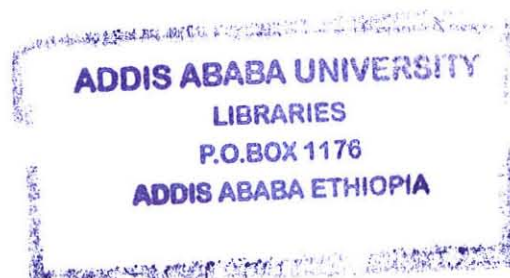


ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

**AN ASSESSMENT OF THE IMPLEMENTATION OF HEALTH
EXTENSION PROGRAM IN SOME SELECTED WOREDAS OF JIMMA
ZONE OF OROMIA REGIONAL STATE**

BY

MUHAMMEDSANI MUJAHID



May 2011

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**THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS
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COLLEGE OF EDUCATION DEPARTMENT OF CURRICULUM AND
TEACHERS PROFESIONAL DEVELOPMENT STUDIES

(ADULT AND LIFE LONG LEARNING)

AN ASSESSMENT OF THE IMPLEMENTATION OF HEALTH
EXTENSION PROGRAM IN SOME SELECTED WOREDAS OF JIMMA
ZONE OF OROMIA REGIONAL STATE

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Acronyms and Abbreviations

ADLI→Agricultural development led industrialization

CNHDE→Center for national health development in Ethiopia

CSA→Central statistics agency

FGD→Focus group discussion

H→High

HEP→Health extension program

HEW→Health extension worker

HSDP 1→Health sector development program-1

HSDP 2→Health sector development program-2

L→Low

M→Medium

MDG→Millennium development goals

MOE→Ministry of Education

PASDP→Poverty alleviation sustainable development program

PHC→Primary health care

RDPS→Rural development policies and strategies

TGE→Transitional government of Ethiopia

V.H→Very high

V.L→Very low

Abstract

The purpose of this study was to assess the implementation of health extension program in some selected woredas of Jimma zone of Oromiya Regional State. To accomplish this purpose, the study employed a descriptive survey method; this is supplemented by qualitative research methods to enrich the data. With this respect, household models, health extension workers zonal and woreda health extension experts were sources of data for the study. The data gathering instruments included questionnaires, interviews, focus group discussions and document analysis. Data obtained through questionnaires were quantitatively described and interpreted in light of available literature where as the information obtained through interview, FGD and document analysis were qualitatively described to supplement the quantitative data. The result of the study revealed that model households participated in health extension training through the organizers of model households were health extension workers and kebele administrators. Model households agreed on the criterion for selecting only female health extension agents in their kebeles and neighboring kebele. Model households are giving training during coffee ceremony, in development work and in large community meetings to the other households. Furthermore, the study revealed that lack of trained supervisors, lack of support or incentives, lack of career growth and continuing education to health extension workers, and lack of clearly defined job description to the supervisory personnel hindered proper implementation of health extension program in the study area. Finally, recommendations are made based on the results of the study. The point of recommendation include; timely response to social and psychological need of health extension workers such as arrangement of upgrading program based on their performance and year of service can decrease dropout rate. Regular supportive supervision and follow up of health extension workers will increase the motivation of health extension workers and facilitate the provision of quality services.

CHAPTER ONE

1. Introduction

1.1. Background of the Study

The roles of education and training are basic pillars in the overall individual's as well as societal development in increasing productivity and incomes .It facilitates every one's participation in economic and socio-cultural life. UNESCO (2002) states that, education and training help individuals to escape poverty by providing them with the skill and knowledge to raise their behavioral change and make the right decisions for solving their problems on their own free will and effort. All adults and youngsters should get education and training in order to cope with the world they live in. It is obvious that individuals and groups are different in their life styles and personalities. This reality makes impossible ensuring that the education and training needs of all individuals only with in the formal system. UNESCO, (2003) says that people who have not been able to benefit from formal education and training must be given opportunities to acquire skills and knowledge with in non-formal adult education framework.

Non-formal adult education and training emerged from the inability of formal education system to provide an access to a great majority of the people. It is organized as a result of the inefficiency of the formal education system in terms of its access and failures to provide the necessary skills and to enable the

Learners participate in socio-economic development of society. (Fordham; 1993).

Akinpelu (2002) said that emphasis was given to literacy as a strategy for alleviating poverty in the past. But said the writer, but In recent years it is affirmed that poverty alleviation can also be approached through the use of adult education programmes, especially those that will provide skills with which people can earn a living or improve their conditions. Continuing education and continuing professional education such as agricultural and health extensions education are included in the alternatives.

The government is making extensive changes in socio-economic lives of the people since 1991 in Ethiopia. The education and training policy was launched in 1994 and being implemented on the base of political philosophy of federalism.

It emphasizes that, non-formal forms of adult education will concentrate on both basic literacy and occupational skills which will be given parallel to the formal schooling (TGE, 1994). This has adopted a new direction of rural centered development on the basis of decentralization. Its sub-articles 2, 3 and 6 state that non-formal forms of adult education deal with literacy, numeracy, environment, agricultural, crafts, health and civic education. It gives more focus on agricultural led industrializations and health extension programs reflect the need to pay equal attention to need based rural community farming and health training.

On the other hand, poverty alleviation and sustainable development program serve as means to refocus activities and resources towards reducing the level of poverty by making health services accessible to the poor and vulnerable population. In a country where 85% of the population lives in rural areas and 51% of GNP is derived from agricultural sector, the importance of particular policies and strategies to support the rural population and the agricultural sector as an essential part of this can not be underestimated. In this sprit, both the rural development policies and strategies (RDPS) issued in 2001 and the agricultural development-led industrialization (ADLI) policies developed in 1994 have strategic importance for health sector development (MOE; 2002).

Rural development policies and strategies outlines different policy directions related to health, emphasizing health both as a human right and as playing a key role in building the capacity of the population to contribute the over all development and stressing primary health care.

According to the poverty alleviation and sustainable development program, education is one of the key in achieving its goals. It considers the non-formal adult education for out-of school children at primary school age. For youth and adults of above 15 years of age skill training should be provided by literacy program (MOFED, 2003:1).

Ethiopia, as adult learning in health sector, had adopted primary health care in early 1970's by all people of the country as the national strategy to achieve equitable access to health services. The

policy direction of 1976 gave emphasis on primary health care, rural health services, prevention and control of common diseases, self-reliance and community participation. The government endorsed later the health for all target and primary health care strategy of 1978. But the system did not work because of inconsistent and insufficient supervisor and in service training and the adult education programs in Ethiopia (Habtamu, 2007) were emphasizing reading and writing rather than primary health care training as well as the top-down nature of the implementation.

The health sector undertook various reforms after the adoption of the 1993 policy. That is why the decentralization has particularly given the opportunity for the woreda management of health services (TGE, 1993). A 20 year health sector development program is being implemented in Ethiopia currently in phases (1997/98-2001/2002 is the first that indicated the challenges in achieving universal coverage of primary health care and revealed that the necessary basic health services did not reach the people at the grassroot level as envisaged and desired due to the nature of the services given by the health system.

During the 2nd phase of HSDP (2002/3-2004/05), the government has introduced an innovative adult education program called Health Extension program. This is an innovative community based program that aim to create health environment and healthy living by making available essential health services at the grass root levels, primarily focusing on preventive and promotive aspect. The modalities for HSEP implementation include an outreach program run by female health extension workers, two per kebele serving 500 people (HSDPI, 2003). Health extension program is implemented by deploying two female health extension workers per each village who got training for a year at technical and vocational training and education centers (MoE, 2003).

In addition to this, health extension workers are expected to select model households and work with them. These are the families considered to be innovative and ready to change and influential community members. The HEW gives trainings on the packages for up to 60 members and let them graduate when they are convinced and well informed of the interventions. The graduates are expected to demonstrate practical changes in the use of Health programs, environmental and personal hygiene and serve as models to others. This will be expanded gradually until it covers the whole village.

The HEW, in addition to the family packages, they also run house to house visit and deal with individuals to give training. Make demonstrations and educate families particularly mothers with regard to harmful traditional practices (MoH: 2003).

It is expected that, as part of adult education there are many factors that determine the successful implementation of the HEP. Even though there are appreciations to this innovative program, there is no systematic and organized study with regard to the effectiveness of the implementation of the program. That is why it is relevant to undertake a study on the challenges and opportunities of the implementation of health extension program for policy intervention.

1.2. Statement of the Problem

Geographically, as HSDP II (2003) noted, Ethiopia is found in Horn of Africa and has a total area of 1.1 million square kilometers. In the sub-Saharan Africa it is one of the most populous countries: over 85% of the people live in rural areas and 52.2 per square km are the average population density with great variation among regions' 2.9% is its annual total population growth in that of the urban population is 4.1. %. It is also one of the least developed countries in the world with an estimated USD 6.4 billion giving per capital in come of USD 952. According to MoH, (2007), poverty is persistent with 47% of the population estimated to live below the poverty line. Its health education is worrying. The most health problems are related with infectious disease and nutritional deficiencies reliable to preventive measures. Things like low education levels, wide spread of poverty, scarcity of water, poor sanitation facilities and health services have contributed to the ill health situation (World Bank, 2007).

It is recommended that among others, the provision of the various forms of adult education such as agricultural extension, health education and others. It could help poor rural people to lead the improvement of their livelihood and to know how to improve their environmental situation. As Duke (1988); noted that it also contributes to the development of healthful living among the society. By that, it can be concluded that it also plays an essential role in the alleviation of poverty.

Ethiopia had adopted primary health care program to the rural community since 1970's as a national strategy to achieve equitable access to health care services. But it did not achieve its

goals. The reason is that an adult education program in the country has mainly emphasized reading and writing without being linked with relevant community development activities. Until the people were not able to sense its importance practically, they were not interested to participate in the program. According to MoH (2007), the program lacks coordination and feedback. That is why it becomes difficult to find its full recorded reports on the number, age and sex of participants in the program and also its impacts on the socio-economic development of the country. An effective implementation of the PHC was also tackled in relation with structure of the Ministry of health itself. As Habtamu (2007) noted, the structure was limited to central and regional level and maintained vertical program with no management structure at district level and below.

In order to achieve the goals of health policy, 20 years health sector development strategy has been formulated by the government, which is being implemented through a serious of five year plan. The Federal Ministry of Health launched a new health care plan in 2003 which is known as the “accelerated expansion of primary health care coverage”, Through a comprehensive health extension program which designed in alignment with the wider policy framework such as PASDP and MDGS (HSDP; 2003).

The objective of health extension program, according to MoH (2005), is to increase awareness, knowledge and skill among community members so that communities are empowered to take care of their own health through:

- promoting healthy life style;
- availing basic health care services;
- promoting equity in health delivery;
- improving quality of health care; and
- promoting gender empowerment.

Accessibility, community participation, decentralization, equity, health promotion, disease prevention and political commitments are the basic principles of primary health care in health extension approach to bring a remarkable change in the health care delivery system. Health extension is a basic shift of methodology and adoption of attitudes towards removing the top-

down and non participatory approach to a participative and bottom-up way of planning health development schemes (MoH, 2005).

At various levels, political commitment is crucial and necessary for the formulation and implementation of the appropriate health and health related policies and strategies. In addition to the commitment of the central government, commitment of the local government is extremely important for the implementation of the health extension strategy.

The local commitments have a strong impact on health service. It is a supportive environment and necessary for a successful implementation of health extension program. Financial and political commitment for the successful implementation of health extension package at all levels will be and induction or reflection of the accountability of the politicians and policy makers for health and welfare of the people. According to HSDP II, (2003), the implementation and realization of decentralized and democratized health care delivery system in Ethiopia is a yardstick for the success of all development endeavors.

Through the nature of decentralization program, Oromiya Regional state has launched its implementations to the various woredas and kebeles. Eventhough there are overall appreciations to the program in the region, there are no study organized and systematic assessment of the implementation of HEP at a local level.

That is why it is important to undertake an assessment of the program implementation. In addition to this, identifying factors that affect (influence) the implementation of the program would help for better policy interventions; there by the program will address its designed objectives.

Thus, the following research questions can be formulated

- 1) How do households participate on the extension health training and implementation?
- 2) Does the extension program incorporate different methods of adult learning?
- 3) What are the major challenges and opportunities that negatively and positively influence the implementation of health extension program's package?
- 4) What are the perception of the household towards the health extension workers and the service they provide?

- 5) What are the major administrative activities to the successful implementation of the program?

1.3. Objectives of the Study

The general objective of the study was to assess the implementations of health extension program in some selected woredas of Jimma zone.

The specific objectives of study

- 1) identifying the challenges and opportunities of the implementations of health extension program in some selected woredas of Jimma zone.
- 2) identifying the methods of health extension training program.
- 3) examining the perception of households towards health extension worker and service they provide.
- 4) identifying roles of the administrative body to the successful implementation of the program.

1.4. Significance of the Study

The health extension sector is given particular emphasis for the overall future transformation of the national health development. One of the factors for its success is the sustainable prevention of health action and increased health awareness.

Hence, the researcher believes that this study could have the following significances.

- 1)It may help the health extension program practitioners and policy makers to understand the status of implementation of health extension program in the region in general and in selected woredas of the zone in particular.
- 2)The woreda/kebele/ may benefit from the findings of the study for if can identify the strengths and weaknesses of the implemented health extension program.
- 3)The outcomes of the study may contribute some ideas to the field of the health extension as a country experience.
- 4)It can help other researchers as stepping stone for investigating health extension program related issues.

1.5. Delimitations of the Study

The study aimed at expressing the implementation of health extension program as adult learning and its hindering factors in detail. To make the study manageable, geographically it was delimited only to 4 urban and 2 rural kebeles in three woredas of Jimma zone of Oromiya region, where the researcher has wide work experience in the zone.

1.6. Limitations of the Study

In conducting this study, the researcher has faced the following problems, which contributed to the limitation of the study.

1. Shortage of reference materials, especially on health extension program of the rural people even in international context.
2. Lack of transportation to some rural health posts was also another limitation that obliged the researcher to travel on foot. Thus; all these may have some effect on the result of the study.

1.7. Definitions of Key Terms

Package: A set of content and activities that the health extension implementation contains, and to bring about health behavioral change.

Health Extension Program: A program designed to achieve significant health care coverage in Ethiopia targeting house hold.

Health extension workers: are teachers /facilitators trained for one year predominantly about prevention and promotion of health services to be assigned in health post at kebele level.

Model Household: are representatives of the community, who get a health extension training about prevention and promotion of health service and they are community health workers.

Community participation: is a process during which individuals, groups and organizations are given the opportunity to become actively involved in the program development, implementation and evaluation (Nyerere, 1974).

CHAPTER TWO

Review of Related Literature

2.1 Health Education and Behavior Models/ Theories and Definition of Health Extension Education

Simonds (1976) defined health education as aimed at bringing about behavioral changes in individuals, groups and larger populations from behaviors that are presumed to be detrimental to health, to behaviors that are conducive to present and future health. Moreover, Green (1991), defined health education as any combination of learning experiences designed to facilitate voluntary adoption of behavior conducive to health.

As a part of any planning model, it is necessary to attempt to classify and explain the multitude of factors which can, and do influence human behavior. Current models/theories that help to explain human behavior, particularly as it relates to health education, can be classified on the basis of being directed at the level of individual (intra personal), interpersonal and community with in these three categories, those models/theories that have tended to dominate in the health education field in the past 20-30 years (Glanz, Rime and et al, 2002).

2.1.1 Individual (Intrapersonal) Health Behavior Models/Theories

Stage at change model or Tran's theoretical model

According to Prochaska and Diclemente (1982), behavioral change is viewed as a process, not an event, with individuals at various level of motivation or readiness to change or attempt to change towards health behaviors. Since people are at different points in this process, planned interventions should match their stage. There are six stages that have been identified in the model:

- **Precontemplation:** the person is unaware of the problem or has not thought seriously about change.
- **Contemplation:** the person is seriously thinking about change (in the near future).

- **Preparation:** the person is planning to take action and is making final adjustments before changing behavior.
- **Action:** the person implements some specific action plan to overtly modify behavior and surroundings.
- **Maintenance:** the person continues with desirable action (reseatng) the predict recommended steps while struggling to prevent lapses and relapse).
- **Termination:** the person has zero temptation and the ability to resist relapse

It is more at a spiral as the person may go through several cycles of contemplation, action, relapse (or recycle) before either reaching termination or existing the system without becoming free of the additive behavior. Prochaska has used a “revolving-door schema” to explain the sequence that people pass through their efforts to become free from addition; people do not go through the states and graduate. They can enter and exit at any point and often recycle several times. Other studies indicate that individuals often go through these same changes whether they use self-help or self-management techniques, seek professional counseling organized programs.

