as follows;

> *To me i*t is not important participate in this health army group; it is only wasting time and energy because everything at home is in the hands of my husband. Even I can't use contraceptive method without his consent; I can't say anything without his approval.

Such attitude constraints the arguments of the participatory model, it stresses the importance of cultural identity of local communities and of democratization and participation at all levels international, national, local and individual. It points to a strategy, not merely inclusive of, but largely emanating from, the traditional receivers (Servaes, 1995).

Almost half of the respondent in focus group discussions and those who are members of the group showed a negative attitude and no appreciation of one to five health army groups as a result of only women are in the group.

Another participant argues that, it is not necessary to form one to five health army groups, most of the time they waste their time without any thing. They all are the same, no one know anything that different from one another and it might be important to share ideas that someone else has different idea in relation to maternal and child mortality. She also added that the health extension workers also have no interest in the group structure. But since the *Woreda* officers forced to write them a report simply formed them. Finally when she pointed that she gets from FGD "The advantage that I got from the health extension program is about ignoring what is believed in witchcraft, and also early marriage is the number one."

Both the Focus group discussion and the interviewee respondents particularly stressed that they waste their time them of thinking and behaving as what the health extension workers said watch

what is being exhibited on the discussion and interpret it according to what happens in their communities.

When one interview respondent from *kebele* four expresses her attitudes of one to five army groups;

> of course I am attending the meeting once starting from the time we established the group, I don't know who formed the group, but the kebele leader tell me as I a m representative of the group and if I am absent from that group discussion, I will pay ten birr. So, in order not to be punished with that amount of money, I am obliged to attend the group meetings.

This practices opposes the idea of participatory model incorporates the concepts in the emerging framework of multiplicity. It stresses the importance of cultural identity of local communities and of democratization and participation at all levels international, national, local and individual.

On the other hand, Participants of the FGD and various interview sessions revealed- that those health army groups are acting as a bridge between HEWs and the community which could shed light on the effectiveness of the program. One of the interviewees who were also Health army groups said:

> At the beginning on our meeting child and maternal mortality was our issue; the people were introduced and told about HEWs by Health army groups' leader of the kebele and Woreda officials. At the end of the meeting they were told us to organized health education and community conversation sessions, the message is passed over through me and others having the same work division. We are

representatives of people in the village. Prior communication occurs between us before any health service reaches the people.

Generally these gender based group structure raises negative attitude from the communities' knowledge, beliefs and attitudes. And the communication messages and interventions that are used by health extension program is reinforce existing beliefs and social norms or ultimately establish new beliefs, attitudes and social norms that women cannot do anything without the interest of their husband. Because of this health extension workers are not effectively communicating the person which in turn adversely affects the understanding and acceptance of new behaviors as well as revised gender perspectives. Including gender concerns in this communication program makes the messages not to be effectively communicated. Additionally, when the structure is formed the concerned body does not communicate the group members and the group members are not introduced and oriented about the aim of creating such group.

Similar to the findings of this study, the research in Malawi also shows that social norms related to social identities influence on health promotion and the cultural context reveals a major disjuncture between the health program and the culture of Malawi community.

What the researcher understood in this *Woreda* community has no sense of ownership over its group structure of army group; it also has perception of the agenda on them that simply imposed from the outside of the health extension workers.

This community perception can be constructed to the ideas of Clarke who pointed that, the participatory approach is to establish active citizenship, a sense of empowerment, partnership, accountability and ownership. All of these concepts and attributes are linked and are

complimentary. Without active citizenship and community participation, a sense of ownership over the development process cannot be achieved (Clarke, 2009).

Additionally, the researcher observed that health extension program does not make gender analysis in the context of participatory development before the program functionalize; gender analysis helps to understand how gender differences affect access to resources and the participation of women in development activities. Such an analysis would help them to take appropriate measures to ensure that men's are not excluded. Ideally, gender analysis should not be a separate participatory method but should be integral to all participatory methods.

4.4 Expectations about HEWs: The need for curative service

HEWs are primarily required to give primary health services by focusing on the individual family. In the document of FMOH (2007), the following definition was given. The definition shows that the primary goal of the program is to focus on health promotion and prevention. It was defined as:

> A package of basic and essential preventive and selected high impact curative health services targeting households. HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facilities.

From the above definition we can understand that, the program should focus on preventive and promoting packages. In addition, a curative service on the most prevalent diseases was also incorporated. Participants of this particular study indicated that clients are not getting access to curative health services as expected; even services on high impact diseases like malaria and diarrhea were reported as inefficient.

Interviews and FGD sessions uncovered that there is a gap between what people expect from HEWs and what is being provided. The community expects curative services like what is given in the health centers and hospitals. Participants reported that extension workers' role is limited and are considered deficient in the delivery of curative health services like the treatment of the sick. It was said that the beneficiaries are dissatisfied because of the gap in expectation which in turn brought for the gradual decline in acceptance. One of the key informants from kebele three HEW said that;

> It is obvious that people do expect a lot. As these rural communities live far from the nearest health facility, they need the treatment for most prevalent diseases like diarrhea. HEWs are also expected to render services like TB treatment. Theoretically HEWs are responsible to address such issues through prevention. But people need the curative service. Additional trainings were given to selected extension workers. Currently, however, HEWs provide treatment, but only of febrile diseases (mostly malaria) which itself is inefficient. They could address other diseases if continuous trainings had been given. There have been such efforts though it is not enough. I hope the people will benefit from additional services after some time.

