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ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF DEVELOPMENT STUDIES

Assessment of the Performance of Health Service Extension
Program and the factors affecting it: The Case of Kembata
Tembaro Zone. SNNPR

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Title

**Assessment of the Performance of Health Service Extension Program
 and the Factors Affecting It: The case of Kembata Tembaro Zone.
 SNNPR**

BY

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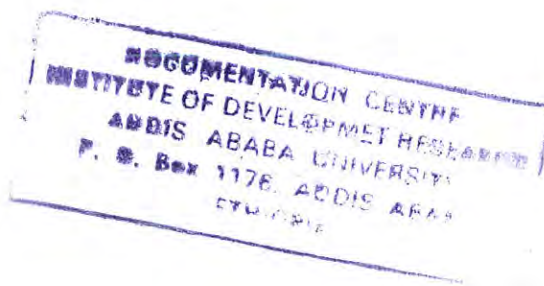
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Abstract

This brief summary represents an overview of the key research findings discussed at length in the main body of the report. In KTZ, the HSEP that has been underway as part of national program since 2006 was designed to improve the underserved majorities' access to basic health care services, thereby to improve the health status of all people. To determine the worthiness of the program and to identify the factors affecting it, it was found necessary to carry out an in-depth empirical assessment of the program in the study area. Accordingly, the study was conducted and thus its results are expected to inform the local implementers whether the program is performing or not, and as how to improve the program's implementation in the future. In the study, both qualitative and quantitative methods were used. Thus, two types of field data gathering instruments were used. Focus group discussion, semi-structured interviews, key informants interviews and personal observation were used for collecting qualitative data. In the mean time semi-structured interviews with survey items were used to collect the quantitative data. The study has shown that the HSEP is performing to the acceptable level (i.e. almost all health posts are performing over three-fourths of their assigned activities). However, as the study has revealed, the local implementers need to tackle inadequate community support, poor basic drug supplies, poor supportive supervision and HEWs' low capacity to keep the program properly functioning and sustainable. In contrast, communities' recognition and appreciation which grew to the stage where social capital appeared to promote the program's implementation. Indifference in culture, linguistic and social aspects between the HEWs and the community they serve combined with good attributes of HEWs overshadowed the negative impact of improper selection criteria on the program. These factors need to be maintained. The perceived progresses/improvements/ in the community and the program's performance as determined by the study, go to substantiate the practical significance of the program, besides calling for its re-strengthening as a worthy initiative to embark upon.

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ACRONYMS

- CHS-Community Health Service
CHWs- Community Health Workers
CHWs-Community Health Workers
CIH-Community Involvement in Health
FMoH-Federal Ministry of Health
HPs-Health Posts
HSDP-Health Sector Development program
HSEP-Health Service Extension Package Program
KTZ- Kembata Tembaro Zone
KTZFED- Kembata Tembaro Zone Finance and Economic Development
KTZHMT-Kembata Tembaro Zone Health Management Team
MoH- Ministry of Health
NCFCP- National Committee for Central Planning
OECD- Organization for Economic Cooperation and Development
PAHO- Pan Africa Health Care
PHC- Primary Health Care
SNNPR- South Nations Nationalities and Peoples Region
TBAs- Traditional Birth Attendants
TCC- The Carter Center
UNICEF- United Nations International Children Emergency Fund
VMWs- Village Malaria Workers
WHO- World Health Organization

Chapter One

Introduction

1. Background of the Study and Statement of the Problem

1.1 Background of the Study

The success in any health service provision system is the function of the development and maintenance of adequate and qualified personnel, availability of the required logistic and material support according to the health need in the health systems to increase access, improve quality of the service ultimately achieving the health target. In many developing countries, the overwhelming majority of the rural population and other underprivileged groups are prone to different diseases because of a hostile environment, poverty, ignorance of causes of disease and lack of protective measures, lack of health services (WHO, 1975:14).