Consumer Information Processing Model

According to Bettman and McGuire (1986), the consumer information processing (CIP) model developed out of the study of human problem solving and information processing. Information processing has been one of the dominant paradigms in social psychology for quite a whole, even though CIP is still relatively new. This model was not developed specially for health related behavior, but it has many useful applications in the area of health education. Information is a necessary tool in health education. However, just as knowledge is necessary but not sufficient for behavior change, information is necessary but not sufficient for knowledge. There are limits to any person’s information processing capacity. This is defined as the limitations up on individuals in the amount of information they can acquire, use and remember.

By understanding the Key concepts and processing of CIP, health educators can examine why people use or fail to use information, and then design information strategies that have better chances for success. The search for information is the process of acquiring and evaluating

information. This process is affected the person's motivation, attention, and perception at that point in time. In general, consumers tend not to be engaging in extended information searches.

There are two central assumptions of CIP individuals are limited to how much information they can process. Secondly, in order to increase the usability of information, individuals combine little pieces or bits of information in to "chunks" and make decision rules to make choice faster and move easily. This model has now been extended to consider that the information how environment affects how easily people obtain, processes and use information. According to Bettman's (1986), there are some basic CIP concepts that can be applied to health education. Before people use health information, it must be: 1) available 2) seen as useful and new, and 3) process able or in a friendly format. It is necessary to choose the most important and useful points to communicate (either verbally or in print) and place this information first and/or last in the presentation in order to be remembered best. The information designed specially for the target population must be placed conveniently for their use.

Theory Reasoned Action

As suggested by Fishbein and Ajzen (1980), in this theory a person's intention to perform a specific behavior is a function of two factors:

1. Attitude (positive or negative) towards the behavior and,
2. The influence of social environment (general subjective norms) on the behavior

The attitude toward the behavior is determined by the person's belief that a given outcome will occur if she/he performs the behavior and by an evaluation of the outcomes. The social or subjective, norm is determined by a person's normative belief about what important or "significant" offers think he/she should do and by the individual motivation to comply with those other peoples' wishes or desire.

Attitudes are a function of beliefs in this theory. If person believes that performing a given behavior will lead to on the whole positive outcomes, then he/she will hold a favorable attitude towards performing those behavior subjective norms also a function of beliefs. However, these are beliefs of a different kind. These are the person's beliefs that surtain individuals or groups

think she/he should or should not perform the behavior. If the person believes that most of these significant others think she/he should perform the behavior, the social pressure to perform it will increase the more she/he is motivated to comply with these others. If she/he believes that most of this reference group is opposed to performing the behavior, her/his perception of the social pressure not to perform the behavior will increase along with her/his motivation to comply with these references. The beliefs which underline a person's subjective norms are termed normative beliefs.

Social Learning Theory/Social Cognitive Theory

In social learning theory, human behavior is explained using a three-way reciprocal theory in which personal factors (one's cognitive process), behavior and environmental influences continually interact in a process of reciprocal determinism or reciprocal causality. These are very dynamic relationships where the person can shape the environment as well as environment shaping the person. Change is bi-directional. According to this theory, reinforcement contributes to learning, but reinforcement along with individual's expectations of the consequence of behavior determines behavior. This type of approach has been referred to as "value expectance theory".

As suggested by Rotter (1954), there are several constructs in social learning theory (SLT) which may be applicable learning situations in health education. Behavioral capability refers to the knowledge and skills necessary to do a behavior which influence actions. If individuals are to be able to perform specific behaviors, they must first know what the behaviors are and how to perform them. Therefore, clear instructions and/or training may be needed. Another construct is expectations, refers to the ability of human to think and, therefore, to expect certain results in certain situations. Expectations are the values that people place on an expanded outcome. The more highly valued the expected outcomes, the more likely the person will perform the needed behavior to yield that outcome.

In addition to, Bandura (1997), considered self-efficacy the single most important aspect of the sense of self that determines one's effort to change behavior. A person can increase self-efficacy through; 1) personal mastery of a task: 2) observing the performance of others

(vicarious experience); 3) verbal persuasion, such as receiving suggestion from others; and 4) arousal of her/his emotional state. In the construct of emotional coping responses, a person must be able to deal with any sources of anxiety surrounding that behavior in order to learn.

2.1.2 Interpersonal Health Behavior Theories

Social Networks/Social Support Theories

Based on Israel (1982), most health educators today recognize the crucial importance of social environment and advocate changes in the social ecology which is supportive of individual change leading to better health and a higher quality of life. However, within the community, long term behavior change depends on the level of participation and ownership felt by those being served. In order to see how social networks and social support theories might impact on health needs, it is first necessary to define what is meant by certain concepts.

Social networks can be kin (extended family) or non-kin (church or work groups, friends or neighbors who regularly socialize, clubs and sporting teams), social networks have certain types of characteristics:

1. Structural, such as size (number of people) and diversity (extent to which members really know one another)
2. Interactional, which include mutual sharing, durability (length of time in relationship), intensity (frequency of interaction between members)
3. Functional, such as providing social support connections to social contacts and resources, and maintenance of social identity.

As suggested by House (1982), social support is the function content of relationships that can be categorized in the following four broad types of supportive behavior.

1. Emotional support, listening, showing trust and concern
2. Instrumental support, material aid
3. Information support, providing advice, suggestion, directives, referrals, and
4. Appraisal support, affirming each other and giving feedback.

2.1.3 Community Level Models/Theory

Community Organization

Even though community organization does not use a single unified model, there are several key concepts that are central to its practice to bring about change on the community level. The first of these, empowerment has been described as a process by which individuals and communities gain mastery over their lives by becoming enabled to take power and then to act effectively to transform or change their environments. Within community organization, this concept of empowerment operates on two levels at the same time. First, the individual who is involved in the community organizing effort may experience increased social support. This support may result in a more generalized sense of control. An increased sense of control (empowerment) could have positive benefits on one's health. On the second and broader level, community organization can contribute to community level empowerment which leads to increased community competence. Community competence may be thought of as the equivalent of self-efficacy and behavioral capability on a community level; both the confidence and skills to solve problems effectively are present within the community. The health practitioner or community organizer could play a crucial role in helping communities increase their problem-solving ability.

Two principles which are important in community organization practice are the principle of participation and the principals of relevance. Dewey (1946) and Lindeman (1926) paid close attention to the principle of participation or "learn by doing" in their work within the field of adult education. Adult education was (and still is) considered a process of increasing people's understanding activating them and helping them make decisions for themselves. This idea fits nicely with the community organization principle of gaining true involvement and participation by community members at each stage within the process. The principle of relevance was identified by Nyswander (1956) as one of "starting where the people are". The change agent who begins with the individual or community's felt needs rather than a personal or agency plan will experience far more success than imposing agenda from outside. It is widely acceptance that communities should identify their own needs and issues to be addressed. When an issue is chosen by the community, a sense of ownership emerges which leads to empowerment and the development of a competent community. However, in the concept of issue selection one must

differentiate between problems, which are troublesome and issues, which are problems the community feels strongly. In addition, the selected issue should also be: 1) specific, 2) simple and 3) winnable.

One of the most important concepts by Brazilian educator Paulo Freire (1973) was recently added to the model of community organization. In the concept of critical consciousness, Freire spoke of entering a dialogue with illiterate peasants so that they could teach themselves how to read and write as well as how to understand the root causes of their problems.

According to Freire, the educator's main role is to converse with the students about concrete situations and offer them the tools in order for the students to teach themselves to read and write. It is a collaborative effort. From this understanding, a person could rally learn to think critically about real-life problems and take action to change his/her own plan of action to deal with any problems collectively identified.

Diffusion of Innovation theory

Diffusion of innovations theory provides an explanation for how new ideas, products and social practice diffuse or spread within a society or from one society to another. Diffusion can be thought of as a special type of communication in which messages are concerned about a new idea, if a health education program is viewed as an innovation, this theory could describe the pattern the target population would follow in adopting the program (Rogers, 1983). Time is an important element in this diffusion process. Five adopter categories are used to classify members of a social system on the basis of their innovation: 1) innovators (active information seekers of new ideas); 2) early adopters very interested in the innovation but not the first to sign up); 3) early majority (need external motivation to get involved); 4) late majority (are skeptics and will not adopt an innovation until most people in the social system have done so); and 5) laggards (last to become involved by a mentoring program or through constant exposure and have limited communication networks).

Another aspect of time considers the rate of adoption, which is the speed in which an innovation is adopted by members of a social system, when the number of individuals adopting a new idea is plotted on cumulative number or percentage of adopters over time.

According to Fullan (1991) and Rogers (1995), there are certain characteristics which are associated with successful diffusion efforts. These attributes of innovations can help to explain the different rates of adoption of innovations by individuals. Some of these include: 1) relative advantage. The level at which an innovation is perceived as better than the idea it attempts to replace; 2) compatibility the level at which an innovation is viewed as being consistent with the existing values, past experiences and needs of the potential adopters; 3) complexity the level at which an innovation is viewed as difficult to use and understand; 4) trial ability or flexibility the level at which an innovation can be experimented with on a limited or "ideal" basis; 5) observe ability the level at which the results of an innovation can be seen by others.

This process of diffusion of an innovation involves someone who has knowledge or experience with using the innovation, someone else who does not yet have knowledge of the innovation, and a communication channel between the two people. The communication channel is the means by which messages get from one individual (another. Mass media channels are the most rapid and effective ways to create an awareness/knowledge about an innovation. These channels are mass media such as radio, television, newspapers, and magazines, where source are create-potentially reaches an audience of many. In regards to improving health, when physicians and community leaders act to reinforce information that is also provided through mass media channels. There is a much better chance that consumers will decide to act. Interpersonal channels, which involve a face-to-face exchange between two or more people, are more effective in persuading an individual to adopt a new idea. The innovation decision process is a five-step procedure through which an individual posses. These steps include: 1) knowledge, 2) persuasion 3) decision 4) implementation, and 5) confirmation. The person has an awareness/knowledge of an innovation forms an attitude about it. Decides to accept or reject, implements the new idea and confirms the decision.

Organizational Change Theories

Zimmerman (1994), organizations are complex and layered social systems change may be influenced at each of these levels. Health education strategies that are directed at several layers at once may be the most durable over time in producing the desired results. In terms of sociology, ecology refers to the study of human populations in terms of physical environments spatial

organization distribution and cultural characteristics. Since organizations can be influenced at many levels in their ecology, no single theory can completely explain how and why organizations change. Among the many theories of organizational behavior two have shown special promise in the area of public health; i) stage theory and ii) organizational development.

i. Stage Theory of Organizational Change

Lewin (1951), this theory helps to explain how organizations plan and implement new goals, programs, technologies and ideas. Organizations are believed to pass through a series of “stages” with each stage requiring a unique set of strategies if the innovation is to progress. A strategy that may be effective at one stage may be wrongly applied at the next. An innovation’s current stage of development must be correctly assessed and the proper strategies select in order to be successful in the application stage theory.

Goodman and Smith (1991), one shortened version of stage theory, organizational change consists of four stages: 1) awareness (problems are recognized and analyzed and solutions are suggested and evaluated); 2) adoption (policies are formulated and resources for beginning change(s) are allocated); 3) implementation (the innovation is implemented. Reactions take place, and changes in roles occur); 4) institutionalization (the policy or program becomes an integral part of the organization and new goals and values are a part of its structure).

These stages are “in sequence”. However, movement can be forwarded, back worded or abanded at any point in the process. It is also know that different actors may play leading roles at different stratages of the organizational change. Senior-level administrators tend to be important at the awareness and early adoption stages. Mid-level administrators become important at the adoption and early implementation stages. Workers (e.g. teachers) are instrumental at the implementation level /stage/. Finally, senior-level administrators again play key role during the institutionalization stage.

ii. Organizational Development

Human relations and the quality of life at work are often the targets of organizational development theory. According to Robertson (1987), it has been divided into two main sections 1) change process theories and 2) implementation theories, change process theories deal with the

underlying dynamics of change. And these have not yet been integrated into an adequate explanation of the change process. On the other hand, implementation theories are much better defined. These are the activities that health educators would use to make sure the change is successful under implementation. There are procedure theories which identify the sequence of actions needed for producing change in the organization. These four steps include: 1) diagnosis-a specially trained person, usually an outside consultant, helps the organization identify its most striking problems which interfere with its functions; 2) action planning-strategies are developed for addressing these diagnosed problems; 3) intervention-the consultant usually does not offer specific solutions but will aid in problem solving among the organizations members in group interactions; 4) evaluation-the effort of the planned changes is assessed, and these changes in the organization are allowed to settle.

Generally speaking, stage theory and organizational development theories have the greatest potential for creating positive health changes in organizations when used together. One example would be using consultation (organizational development) as the intervention in both the adoption and institutional stages (stage theory) in an organizational change.

2.1.4 Review of Health Educational Communication Method in Ethiopia Principles of Health Education in Ethiopia

MOH (2003) stated the following principles of health education

- Health education is not a one time affair. It is a continuing process based on planned and organized activities.
- It is planned to address different community members and not limited to a specific audience.
- It uses different communication methods as appropriate and not limited to a specific method only.
- Health education strategy from planning, implementation, and monitoring and evaluations stage involves active and full participation of the concerned audience; and not limited to program heads and administrative offices.

- It is given based on the objective reality of the area, culture, tradition, language and local resources.
- The program to be successful requires coordinated approach, full participation of different professionals and resources, and the community at large.

Places for Delivering Health Education

Health is the tool for enabling the community to identify the factors which have negative influence on their health; and helps them to solve these problems by their own initiatives and efforts. Today, health education can be found nearly every where. The setting are important because they provide channels for delivery programs, provide access to specific population and gate keeps usually have exiting communication system for diffusion of programs and facility development of policies and organizational change to support positive health practices (Mullen, et al, 1995).

To achieve the expected results, MOH (2003), stated that health education delivery at different stages or places where people are in:-

Health Institution

Health institutions are ideal place for communicating health message and health program. Health institutions are convenient for giving health education to patients on person to person basis; providing counseling to their problem and having them to face their problem calmly and take action towards alleviating these problems. It is conducive place to give health facility users, patients, care takers of patients, workers of health institutions and etc. it is also a place where there are different health professionals who can assist in disseminating health message. Health posts are ideal place for communicating health message.

Working Place

These places are large scale farming stations production and distribution, mining, service deliveries, animal breeding and fattening places etc. workers in these places due to lack of knowledge; level of health awareness, lack of appreciations for positive health behavior or being subjected to harmful health behavior etc, are easily exposed to various health risks. Hence special

attention should be given to health risks. Hence special attention should be given to these places to deliver to continuous health education in order to reduce health risks among these productive segments of the population.

Living Areas and Villages

Different members of the household can be contacted in person and can be given health education on critical health problems of the area. These are the places where the health extension workers are assumed to bring about health improvement and behavior change and consequently lead a healthy and productive life.

Religious Institutions and Traditional Social Meeting Place

These places, including churches, mosques Idir are where we can contact people of different ages. They are good places for communicating health messages and therefore, health extension workers organize themselves and use opportunities.

2.1.5 Methods of Communicating Health Education

WHO (1988), health education can be given to individuals, groups and variety of audience in different methods. Therefore, methods of communicating health education can be explaining, story telling, using posters, pictures, printed materials, electronic (radio, TV), songs, music, drama, dialogue, films, exhibiting (during holidays) etc.

Person to Person (Home-Visit) communication Method

This is the method of communication in which the health extension workers exchanges ideas and information with the community and individual around health development program. Person to person communication is useful in rural areas where mass media is not available. The advantage of this method is that it enables the health extension worker visit house to house, sanitation facilities etc. this person to person communication method helps to create positive attitude for behavioral change.

Communicating Health Message through Group Discussion

According to WHO (1988), group discussion is a method in which health extension worker communicates in with two or more people. If communication is two-way it will increase participation and desire to receive the message. It will help for synthesizing knowledge, ideas and skills. It will create forum for learning and exchange experiences.

Better result is achieved in group discussion if the discussants are fewer in number. If the group is large the level of participation will be low. Therefore, the discussion should be organized in such away as to enable full participation of all the group members. Group discussion helps for in-depth exchange of ideas and experience and enables to have better understanding of the group members. The health extension worker has the responsibility of leading, giving information encouraging free discussion in order to achieve successful and common decision on the major topics discussed.

Method of Communicating Health Message in a Large Meeting

This is a meeting in which the whole kebele, village and the area people participate. It is useful to communication important health information message immediately.

Based on Ramach (1995), it is preferable if the meeting period lasts about 40 minutes and if the presentation is assisted by visual aids the education topic to be communicated must take into account such things as suitability to the audience, matching to their level of education to their experience and desire.