The *Woreda* reproductive health officer argues that, people actually need extension workers to attend the sick. He feels that sufficient work is not done as the main goal was to focus on the preventive aspect. Accordingly, he revealed that some necessary conditions are being done to enhance the capacity of HEWs to make them ready to respond for the curative service clients expect.

The expectation of the people was also found to be different from place to place. Compared to less remote areas, in more remote *kebeles,* there were higher expectations too. A HEW, working in one of the remote *kebele,* underscored that some even tend to call them 'Doctor' and expect higher level medical services. She said this is not surprising to her as she know that people also used to call individuals who are known in those areas for customarily bringing drugs from urban areas (for sale to the people with profit) with the same name-'Doctor'. The researcher asked if the community was initially told who HEWs are and what their distinct service is. She said that such exaggerated expectation is the consequence of high value and expert position the clients have for HEWs. For this, she traces the source of the problem to the time of initial orientation about HEWs and blames responsible bodies.

Here is what she said:

> First of all, the people have no clear understanding of who HEWs are. We, HEWs are assigned here to provide primary health care (more on prevention than curing), but the community has no clear image of what is expected from us. The problem is that sufficient orientation was not given initially. As a result the people have no clear knowledge of what a HEW is entitled to do. It is wrong to blame the people. Responsible bodies have not carried out their task properly. The community should have been told clearly what the primary purpose of the overall program is.

The FGD participants also identified that people need from HEWs not only health education but also direct medical assistance to the sick in terms of drugs and injections. Going through very elementary and/or inefficient training and being only a grade ten complete; it might be difficult

for HEWs to provide what a junior nurse performs, let alone what a medical doctor does. Generally, what the interviews and FGD sessions revealed is that the gap between people's expectation and what the HEWs are providing, created a greater dissatisfaction which contributed for the gradual loss of acceptance in the community.

4.5 Communities perception about health extension workers

The effectiveness of interpersonal communication often relies on the communicator's perceived attitudes towards each other. This perception determines the power balance and communicative behavior. Therefore, when perception is affected negatively, it apparently affects the effectiveness of the communication.

The community in this group has both positive and negative attitudes on the health extension workers. From *kebele* three the interview respondents stated that,

> **"***Health extension workers are like bats."* You know bats are disease transmitters and since, they are coming in the night no one can't catch them because of the darkness. Health extension workers are also coming to us when somebody, (woreda health officer, Zone health officers….) asks them to write a report or when they want to visit what are doing. This is the only option that the health extension workers they are going to the rural communities.

Analogous to the above argument another women's interview respondent from *kebele* five also added that,

> *"Health extension workers are like welcoming cloth"*. This implies that health extension worker are selected from their own *kebele* those students who drop

> from grade ten and unable to pursue preparatory class. Before they were gone to the training centers they were wearing cloth like us. But after they were back they simply change their cloth, nothing is added on them. From all these we can understand that the educational quality of the health extension practitioners is under question mark which adversely affects their quality of work.

In this regard also shares from his participant observation, all the concerned bodies including the government, society, stakeholders and the health extension workers themselves has to contribute their share for the improvement of this sector by producing qualified health extension workers.

The improvement of health extension education is probably the most important question that all HEWs have to be addressed as quickly as possible. But it found that this is negatively affecting the motivation, commitment and accountability of the community not given respect. They ascertained that this is creating a feeling of reluctance among them which seems threat to continue of HEP program. Because of this, the data indicated that more than twenty-one HEWs left from this profession starting to the HEP program were launched.

But in case of the head of *Woreda* health officer's attitude towards health extension program, being a female is an important attribute. As women in service, they understand the challenge that women have to go through in *woreda*, so there is this strong desire to support their fellow citizens. He pointed out that maternal and child Health is strongly linked with having a robust health system and if the health extension workers are part of that system, as women themselves, and it is sure that they would be able to support the women in the community.

On the contrary to the community's perception the reproductive health officer pointed out that the health extension worker has to be selected from the community where they are assigned to

serve. Being a member of that community is also a strong motivator to support their relatives, their family members, and their neighborhood.

He also added that language and cultural understanding is very important. If you bring in someone else from another ethnic group cultural difference and deploy them in those areas, it won't work. Being able to effectively communicate using the local language is important and this has to be given due attention.

What the researcher understand, there is two divergent thoughts between the communities perception and the *woreda* health officers on HEWs. The officers' argument is the Guide line documents (FMOH, 2007) that everything they did is the same to the documents.

4.6 The role of the community in the communication process

Health extension workers are placed to play an important role in enhancing the program' effectiveness with special contributions they have rendered to communities and mother-child activities have been critical to increase workers' performance since they address everybody within a given period of time (FMOH, 2007).

One of the interviewed *kebele* four health extension workers stated that, one contribution made by the community members was constructing the health posts where the health extension workers are based. The way the construction was done is that the government has provided materials that are not easily available at the community level, like corrugated iron sheets, nails, cement, and these types of things that need to be bought elsewhere are provided by the government to the community. However, the community contributes their time and energy in constructing those health posts. So, that they have played a very important role.

Another woman's from FGDs in *kebele* six stated that;

> In our *kebele* there was a structure formed that the community have what they call health committees in every village and these health committees have representatives from the elderly, respected individuals within the same village, women, religious leaders and so on. So, they provide the oversight to the health extension workers on what to be done and how it should be done, but this as in orally that we cannot see it in practical.