Meeting the main problems of the underserved people accounting for about 80% of the population in the developing countries require that the health services should seek out these people, identify their needs and wants, and protect, treat and educate them (FMOH, 2006:1; WHO, 1975:1). To achieve this, many developing countries adopted the strategy modeled on that of the developed countries which in turn relying on relatively advanced health services staffed by highly qualified personnel. They thought that view of expanding them progressively to the entire population as resources increased over time (WHO, 1999:1). However, this led to unintended to be achieved i.e. this resulted in the concentration of the services largely in the cities and towns, thereby being predominately curative in type and accessible and consumable to the urban few (FMOH, 2007:1; Carra, 2004:13, 20). The unrealistic ambition basing itself on western style of health service provision unlikely to expand to meet to basic health needs of all people as it demands relatively huge resources which is beyond the developing countries' resource potential (i.e. physical, human and financial, etc.). In addition, it failed to address the real problems and needs of the rural people (Carra, 2004:20). This called for the fresh look at on the world's priority health problems and alternative approaches to their solution.

One of the emerged paradigm shift changes in the world in terms of health care system is the concept of primary health care (WHO,1978), which evolved as a result of the growing disenchantment and criticism of the existing sophisticated health system approach (professionally-oriented medical care model) (WHO,1999:14,18; WHO, 1981:37) view in the extent of health problem, inadequate and inequitable health resources distribution (WHO, 1978:16), with intention to close disparity between the 'haves' and the 'have-nots' So as to ensure equity in terms of health resources distribution (Carra, 2004:21), and ultimately attain the goal of 'health for all' strategy that will lead to a socially and economically productive life (WHO, 1981:10).

The primary health care concept with its embodied underlying principles such as community participation, inter-sectoral collaboration, appreciate technology, training and supervision of the Community Health Workers, means of support and referral, and methods of communication between the PHC levels and other subsequent higher levels of the health systems (WHO, 1978:41). Besides, it includes equity, focus on prevention and health promotion and decentralization (Challu, et al., 2004: 24).

As it was affirmed in the Alma-Ata conference in 1978 (emergence of PHC concept), PHC approach was believed to be the means to achieve an acceptable level of health care worldwide; eventually to meet the goal of health for all by the year 2000 (WHO, 1978:17). To achieve this Community Health Workers who can read and write, and are living within and selected by the community are perceived to be an entry point in the PHC based health delivery system (HaileMariam and Oakley, 1999:2; Damene, 1989:1; WHO, 1978:25). PHC is also viewed as alternative approaches to meetings basic health needs of developing countries.

In addition to increasing health care access and availability, CHWs are the single most important driving force of promoting community participation (one of the basic principles of PHC) (HaileMariam, 1999:3). The training and use of CHWs who can be trained rapidly, less expensively and in greater number than doctors, nurses, etc with high professional skills is particularly important for PHC in rural areas (Damene, 1989; WHO,

1975:19). Apart from promoting access to basic health services for the community, it is recognized that the CHWs ensure self-reliance for their respective community (WHO, 1999). Based on this framework, as many countries as possible in the world various types of locally trained health personnel have been trained and engaged to suit the system.

Ethiopia as one of the member states of the WHO, signed the Alma-Ata charter, has almost three decades history of PHC which characterized the training and use of community health workers. That is, Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs) before the change in political power took place in 1991, as stated in the Ten Year Perspective Plan of the country. To realize the intended level of PHC, due emphasis has been placed on training with a target of achieving two trained auxiliaries (one CHA and TBA each) for every 1000 people, by the plan period (1993/94). Approximately, over 1308 CHWs and 11762 TBAs had been trained and returned to their corresponding communities before the new government assumed the political power (Damene, 1989:15).

As pointed out by different researchs conducted in various countries in the world, including Ethiopia, the community health service programs have been facing many problems attributed to various internal and external factors (MOH, 1989: 35; Oakley, 1989; 1999:40, 44-47, 54-5, 59). However the PHC Program continued in many countries through learning from experience of others or own country's performance.

For instance, in the previous regime, the community health workers program faced many problems; predominantly lack of community and health system support (Damene, 1989: 38). Even if the concept of PHC is maintained in the newly developed health policy in 1993, it has not been launched in a package form until 2006/7 where HSEP now underway has been launched.