Traditional Methods of Communication Message

Traditional method of communicating message such as: songs, anthems, poems, printing on cloth etc are useful for communicating messages, exchanging experience in a motivating, recreating and informative ways, especially good for those who can not read or write to enable them to group messages that needed to be communicated. However, this method is supported with other communication methods.

Communicating Messages through Demonstration

MOH (2003) demonstration is a teaching method in which the students are taught the basic concepts of what we want to teach in theory. After they have grasped the basic concept, then they are made to try on their own in practice. It is learning by doing. Teaching given through demonstration arouses the will and interest of the trainees; and what they learn this way is well understood and practiced later on. If the demonstration is not prepared well, the trainees will lose confidence and the expected result will not be achieved. Hence, demonstration should be based on the immediate needs of the trainees and must be carefully prepared. It can be used for teaching such things as preparing and feeding babies, building healthful housing, building sanitary latrine and usage, giving vaccination and etc.

Using Role-Play for Message Communication

In role play certain persons play the role of another's character in a type of drama. The character or role-play is based on the objective reality which the audience known as very well. It is like real life. In role play a script is not necessary. Through role play people can better understand the cause of certain problem in question and the solutions from the characters in the play.

Communicating Message in the form of Drama

Drama is a person, in which the subject matter or topic is studied either well written or in words and then presented in educative and recreating manner. The preparation and presentation of drama should be based on objective reality and must take into consideration the culture and tradition. Drama should be prepared and presented in a recreating manner and at the same time informative and moving towards better positive behavior change.

Communicating Message in the form of Mass-Media

This method consists of radio, television, written materials, newspapers, journals, films pamphlets, leaflets, brochures, booklets, calendars, pictures and photos. They are useful for transmitting message and this can be done by health professional or other development worker during his/her oral presentation for better explanation. In order to achieve the objective of the program, the extension workers should understand the language and culture of the people.

2.1.6 Health Extension

Definition of Health Extension

Health extension is a term of more recent origin than health education. As defined by Green (1991), it is “any combination of health education and related organizational, economic and environmental support for behavior of individuals, groups or communities conducive to health.

Moreover, MOH (2005), defined it as a community based essential health care deliver system to individuals and families in the community through their participation. It is also a promotive, preventive and basic curative service targeting house holds particularly women and children. The service is delivered to each village by two ladies called health extension workers (HEW) with support voluntary community health extension workers (VCHW).

Objectives of Health Extension Package

As stated by MOH (2004), the health extension package is organized to improve access and equity to prevent diseases and promote essential intervention through community/ kebele-based health services by enhancing community education/ dialogue for sustainable preventive actions for active involvement/ participation, empowerment and ownership of the people to manage their own health issues. These objectives will be realized through promotion of behavior and making the environment conducive for health. Health is a basic right, which is also essential for social economic development WHO (1988). Therefore, the constitution of federal republic of Ethiopia confirms that all the citizens have the right to a clean and healthy environment (TGT,1993). The health extension package program needs to be carried out through participatory approach to ensure acceptance and sustainability. It is assumed that the targets of the educational activities will be the women, who shoulder the major responsibility for the health, hygiene and nutrition and care of the family (HIDPII,2005). These essential packages are:

1. Hygiene and environmental sanitation
 - Solid and liquid waste disposal, water quality control, food hygiene and proper housing
2. Disease prevention and control

- HIV/AIDS and other STD prevention and control
 - TB prevention and control
 - Malaria prevention and control
3. Family health service
- Maternal and child health, family planning, immunization
 - Adolescent reproduction health
 - Nutrition

Characteristics of Health Extension workers

The targets of health education and communication and other preventive and promotive health service will be mostly mothers and children. The deployment of female health extension workers to community based health extension has been adopted as preferable strategy. This time two female health extension workers are deployed in each rural kebele (HSDP II, 2003).

A health extension workers is a health care provide, permanent government employee trained for one year in preventive and promotive health measures and who work with the community to address the health needs of the community. They should be trusted by and identified with their community. Because, they are chosen for this purpose to live and work in the community they need to be accepted and accountable to the communities.

The role of Health Extension Workers

Their basic role is to make health services more fully available to the community, achieve these objectives by performing.

- Linking communities with health resource and services
- Providing health information, mobilizing communities to determine health needs to take greater responsibility for their health, advocating for appropriate health resources, services and actions.
- Raising awareness and increasing knowledge about disease prevention and health promotion and rendering first aid service.

Besides addressing the whole public, the health extension worker are expected to select modern house holds and work with them. According to MOH (2005) the selection of the native trainees is the privilege of the various organization and missions. Important criterians for choosing the trainees/community household are:

- Lasting presence in the village
- Member of the community
- Recognition and acceptance by the village people
- Initiative, credible life style, able to learn and teach
- Ability to read, write and speak the national language
- Not resistant to change

These are the families considered to be innovative and are ready to change and influential committee members. The health extension worker give trainings on package for up to 60 members and graduate them when they are convinced and well informed of the interventions. The graduates are expected to demonstrate practically change in the use of health program environmental and personal hygiene and are serve as models of others.

Therefore, the key responsibilities of health extension workers include prevention and control of disease, promotion of health, helping the community to take the necessary action for early diagnosis and treatment and where necessary referral to higher and better health care facilities.

2.1.7 Health Extension Package Implementation in Ethiopia

According to Habtamu (2007), Ethiopia had endorsed primary health care strategy since 1970's to realize equitable access health service but the achievement had been very limited. A review of the HSDPI (2002), indicated that due mainly to inconsistent and insufficient support from health system including health supportive provision and in-serive training as well as lack of remuneration and incentives. The other factors which do not allow effective implementation of the primary health care were related to the structure of the ministry of health itself. The structures was limited to central and regional level and maintain vertical programs with management structure at district level and below. As a result of this, it has not reached the people at the grass root level as envisaged and desired. In response to this, the government has introduced an

innovative program called health extension program and this started implementation during HSDPII (2003).

Policy Environment-Health and Health Related Policies

Health is a development issues that can be considered from different social, economic, political and other conditions. The formulation or development of supportive policies and strategies is a prerequisite for successful planning and implementation of health care delivery system especially community health services.

According to MOH (2005), some of the health and health related government policy direction and priority areas including health policy, drug policy, women policy and population policy, health sector development strategy, economic policy, rural development policy and others have been implemented. The main focus of these policies and strategies is promotion of health and welfare of the people especially rural people who are at low access to all social and economic services. All these are in line with the rural-focused general development strategy of the country.

In the health policy of this country, equity in health care coverage and the quality of health care, prevention of disease and promotion of health, use of appropriate technology, democratization and decentralization of the health service strengthening and recognizing of health services, intersectional collaboration and co-operation, community development and participation have well-underlined as priority areas.

Much of the health policy and strategy is shaped and dominated by the principles of the primary health care approach launch by the WHO at Alma Ata in the former USSR in 1978. An enabling environment and opportunities is the government structures that have government ministers that are responsible and involved for the rural development. These are ministries of rural development and capacity building and rural infrastructure.

2.1.8 Opportunities and Challenges of Implementation of Health Extension Program in Ethiopia

MOH (2005) stated the following opportunities and challenges.

Opportunities

- Government readiness to implement the strategy,
- The policy and strategy environment health and health related policy HSDP,
- Decentralization and democratization of health delivery system,
- Economic and rural development strategy,
- Experiences gained from agricultural extension,
- Rich experiences and support from NGOs and other agencies,
- Woreda level-strengthened authority or power,
- Availability of trained and experienced community health workers.

Challenges

- Lack of time or high workload on the extension workers to cover all these activities,
- Lack of budget for the implementation of preventive and educational activities,
- Weak institutional arrangements to support the implementation, monitoring and evaluation of the extension program,
- Poor economic-lack of resources may limit the implementation of the program,
- Lack of motivated and skilled staff for implementation, monitoring and evaluation and supervision,
- Poor communication network and transportation facilities,
- Poor logistics supply and inaccessible implementation areas, ✓
- High turnover of health extension and other community level health workers,
- Lack of strong institutional support, ✓
- High turnover of staff that may lead to discontinuity of the programs.

2.1.9 Guiding Principles and Strategies used in Health Extension Package Program Implementation

MOH (2005), health extension strategy can be seen as a part of their wider movement or reform from the more tradition forms of top-down development practice to the participatory development and implementation direction. In line with, the health extension as a health development strategy follows the following principles in its working direction:

- The supremacy of the people's involvement peoples priorities, interests, needs and wishes must be respected and accumulated in all aspect,
- People's knowledge and skills must be seen as a potential contribution to the health extension scheme or activities.
- Women involvement in all decision making process should be the center issue in the health extension strategy,
- Community ownership, empowerment and autonomy on the program and self-reliance need to be performed,
- Community health actions need to be promoted or taken participation of the community in the health schemes of the communities.

Enhancing Political Commitment and Support

For the formulation and implementation health and health related policies and strategies, political commitment is crucial and necessary at various levels. MOH (2005) stated that besides, the commitment of the central government, commitment of the local government is extremely important for the implementation of the health extension program. This local level commitment will have a strong impact on the health service. Presence of this commitment is a support environment, which is necessary for a successful planning and implementation of the health extension program. The financial and political commitment for the successful implementation of health extension package at all level will be an indication or reflection of the accountability of the politicians, practitioners and policy makers for health and well-fare of the people.

This is to reorient health services to fit the health extension package by reviewing and strengthening of organizational infrastructure facilities. The attitude of staff, which were trained

and coached in an old health service delivery system (medical focused) need to be changed inline with the present innovative approach, that is preventive and promotive services.

Enhancing Decentralization and Strengthening of the Implementing Role of the regional Government

Decentralization, which comes after the devolution of power facilities the participation of people in the decision-making process, resource allocation and utilization, creates a supportive environment MOH (1993). The woreda level skill should be enhanced or upgraded in order to create a supportive and facilitating environment for health extension strategy, staff development, logistic support, teaching materials design and development are necessary resources needed for the health extension program.

According to the present government decentralization policy, development planning and budgetary activities are carried out at woreda level and transferring responsibilities, which zones and regional health bureau held were transferred to woreda health departments.

To make Possible the Organizational and Functional Restructuring

- Setting up different committees whose members are drawn from different sectors, agencies, community leadership organizations, civic societies, women and youth groups,
- Designing responsible unit/body/ person who make a follow up,
- Staffing the unit with the responsible and skilled person both technical and administrative staff,
- Carrying out capacity building and training, carrying out training needs assessment and priorities,
- Creating, forming and strengthening and co-coordinating the necessary infrastructures and organizations such as health committees, health counsels, boards, community-based organizations, women's groups, youth groups and others.

Enhancing Team Development and Motivation of the Health and Management Staff- Changing Attitude of Professionals

This will facilitate the working capacity of staff working in health extension services. This will be realized through creating and organizing discussion forms, experience and information networks, team development sessions, shared vision and mission development meetings. Introducing motivating and reward system for the staff for a better achievement. Development better training and education system. Implement collective and progressive leadership in the organization. Develop mechanisms that lower or minimize the attrition rate or turn over of the staff in the organization. Introduce good health communication system in the organization.

Poor motivation of some staff hinders the success of the supervision. This needs the awareness and change of attitude of the health professionals and the health extension agents for this purpose. This activity requires the motivation of the health professionals and other staff to be fully committed to improve the health status of the rural population who are at lower level of health status.

The Need for Motivation and Management of Health Extension Workers

There needs to be proper procedures in all staff management process that include employment, retention, support on the job training, coaching, performance appraisal/reviews, recruitment, promotion, information network, transfer, designation of tasks and job descriptions, taking disciplinary measures, leave, creation of better working condition, creating reward and motivating system, using good method of resolution of possible conflict, bearing responsibility and accountability of works. The immediate responsible supervisor or head of the program needs to carry out periodic assessment of work performance and based on the assessment need to take the necessary corrective and preventive measures. These can be simple feedback for better future performance, recommendation for promotion or reward, on-job training or disciplinary action.

Continuing Education

It is also essential because of several factors. The main reasons may due to the fact the effectiveness of performance of the health extension workers increase with the information or knowledge. The second reason can be due to the fact that health or any other government policy

or strategy can effectively performed when there is continuous flow of information to the health extension workers; the third reason is to keep their credibility as a good source of information is mandatory. All these have a high resource implication for the regional government.

Promoting Community Involvement

As recommended by MOH (2005), community participation is a health development strategy. This is because; health can be achieved through community involvement or participation and collaboration of wide range of stakeholders. Participation of the community in decision-making process is a reflection of the political power of the people and mobilization of resources. This promotes empowerment self-reliance, responsibility and ownership for health actions. The type and level of community participation are expressed in terms of the needs assessment, leadership, organization, resource mobilization and management.

Community involvement can be indifferent forms which include gaining of individuals or community members' greater responsibility for their health decision making on health issue, identifying priorities, mobilization, allocation, contributions, management and control of resources (Collins, 1994). To adopt a revolutionary and innovative approach in health development, in which the communities have a part and voice in community diagnosis and controlling the health determinants. There is high implication for community participation in community-based health service. Health developments like any other type of development a multi sectoral process; especially in this particular case of community-based health extension is crucially important.

For participation of people in development, two measures are taken; these are structural change and capacity development of people. For empowerment peoples participation in development, as a means, is essential. It is the right of people to take part decision making and action. This builds self-esteem, enhances sense of responsibility.

Conditions that Help Community Involvement in Health Care

As identified by MOH (2005), factors influencing involvement of the community in health extension program include:

- Enhancing reform in health services that responsive to the needs of the people, decentralization that take the powers and authority down nearer to the community, reorientation of the health services that is working towards to the community involvement and empowerment.
- Respecting community values and norms (diversity)
- Willing community trust and respect,
- Making available resources, skilled health staff, logistic support, interactive teaching materials that attract and meet the needs of the people.
- Creating and understanding or agreeing on common purposes, goals and objectives of health extension package with in the community.
- Enhancing information, education and communication about health and other development issues to create understanding with the community.
- Enhancing the capacity and skills of the health staff-how to effectively work with communities,
- Training and retraining of staff to adopt/use participatory approach in health development and its implementation,
- Creating participatory community dialogue or forms to discuss issues, where success in health extension and other development issues are discussed and success will be shared and owned with the community,
- Giving top priority to women and youth involvement in health extension issues,
- Collaborating with other sectors as they share their experiences and agenda, which is essential to address the community needs,
- Promoting or creating experience sharing visits among communities (visits can be by their representative leadership organizations).
- Carryout periodic monitoring and evaluation of the level of community participation in health extension.

Through strengthening woreda level health system, community participation will be enhanced and facilitated more effectively in the planning and implementation of health services and creates

harmony community and woreda level condition harmony with the national health policy guidelines and resource allocation and utilization.

Community Involvement and Collaboration in Health Extension Program Includes;

- Diagnostic study of the community, identification of needs
- Selection of health priorities, planning, implementation,
- Monitoring, supervision, evaluation of activities
- Allocation and management of resources

Benefits of community involvement includes for the sustainability of development and maximum utilization of health services, local knowledge, skills and resources.

In line with Goldman (1991) and MOH (2005), especially creation of the awareness of the need of the project and winning the trust of the community and working through the community organizations are important approach to enhance community involvement.

Enhancing Supportive Supervision

This will try to find out and correct any constraints encountered in the implementation of the health extension program. Effective supervision requires team of experts with an appropriate skill mix, continuity among team members, strong management skills, and client orientation. Supervision is a well-planned activity undertaken at scheduled time that is undertaken by highly skilled health professionals and health managers aimed at providing information, feedback on the performance of health extension activities.

The supervision activities are carried to promote staff support, motivation, communication, skill or capacity building, better coverage, better performance, high health impact, cost-effectiveness, provide information on staff performance and useful information for staff promotion or development and to promote team spirit.

Necessary Conditions for Effective Supervision

- Effective decentralization process-delegation of authorities, resources, decision-making power,

- Effective strategic management of the federal government ministry of health,
- Effective multi-sectored collaboration and coordination at different levels,
- Creation of effective supervisory system,
- Development of supervision schedule that indicates frequency of supervision visits and duration of supervision,
- Sustainable and effective supervision programs,
- Selection and designation of proper or qualified staff with technical managerial skills,
- Proper training of staff,
- Availability of qualified staff of higher skills, education, experience, training and positive attitude towards health extension program or community health services,
- Good communication and understanding and participatory discussions among the staff for maximum gain from the supervision,
- Development and creation team-working and team spirit among the staff involved in the supervision activities,
- Availability of checklists to be used to measure performance,
- Giving rewards or incentives to staff with better performance.