The health extension workers engage these village health committees throughout the planning process as well. So when she sets her targets on how many and what type of services she is going to provide over the years and what targets she needs to achieve, she will consult with the health committees and she will definitely use them to mobilize the community as well.

On the other hand from the from the FDG perspective they pointed out that, they constructed residential houses for the health extension workers, so that they live in the same premises as the health posts and are available 24/7 to provide services. That was also an important contribution by the community. Constructing residential houses for the health extension works near where they are working will create favorable working conditions and saves the workers from spending their extra money and time. Take part in construction building is understood by the health extension worker and also *woreda* officers as there is a community participation.

But the interviewed women when they came at health post in collaboration with participant observation revealed that the major function the communities in the structured group is like sponge only absorbing what health extension workers are said.

This line up with the idea of Pretty et.al, (1995) Participation for material incentives that People participates by providing resources, for example labor, in return for food, cash or other material incentives. Much on-farm research falls into this category, as farmers provide the fields but are not involved in the experimentation of the process of learning. It is very common to see this called participation; people have no stake in prolonging activities when the incentives end.

But in relation to their communication in the issue of maternal and child mortality FGD argues that, they have no role, they are doing what the HEWs orders. Primarily the communities participate by being informed about what is going to happen or has already happened. Community's feedback is non- existent, and their participation is assessed through methods like hand counting and contribution to the discussion. This participation is similar to Mefalopulos and Tufte (2009) referred to as participation by information or passive participation (see 2.3.1).

4.7 Communication strategies in assembling participation and changing behavior

Still perceptions of women are not changed about the importance of health extension program on changing their life of the community. From the FDGs participants one pointed out that,

> Most of the time the health extension workers teach us to use family planning methods in order to effectively cultivate our child healthfully. But while we are taking the contraceptive method, there are two major problems, those are either you become over fat or over thin and even it changes our behavior totally.

The respondents from Health extension workers stated, the FMOH (2007) stated that in order to make this package effective and successful, it is very important to involve communities starting from the planning stage and during implementation, monitoring and evaluation of the package. Nevertheless, before going into implementation, there is a need to promote the programs and

mobilize communities. Sensitization and orientation activities should be undertaken at public places, among farmers, women and youth associations, at religious places, market places, schools, civil society organizations such as *Idirs* (local association for helping someone who has lost his loved one) to raise their awareness about the package. But most of the respondents interviewed are looking these ideas in different way.

Additionally, health extension workers from *kebele* five stated that,

> Of course the *woreda* health officers trained us there should be community participation although the reverse is true in practical. Since our focus is preventions there should be active community participation at all stage of Planning, implementation, monitoring and evaluation, even if the truth is that no more community at large is participating except at the implementation stage doing ordered them from us.

As stated in the Literature Review, Yoon (2000) argues that allowing people to participate in the implementation, evaluation and decision-making processes concerning the health communication strategy, will empower them to benefit and will enable sustainable outcomes.

4.8. Communication barriers in the Mother-child program

4.8.1 Harmful traditional practices applied on children

A healthy society is created from healthy children. The children of today are the leaders and productive forces of tomorrow. The major causes of child and maternal mortality in *Baso liben woreda* are lack of education on the part of parents about child health care, and means of preventing diseases. Harmful traditional practices that are existed for a long period of time in the

society are and still applied on children and women. As the *woreda* health documents (2011) indicated, 75 percent of these *Woreda* females are married under the age of 18. Early marriage and early childbearing is common in *Baso liben Woreda.* The documents also showed that about 50% of females in *Baso linen Woreda* got married under the age of 15. From *kebele* three the health extension worker noted that once girls became pregnant, for instance, they were regarded as adults and the way the society views them changed. Besides the status, the girls or boys' parents' social status changed by virtue of becoming grandparents which was much valued in the society.

The focus group also noted that early marriage practices could increase the girls' vulnerability to different problems which are very common in this community. The increased prevalence of forced and early marriage was also reported in community radio which is located in *Debremarkos* city. Although most people acknowledged the complications associated with early child bearing due to early marriages, most communities did not act to control such threat.

4.8.2 Witchcraft

There are number of Witchcraft in *Baso liben*. However, there is nothing known about these medicines. As the health extension workers from *kebele* three pointed out the number of children who died due to these medicines is not small. Therefore, it is known in *Baso liben woreda* that giving traditional medicines to their children, whose efficiency is not yet known, is dangerous.

Health extension from *kebele* four explained that not only the community but also *kebele* officials, leaders and the people at large believe witch crafting and they are strongly using their ideas and suggestions.

They have realized that close follow up and promotion by local leaders to stop witch crafting traditions and those needed further strengthening their knowledge about its risks should be improved. But it is difficult to say that there is visible coordination among the community between .This needs rethinking about the risk and consequence of that bad practice. At *kebele* level, efforts are being made to mobilize community organizations like *Idirs*, churches and mosques to make them more supportive and encourage them to know the bad habit of witch crafting.

Behind the above cultural communication problems in the interviews with HEWs and the Woreda health officer as well as from FGD pointed out the following.

- **Facilities:** In this regard, HEWs informants put poor transportation and communication as the most important barrier. They ascertained that facility induced problems have resulted in irregular stakeholder interaction, particularly among the providers.