In this study, an attempt was made to assess the performance of and factors affecting HSEP in KTZ .As HPs are basic units in the implementation of HSEP,the study focused mainly on HPs as sample units. Hence, though the study is limited to KTZ, the similarity of HPs in terms of their job description all over the country may make the study result a good source of experience to be learned country wide. Thus, the study has provided

remedy by way of suggestion and recommendation for correcting the pinpointed loopholes, and thereby to improve the implementation of the program in the study area.

1.2. Statement of the problem

Ethiopia is a country with the overwhelming majority (above 80%) of the population living in the rural areas where the health condition is worse (FMOH, 2006:1). In addition, the existing health care service providing institutions, personnel are unequally distributed and concentrated in urban centers at the expense of their rural counterparts paradoxically where the health related problems are more pronounced (FMOH, 2006:1).

Cognizant of this reality, with a view of alleviating the health problems of the under-served rural community along with the ultimate goal of achieving health for all Ethiopians, a new approach is put in place. Thus in recognizing the role of promoting and expanding PHC to achieving the health targets, the HSEP which avoids the traditional approach in health care delivery system has been underway since 2005/2006.

The main function of health care service delivery and its quality largely depends on increasing the coverage of and promoting preventive and curative activities (Health planning, FMOH, 2004: 41). If a better performing health system is to be attained, adequate and motivated personnel, availability of medical supplies and sustainable financial resources, are indispensable.

The main purpose of this health care strategy, which is now underway, is to provide a comprehensive and integrated PHC at the community level. This approach still centers on preventive and promotive as activities without neglecting essential curative services in participatory way (FMOH, 2005:2). To his end, however, attention is given by designing HSEP and training HEWs as key role players in the effort of extending basic health core services in a community, as where people will get basic health care services as close to their home as possible. (Tesfaye , 2004:2). Besides, HSEP entitles people with an

opportunity to participate on issue of their health through planning, implementing and evaluating their own health care (Tesfaye, 2004: 3-4).

In Ethiopia, it is clear that HSEP has nearly one-half year (i.e. at Infancy stage). Therefore, it is rational to assess whether the program is functioning properly or not; and identifying factors which could influence the program's proper functioning so as to ensure its effective implementation. But this study does not go further to the impact evaluation of the program because of the short period of operation.

1.3. Significance of the study

Since the HSEP now in implementation is a new phenomenon from the country's experience and the study area as well, the study has great importance in the following aspects:

- The study has provided more realistic picture of the performance of HSEP in the study area.
- Ensure effective implementation of the program in the study area through pointing out the factors affecting the program negatively and attaching corrective measures to them.
- The output of the study serves as a documented input for the concerned stakeholders in the study area and subsequently to think of the remedial action on the identified issues.

1.4. Research objectives and questions

1.4.1. Research Objectives

Generally the study has the objective of determining the performance of HSEP in the study area and the factors affecting its performance.

More specifically, objectives of the study are:

- to assess the performance of HSEP in the study area.
- to identify the level of community's recognition and appreciation of HSEP.
- to investigate the support of HPs and HEWs both get from the public health system and community.
- to identify the criteria used in the selection process.
- to examine personal attributes of HEWs.

1.4.2. Research questions

In order to attain the research objectives, the following questions were developed.

- Is the HSEP properly performing in the study area?
- Does community recognize and appreciate the HSEP?
- What is the level of support to HPs from community and health system?
- What were the criteria on which HEWs were selected?
Was the community involved in the selection process?
- What type of attributes do HEWs possess?
- Does the health system provide supportive supervision and refresher courses for HEWs?

1.5. Scope of the study

The study was conducted in and thus its output belongs to Kembata Tembaro Zone. Besides, the study solely focused on the performance of HSEP and the factors affecting it in the study zone.

1.6. Limitation of the study

The study was mainly constrained by the following factors.

Firstly, unavailability of updated research works on the recently implemented HSEP in the study area and the county wide as well. Secondly, the study did not go further to show the impact of the program. Thus, both constraining factors were mainly attributable/or related to the program's short period of operation.

Chapter two

2. Review of Related Literature

2.1. The concept of community health promotion

Evolution in public health shows that public health practices as both science and art of preventing common disease, enhancing longevity, promoting health and well-being of the community through co-managed (medical profession community effort is important for the early diagnosis and prevention of disease, and promoting health education on participatory base so as to assure every one attaining better health (C.L. Anderson, 1982:3).