Stakeholders and Roles in the Health Extension on Package

Planning and implementation of health extension program involves a wide long of sector stockholders, government departments, public and private agencies, donor agencies, civic societies, professional associations, community leadership organization, women and youth groups community members, media groups partementarians and political and government units. However, the major or key leading role players will be the health sector at different levels to ensure sustainability on effectiveness of the health extension package.

Developing and strengthening referral Arrangement

To fit into the health care delivery system and infrastructures and create harmonization with other health care facilities there is a need to device a smooth and effective referral system that meets the health needs of the people in the areas of family planning, maternal and child services, adolescent health services prevention and control diseases, first aid management, immunization services, and

other services which are beyond the capacity of health extension workers MOH (2004). This may again help to form linkages with the next health care facility staff that may serves information and educational support.

In a referral system the necessary points are:

- Building public confidence
- Provides accurate and helpful information and advice
- Support families to facilitate referral
- Incorporating the relevant and necessary information
- Developing good relation and communication with health care facilities that receive referred cases.

Chapter Three

Research Design and Methodology

This deals with research method, source of data, sampling technique or procedure, instrument of data collection, pilot study and methods of data analysis.

3.1. Research method

The main purpose of this study was to assess the implementation of health extension program in some selected woreda's of Jimma zone.

To serve this purpose, descriptive survey method was employed as an appropriate methodology to reflect the intended program of the study. This is due to the fact that descriptive survey is the most important research design to collect descriptions of existing phenomena with the intent of employing data to justify current conditions and practices or to make more intelligent plan for improving program implementation (koul, 1984).

3.2. Sources of Data

The sources of data for the study were classified into two (primary and secondary).

Primary Data Sources

Model House Holds who have gained training and implemented health extension program, kebeles' health extension workers, and woreda and zonal health extension experts were used as sources of primary data. All these were the most important agents who were thought to have better information about the implementation of health extension program in the selected woredas and/or kebeles.

Secondary Data Sources

The secondary data sources were obtained from documents, work plans, reports and works in the study area that were from regional, zonal and woreda health offices, Ministry of Health, CSA,

internet and so on. Moreover, the relevant reviews of literature (books, journals, published and unpublished materials) were examined as secondary sources.

3.3. The Population, Sample and Sampling Procedure

On the basis of their accessibility and familiarity to the researcher three woredas were selected randomly out of the 18 woredas of jimma zone. Then with close collaboration of the health extension experts of the woreda, two kebeles from each woreda were selected and a total of 180 household models in 2 rural and 4 urban kebeles were randomly selected proportional from the total of 1865 household models that have gained and implemented health extension training in the respective kebeles.

Health extension workers were also selected purposively from the selected sample kebeles. This was due to the fact that purposive sampling methods were very convenient in the situation where the sample to be selected is very small and to get some idea of the population characteristics in a short time (Kidder, 1981).

In addition to the selected woreda health office department, head of woreda health extension experts were selected by using purposive sampling technique. From the zonal office department, the head of health extension program experts were selected by using purposive.

Table 1: Sample size and sampling technique

	Woreda	Kebele	Total model household	Total sample household	Sampling techniques
1	Omo Nadda	Waqtola	300	30	Simple random
		Asendabo	250	25	Simple random
2	Sokorru	Sokoru	400	40	Simple random
		Deneba	515	50	Simple random
3	Kersa	Serbo	175	15	Simple random
		Chari	225	20	Simple random
	Total		1865	180	

3.4. Instrument of Data Collection

Both the quantitative and qualitative data gathering instruments were employed. The instruments were designed to fit and address the types of information required for the study. The main instruments of the data collection in the study were questionnaires, interviews, document analysis and focus group discussion guides.

Questionnaire

As defined by Good and Hatt (1952:33), the word questionnaire refers to a device for securing answers to a series of questions by using a form which respondents fill in themselves. In addition to this, Barr (1953:65) also defines, questionnaire as a systematic compilation of questions that are administered to a sample of population from which information is desired.

With regard to this, two types of questionnaires were prepared to collect data from two groups of respondents (households and health extension workers). To gain all the possible information from the respondents, the questionnaire included both open-ended and close-ended questions.

The questionnaire include key contents such as personal information, participation of household in the program, methods of health extension package training, the perception of households towards health extension service and health extension workers, challenges, opportunities and prospects of implementation of health extension program.

Interview

As Koul (1984) defines, interview is a process of communication or interaction in which the subject or interview gives the needed information verbally in face to face action (situation). And, Wiersam (1995) defines semi-structured interview as one in which the procedure to be followed is standardized and is determined in advance of the interview. It imposes a degree of formality which does not permit the interviewer to establish the kind of relationship him/her self and the interviewee which is necessary if the interview is to be conducted at some depth and the interviewer has no freedom to rephrase questions, add extra ones or change the order in which the questions have to be presented. Thus, semi-structured interview questions were prepared together factual and detailed information from health extension experts at zonal and woreda level. Those respondents are selected purposively, which in turn, is the major way in which the quality evaluation seeks to understand the participation of the household in the program, methods of the program training, administration of the program, challenges, opportunities and prospects of the program through indepth, intensive interviewing to find out what is in interviewees mind.

Focus Group Discussion

This method of data collection was arranged with the purpose of supporting the data obtained by the questionnaire and interview. As indicated by Mcneill and Chapman (2002), focus group discussion produces a good deal of qualitative data expressed in the word of participants. Therefore, this technique was employed to acquire the necessary data from health extension workers and model household about the perception of the community towards health extension workers and problems encountered, while working in the community, health extension workers

view about the problem they faced for being female, and the relationship between health extension workers and other workers in the kebele, and suggest ways of improving health extension program implementation in their respective district.

Document Analysis

Besides the above mentioned instruments, various documents related to administration opportunities and challenges of health extension implementation program were used to obtain relevant information.

Table 2: Source of Data Collection and corresponding Data Collection Instruments

Respondents	Instruments
Model households	Questionnaires and focus group discussion
Health extension workers/trainers	Questionnaires and focuses group discussion
Zonal and woreda health extension experts /officers/	Semi-structured interview
	Document assessment

3.5. Piloting the Instruments

“A Pilot study can be done to determine whether the procedure has merit and to correct obvious flaws “Burg, and Gall, (996:65),

Therefore, following the design and preparation of each of the instruments particularly the questionnaire was submitted to the clients for a comment. In addition, the zone and woreda health extension experts were invited for additional comments/correction. Then, the questionnaire which was prepared in English was translated in to Afaan Oromo. The respondents

in the pilot study were not included in the actual data collection process. With regard to questionnaire, in the mid December, 2010, a pilot test was administered to 15 respondents in OmoNadda woreda within two kebeles (Asendabo and Wak Tola) in the study area.

The purpose of this test was to check the appropriateness of the items in the instrument and to make necessary amendments based on the obtained feed back from respondents.

Finally, the response obtained from questionnaire, nterview, focus group discussion and document analysis were analyzed and interpreted.

3.6. Methods of Data Analysis

To analyze the data gathered, both the quantitative and qualitative methods were employed with a special focus on qualitative analysis. This was done because qualitative research is policy and evaluation research and yield useful insights about program implementation such as HEP (Seyler, 1993). Moreover, the analyses were supported with some descriptive statistics. The data collected by various tools were analyzed and interpreted.

All the close-ended questions of the questionnaires were quantitatively described by using frequency distribution and percentage, where as data collected through open-ended questions of the questionnaires, interview, focus group discussion and document analysis were analyzed qualitatively. In other words, analysis of data was done a help of descriptive statement and simple statistical method based on frequency and percentages, calculated on the basis of response of the respondents.

Chapter Four

Presentation, Analysis and interpretation of data

The purpose of this study was to assess the implementation of health extension program in some selected Woredas of Jimma Zone. For this study 2 rural and 4 urban Kebeles were selected from three Woredas. Data were gathered from model households and the extension workers using closed-ended and open ended questionnaire, interview was conducted with zonal and Woreda health extension experts and focus group discussion was also conducted with model households and health extension workers.

4.1 Study Area

Three Woredas of Jimma Zone mainly Omo Nada, Sokorru and Kersa were included in the study. Jimma is one of the eighteen zones that are found in Oromiya Region, is located in the South West part of Ethiopia. The capital of zone is Jimma town which is located 355kms South West of Addis Ababa. Omo Nadda woreda is about 55kms east of the zonal capital Jimma town. Based on 2009 census population of the zone in 2010 is 2,788,390 residing in the 18 Woredas and 75% of the population are residing in 512 rural kebeles (zonal document/2010). Based on the decentralized nature of preventive primary health care, in 2005 Oromiya Regional State in general, and Jimma zone in particular, has been implementing health extension program packages in 472 health posts by assigning 1047 health extension workers in the rural Kebeles. As reported by the zonal health department, tuberculosis, unspecified diarrhea, skin disease, stomach parasite, gastric disease and HIV/AIDS are the main health problems of the zone currently.

4.2 Model Households Involvement in Health Extension Training

Community participation is a health development and implementation strategy. This is because health extension can be achieved through community involvement or participation and collaboration with wide range stakeholders. Different settings or places are important to deliver health extension training to the community.

In relation to this, informants were asked some questions to investigate household participation and their responses are presented and analyzed as follows.

Table 3: The distribution of model households' participation in health extension training

No	Items	Model household			
		Yes		No	
		No	%	No	%
1	Have you participated on health extension/packages program training in your Kebele?	176	97.8	2.1	11
2	Did health extension workers organize you to participate on health extension program?	153	85	25	13.9
3	Did the Kebele administrator organize/recruit you to participate on health extension program.	137	76.1	41	22.8
4	Did health extension training take place in your Kebele compound?	121	67.2	57	31.7
5	Did health extension training take place in religious institutions?	62	34.4	11 2	62.2
6	Did health extension training take place in your village?	127	70.6	55	30.6
7	Did health extension training take place in your working places?	145	80.6	31	17.2
8	Did health extension training take place in your Kebele health post?	151	83.9	25	13.9
9	Do you think that health extension training was appropriate to your language and culture?	174	96.7	-	-
10	Was the health extension training applicable to your real life situation?	170	94.4	6	3.3

Concerning the participation of model households in the health extension training program, 97.8% of the households responded that, they participated on health extension training. This process was done in a context of true health message communication one in which the learners/household and health extension workers/facilitate.

Interview responses from zonal and Woreda health extension experts showed that the level of community participation on health extension program reached 68% and 75.8% respectively. This shows that health extension program is a community based and the households were agreeing on common purpose and objectives of health extension program. This is similar to Lindemon (1926). Adult education was (and still is) considered as a process of increasing peoples understanding and helping them to make decision for themselves when there is true involvement and participation by community members at each stage with in the process. Moreover, Frerie

(1990) for education to be humanizing, it must involve the learners in problem identification in which learners and facilitators trust and respect each other. Israel (1982) also claims that behavioral change depends on the level of participation and ownership by those being served.

Regarding the organizers of households, 153 (85%) of respondents were organized by the local health extension workers where as 137 (76.1%) were organized by their local Kebele administrators.

Moreover, interview responses from zonal and woreda health extension experts showed that the organizers of the community on health extension training were the joint task of both the health extension workers and kebele administrators.

This reveals that the organization of model households for health extension training was a collaborative task of both the local health extension workers and kebele administrators. This is in line with what the MOH (2003) has stated in the implementation guideline that model households have to recruit by kebele administrators and health extension workers and community organizer could play a crucial role in helping communities to increase their problem solving abilities.

As presented in table 3 (item 4), 121 /67.2/ percent of household respondents said that health extension training takes place in their kebele compounds. This is because the kebele compound is one of the training places of health extension program.

Regarding villages, 70.6 percent of household responded that health extension training takes place in their villages. This shows that villages are also places of health extension training delivery. On the other hand, 145 (80.6%) and 151 (83.9%) of respondents said that health extension training takes place in their working place and kebele health post respectively. As a result it can be concluded that health extension training mostly takes place in health post, working place and village of the study area. From this we can observe that there are different places of adult education program delivery in general and health extension program training in particular.

This goes with what the Ministry Health has planned. MOH (2003) states that there are different places of health message communication delivery; these are kebele compounds, villages,

working places, religious compounds and health posts. The existence of different places of health extension training delivery is important to attract and increase the community participation to the training packages and have positive impact on the implementation of health extension program. Since, these places are found around the community's residential places, it would be easy for household heads to attend the training programs.

As can be seen from table 3, (item 9) almost 97 percent of respondents responded that the health extension training is appropriate to the communities' language and culture. This could increase the communities trust and involvement/participation to the effective implementation of health extension program and its sustainability. Similarly, Knowles, and Associates, (1998) and MOH, 2003 stated that when adults learn in their own language, norms and values it increases their decision-making abilities. So, they would become owner of their health issue.

Regarding real life situation, almost 94.4% of respondents said that, health extension training program has a real life application. It could be shown during the demonstration of the packages around their village and houses. This shows that the content of health extension is concrete, real life related, constantly changed to meet new needs, to deal with real issues of current concept. This is in line with the view of Freire (1973)" a person can learn to think critically about real life problems and take action to change his or her own plan of action to deal with any problem collectively identified". In addition, Knowles (1984) asserts that one of the principles of adult education is that it should be applicable to real life situation, when designing a curriculum for adult learner; courses should be organized around the acquisition of skills necessary for one to earn a living. These skills may be computer, farming, health and business.

Generally, community participation can have positive influence on effective implementation of the health extension program as intended by MOH (2005). Community participation on training enables to develop self-reliance, self-confidence, beliefs in one's capacity in general, and develop strong will power initiative to participate in development undertaking of the community and to investigate one's own health problem, awareness about their causes, and once known to take alternatives actions in search for solution.

4.3 Methods of Health Extension Training

Health extension training method comprises these techniques of communication between health extension workers and communities. There are several health extension training methods. These include person to person/home visit, group discussion, demonstration, lecture, print material, and visual materials such as pictures.

None of the methods can be singled out as being the best one. A combination of methods is more effective than just one method. These methods also differ on the number of issues to be addressed, and the problems to be solved; efforts and resource required. Use of wide range of health extension methods will help the extension system and improve the communication process that leads to better adoption of health extension program (Bedar, 2001; MOH, 2003). To identify the different health extension training methods used by health extension workers, some questions were raised to the respondents, and their responses are summarized in the following table.

Table 4: The distribution of methods of health extension training

No	Methods of training	No of health extension workers in percent and degree of comparison			
		Frequently	Sometimes	Rarely	Never
1	Lecture	10 (76.9%)	3 (23.1%)	-----	-----
2	Group discussion	2 (15.4%)	11 (84.6%)	-----	-----
3	Demonstration/learning by doing/	-----	4 (30.8%)	8 (61.5%)	1 (7.7%)
4	Drama (in an entertaining way)	-----	-----	1 (7.7%)	12 (92.3%)
5	Person to person discussion (house to house visit)	5 (38.5%)	7 (53.8%)	1 (7.7%)	-----
6	Pictures or photographs	1 (7.7%)	8 (61.5%)	4 (30.8%)	-----

Table 4 shows the responses of HEWs on the frequency of methods they use in conducting health extension training.

As illustrated in table 4 (item one), 76.9% of health extension workers responded that they are frequently using lecture method in health extension training. This indicates that, lecture method

is one of the communication method of health extension activities, because, the health extension workers always present orally new information to the trainees.

As shown in table 4, 84.6% of health extension workers responded that, they are sometimes using group discussion in health extension packages training activities. This is different from the view of Lokoko (2002), who consider group discussion as one of adult education method which provides an opportunity for learners to think together constructively for the purpose of learning, solving problems, making decision, and/or improving human relationship.

As presented in table 4, 61.5% of health extension workers responded that they are rarely using demonstration or learning by doing on health extension training. This view is strengthened further by health extension workers during focus group discussion explained that, they rarely used demonstration method for teaching on some health extension packages such as preparing and feeding babies, building healthful housing, building sanitary latrine and usages.

As pointed out in table 4 (item four), 92.3% of health extension workers responded that, they are never using drama on health extension training. As a result, drama is not one of the communication or training methods of health extension training in the study area. However, MOH (2003) recommended that, drama is one of health message communication. It should be prepared and presented in a recreating manner and at the same time informative and moving towards better positive behavioral change.

As indicated in table 4 (item five), 53.8% of health extension workers responded that, they are sometimes using person to person discussion (house to house visit) as a teaching method. This method of health extension training enables the house hold more secure in his/her surrounding and willing to discuss health problem openly, such as personal hygiene, environmental hygiene, infant mortality, HIV/AIDS, TB and etc...on the spot.