- **Social mobilization skill:** The focus group informants have admitted that HEWs lack the initiation and have no well developed knowhow on how to mobilize the *kebele* community. As a result, they have no ability of mobilizing the community for health activities. It is said that this limited their ability to establish instrumental rapport with their clients which is the most important prerequisite for social interaction.
- **Social influences and networks:** HEWs explained that there are no positive social environments that encourage their work. People's perception, attitude and value to their activities are declining through time. They said that the support they used to enjoy is not as strong as it used to be. Generally, HEWs reported that the overall social environment is becoming boring for the reason which they did not actually know.

- **Limited support from the leadership:** According to HEWs, the local administrators, higher officials in the *woreda* and community leaders are reluctant to work with them. However, they indicated that local government bodies possess significant authority that enables them to promote the recognition of HEWs.

Chapter Five

5. Conclusions and Recommendations

This research has explored communication strategies, and particularly community participation, in the Health Extension Program to reduce chid and maternal mortality in the rural areas of Amhara region by taking *Baso liben* as a case study.

It has specified meticulous attention to explore strategies of health communication program and whether there is community participation or not. This chapter squashing up by presenting the general idea of the findings and, based on them, listing down what has to be carried out in the future for the sake of rectification of the health extension program on the issue of mother and child mortality.

5.1 Conclusions

With regard to communication strategies used by the health extension workers mainly depends on interpersonal communication, door to door communication and team communication. Among those methods of communication, interpersonal communication has a better acceptance by the community and the health extension workes. In relation to door to door communication, the people are mainly informed that it is not that communications direct advantage but it will give the opportunity for the health extension workers to get the husbands directly. Contrary to this, in this door to door communication, it is difficult for the health extension practitioners to reach each individual's home.

The health related structures which are created for women are not effective; they do not match with the community's culture and belief. Rather than solving the communities health related

problems, these structural organizations create misunderstanding and dispute among the family members. As per the structure, the wife does not perform any actions without her husband's good will and permission. Even if such structures mainly consist of women, these women who get such skills and knowledge from the health extension practitioners are not able to employ the information without the consent of their husbands.

The communities' attitude towards the health extension workers is more or less not positive. This is because the communities' original perception about the health extension workers greatly differs from those who assigned to work with the community. Accordingly, the extension workers are usually engaged in writing reports to their bosses. The reason why they are not successful in their practical performance is that almost all of them are those who are drop outs from grade ten. This situation seems to have pushed the community to believe that they do not have the appropriate knowledge and skills for the job. This adversely affects the success of the health extension program.

There is no clear understanding between the health extension structure and the communities. This means the communities perceive the health extension structures as something that stand for political purposes rather than for health related issues.

Confrontation with traditional healers in the HEP; expectation of clients for more curative service; involvement of HEWs in political activities; and the effect of 'time' were considered the major factors. The combination of these factors has certainly affected the credit and relevance to health services of HEWs.

According to the policy documents and other others, the Ministry of Health recommends the implementation of a participative development process. However, the concerned health workers

are not able to employ this method and they usually resort to the top-down style of communication.

5.2 Recommendation

When the government approved the health extension program, 75% is based on prevention mechanisms. Accordingly, to achieve this mission, assigning skillful and knowledgeable health extension workers in the sector is of paramount importance. Especially those professionals who satisfy the needs of the community and those who have similar culture and belief are likely to be effective; so, attention has to be given to this issue of the selection of health workers who are qualified and who are familiar and have good understanding the culture of the community.

With regard to the structure, there should be a clear idea and procedure on how to work with it. This does mean that the community always perceives the structure as a political tool other than its formal purpose - that is serving the community as a preventive health set up. It is important for development community to know why the time and efforts would be spent on programs that are not compatible with bringing about development.

Health army group based on gender should be restructured to include both sexes because this is likely to help develop men's awareness that might help communities find culturally appropriate ways to change existing beliefs, attitudes and social norms that restrict gender equity and equality. The development of the framework for communication particularly takes under consideration the gender-related factors that influence the child and mother mortality reducing program.

The planning on the health extension program should be based on identifiable purposes by the community members in order for them to be accepted and implemented as recommended.

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Appendix 1

Interview questions for both Woreda Health officers and the Health Extension Workers

1. What the role of Health Exertions program?
2. What kinds of communications strategies have you been used to reduce child and maternal mortality in the Health Extension program?
3. Are there active stakeholders of audiences to address?
4. What is their respective role in the communication process?
5. What kind of Persuasive communication techniques are you used in the health extension program for addressing the issue of child and maternal mortality for rural community?
6. Have you used a media for this program? If you have been used what kind media?
7. What can the community do to address the issue of child and maternal mortality?
8. What can the Medical Professionals do to address the issues of child and maternal mortality?
9. Are the Health Extension Workers capable in communication strategy?
10. What are the cultural factors within the community were deterrents to effectively addressing child and maternal mortality?
11. How can solve those Cultural problems?
12. Is there community participating in the designing, implementation, evaluation process of Health communication?
13. Is there know the community change knowledge, attitudes, or behavior on the child and maternal mortality issues? Did it occur as a result of the one to five army programs?
14. Does the program achieve the intended goal?

15. Can the changes in outcomes be explained by the program, or are they the result of some other factors occurring simultaneously?
16. Are successful Communication activities in child and Maternal mortality being expanded to apply to other audiences or situations?

17. What were the major challenging problems in communicating the community about the issue of child and maternal mortality?

18. What kind of relation do you have between the community and you?

19. Who developed communication strategy (individual, the community or involvement of communication specialist)?
20. Was there any research done to ascertain what would work in such a strategy?
21. Can you please describe your view of the current communication process between the Health Extension program and the community with regard to the child and maternal mortality?
22. What would you say that the Health Extension program had any successes (if any) with the current communication strategy used?