2.2. Historical Development of the CHW scheme

Historical facts attest that people putting their health and life at the mercy of others dates back to ancient Rome. Thus, the development of health care practitioners with various levels of skills is not a new phenomenon. Among many constraints to the development of health services, particularly in under served rural communities has been lack of clear thinking alternative about the appropriate kind of health worker to provide health service for the needy people (WHO, 1975:19). However, through time it became widely recognized that using community health worker who received short term practical training in ways which suit the health need of the local community can lead to at least better level of health than those with high professional skill (Demene, 1989). Apart from this, those with high professional skill are limited in numbers (WHO, 1975:19). Therefore, the experience of using community health workers became quite extensive having different nomenclature in different countries. For example, in post- colonial Africa, these people are named as medical assistant in Sudan, Uganda, Kenya, Malawi and Nigeria, and as health assistant in Ethiopia (Demene, 1989:5). The training and using of barefoot doctors in China to provide basic primary health care, which was launched in the late 1960s marked to be a landmark in the success history of the CHWs scheme (WHO, 1983).

Mostly, the auxiliaries in practice until Alma-Ata declaration in 1978 were serving as the government employees or specific to certain institutions for their support (Demene,1989:5). However, with the emergence of PHC, it has become evident that the CHWs (local inhabitants) who received short term training to provide their respective community with primary health needs services such as undertaking preventive activities (through health education), basic medical treatments, and managing vaccination campaigns (WHO, 1999 :38; WHO, 1983:50). Government driven rural health projects with success story share their knowledge and experience of treating health problems locally with simple means (Borget, 1983:62). The common advantages of local inhabitants as health workers at community level are widely mentioned in the literature. The widely mentioned advantages of using local inhabitants as health workers at community level are: their ability to easily understand, the local health needs and the expectation of the community served, ease of cultural and linguistic barriers, etc (Damen, 1989:6). Study in Nigeria has shown that community health workers being local inhabitants within community suited to providing health education and encouraging local people to learn new ideas about health (Bichmann and Dillo, 1999:90). In contrast cultural and linguistic barriers appeared to contribute to low health services in Latin America (PAHO, 1996: 96). Based on gains and challenges over the past three decades, WHO concluded that many primary health care programs have not been able to achieve their expected potential; mainly because these programs have not adequately been addressing the needs and interests of the poor. In turn, this is attributed to planners' more focus only on supply-side (reaching the poor mainly in rural areas with services) to the neglect of qualities and responsiveness of services (Carra, 2004:200). In addition, these programs were characterized with weakness in terms of inadequate funding, lack of staff time for preventive and community out reach and insufficient training and equipments (Oakley and HaileMariam, 1999: 26).

Demonstrated facts in many publications to date indicate that the CHWs program attained higher service coverage and rate of utilization by the underprivileged segment of the population than the previous system of health care delivery (Berman, 1984:417).

Despite the above positive prospects, evaluative studies of CHW program have shown a weakness in maintenance of the programs, if established by donor agencies; even it would be doubtful in terms of cost-effectiveness (WHO, 1999:59). Some others have even warned against the situation where their harm outweighs their good benefit if not properly maintained. Still some authors conceived CHWs as the direct adoption of the Chinese barefoot doctors model which might have appropriateness to the culture of various communities elsewhere.

Hereunder, as the PHC approach is pursued by many countries in the world, it is worth a review the promoting and constraining factors experienced by CHWs scheme in various countries. The following characteristics stand out among others:

1. Personal characteristics of CHWs,
2. Community participation
3. Selection and training of CHWs
4. Remuneration
5. supplies and equipment
6. supervision and Training

2.2.1 Personal characteristics

The CHWs are the living embodiments of the principles of the PHC, as they form the link between the community and the established health system (Steknburg, et al., 2000:1; Oakley, 1989; WHO, 1987:49). Hence, among many factors, provider-client relationship influences the perception of users on the quality of the service delivered (Stekenburg, 2000:11). Abusive and inappropriate behavior of health workers hinders the access and utilization of health care services (OCED and WHO, 2003:40). Since people under a given health service catchment area are interested in the competence of health workers like the diagnostic and prescriptive skills (Mtmew, 1994). If CHWs provide the wrong treatment and do not refer patients when necessary, this may threaten the proper functioning of the system (WHO, 1975:20).