Similarly, focus group-discussion from health extension workers explained that through house to house visit, they are in a position to check the validity of any claims of the house hold with the results of their own observations and on the basis of any additional information, they found it much easier to work with the households to arrive at possible solution. The implementation states that person to person communication is useful in rural area where mass media is not

available; it enables the health extension workers visit house to house sanitation facilities and helps to create positive attitude for behavioral changes MOH (2003).

From table 4 (item six) 61.5% health extension workers responded that they are sometimes using pictures. Because they are using pictures during heir oral presentation for better explanation. This is in line with MOH (2003), suggestion that pictures are useful for communicating messages to adults those who cannot read and write and these materials are very useful to health extension workers during their oral presentation for better explanation.

Therefore, as indicated in table 4, among the different teaching methods listed above, lecture method is the most widely used method followed by group discussion, person to person discussion and using picture. This implies that most of the health extension workers of selected kebele were still using the lecture method dominantly. However, as most of the trainees in such packages are adults, the implementation of various methods in vital, because as Lekoko (2002) noted, methods to train adults should be as varied as possible so as to cater for various learning needs and to break the monotony of using a single method. Over use of lecture relegates adults to a receptive position which is contrary to the principle that adult learning should be participatory in nature.

4.4 Model Households' Perception towards Health Extension Workers and their Service Provision

Community perception is important for the smooth running of health extension program. In the absence of the necessary understanding by the beneficiaries, it is hardly possible to realize the objective of the program. Accordingly, to examine the perception of the community households towards health workers and the services they offer, some questions were raised and their responses are summarized in the following table.

Table 5: The distribution of model households' perception towards health extension workers and their service provision

No	Items	Model households	
		Frequency	Percentage
1	Do you agree that the criterion for selecting health extension workers from neighboring kebeles including your is satisfactory		
	A. Agree	163	90.6
	B. Disagree	15	8.3
2	The selection of only female health extension workers is acceptable		
	A. Agree	149	82
	B. Disagree	29	16.1
3	Where does health extension worker live?		
	A. In the rural kebele	161	89.4
	B. In the town kebele	17	9.4
	C. I don't know	-	-
4	Level of your satisfaction with health extension workers services?		
	A. High	113	62.8
	B. Medium	65	36.1
	C. Low	-	-

The majority of the model households 163 (90.6%) mentioned that it was good that the health extension workers selected from their own kebeles. This implied that, the communities are nearer to the program/the program is found at the grass root level. Therefore, the highest proportion of the households believe that the HEWs selections from nearby kebeles were their satisfactory. Regarding health extension workers' sex, majority 82.6% of the respondents agreed about health extension workers being female and 12.9% of the study participants being against female preponderance in health extension program.

As reported by model household during focus group discussion, majority of the participants speculate that health extension workers are very much close to women and as a result many of the service utilizes were mothers and children, but some discussants recommended that, to strengthen very good service provided by health extension workers, it is also good to involve male health extension workers to deal with health related problems of male community members. The discussants ascertained that after they got informed by health extension workers, the women of the village started to clean and maintain the cleanness of their houses and also they take care of their children in better way than before. The discussant also added that by observing the activities of health extension workers in the village, some village mothers started to advise their daughter not to think of marriage before they become educated like health extension workers. Therefore, it shows that health extension workers are females who were very much close to them and take time to teach on their health and other related problems to the family. Therefore, it is simple to conclude that the communities highly regarded the importance of health extension workers being female.

As shown in table 5, overwhelming number (89.4%) of the model household respondents knew the presence of health extension workers in their own kebele where as 9.4% of the study subjects mentioned that health extension workers live in the woreda town. This shows that the majority of health extension workers are living in their working kebeles where as few health extension workers are living in their woreda town. Health extension program implementation guide line did not state about the residential condition of health extension workers. Probably the assumptions are that the majority of health extension workers were recruited from their own kebele or neighboring kebele. Therefore, the need for residential place is not the priority in this case as far as they reach the households in time to deliver the intended services.

But the actual situation is different that the majority of house hold reflected that health extension workers were living in their working kebeles. Therefore, this also increased the communities' perception about the health extension program/health services and its sustainability.

As it is clear from table 5, majority (62.8 percent) of household respondents were highly satisfied with the service provision of health extension workers, while 36.1 percent of the respondents were moderately satisfied with the service provision of health extension workers. This indicates

that household satisfaction with the service provision of health extension workers varies from woreda to woreda or kebele to kebele. However, the majority of households were satisfied with the service delivery of health extension workers.

The focus group discussion by the model households strengthens the above result. Majority of the households were benefited and satisfied much from the presence of health extension workers in their kebeles.

The discussants also elaborated that it is after the assignments of health extension workers that all households in the kebele started to construct and utilize the pit latrine. Previously, pit latrine was only found in the town. Currently every one in the village has a pit latrine. They also added that the health extension workers not only taught to construct pit latrine but also how to use and maintain the cleanness of the pit latrine. Using soap or ash to wash their hands after defecation is a common practice among the villagers as they speak out during discussion. The discussants also reported that it is health extension workers that taught them to conduct voluntary testing for HIV/AIDS before marriage and not to make sex outside. The household also added that it is HEW that taught them to isolate human and animal residence in order not to be infected by the disease that can transmit from animal to human being. From this finding we can conclude that the majority of households have more positive attitude for health extension workers' service provision. As a result they feel satisfied by the service they are provided and it increases the communities' participation and ownership of their health issues. In line with this MOH (2003) states that the selection of extension workers from their kebele and including neighboring kebeles and their service provision will increase the communities' perception towards the program implementation and to be the owner of their health issues.

4.5 Implementation/Demonstration of Health Extension Packages

In the context of adult education program, implementation refers to putting the program goals and design to work by conducting teaching learning activities and assessment exercises aimed at fulfilling the desired expectations. And the implementation of health extension package increases the observation ability and sustainability of the program by others. With regard to the

implementation of health extension packages the collected data are presented in table 6 and the analysis present below.

Table 6: Responses on the implementation of health extension packages

No	Item	Model household			
		Yes		Not	
		No	%	No	%
1	Have you implemented/demonstrated health extension packages in your house?	169	93.9	9	5
2	Did you get available material for the demonstration of health extension packages from health post?	15	8.3	163	90.6
3	Did you use locally available materials for the demonstration of health extension packages?	155	86.1	23	128
4	Was the demonstration/implementation of health extension packages cost effective?	178	98.9	-	-
5	Did you transfer the knowledge and skill obtained from the training and demonstration to others?	172	95.6	6	3.3
6	Did you get reward/motivation when you demonstrated the packages in their house?	165	91.7	-	-

As shown in table 6 (item one), almost 94% of model household responded that they demonstrated health extension packages in their house. The demonstrated packages are family planning, environmental sanitation by constructing pit latrine, personal hygiene, and housekeeping by constructing shelf and food nutrition. This shows that individuals are able to perform or demonstrate specific health extension packages/behaviors. They know what the health extension packages are and how to perform them through clear instructions and/or training and the demonstrated packages are problem based/need based for adults and as a result of this households are mastery of a task. This is in line with the view that of Rogers (1983) “diffusion can be though of a special type of communication in which messages are concerned about all idea, if a health extension program is viewed as an innovation and the target population would follow in adopting the program”. Moreover, Rotter (1954) also wrote that, behavioral capability

as the knowledge and skills necessary to do a behavior which influences actions. If individual are to be able to perform specific behaviors, they must first know what the behaviors are and how to perform them. Therefore, clear instructions and training may be needed for smooth implementation.

Regarding sources of available materials to the demonstrated health extension packages, 86 percent of household models responded that they use locally available materials. This indicates that health extension program preventive health care services mostly used locally available materials to the demonstrated packages and it makes the program friendly to the community and increases community empowerment because it reduces demonstration and the costs of materials.

As shown in table 6 (item four), almost all model households responded that, health extension program is more of cost-effective. This is because the program used different health extension training methods, the training takes place in different places which are nearer to the residence of the communities and the preventive nature of the program. As a result of this, it reduces the transport cost of the trainees to get training from their kebele to woreda towns, and it is more of preventive than curative. Thus, it reduces the cost for buying curative/medicated materials and the people easily construct pit latrine.

Similarly, interview responses from zonal and woreda health extension experts revealed that in previous time the communities come to woreda health center to get health services, but now a days the health extension workers and health post are found in the community villages and kebeles. They also responded that the old health service delivery system (medical-focused), needs to be changed in line with the present innovative approach, which is a preventive and promotive service. This also reduces the costs to buy medicine.

Regarding knowledge transformation from the model household to the other community, 95.6 percent of model households responded that they transferred the knowledge and the skill they obtained from the training and they demonstrated the packages to the other community members who were not getting the knowledge and the skill from the training. The model households are giving the training during coffee ceremony, developmental work in large community meetings and at any suitable situation to about 4-6 households on the average. This indicates that health

extension implementation program is transferred from the model household to the other communities and also indicates the extent to which numbers of people really know one another. This is similar with that of Bandura (1997) who claims that a person can increase self-efficiency through observing the performance of other. Fishbein and Ajssen (1980) on their part say that if a person believes that performing a given behavior will lead on to the whole positive outcomes, then he/she will hold a favorable attitude towards performing those behaviors. HSDPii (2003) stipulates that besides addressing the whole public the health extension works are expected to select model households and work with them. These are the families considered to be innovative and ready to change and influential community members. The health extension worker gives training on the packages to the members and let them graduate when they convinced and well informed by the intervention and serve as a model to others.

Therefore, there is a positive attitude of the model households on health extension packages to transfer and share the knowledge and skills to the other communities.

Regarding motivation system, 91.7% of model/households responded that, they get reward for the demonstrated packages.

This indicates that there is strong follow-up mechanisms by health extension workers to identify who has demonstrated all the packages and/or not. As reported by health extension workers during focus group discussion, all participants described that there is provision of certificate to those who demonstrated all the packages following through house to house visit and checklist. Most of the time, health extension workers provide certificates as reward and finally, they graduate as models to others. This is similar to what HSDPii (2003) claimed that health extension workers should give certificate to model households when they are expected to demonstrate practical changes in the use of health program. Therefore, reward system has a positive impact to increase community participation on health extension program and for its sustainability.

4.6 Administrative Activities

Administration is an integral element of implementing adult education programs. Administrative functions are those activities that the administrators do in order to make the program successful

(Boyle, 1980). Those activities may include handling participant registration and attendance records, distributing program materials (for example, course outlines, program packages), handling financial issues (payment for expenses associated to the program), issuing or awarding professional license or certification, carrying out supervision activities and providing refreshment courses/additional information, motivation and collaboration of various government and non-government sectors. In relation to this, informants were asked some questions to investigate the administration activities and their responses are summarized and analyzed as follows.

Table 7: Percentage distribution of administrative activities

No	Item	Health extension workers			
		Yes		No	
		No	%	No	%
1	Did you get refresher courses about health extension packages?	10	79.9	3	23.1
2	Did you have detailed job description of duties and responsibilities on health extension program?	12	92.3	1	7.7
3	Have you got supervised by woreda health extension supervisor?	9	69.2	4	30.8
4	Did the woreda health office department provide any motivation for you?	2	15.4	11	84.6
5	Did you get feedback from the supervision?	8	53.8	5	46.2
6	Did the school principals and teachers help as the major actors in the kebele for the implementation of health extension package?	5	38.5	8	61.5
7	Did religious leaders help as the major actors in the kebeles for the implementation of health extension program?	2	15.4	11	84.6
8	Did NGOs help as the major actors in your kebele for the implementation of health extension program?	8	61.5	5	38.5
9	Did agricultural workers/DAs help as the major actors in the kebele for the implementation of health extension program?	10	76.9	3	23.1
10	Did kebele administrators help as the major actors in the kebele for the implementation of health extension program?	11	84.6	2	15.4

With regard to the provision of refresher training to the HEWs 79.9% of health extension workers participate in one or two refresher training prior to investigation which is provided by woreda health office and NGOs. Twenty three percent of them did not participate in any of refresher courses. All of them reported that they want to be refreshed on how to manage normal labor, how to give vaccination (especially, on how to plan the targets and about the monitoring charts) on HIV/AIDS and other STDs control and prevention. They also need to get refreshed on how to care about child feeding, pregnancy control, and maternal and child health. It is clear that from what has been stated above there is much commitments of woreda health office and NGOs in the provision of refresher courses for health extension workers.

The implementation guide line states that, the existence of refresher training in health program will help in overcoming health problems facing at the implementation stage and ensure the sustainability of health development (MOH 2005).

Regarding job duties and responsibilities the same table (item two) indicates that almost 92.3 percent of health extension workers have detailed description of their job duties and responsibilities that guide them as to what to do with in given framework. As a result, the health extension workers avoided anything which harms people's interest, honor or any thing contrary to their well being; did everything which is good to the peoples, treated all members of the community equally and gave to people trust, credit, good will and respect.

Interview responses by both zonal as well as woreda health extension experts and the document analysis sourced from zonal health office show that the duties and responsibilities of health extension workers were distributed to all kebeles health post. Therefore, distribution of job description duties and responsibilities of health extension workers to all rural kebele health post is the task of the zonal and the woreda health office for successful implementation of the program. As shown in table 7, about two-thirds (69.2 percent) of the health extension workers responded that they are supervised by woreda health supervisors and 30.8 percent of them are not supervised by woreda health supervisors. Similarly, supportive supervision, interview response from zonal and woreda health extension experts explained that the reason for not supervising the health extension workers were lack of transportation to reach inaccessible areas, absence of fixed budget to the program, and high turnover of skilled staff in the zone and woreda health office. As

a result, areas of kebeles that are near to woreda towns are regularly supervised by woreda health office supervisors. It is stated in health extension program guide line that supervision is the basic tool to correct any constraints encountered in implementation of health extension program.

The available zonal document also revealed that management support and supervision are the key elements which “make or break” any community health program.

Interview response from woreda health extension expert revealed the reasons for not giving feedback to health extension workers were absence of team of experts with an appropriate skill mix, and lack of strong management skills. But the health extension program guideline stated that giving feed-back requires team of experts with an appropriate skill mix and strong management to promote motivation and communication skills of the activities of health extension workers (MOH, 2005).

As presented in the table 7 (item 6) 61.5% of health extension workers responded that there was no involvement and collaboration of school principals and teachers for the implementation of health extension packages while 38.5% of them responded that there was involvement of school principals and teachers for the implementation of health extension packages. It shows that cooperation among the school principals as well as teachers and health extension workers in their own kebeles are weak.

This is because of low relationship between the school community and health extension works and the school principals and teachers lack awareness about the program objectives. But, it is stated that in the health education guideline that, health extension workers should select model teachers and give training on health extension packages to be implemented in the school because, the school teachers generally belong to a learned community segment with their knowledge and skills, they can easily communicate health messages to community and in the school the students are believed to be agents of change for the community. Once they understand the objective of the program, they can easily transmit to their parents and would influence them to implement the program. Thus, schools are important place to deliver organized and continued health education as well as to introduce other health program such as immunization, HIV/AIDS control and

prevention. Goodman and Smith (1991) also state that the involvements of teachers are instrumental to the implementation of health extension program.

Regarding religious leaders to be the major actors for the implementation of health extension packages, almost 84.5 percent of health extension workers responded that there is no involvement of religious leaders to cooperatively work with health agents to teach the community. This is due to the fact that health extension workers did not organize themselves with the religious leaders to the successful implementation of the program. Where as the program guideline stated that the health extension workers should cooperate with the religious leaders for communicate health extension message in religious institution are good places for communicating health message and health extension workers should organize themselves and use the opportunity.

As presented in the same table (item 8), 61.9% of respondents responded that there is the collaboration of NGOs for the successful implementation of the program and 38.5% of respondents indicated that there is no collaboration of NGOs for the implementation of health extension program.

Moreover, interview responses from zonal and woreda health extension experts explained that the existence of NGOs varies from woreda to woreda, even kebele to kebele and their cooperation also varies from kebele to kebele. NGOs like FIDA, plan Ethiopia, woreda vision and world learning are found in different woredas and kebeles of the zone and they said that woredas/kebeles which have NGOs cooperatively work with health extension workers and they are providing health materials/resources and training to the community and health extension workers.

This shows that woredas/kebeles and NGOs are working cooperatively with health extension workers to the successful implementation of health extension program.

Regarding the cooperation of agricultural workers (DA's) almost 75% of health extension workers responded that there was a significant cooperation among health extension workers and agricultural workers (DA's).

Responses of health extension workers from focus group discussion strengthened the above results. Majority of health extension workers said that there was strong collaboration between agricultural workers and them selves. The reason given by discussants was the strong management of the kebele leaders to make strong relation between health extension workers and agricultural extension workers. As a result of this, the agricultural workers in their field work taught the community about importance of environmental sanitation to develop healthful living and to increase their productive capacities.