Appendix 2

Points for focus group discussion

1. What is child and maternal mortality means?
2. What are the basic causes for child and maternal mortality?
3. How do you know that cause for child and maternal Mortality?
4. Is there child and maternal mortality in your Kebele? How can solve it?
5. What is the important of, this one- five group for child and maternal mortality?
6. Did you get vocational training by Health officer trainers of this program?
7. How did you learn or come to know about the one to five health Extension program group?
8. What Motivate you want to join in the one to five groups?
9. As a one to five member, in what kind of activities do you participate?
10. In what ways do you participate in changing the conditions in your village related to child and maternal mortality?
11. Does your tradition allow are such kind for solution to avoid child and maternal mortality?
12. What recommendations can you present to improve this Health Extension Program?
13. How does your group member usually exchange information?
14. How far your communication approaches were culturally appropriate?

Appendix 1

የቃል ጥያቄዎች ለወረዳ የጤና ባለሙያዎች እና ለጤና ኤክስቴንሽን ሠራተኞች

1. የጤና ኤክቴንሽን ፕሮግራም ሚና ምንድን ነው
2. በጠናው የኤክስቴሽን ፕሮግራም የእናቶችንና የህፃናትን ሞት ለመቀነስ ምን አይነት የኮሙዩኒኬሽን እስትራቴጂዎችን ትጠቀማላችሁ?
3. ጉዳዩን ለማከናወን ንቁ ባለድርሻ አካላት አሉ?
4. በኮሙቶኒኬሽኑ ሂደት የእያንዳንዳቸው ሚና ምንድን ነው?
5. በገጠር አካባቢ የሚኖሩ እናቶችን እና ህፃናትን ሞት ለመቀነስ ምን አይነት የኮሙቶኒኬሽን ስልቶችን ትጠቀማላችሁ?
6. ለዚሁ ፕሮግራም ሚዲያ ተጠቅማችሁ ታውቃላችሁ ተጠቅማችሁ የምታውቁ ከሆነ ምን አይነት ሚዲያ?
7. የእናቶችን እና የህፃናትን ሞት በተመለከተ ህብረተሠቡ ምን መሰራት ይችላል?
8. የእናቶችን እና የህፃናትን ሞት በተመለከተ የሚዲያ ባለሙያዎች ምን ማድረግ ይችላሉ?
9. የጤና ኤክስቴንሽን ባለሙያዎች የኮሙዩነሄኬሽን እስትራቴጅ ከህሎት አላቸው?
10. እናቶችንና የህፃናትን ሞት ለመቀነስ እንደ ተግዳሮት የሚሆኑት በህብረተሠቡ ውስጥ ያሉት ባህሎች የትኞቹ ናቸው?
11. እነዚህን ባህላዊ መሠናሎቹ እንዴት ማወገድ ይቻላል?
12. የጤና ኮመዩኒኬሽኑን በማዘጋጀት፣ በመተግበሩ እና በመምሙ በኩል የህብረተሠቡ ተሣትፎ አለ?
13. ስለ እናቶች እና ህፃናት ሞት የህብረተሠቡ የባህሪ ነው፤ የአመለካከት እና የእውቀት ለውጥ አለ ካለ በአንድ ለአምስት ሠራዊት ፕሮግራም ምክንያት የመጣ ነው?
14. ፕሮግራሙ የታቀደለትን ግብ አሣክቷል?
15. ውጤታማ የኮሙዩኒኬሽን ክንውኖች እየተስፋፉ ነው?
16. ስለ እናቶች እና የህፃናት ሞት ህብረተሠቡን ኮሙዩኒኬት ለማድረግ የገጠሟችሁ ዋና ዋና ችግሮች የትኞቹ ናቸው?
17. በእናንተ እና በህብረተሠቡ መካከል ያለው ግንኙነት ምን አይነት ነው?
18. በኮሙዩኒኬሽን ስትራቴጂውን ክንዋ የሕብረተሰቡ ሚና ምንድን ነው?

19. በዚሁ ስትራቴጅ ምን መሠራት እንዳለበት የተሠራ ጥናት ነበረ?
20. የእናቶችንና የህፃናት ሞት በሚመለከት በአሁኑ ወቅት በህብረተሠቡ እና በጤና ኤክስቴንሽኑ መካከል ያለውን ኮሙዩኒኬሽን በእርስዎ አስተያየት ይገልፁልኛል?
21. አሁን ከምንጠቀሙበት የኮሙዩኒኬሽን እስትራቴጅ (ስልት) አንፃር የጤና ኤክስቴንሽን ፕሮግራም ውጤታማ ነው ማለት ይቻላል?