It is evident that active workers got more involved than inactive ones in health educational activities (WHO, 1999:39). The PHC workers, intolerance to the problems they face in their working condition may lead them to move away somewhere else in seeking better-paid jobs, even if basically they may be willing to stay in villages (WHO, 1975:20). Since the CHWs are fore line activists in the PHC service delivery, their personal characteristic would have crucial role in the successful implementation PHC programs.

2.2.2 Community participation

The notion of community involvement for health has become forefront slogan, since the emerging trends towards "people's participation" in the 1970 and 1980s. However, in many instances it appeared that people have been denied their participation in the health development processes. Thus government-based nature of health services provision that does not involve community participation), in many countries, remains still standing.

Nevertheless further advancement in the concept of community participation, the more recently emerged notion of "community action for health", centers still on "action" and put forward a more proactive and direct involvement of people in health development activities at a local (WHO, 1994a :15).

As CIH is the basic concept and an integral part of the public health programs, it calls for partnership between health services and the community. It also ensures community's lead role in health development effort and the necessity of the formal health system to share power rather than limiting its role to fostering cooperation. In the framework of CIH, local people are agents for health and development, rather than just being passive consumers of health services and fruits of development process (WHO, 1994a: 16). As such, CIH echoes the very idea of community involvement in health development and stresses the importance (role) of community-government partnerships in efforts on combating problems of health care and development (Oakley and Hailemariam, 1999:16).

Basically, all community-based preventive and protective programs to promote health are important for achieving:

- Increased community participation in decision-making in health matters.
- high level of accountability; of the health service
- High level of health promotion through health education and creating awareness on the part of needy people.
- High level of local action in health development activities (Oakley and Hailemariam, 1999:17).

In almost all development programs /projects, participation has become a custodial in cognizant of health for all will not be achieved in resource short fall countries without the skills, energies and commitment of people at local level (Oakley and Hailemariam, 1999:18-19).

Now, Participation is increasingly recognized as both a means and an end in itself (WHO, 1999:7). Generally, for these and many other reasons, CIH is important to ensure that health care services will reach the poor people.

The lesson to cane be drawn from the above broad based case studies of various counties could have message for all developing counties facing resource shortfall, particularly for health and health services. The promotion community participation in the health development process will be an important source health services (Bauma and Hailemariam, 1999:102); and ultimately to ensuring self-reliance of the community's health system on sustainable base by way of promoting available local resources to be channeled into health development system (Oakley and Hailemariam, 1999:147).

In Jamaica, community participated through their health committee by fencing, provision and kitchen, water tank and refrigerator for a health center, and carrying out health educational activities. In similar wise, community organizations in Senegal involved in fund raising for the local health posts and purchasing medicine as well as pharmacy kits (Bauma and Hailemariam, 1999:99). Recently, projects in India and Ghana attained high level of mobilizing community resources to health development activities. This was

attributed to intensive training of community based health workers, the involvement of community leaders, and extending local delivery of services (WHO, 1999:23). For example, Navrongo health district project, in Ghana, which later scale-up to national policy, attained a remarkable success because of intensive involvement of the community (Frank, 1999:110). In rural India, there are cases in which community used village temples as satellite clinic sites and procured essential drugs from community contributions (Oakley, 1999:24). In India a total more than 200 health posts were established by community participation (Sallie, C.H. et al., 2003). The community financing of health services has been successfully established in rural communities of India, Indonesia and China implying that high level of self-reliance (Oakley, 1999: 27).

Despite the fact that the CIH has multi-dimensional impact on the health care systems at the community level, various elements, more commonly a wide range subjectivity of the subject's interpretation district, lack of common understanding at district health level and health workers' attitudes toward the local people are the most prominent (Oakley, 1999:129). More serious of this type has been shown in Nepal case study i.e. local people have been viewed as "ignorant" and "uneducated" on the part of health staff (Oakley, 1999: 126).