Eighty five percent of health extension workers responded that there is high cooperation and relationship between themselves and the kebele administrators for the implementation of health extension program. This is because that the kebele administrators are aware about the significances of the program objectives.

The result presented above is further strengthened by the participants during focus group discussion held with the health extension workers. The majority of health extension workers described that the majority of kebele administrators have good awareness about the preventive health care and they are cooperative with health extension workers. For example if health extension workers want to give health education at meeting place they give their time to health extension workers at the beginning of the meeting. This is similar to the implementation guideline; it states that the kebele administrators should have a commitment or responsibilities to work with health extension workers because health extension program is a collaborative activity of various government and non-government sectors to bring about health development.

4.7 Opportunities of the Implementation of Health Extension Program

Opportunities are important inputs which increase the effective utilization of the program by health agents and the community to bring about a behavioral change with in the life of the community. As MOH (2005) recommended the government's readiness to implement the strategy of health and health related policy, decentralization and democratization, health delivery system are the corner stone to the effective implementation of health extension packages. In relation to this, informants were asked some questions to investigate the opportunities and their responses are summarized and analyzed as follows;

Table 8: Percentage distribution of opportunities of implementation of health extension program

No	Item	Health extension worker				
		Rate of frequency				
		V.H	H	M	L	VL
1	Health extension ensures equitable access to service	10 (76.9%)	1%	----	--	----
2	Existence of community involvement to the implementation of health extension packages	-----	8%	----	--	----
3	The decentralization nature of health delivery system	2 (15.45%)	9%	---	--	----
4	The bottom-up approaches of health extension implementation strategies	10 (76.9%)	4%	----	--	----
5	Low cost intervention to address the major cause of health problem	11 (84.6%)	15.4%	---	--	----
6	Health extension implementation involves individual particularly women and children	11 (84.6%)		----	--	----

As indicated in table 8 (item one) all of health extension workers responded that health extension program highly ensures equitable access to services.

This indicated that there is health extension program service in all study kebeles. The zonal and woreda health extension document also strengthen the above result, it showed that all 532 rural kebele in the zone get health extension services. The presence of health extension service in all kebeles is likely to encourage the participation of the community, because they see the establishment of health post as opportunities for their health problems and increases the sense of ownership/decision makers about their health issues. MOH (2005) states equitable access to health services helps to promote the perception and participation of the community about their health.

Regarding existence of community involvement, 69.2% of the health extension workers responded that the involvement of the communities to the implementation of health extension

program is medium. This is because in the previous time, that is before the origin of the program in Ethiopia in general and in the zone/woreda of the study areas in particular, there were no such kinds of community health services. At the same time, there was no participation of the community as a whole to prevent their health problems.

Interview respondents from zonal health experts strengthened the above findings, they described that the involvement of the community increases from time to time. For example in 2008, it was 51% whereas in 2010 it is almost 65% (at medium level). Therefore, the involvement of the community on health extension packages clearly shows that their awareness about their health issues/problems increased from time to time and it is also an opportunity to the successful implementations of the program.

Regarding the decentralization of health extension delivery system, 92.3% extension workers responded that the decentralized nature of health extension delivery system is high. This finding is supported by interview respondents from zonal and woreda health extension experts. They described the reason that the existence of decentralization of health extension delivery system is because of the transfer of the major part of decision-making, health care organization, capacity building, planning, implementation and monitoring from the federal, regional, zonal woreda and to the kebele with clear definition of rules. As a result of the decentralized nature of health extension delivery system there is an opportunity for the successful implementation of health extension program in the study area. It is similar to the implementation guideline, it stated that for the formulation and implementation of health and health related policies and strategies. Political commitment is crucial and necessary at various levels. Besides, the commitment of central government ,commitment of local government is extremely important for the implementation of the program at all levels which will be an indicator or reflection of the accountability of the politicians, practitioners and policy makers for health and well fare of the people (MOH, 2005).

As shown in table 8 (item four), 92.3% of health extension workers responded that health extension program was of highly a bottom up approaches/characteristics. This is due to the establishment of health council with strong community representation at al levels and health communities at grass-root level to participate in identifying major health problems, budgeting,

(to the construction of health post), planning, implementation, monitoring and evaluating health activities. Therefore, a bottom-up nature, approaches health problem and at the same time good opportunities to the identification their health problem and at the same time to address their major cause of health problem.

Regarding the cost-effectiveness of the program, all of respondents said that health extension implementation is highly cost effective. This is due to the fact that it reduces the transport cost of the community to get health services from woreda town, and its preventive nature reduced the cost to buy medicine and most of the time the communities' used/locally available material to prevent their health problems. As a result of this, the cost effective nature of the program is a good opportunity to the effective implementation of the packages, and its sustainability and the involvement of the communities on the packages.

One of the opportunities of implementation of health extension program identified in focus group discussion and interview was that health extension workers being females, they could make a good role model for female children living in rural communities. They were also found to have been trying their best to attain promotive health at house hold level.

The competence of health extension workers in communication skill, and intervention related to family planning, prevention and control of HIV/AIDS and intervention related to immunization were found to be strong, because of

- the establishment of health post in all the 532 kebeles of the zone;and
- the majority of health extension workers were recruited from the community makes the community to trust the program.

On the other hand, from the zonal health extension document the opportunities of health extension program are:

- the zonal health service coverage is reached to 93.3%;
- the rural kebeles health extension packages coverage is increased from time to time and it reached to 97.2% and the total urban and rural kebeles of health extension packages coverage has reached to 88.5%;

- traditional harmful practices, like female genital mutilation and early marriage totally reduced as a result, the females' educational enrolment rate is increased;and
- a vaccination system was mostly carried out around the living villages of the community.

4.8 Challenges of Implementation of Health Extension Program

Factors and conditions that constrain the implementations of health extension program are lack of time or high work load on health extension workers to cover all these activities, weak institutional arrangement to support the implementation, monitoring and evaluation of health extension program, lack of motivated and skilled staff for implementation and evaluation and supervision, poor communication network and transport facilities lack of strong institutional support and poor logistic support and the presence of inaccessible areas. In relation to this, informants were asked some questions to investigate the challenges, and their responses are summarized and analyzed as follows;

Table 9. The distribution of challenges of implementation of health extension program

No	Challenges	Health extension workers				
		Rate of frequency				
		V.H	H	M	L	V.L
1	Lack of time on health extension workers to cover all health extension package	10 (76.9%)	-	3(23.1%)	-----	-----
2	Lack of text book/reference as well as demonstration materials	2 (15.4%)	7(53.8%)	4(30.8%)	-----	-----
3	Lack of regular supportive supervision from health center and woreda health office	8 (61.5%)	1(7.7%)	3(23.1%)	-----	-----
4	Inadequate number of health extension workers to the target group ratio	10 (76.9%)	3(23.1%)	-----	-----	-----
5	Lack of continuing education to health extension workers	13 (100%)	-----	-----	-----	-----
6	Weak relationship between health extension workers and other sector workers	-----	-----	4(30.8%)	8(61.5%)	1(7.7%)

As indicated in table 9 77% of health extension workers responded that lack of time has highly affected the implementation of health extension packages. This is because of the broadness of the health extension packages. Similarly, concerning time, focus group discussion by health extension workers and interview responses from the zonal and woreda health extension experts explained that the given time to the implementation of the program did very little to effectively address the general objectives of health extension packages towards the community. They also discussed that 96 hours are not enough to carry out house to house visit to communicate a health message across community. This is because, some villages are very remote from the health post and they are difficult for transportation. The implementation guideline, however, states that, 96 hours are enough to effectively address the whole packages for the community (MOH, 2005).

Therefore, time is one of the constraints for implementation of health extension packages in those rural communities.

Regarding the adequacy of text books /reference as well as demonstration materials, 69% of health extension workers responded that, there is high shortage of text book as well as demonstration materials. However, the zonal document analysis indicated that text book/reference as well as demonstration materials were distributed to all woredas health offices and to all rural kebele health posts.

Generally, when health extension workers prepare programs, they usually consult books for more information on the relevant packages matter. Regarding books broadness and deepness health extension workers understanding of their areas of interests, which can be incorporated in to the development and implementation of the program for the ultimate benefit of the adult learners? And the health extension workers will also question, refine and modify their perspectives on packages.

As shown in table 9 (item three), 69.2% of respondents said that there is lack of regular supportive supervision from the woreda health office and the clustered health centers where as 30.8% of health extension workers were more or less regularly supervised. This is due to the fact that lack of transportation to reach inaccessible area, lack of motivated staff and mostly regular

supportive supervision is carried out in kebeles, which are nearer to woreda town and health center.

This result is strengthened by interview respondents from the zonal and woreda health extension experts. They explained that there was no regular supportive supervision across each rural health post in the zone. This is because of lack of skilled or experienced senior staff, lack of resources to carry out; feedback is not given most of the time, high turnover of skilled staff because of absence of career growth or promotion and most of the time very distant area is not covered by supervision.

As a result of the above factors, lack of a regular supportive supervision is one of the constraints to the successful implementation of health extension program in the study area.

As presented in table 9 (item four), all of the respondents indicated that, inadequate number of health extension workers to the target population ratio highly affects the implementation of the packages. This is difficult to manage and supervise the activities of 5000 people by one health extension worker. In some kebeles, the target population is beyond the standard of the implementation guideline or more than 5000 people managed and supervised by one health extension worker. This also takes time for supervision activities. As a result of this, some people returned back to their first phase.

Therefore, inadequate number of health extension workers to the target community was also the major challenges to the implementation of the program.

As shown in table 9 (item five), all of the health extension workers responded that they did not get opportunity for upgrading their educational level. However, MOH (2005) recommended that continuing education or upgrading the educational level of health extension workers is essential because of several factors. The main reasons may be due to the fact that the effectiveness of performance of the health extension workers increases with the information or knowledge and to keep their credibility as a good source of information is mandatory. These positively influence the motivation of health extension workers in general and the successful implementation of health extension packages in particular.

Report from woreda health office revealed that, due to lack of continuing education, in some kebeles there is high turn over of health extension workers and it also described that the regional health bureau did not develop policy guideline and standards for continuing education and career structure to health extension workers.

Therefore, lack of continuing education is one of the major factors which affect the implementation of health extension program in the study area.

As pointed in table 9 (item six), 70% of health extension worker responded that there is good relationship between themselves and other sector workers in their surrounding kebele. This is particularly true with agricultural workers, kebele administrators, in some school teachers and health extension workers. This is due to the fact that, strong managements of the kebele administrators and awareness about the programs objectives that health is a collaborative activity to bring about healthy generation in all aspects of development activities. This is not the major challenge for the successful implementation of the program.

Based on interview responses from zonal, woreda health extension experts and focus group discussion by health extension workers there were also other challenges. The challenges and gaps were:

- The recruitment were planned to be from the same kebeles to allow better integration. But in few kebeles young ladies from urban and pri-urban center were recruited. This may have effect on permanent availability of health extension workers in the kebeles.
- Documentation and reporting was not instituted properly.
- Referral system and linkage with health center is weak. The health extension workers do not have good relationship with health worker working in higher level health institutions such as the health centers.
- Health extension workers did not get career growth and transfer mechanism to the nearest kebele based on their services.
- Most of the health post has deficiency of medical equipment for patient's examination, and drugs/supplies useful for promotive, preventive and curative health services. One of

the constraints discussed at field study where health extension workers were represented was that the availability and sustainability of resources is a major concern.

The other challenge is limited human resource capacity of district health systems to support the program. Also integration of health extension program to the whole health system, creating practical linkage with health center and hospital services, and ensuring effective and regular support from the higher level of the system is also a challenge.

On the other hand, from the zonal health extension document the challenges of health extension program are:

- there was no annual/review/ experience meeting in the zone and region.
- there was absence of regular supportive supervision in between the zone and regional health office department.
- there was no research on health extension activities among zonal and regional health office department
- some woreda health offices did not recruit health extension workers based on the stated criterion.
- most woreda administrators were not given feedback on the implemented packages by observing the rural kebeles
- high turnover of health extension workers;
- some kebele administrators did not regularly follow up and gave feedback for some health extension workers;and

4.9 Prospects of Implementation of Health Extension Program

Responses of health extension workers, households, zonal and woreda experts from focus group discussion and interview discussed that due to the establishment of health post in each rural kebele of the zone the existence of health extension workers, acceptance and awareness of the community on the program, the involvement of some stakeholders such as agricultural workers, kebele administrators and NGOs, the presence of different places of health extension delivery and varieties of different health extension training methods in the study areas were a good

prospect for the implementation of health extension program. The prospects of the implementation of health extension program in the study area include the following.

- It will undertake measures to reduce morbidity, disability and mortality for the major communicable disease in the zone.
- It will strengthen and expand family planning health and nutritional service for mothers, children and youth at all levels of health system, including community level in the zone.
- It will provide and increase the coverage of hygiene and environmental health service to the community.
- It will promote political and community support for preventive and promotive health service by educating and influencing planners, policy makers, women groups and potential collaborators.
- It will help to review and strengthen the existing health management information system at all levels (including community level) to produce timely information for planning, management and efficient decision making in the zone.
- People will construct and use a healthy home and as a result avoid illness which might arise from unhealthy house.
- People will develop skill of building a healthy house.
- Observation of the model households will help disseminate health information and practice among all members of the community.
- People to people experience sharing will be developed and their contribution will be increased.

Generally, these would enable to bring about behavioral changes to ensure that communities perceive and manage their own health related activities to create healthy environment as well as healthy living and it brings healthier and productive generation.

Chapter Five

Summary, Conclusions and Recommendations

This part deals with the summary, conclusion and recommendation. In this section, first brief summary on the study and major findings were presented. Second, conclusions of the fundamental findings were made. Finally, some possible recommendations were given on the basis of major findings of the study.

5.1 Summary

The main purpose of the study was to assess the implementation of health extension program in Jimma zone of Oromiya regional state. Urban and rural kebel from three woredas were selected on the basis of accessibility for transportation. In order to come up with certain understanding about the implementation of health extension program, the following basic questions were raised to guide the effort at finding solutions to the problem under investigation.

1. How does the involvement of household models on health extension training look like?
2. Does the extension program incorporate different method of adult learning?
3. What the perception of the households towards the health extension workers and the service they provide?
4. What are the major administrative activities for the successful implementation of the program?
5. What are major opportunities and challenges that positively and negatively influence the implementation program?
6. What does the prospects of health extension program look like?

In dealing with the research problems, descriptive survey method was employed and relevant literature was reviewed. A total of 197 persons, that is, 180 model household, 13 health extension workers, 1 zonal and 3 woreda health extension experts have participated in the study.

The data for the study were collected by means of questionnaire, interview, focus group discussion and document analysis. The data collected were critically analyzed and interpreted.

Based on the analysis and interpretation of the data, the researcher has listed the summary of the finding here under.

- Majority of model households participated in health extension training.
- The organizers of model households were health extension workers and kebele administrators.
- Health extension training mostly takes place in health post, working places and villages of the study areas.
- Overwhelming majority of the model households witnessed that health extension training is appropriate to their language and culture and has real life application of the program
- The study indicated that, health extension program used different teaching or communication methods, but the lecture method is the most frequently used method.
- Majority (90.6%) model households agreed with recruitment of only female health extension workers from neighboring kebeles including their kebeles and they are satisfied with the service provision of health extension workers.
- The model households implemented health extension packages. They also transferred the knowledge and the skill that they obtained from the training and implementation to others. The model house holds are giving the training during coffee ceremony, developmental work, in large community meetings and at any suitable situation to about 4-6 households on the average.
- Model households get reward in the form of certificate to the demonstrated packages in their house.
- The study indicated that, there is lack of regular supportive supervision and feedback to health extension workers. This is due to lack of transportation to reach in inaccessible area, absence of fixed budget, high turn over of skilled staff, absence of team experts with

an appropriate skill mix, and strong management skills in the zone and woreda health office.

- There were collaboration with various stakeholders in the study areas for the implementation of health extension program such as agricultural workers (DAs), kebele administrators and NGOs such as FAYA, Woreda Vision Plan Ethiopia and Woreda learning. But collaborations of teachers and religious leaders were weak: This is because, the relationship between teachers and health extension workers is low, and teachers lack awareness about the program objectives and health extension works did not organize themselves with the religious leaders.
- Health extension program ensured equitable access to service because, it reached all rural kebel of the study area.
- The study also revealed that the decentralization of health extension delivery system is high. There is the transfer of decision-making, health care organization; capacity building, planning, implementation and monitoring of health extension activities from federal, regional, zonal, woreda and kebele with clear definition of roles and responsibilities. As a result the decentralized nature of health extension delivery system is an opportunity to the successful implementation of health extension program in the study area.
- The study also identified that health extension program is highly cost-effective. This is due to the fact that it reduced transport cost of the communities to get health service from the woreda town and its preventive nature also reduced the cost to buy medicine and the communities also used locally available materials to construct pit latrine, house shelf and isolate their residence from animal to prevent their health problem like personal hygiene and environmental sanitation. As a result of this low cost intervention is one of the opportunities for the implementation of health extension program in the study area.
- The study also showed that lack of time on health extension workers to cover all health extension packages is one of the major challenges to the implementation of health extension program in the area.