Appendix 2

Points for focus group discussion

1. የእናቶች እና የህፃናት ሞት ማለት ምን ማለት ነው?
2. ለእናቶች እና ለህፃናት ሞት ዋና ዋና ምክንያቶች የትኞቹ ናቸው?
3. እነዚህን ለእናቶች እና ለህፃናት ሞት ምክንያቶች መሆናቸውን እንዴት ማወቅ ይቻላል?
4. የእናቶች እና የህፃናት ሞት በቀበለያችሁ አለ?
5. እንዴት ማስወገድ ይቻላል?
6. የዚህ የአንድ ለአምስት ጥምረት ከእናቶች እና ህፃናት ሞት ገር በተያያዘ ያለው ጥቅም ምንድን ነው?
7. ትምህርታዊ ሥልጠና በዚሁ ፕሮግራም የጤና ባለሙያዎች ተሠጥቷቸኃል?
8. ስለ አንድ ለአምስት የጤና ኤክስቴንሽን ፕሮግራም እንዴት ነው የምታውቁት ወደም የምትማሩት?
9. አንድ ለአምስቱን ቡድን ለመቀላለቀል ማን አነሣሣሽ/ችሁ?
10. የአንድ ለአምስት ቡድን አባል እንዲመሆንህ/ሺ መጠን በምን አይነት ተግባራት ትሣተፋለህ/ሽ?
11. በአካባቢያችሁ ያለውን የእናቶች እና የህፃናት ሞት ሁኔታ ለማሻሻል በምን አይነት ሁኔታዎች ትሣተፋላችሁ?
12. ይሄንን የጤና ኤክስቴንሽን ፕሮግራም ለማሻሻል ምን መደረግ አለበት ትላለሽ?
13. የእናንተ የቡድን አላት ብዙውን ጊዜ መረጃ የመለዋወጡት እንዴት ነው?
14. የእናንተ ተግባቦት አቀራረብ ከባህል አንፃር ምን ያክል ተገቢ ነው?

Appendix 3 for FGD kebeles

No	Sample kebels Name	Name the FGD	Number women's in each FGD	Number women's Used for interviewing	Place of FGD
1	yelemelem	Kebele 1	6	2	In the health post
2	Arantuamba	Kebele 2	6	1	Center their home
3	Lmchim	Kebele 3	6	2	In the group leader home
4	Mchig	Kebele 4	6	2	Center of their home
5	Dogem	Kebele 5	6	2	In the health post
6	Komie Zemie	Kebele 6	6	2	In the home of one group member
Total			36	13	

Appendix 4

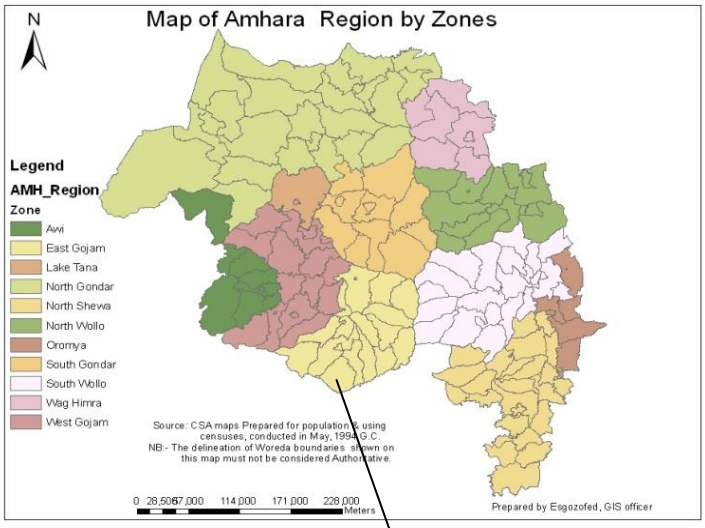
Number of Health Extension workers used for interviewing

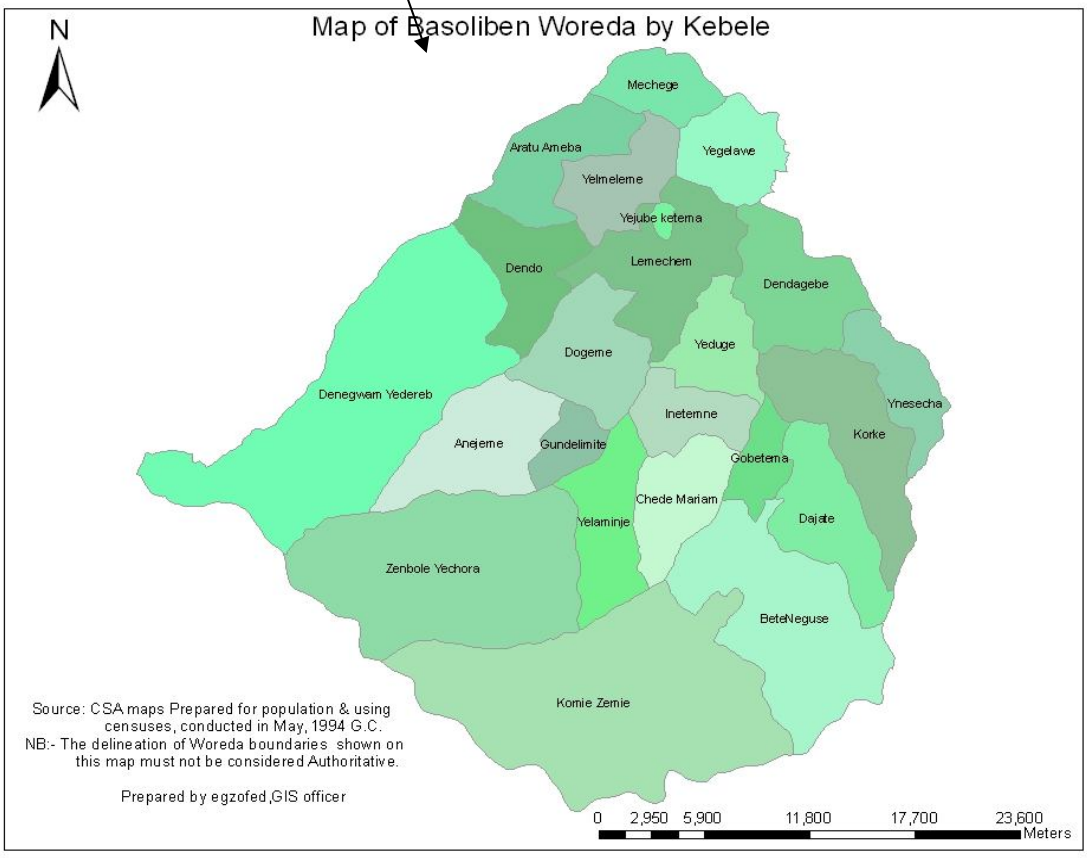
No	Sample kebels Name	Number Health extension workers used for interviewing	Total number of employees
1	Yelemelem	1	2
2	Arantuamba	1	1
3	Lmchim	1	3
4	Mchig	1	2
5	Dogem	1	2
6	Komie Zemie	1	2
	Total	6	12

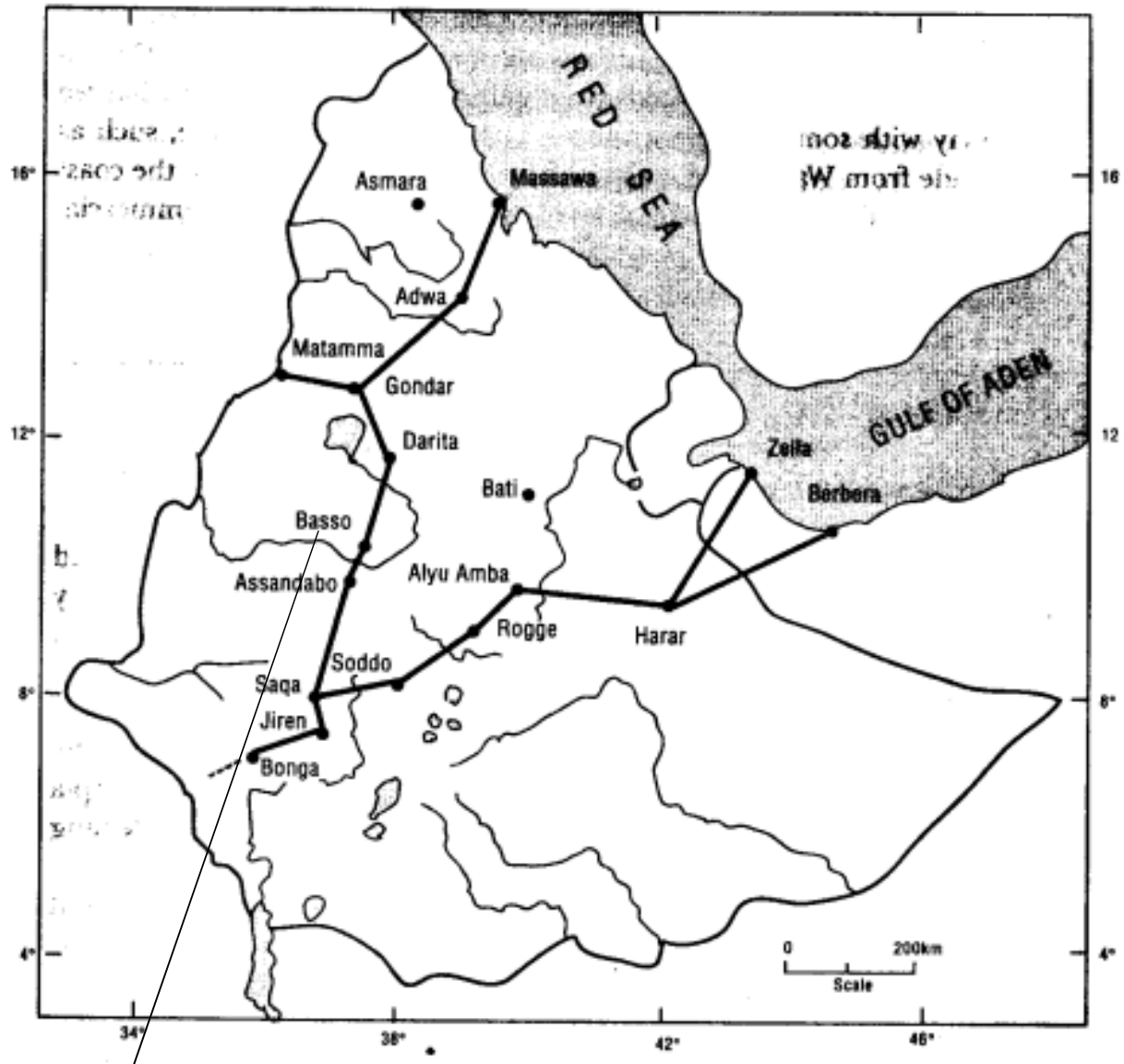
Appendix 5

Officials used for interviewing

No	Name of the health officer	Position
1	Endaweke	Gender officer In Bao liben Woreda health office
2	Mengstu	Reproductive health officer
3	Getachew	The head of woreda health officer


N
Map of Amhara Region by Zones
Legend
AMH_Region
Zone
Awi
East Gojam
Lake Tana
North Gondar
North Shewa
North Wollo
Oromya
South Gondar
South Wollo
Wag Himra
West Gojam
Source: CSA maps Prepared for population & using censuses, conducted in May, 1994 G.C.
NB:- The delineation of Woreda boundaries shown on this map must not be considered Authoritative.
0 28,500 57,000 114,000 171,000 228,000
Meters
Prepared by Esgozofed, GIS officer