- Shortage of textbooks, as well as demonstration materials is also a major constraint to the successful implementation of the program in the area.
- Kebeles far away from the woreda town were not regularly supervised by woreda supervisors for reasons associated with lack of this is of transportation, lack of resources, feedback is in time, and high turnover of skilled staff.

5.2 Conclusions

Based on the summary of the findings the following conclusions were drawn.

- Even though the health extension program is new initiative and it is in its infancy stage, there was encouraging effort done in the study areas to help households participate in health extension training. This is because the program is based on their need, the training is also made appropriate to their language and cultures and the existence of different places of health extension delivery, such as health post, working places, villages and kebele administration compounds. Thus this might have its own positive impact on the implementation of health extension program.
- Moreover, in this study it was found that with the help of extension workers, model households have implemented all health extension packages and were able to transfer their experiences to the other people widely.

Even if health extension workers used different health communication / teaching methods, lecture method is the most frequently used method than demonstration, drama and field visit. But this method was not that much convenient to adults since it affects their free participation.

In the study area, the communities have positive perception towards the selection of only female health extension workers from their kebeles and neighboring kebeles and there is strong support and satisfaction from community member for the preventive and promotive service provided by health extension workers. As a result, health extension workers are providing preventive services as intended by health sector development program and services such as family planning and vaccination at out reach level, pit latrine construction and antenatal care, home visit and postnatal care are some of the best performed activities in kebeles included under the study.

The establishment of health posts in each rural kebeles of the study area ensured that equitable access to health service and, the decentralization of health service delivery and integration between sectors and the presence of community health works in the kebele were found to be opportunities to implement health extension program.

Health extension program highly ensured access to services. The presence of health extension service in all kebeles is likely to encourage the participation of the community and the decentralized nature of health extension delivery systems are found to be opportunities for implementation of health extension program in the study areas.

Lack of time on health extension workers to cover all packages, shortage of reference materials and lack of regular supportive supervision, absence of career growth and continuing education to health extension workers were found to be challenges to implement health extension program. This is because of affects the motivation and the work behavior of health extension workers.

On the top of support to health extension workers, the community suggested that the involvement of male health extension worker to support each other and fulfill some needs of the community.

5.3 Recommendations

In light of the findings of the study, the following recommendations were forwarded

- Health extension program can not be independently implemented by health extension workers alone and it needs the collaborations of various stakeholders. In the study area, the collaborations of teachers and religious leaders to the implementation of the program are low. Thus, health extension workers should develop intensive awareness to teachers and religious leaders with common understanding in order to facilitate program implementation.
- Extension agents must have adequate knowledge of the characteristics of each extension teaching/communication method as well as knowledge of the characteristics of respondents. This will enable health extension workers to use appropriate methods with appropriate time and place. In the study area extension workers frequently used lecture method without encouraging communities' participation. Thus, health extension workers

should give emphasis to demonstration, drama and field visit method than relying only on lecture.

- Reference materials are important and effort so far is commendable but more adapted versions might be required. More importantly, upgrading, new and improved approaches and technologies should be introduced through more flexible forms such as news letters and leaflets.
- Supportive supervision requires team of experts with an appropriate skill mix and strong management skill which aimed at producing information, feedback on the performance of health extension activities. This will enable health extension workers to correct any constraints encountered in the implementation of health extension program. In the study area, kebeles far from the woreda town did not get supportive supervision. Thus efforts should be made by woreda, zonal and regional health offices to develop committed team of experts and strong management skills.
- Providing continuing education and career development that positively influences the motivation and work behavior of health extension workers to successfully implement the program. In the study area health extension workers did not get career development and continuing education. Thus, regional and zonal offices should develop policy guidelines and standards for continuing education and career structure to health extension workers.
- Regional health bureau and zonal health offices should conduct research and studies on health extension activities.
- Further study should consider whether to include male health extension workers in order to fulfill male needs and support each other with female health extension workers in program implementation.

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ANNEX

APPENDIX -A
Addis Ababa University
School of Graduate Studies
Department of Curriculum and Teachers Professional
Development Studies (Adult and Lifelong Learning Unit)
Questionnaire for Model Households

The main purpose of this questionnaire is to collect, relevant and appropriate data from model households concerning the implementation of health extension program. It also aims at providing some possible recommendations for the encountered problems. If there are any because your genuine, frank and timely response for each question is quite vital to determine the success and completeness of the study, I cordially request your high collaboration in filling the questionnaire honestly and responsibly.

Thank you!

APPENDIX-B

Addis Ababa University

School of Graduate Studies

Department of Curriculum and Teachers Professional

Development Studies (Adult and Lifelong Learning Unit)

Questionnaire for Health Extension Workers

The main purpose of this questionnaire is to collect relevant and appropriate data from health extension workers concerning the implementation of health extension program. It also aims at providing some possible recommendations for the encountered problems, if there are any. Because your genuine, frank and timely response for each question is quite vital to determine the success and completeness of the study, I cordially request your high collaboration in filling the questionnaire honestly and responsibly.

Thank you!

Part 1: General information and personal data (circle the letter for your choice)

1. Woreda _____ Kebele _____
2. Age
 - a) 18-25 years and below
 - b) 26-35 years
 - c) 36-45 years
 - d) 46 years and above
3. Sex
 - a) Male
 - b) Female
4. What is your current marital status?
 - a) Married
 - b) Single
 - c) Divorced
 - d) Widowed
 - e) If any others, specify _____
5. Educational level
 - a) Grade 5-10
 - b) Grade 10/12 complete
 - c) TVET graduate
 - d) Others _____
6. Experience
 - a) 1-3years
 - b) 4-6years
 - c) 7-10years
 - d) More than 10 years
7. Where do you reside?
 - a) Rented
 - b) With my family
 - c) In the health post
 - d) In woreda town

Part 2: Methods of health extension package training

Rate the level of health extension package methods that practiced during training, by using 'x' mark in the table in the space provided

No	Methods of health extension training	Levels of methods of training			
		Frequently	Sometimes	Rarely	Never
1	Lecturing				
2	Group discussion				
3	Demonstration/learning by doing				
4	Drama/in an entertaining way				
5	Picture				
6	Home visit				
7	Others (specify)				

8. What are the major challenges you faced to apply the methods of health extension package training in your practice? (Multiple answers are possible)
- a) Lack of teaching materials
 - b) Inconvenient of the teaching classroom
 - c) Shortage of local design teaching aids
 - d) Shortage of time
 - e) Broadness of the package
 - f) Large size of the trainees
 - g) Lack of trainees participation
 - h) Others _____

Part 3: Implementation/demonstration of the health extension package

1. Did the model household implemented/demonstrated the health extension package in their locality? a) Yes b) No
2. If your response to question number 1 is 'yes' which package did you implemented? _____

3. If your response to question number 1 is 'no' why? _____

4. Where did the household get available material resource to the implemented package?
 - a) In the health post c) NGOs
 - b) From the community d) From kebele council
5. Which health extension package was highly implemented by the community? (Rank them from highest to the lowest)

No	Package	Rank
A	Family planning	
B	HIV/AIDS prevention	
C	Malaria prevention	
D	Food hygiene	
E	Environmental hygiene	
F	Personal hygiene	
G	Nutrition	

Part 6: Challenges of the implementation of health package

Challenges that affect the implementation of health extension package program are listed below, please indicate the degree of the program for each option by using 'x' mark on the space provided in the table.

VH=very high, H=high, M=moderate, L=low, VL=very low

No	Challenges/problems	Rate of frequency				
		VH	H	M	L	VL
1	Lack of time on health extension workers to cover all health extension package					
2	Lack of text books and reference materials as well as demonstration					
3	Limited facilities for large number of trainees					
4	Lack of regular supportive supervision from the health center and woreda health office					
5	In adequacy number of health extension worker to target group ratio					
6	Poor communication and transportation system and the distances from woreda centers					
7	Lack of motivation to health extension workers at all levels					
8	Lack of continuous education for health extensions workers					
9	Weak relationship between health extension worker and other sector workers					
10	If any others, specify <i>Health</i>					

Part 7: General options of the respondent

1. What are the major health problems in your kebele? _____

2. What are the opportunities and challenges of the implementation of health extension program?
 Opportunities _____
 Challenges _____
 What are the major prospects of the implementation of health extension package in your kebele? _____

11. Did the health extension workers have detailed description of duties and responsibilities on health extension package?
12. What are their responsibilities?
13. Did the health extension workers get refresher course about the health package? And who provided refresher course training to the health extension workers?
14. How supervision is conducted to the health extension worker in your woreda?
15. How many times the supervisor visit health extension workers?
16. Did the supervisor give feedback to health extension workers?
17. In which health extension package the supervisors provided feedback and what kind of feedback they provided?
18. What are the major problems that influence the provision of supervision in your woreda?
19. Was there permanent annual budget to health extension package?
 - a) Yes
 - b) No
20. Who are the sources of for the provision of budget?
21. How much the amount of budget allocated to each kebele?

Part II: General question

1. What are the major health problems in your woreda? _____

2. What are the opportunities and challenges of the implementation of health extension program?
 Opportunities _____
 Challenges _____
3. What are the major prospects of the implementation of health extension package in your woreda? _____

APPENDIX-D

Addis Ababa University

School of Graduate Studies

Department of Curriculum and Teachers Professional

Development Studies (Adult and Lifelong Learning Unit)

Focus Group Discussion Leading Questions for Model Households

Part I: Leading questions

1. What are the major health problems in your locality?
2. Is there a health post in your locality?
3. How do you come and registered in health extension program?
4. In which health extension package you get training?
5. Did the health package training relevant to your need?
6. How about the schedule of the program? Is it convenient for your job?
7. What method did health extension workers used in teaching-learning process of health extension package? Do they use teaching aid?
8. What is your perception about health extension workers and their service delivery?
9. What is your role for the implementations of the health package?
10. What is your opinion towards all health extension workers being female?
11. What is your suggestion towards the implementation of health extension program?

Part II: General Questions

1. What are the opportunities and challenges of the implementation of health extension program?

Opportunities _____

Challenges _____

2. What are the major prospects of the implementation of health extension package in your woreda? _____

APPENDIX-E

Addis Ababa University

School of Graduate Studies

Department of Curriculum and Teachers Professional

Development Studies (Adult and Lifelong Learning Unit)

Focus Group Discussion Leading Questions for Health Extension Workers

1. What are the problem you faced being females?
2. What are your suggestions to improve health extension program in your districts?
3. What is the relationship between you and other sector workers in your kebele?
4. What are the problems that encountered while working in the community?

Yunivarsitii finfinneetti mana barnootaa QO'annoo eebba boodaa kolleejjii barnootaa, muummee sirna barnootaa fi Qo'annao dagaagina Ogummaa barsiisotaa (Damee barnoota ge'eessotaa fi umrii guutuu)

Gaafilee/Unkaalee/Haadha(Abbaa) worraa tiif Hojjetoota Eksiteenshinii fayyaa leenjii fudhataniin gutaman.

Kaayyoon gaafilee kanaa waa'ee tajaajila Eksiteenshinii fayyaa ilaalchisee ragaa sassaabee yoo hanqinni jiraate qaama ilaallaatuuf yaada furmaataa beeksisuudha. Kanaafuu, gaafiiwwan maraaf, deebii ifaa fi sirrii ta'e kennuun qu'annoo kana ni milkeessa.

Galatoomaa!

Haala woli Galaa

1. Maqaa keessan barressunn barbaachisaa miti
2. Gaafilee maraa wolduraa-duubaan dubbisuun;
 - a. Qubee /filannoo/deebii ta'e itti maruu
 - b. Gaafiiwwan sanduuqa/ornaalee/keessatti argamanu mallattoo "X" iddoo /bakka/ duwwaa irra kaa'aa
 - c. Bakka takko tokkottis deebii gabaabaa barreessaa.

Baay'ee Galatoomaa!

Unkaalee Hajjettota Eksiteenshinii fayyaatiin guutaman

Kutaa 1 Ragaa Gaafatamtootaa

1. Aanaa----- Ganda-----
2. Umrii a) 18-25 c) 36-45
b) 26-35 d) 46 fi ol
3. Ga'ee hojii.....
4. Saala a) dhiira b) dhalaa
5. Waa'ee Gaailaa a) Ka fuudhe/heerume (suubboo)
b) Ka hinfuudhin/hinheerumin (qeerroo)
c) Gurse/mmoo/
d) Kan biraa (yoojiraate)-----
4. Haala Barnootaa a) 9-10 (kutaa) c) BLTO (Barnoota leenjii teeknikaa fi ogummaa)
b) 11-12 (kutaa) d) Kan biroo (yoojiraate)-----
5. Hagam tajaajiltanittu? a) Woggaa 1-3 c) Woggaa 7-10
b) Woggaa 4-6 d) Woggaa 10 al
6. Haala mana jireenyaa a) Kiraa b) maatii Kiyya woliin c)Keellaa fayyaa keessa/health post

Kutaa 2: Tooftaalee leejjii paakeejii Eksiteenshinii fayyaa ilaalchisee

Mala kamiin leenjii eksiteenshinii fayyaa fundhattan?

Mallattoo "X" iddoo duwwaa keessa kaa'uun deebii kennaa.

Lakk	Mala Leenjiin paakeejii Eksiteenshinii fayya itti kenname	Mala leenjii /tooftaale			
		Yerro Hedduu	Darbee darbee	Yeroo Gabaabaf	Hinjiru
1.	Ibsaan				
2.	Marii Gareen				
3.	Hojjatani/Gochaan/agarsiisuun				
4.	Taphaan/ Diraamaadhaan				
5.	Manaa gara manaatti adeemuun				
6.	Fakkiidhaan agarsiisuun				
7.	Kabiroo yoo jiraate ibsaa_____				

8. Rakkooleen gurguddoon mala leenjiiwwan paakeejii Eksileenslinii fayyaa hojii irra oolchuu keessatti muudatan maal fa'i?

- a) Hanqina yeroo
- b) baayina leenjifamtootaa
- c) Yeroo leenjiin kennamu leenjifamtootni hirmaachuu dhisuu /dhabuu
- d) meeshaaleen deggersa barnootaa dhabamuu
- e) Bal'ina qabiyyee paakeejichaa
- f) Dareen barnootaa qophaa'e dhabamuu
- g) Leenjifamtootni fedhii dhabuu
- H) Hanqina maallaqaa

Kutaa 3: Hojiirra oolmaa paakeejii Eksiteenshinii fayyaa ilaalchisee

1. Maatiiwwan moodeela ta'an paakeejii Eksiteenshinii fayyaa naannoo isaaniitti hojii irra oolchaniiruu?
 - a) Eeyeen
 - b) miti
 - d) nashakkisiisa
2. Gaaffii lakkofsa tokkoof deebiin keessan "Eeyyeen" Kan jedhu yoo ta'e paakeejii isa kamidha? -----
3. Gaaffii lakkofsa tokkoof deebiin keessan "Miti" kan jedhu yoo ta'e sababni isaa maalif? -----
4. Maatiiwwan moodeela ta'an paakeejii Eksiteenshinii fayyaa Hojii irra oolchuuf meeshaalee isaan barbaachisu eessaa argatu?
 - a) Keella fayyaa irraa
 - b) Ganda irraa
 - c) Meeshaalee naannoo isaaniitti argaman irraa
 - d) Dhaabilee miti mootummaa ta'an irraa
 - e) Kan biroo irraa
 - f) Baasii ofii isaanii irraa

3. Ogeessa Eksiteenshinii fayyaa aanaatiin too'annoofi hordoffiin isinii godhameeraa?
 - a) Eeyyeen
 - b) hingodhamne
4. Gaafii lakkoofsa sadiif deebiin keessan "Eeyyeen" kan jedhu yoo ta'e yero hagam keessatti hordofii argattu?
 - a) Torbanitti
 - b) Ji'atti
 - c) ji'a jahatti
 - d) woggaatti yeroo tokko
5. Ogeessa aanaa too'annoo fi hordoffii godhu irraa yaada(feedback) argattanii beektuu?
 - a) Eeyyen
 - b) hinjiru
6. Gaafii lakkoofsa shaniif deebiin keessan "Eeyyeen" kanjedhu yoo ta'e, yaadni isin argattan maali? -----
7. Eksiteenshinii fayyaa aanaa irraa gargaarsi isiniif ni godhamaa?
 - a) Eeyyeen
 - b) hinjiru
8. Gaafii lakofsa torbaaf deebiin keessan "Eeyyeen" kan jedhu yoo ta'e deggersa maalii akka ta'e ibsaa-----
9. Paakeejii Eksittenshinii fayyaa hojii irra oolchuuf kitaaboleefi barreeffamoota adda addaa Ni qabduu?
 - a) Eeyyen
 - b) hinjiru
 - c) gahaa miti
10. Ganda isin keessa jiraattaniitti paakeejii Eksiteenshinii fayyaa hojii irraa oolchuu keessaatti irra guddaa qaama kamtu sochi godha?
 - a) Mana barumsaa
 - b) Dhaabbilee amantaa
 - c) Waajjira fayyaa aanaa
 - d) Dhaabbilee miti mootummaa
 - e) Hojjettota Eksiteenshini Qonnaa
 - f) kan biraa yoojiraate ibsaa
11. Quunnamtiin isin waajiira fayyaa aanaa woliin qabdan Hagam?
 - a) Gadi aanaa
 - b) Giddugaleessa
 - c) Cima
 - d) Baay'ee cimaa

Kutaa 5: paakeejii Eksiteenshinii fayyaa hojii irra oolchuu keessatti Haala mijaawaa uumame

Milkaa'ina Eksiteenshinii fayyaa ilaalchisee haala mijaawaan uumame yoo jiraate armaan gaditt kan eeraman keessa mallattoo "X" fayyedamuun deebii kennaa.

Lakk	Haala gaarii	Haalamijaawaa uumame				
		Baay'ee olaana	olaana	Giddu galeessa	xiqqaa	Baay'ee xiqqaa
1.	Eksiteenshiniin fayyaa namoota hundaaf tajaajiluu issa					
2.	Hawaasaan fudhatama argachuu isaatiif hirmaanaa argachuu isaa					
3.	Tajaajili fayyaa dimokraatawaa fi qindaawaa ta'e jiraa chuuisaa					
4.	Sagantaan Eksiteenshinii fayya bahi qusataadhaa					
5.	Hojjetooni Eksiteenshinii fayya Dubartoota ta'uu isaanii					
6.	Tajaajilli Eksiteenshinii fayya haadholii fi daa'l'mman giddu galeesa kan godhate ta'uu isaa					
7.	Kan biroo yoo jiraateibsaa					

Kutaa 6: Paakeejii Eksiteenshinii fayya hojii irraa oolachuuf hanqinoota/rakkooleen/muudatan yoo jiraate

Paakeejii Eksiteenshinii fayya hojii irra oolchuu keessatti rakkoon muudate yoo jiraate armaan gaditti malaattoo "X" kaa'uun deebisa.

Lakk	Rakkoolee	Sadarkaa rakkinichaa				
		Baay'ee olaanaa	Olaanaa	gidugaleesa	Gadiana	Baay'ee gadiaana
1.	Paakeejii fayyaa hudumaa hojii irra oolchuuf hanqinni yeroo jiraachuu issa					
2.	Hojjetanii agarsiisuuf meeshaalee fi kitaabolle irrattii hanqina jiru					
3.	Hanqina baajataa fi humna nama baratee					
4.	Aanaa irraafi buufata fayyaa irraa hanqinni hardoffi fi too'aannoo jiraa chuu dhabuu					
5.	Baayinni Hawaasa naannoo woliin humni hojjetettota Eksiteenshinii fayya kan wal hinmadaalle ta'uu					

6.	Hojjettoota Eksiteenshinii fayyaatiif onnachiiftuun kennamuu dhiisuu isaa					
7.	Hojjettoonni Eksiteenshinii fayyaa barnoota wolitti fufiinsa qabu argachuu dhabuu issanii					
8.	Hojjettoota Eksiteenshinnii fayya tiif wajjiraalee biroo waliin quunnantiin jiru dadhabaa ta'uu isa					
9.	Hojjettoota eksiteenshinii fayyaatiif carraan barnoota ol'aanaa dhabamuu isaa					

Kutaa 7: yaada woli galaa yoo qabaattan

1. Eksiteenshinii fayyaa hojjii iraa oolchuu keesaatii haala mijaawaafi rakkoleen muudatan yoo jiraatan ibsaa Haala mijaausaa-----
Rakkoolee-----
2. Ganda isin keessajiraattan keessatti paakeejjin Eksiteenshinii fayyaa hojii irra ooluu isaatiif gara fuulduraatti jijjirama maalii fida jettanii yaaddu

Yunivarsitii finfinneetti mana barnootaa QO'annoo eebba boodaa kolleejjii barnootaa, muummee sirna barnootaa fi Qo'annao dagaagina Ogummaa barsiisotaa (Damee barnoota ge'eessotaa fi umrii guutuu)

Gaafilee/Unkaalee/Haadha (Abbaa) worraa leenjii Eksiteenshinii fayyaa fudhataniin gutaman.

Kutaa 1: Ragaalee gaafatamtoota

1. Aanaa _____ Ganda _____
2. Saala a) Dhiira b) Dhalaa
3. Umrii a) 18-25 b) 26-35 c) 36-45 d) 46 ol
4. Gaa'ila a) kanfuudhe/herume b) kan hinfuudhin/hinheerumin
5. Haala barnoota
 - a) Kan dubisuu fi barreessu hindandeenye fi kan hinbaratin
 - b) Kan hibaratiniif barreessu fi dubbisuu garuu kan danda'u
 - c) 1-8 kan barate d) kutaa 9ffaa
6. Haala hojii a) qotee bulaa b) haadhamanaa c) barataa c) daldalaa

**Kutaa 2: Leenjii paakejii eksiteenshinii fayyaa irratti hirmaannaa haadha /abbaa/ worra
ilaalchisee**

1. Isin leenjii paakejii eksiteenshinii fayyaa fudhattanittuu?
a) Eeyyeen b) hinfudhannee c)gahaa miti
2. Gaafii lakoofta tokkoof deebiin keessan “Eeyyeen” yoo ta’e, yoom leenjii fudhattan? _____
3. Gaafii lakoofta tokkoof deebiin keessan “hinfudhanne” kan jedhu yoo ta’e sababni keessan maali? _____

4. Eenyu akka isin leenjii fudhattanu isin godhe? _____
a) Hojjetaa eksiteenshinii fayyaa
b) Bulchiinsa gandaa
c) Kan biraa yoo jiraate ibsaa _____
5. Leenjiin Eksiteenshinii fayyaa Eessatti kennama?
a) Ganda b) mana amantaaleettii d) naannoo hojii
c) naannoo mana jireenyaatti e) kan biroo yoojiraate ibsaa.....
6. Leenjiin Eksiteenshinii fayyaa aadaafi afaan kessanii waliin wol hidhata qaba jettanii ni yaadduu?
a) Eeyyeen b) hinqabu c)nashakkisiisa
7. Gaafii lakoofta jahaaf deebiin keessan ‘hinqabu’kan jedhu yoo ta’e sababni isaa maaliif?

8. Gaafii lakoofta 6 deebiin keessan “Eeyyeen” yoo ta’e bifa kamiin wolitti dhufe?

9. Leenjiin paakejii Eksiteenshinii fayyaa haala naannoo isin keessa jiraattanuun wolnisima jettuu? A) Eeyyeen b) miti c)nashakkisiisa
10. Lakoofta 9 deebiin keessan “Eeyyeen” kanjedhu yoo ta’e Haala qabatamaa leenjichaa akkamitti ibsatu? _____

11. Lakkoofsa 9 deebiin keessan “miti”kan jedhu yoo ta’e sababni maall?

12. Tokko tokkoon paakeejii Eksiteenshinii faayyaa keesatti sadarkaan hirmaannaa kessaanii Hagam akka ta’e ‘X’ kaa’uun ibsaa

Laak	Gosa paakeejichaa	Sadarkaa hirmaannaa				
		Baay’ee olaana	olaana	giddugalesa	gadiaanaa	Baay’ee gadiaanaa
a	Qulqullina dhunfaa fi naannoo ilaalchisee					
1	Balfaa Gogaa fi dhangala’oo dhabamsiisuu ilaalchisee					
2	Meeshaalee mana keessattii tajaajila kennan ilaalchisee					
3	Paakeejii qulqullina nyataa ilaalchisee					
B	Ittisaa fi too’annoo dhukkuboota ilaalchisee					
1	HIV/AIDS fi dhukkuboota qaamolee saalaa tiin daadarboo ta’an ittisuu fi too’achuu ilaalchisee					
2	Dhukkuboota doronyoo sombaa fi tiibiitiisuu fi too’achuu ilaalchisee					
3	Ittisaa fi too’annoo dhukkuba busaa ilaalchisee					
C	Paakeejii kunuunsa fayyaa maatii					
1	Eegumsa fayyaa Haadhoolii fi daa’immanii ilaalchisee					
2	Paakeejii karoora maatii					
3	Paakeejii sirna wol hormaata dargagootaa					
4	Paakeejii sirna nyaataa					

Kutaa 3 mala/tooftlaalee/ leenjiin paakeejii Eksiteenshinii fayyaa itti kennamuu

Mala ykn tooftaalee paakeejii Eksiteenshinii fayyaa kamiin isin lenjii fudhattaan? mallattoo 'X'; ittii fayadamuun deebii kennaa.

Lakk	Maloota leenjiin paakeejii Eksiteenshiniin fayyaa ittii kennamu	Sadarkaa maloota leenjii			
		Yeroo hedduu	Dabree dabree	xiqqaa	Gankumaa hinjiru
1	Ibsaan				
2	Marii gareetiin				
3	Leenjii gochaan agrsiisuun deggarame				
4	Taphaan /Diraamaadhaan				
5	Manaa gara manaatii adeemuudhaan				
6	Leenjii fakkiidhaan deggerame				
7	Kan birooyee jiraate ibsaa				

Kutaa 4 hojii irra oolmaa paakeejii eksiteenshinii fayyaa illalchisee

1. Isin maatii kessan keessatti paakeejii Eksiteenshinii fayyaa hojii irra olchitanituu?
A) Eeyyen b) hin oolchine c) quubsaa miti
2. Gaafii lakkofsa '1' Deebiin keesan 'Eeyyee' kan jedhu yoo ta'e paakeejii fayyaa isa kami? _____

3. Gaafii lakkoofsa '1' Deebiin keesan hin oolchine kan jedhu yoo ta'e sababni keesan maalinnii?

4. Isin paakeejii Eksiteenshinii fayyaa hojii irra ollchuu dhaa wontoota isin barbaachisu eesaa argattuu?
a) Kellaa Fayya Gandaa irraa
b) Wantoota naannoo keessanitti argaman irraa
c) Dhaabbilee mitiimootummaa ta'an irraa
d) Namoota naannoo jiran irraa
e) Waajjiraalee mootummaa kan biroo irraa
f) Bulchiinsa gandaa irraa
g) Kan biroo yoo jiraate ibsaa

5. Bakka jireenya keessanitti baayinaan paakeejii fayyaa kamitu hojii irra oolaa jira? Gaafiiwwan armaan gadii mallattoo 'X' kennuun deebii kennaa. Isa caalmaan hojii irra oolaa jiruuf lakkoofsa 1 isa baayyee gadi aanaa ta'eef ammo lakkoofsa 8 kennaa.

Lakk	Paakeejii Eksiteenshinii fayyaa hojii irra oolaa jiruu/argamuu/	Sadarkaa
a	Paakeejii karoora maatii	
b	Ittisaa fi too'aannoo HIV/AIDSii	
c	Ittisaa fitoo'annoo busaa	
d	Eegumsa qulqullina nyaataa	
e	Kunuunsa qulqullina naannoo	
f	Qulqullina dhuunfaa	
g	Paakeejii sirna nyaataa	
h	Kan biroo yoojiraate ibsaa	

6. Sagantaan paakeejii Eksiteenshinii fayyaa akka yaada keessaniitii baasii qarshii ni Qusataa?

a) Eeyyeen b) miti c) tilmaamuun ni rakkisa

7. Gaafii lakkoofsa jahaf deebiin keessan "Eeyyeen" kanjedhuu yoo ta'e haala kamiin? _____

8. Gaanfii lakkoofsa jahaaf deebiin keessan miti kan jedhu yoo ta'e sababni isaa maali/ _____

9. Hubannoo lenjii Eksiteenshinii fayyaatiin argattaan namoota biroof hirtanii ni bektuu?

a) Eeyyen b) Hinbeeku

10. Gaafii lakkoofsa "9" deebiin keessan "Eeyyeen" kan jedhu yoo ta'ee gaafilee armaan gadiitiif deebii kennaa

a) Namoota hammamii leenjii lattaniitu? _____

b) Essatti lenjii kannitan? _____

c) Paakeejii fayyaa kam irratti lenjii laatan? _____

d) Yoom leenjii kennitan? _____

11. Gaafii lakkoofsa “9” Deebiin keessan “Hinbeeku” kan jedhu yoo ta’e sababni keessan maali? _____

12. Paakeejii Eksiteenshinii fayyaa hojii irra oolchuu keessaniif badhaasa /onnachiisaan/ isin argattan ni jiraa?

- a) Eeyyeen b) hinjiru

13. Gaafii lakkoofsa “12” deebiin keessan” Eeyyeen” kan jedhu yoota’e Gaafilee armaan gadiitiif deebii kennaa

- a) Badhaasa attami argataan? _____
b) Badhaasicha eenyatu isinii kenne? _____
c) Badhaasa kana erga fudhattanii booda jijjiirama akkamii hubattan?

Kuraa 5: Ilaacha Haala tajaajila fayyaa tiif Hojjettoota faayyaa ilaalchisuun qabdu

1. Hojiiettoota Eksiteenshinii fayyaa ilaalchisee Ganda keessaniif gandootii biroo keessattis ulaagaaleen jarri ittiin filataman quubsaadha jettanii yaadduu?

- a) Baayee quubsaadha b) haga tokko quubsaadha
c) Guutuudhaa guutuutti ninmorma d) quubsa miti e) kan biroo yoo jiraatee ibsaa

2. Gaafii lakkoofsa ‘1’ deebiin keessan “ninmorma” kan jedhu yoo ta’e sababni keessan maali? _____

3. Hojjettoonni paakeejii Eksiteenshinii fayyaa Dubartoota qafa ta’uun isaanii sirriidha ni jettuu?

- a) Eeyyeen b) hanga tokko sirridha c) sirrii mitii

4. Yoo deebiin keessan ‘sirrii miti’ kan jedhu yoo ta’e sababni isaa maali?

5. Hojjettoonni Eksiteenshinii fayyaa Eessa jiraatuu?

- a) Ganda Hojjetanu keesa
b) Magaalaa anaa
c) Eessa akka jiraatanu hinbeeku
d) Kan birro yoo jiraate ibsaa _____

6. Tajaajilli Hojjettoota Eksiteenshinii fayyaatiin kennaman gahaadha jettanii amantuu?

- a) Eeyen b) mitti c) murteessuuf na rakkisa

7. Gaafii lakkoofsa “5” Deebiin keessan “ mitii kan jedhu yo ta’e sababni isaa maalii jettuu?

Kutaa 6 Yaada waliigalaa yoo qabaataan

1. Naannoo keessanitti rakkooleen fayyaa gurguddoon/ijoon/maali?

2. Hojii irra oolchuu Eksiteenshinii fayyaa keessatti haallimijaawaa niif rakkooleen muudatan maali? Haala mijaawaa _____

Rakoolee _____

3. Naannoo jiraattan keessatti Eksiteenshiniin fayyaa hojii irra ooluu isaatiif gara fuulduraatti jijiramni dhufu maali jettanii yaaddu?

4. Isin paakeejii eksiteenshinii fayyaa kanattii hirmaachuu keessan irraa kan ka’e jireenya dhuunfaa kan maatii keessanii irratti jijjiirama akkamiitu mul’ta.....

Jireenya namoota paakeejii eksiteenshinii fayyaatti hirmaatanii fi Kan hin hirmaatinii gidduu garaa garummaa maaliitu jira?

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Declaration

I, the undersigned, declare that this thesis is my original work and that it has not been presented to any other university for the award of a degree, all sources used in this thesis have been dully acknowledge.

Name Muhammedsamir Mujalid

Signature 

Date of submission 06 May 2011

Submission Approval Sheet

This thesis is submitted for examination with my approval as a university advisor.

Name Teshome Tola

Signature 

Date 06 May 2011