N
Map of Basoliben Woreda by Kebele
Mechege
Aratu Ameba
Yegelawe
Yelmeleme
Yejube ketema
Dendo
Lemechem
Dendagebe
Yeduge
Dogeme
Denegwam Yedereb
Ynesecha
Inetemne
Korke
Anejeme
Gundelimite
Gobetema
Chede Mariam
Yelaminje
Dajate
Zenbole Yechora
BeteNeguse
Komie Zemie
Source: CSA maps Prepared for population & using censuses, conducted in May, 1994 G.C.
NB:- The delineation of Woreda boundaries shown on this map must not be considered Authoritative.
Prepared by egzofed,GIS officer
0 2,950 5,900 11,800 17,700 23,600
Meters



Basso, in the 19th century as one port of the long distance trade

(Fig.1), Baso liben map.

Fig 1. Opinion leaders , (religious leader) with Woreda health officer teaching the community about the issue of child maternal mortality.

Fig 2. *When pregnant women help each other by looking family Planning Magazine about what they should do in each stages of pregnancy*.

Fig. 3 when the pregnant women are who can read assisted the other that can’t read.

Fig. 4 when all *Woreda* health extension workers are evaluating each other on the issue of child and maternal mortality.

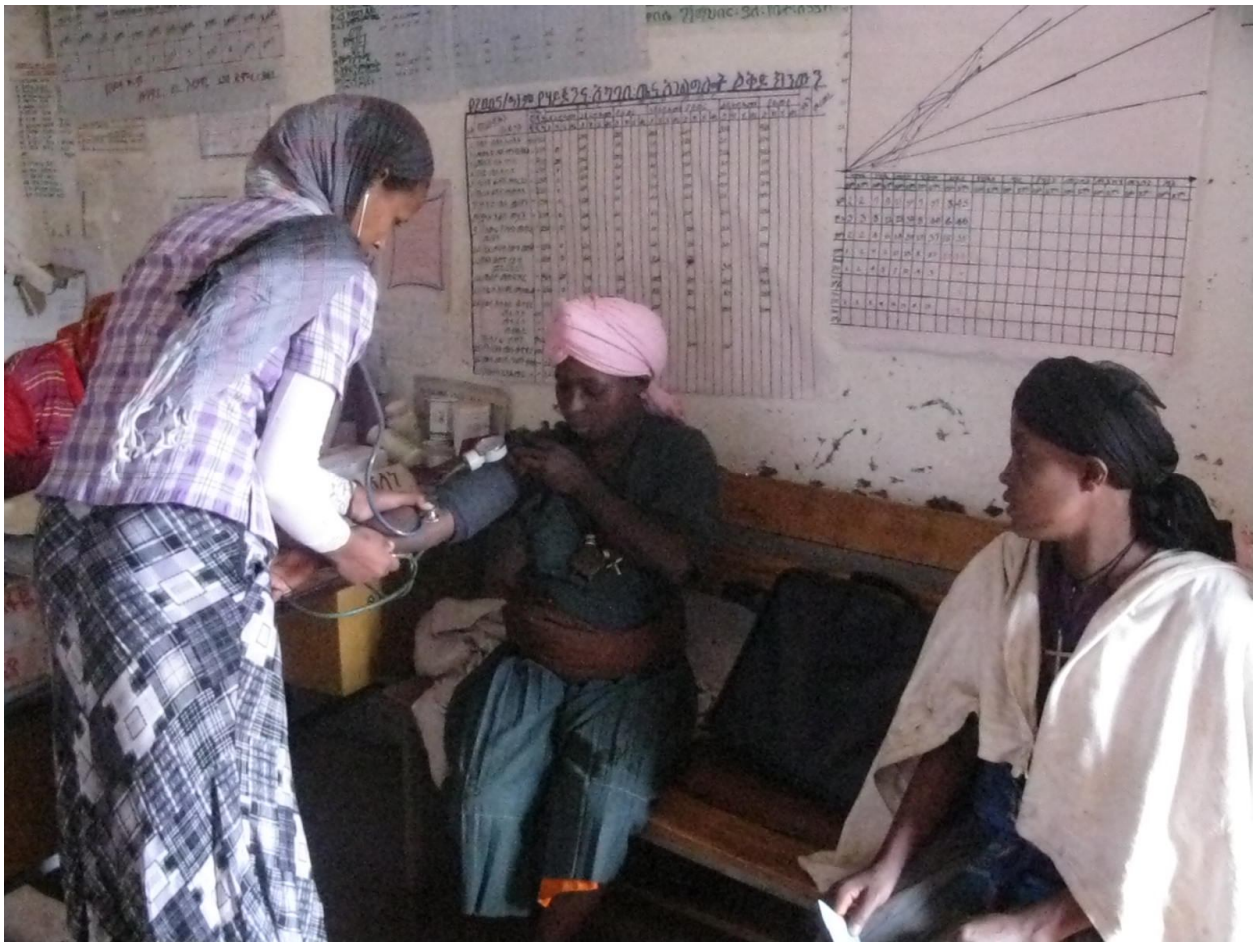


Fig. 5 Researcher observation of in different health post about the services given by the health extension workers.

Fig. 6 The health army group (one-to-five) in the Focus group discussion field.