Thus Werner (1993) and Werner and Sanders (1997) have consistently criticized the failure to adhere to the Alma-Ata Declaration and to adopt PHC as a basic health strategy, with the resources necessary to make it effective. Thus, the impediments to the promotion of CIH remain formidable but not insuperable (Oakley and Hailemariam, 1999:147).

If district professional staff are to play major role in promoting and supporting people's involvement in health development, their attitudes towards and their understanding of people's involvement is crucial to its success. The case studies in Senegal, Nepal and Bolivia conformed that most professional staff neither at the national nor at the district levels received any particular preparation for this new and challenging aspect of their work (Oakley, 1999:129).

Most studies pointed out health workers at the community level as fore front actors in promoting people's participation in development activities (Oakley and Haiemarim, 1999:147). It should be noted that health workers need to feel as their work with communities is recognized and rewarded (Bauma and Hailemariam, 1999:109). This requires firm partnership between community and its concerned health workers. For instance, one popular nurse in Jamaica was described as being greatly loved and respected" by the community members; implying that health workers could be important catalyst in health development efforts (Bauma and Hailemariam, 1999:107). Thus, health workers must appreciate the actual and potential role of health development structure to the extent that their role of providing health services should be on strong partnership basis with local people. In addition, health workers need to recognize, understand and accept the political context which they will be working in (Bauma and Hailemariam, 1999:108).

The reason behind the success of Caranavi District health system, in Bolivia, was strong local collaboration with the existing health services and greater responsibility by local communities (Oakley, 1999:34). By 1989, though the experiment did not have forthcoming support and the key person operating the experiment was lost abroad, with small number of professional group the experiment kept on functioning largely owing to local enthusiasm and initiative. However, it had little institutional support and little prospect of receiving any (Oakley, 1999:41).

Hence, the case study of Caranavi experiment uncovered substantial evidence as people's involvement is a valid and productive health strategy.

2.2.3. The Selection and training of CHWs

I. HWCs' selection criteria

Regardless of the list of criteria for the selection of CHWs that varies from country to country, it is widely held in the literature that the selection criteria were very important for the successful implementation of CHWs program, if applied properly. The widely suggested criteria more recently in the selection process are a health worker should be

literate, preferably young with own initiative, be willing to serve his/her respective community under service, and local inhabitant (WHO, 1999:38; WHO, 1975:88); and the selection process which involves the whole community or the representatives of various segments of the community would increase their acceptance by the community than those nominated by the village leaders (WHO, 1992:117). This is believed to be a means of ensuring the empowerment of the program in general (WHO: 1975:91; WHO, 1999).

The method of selection combined with the type of training given has immense contribution to job satisfaction and performance (WHO, 1983:17). The experience of China in basic health service provision witnessed that emphasis was played emphasis of given on training local personnel, teaching what can be put into immediate use, conducting crash courses, and providing refresher training (WHO, 1983:17). The educational status of trainee candidates vary significantly across countries i.e. a minimum level elementary education in some countries like Botswana, Ghana, etc; and illiterate in Colombia. However, it is generally believed that CHWs with higher than elementary level education are less likely to keep on working as CHWs (Demene, 1989:28). In contrast, in countries like Gambela with illiterate CHWs, drop out rate was low (Demene, 1989:17). Despite this fact, in many countries CHWs with the educational status which allows them to record, report and interpret local data were used to operate (Demene, 1989:9).

Extensive involvement of community in the selection process would enhance the quality of and contribute to reduce the drop out rate of CHWs (Demene, 1989:10). In contrast to this, in instances where the selection of CHWs was carried out by community leaders alone encouraged the relatives of leaders to be selected (Bauma and Hailemariam, 1999:103). Ensuring community participation in the selection process requires properly informing and stimulating the whole community (Leslie, C.H et al., 1985:926; Ofofu, 1983).

It has been evident in many countries that poor selection process of CHWs is likely to contribute to poor performance of the overall basic health care program as it allows wrong people to be selected and trained (Stekeburg, et al., 2002:1; Oakley, 1999:40).

II. CHWS' Training

The duration of CHWs' training varies significantly from country to country. Education and training programs, both undergraduate and postgraduate, at home or abroad, are usually inappropriate to local health needs. To fill this gap the health workers who received short training to provide primary health care service are needed (who carry out curative, protective and promotional work with health care delivery system (WHO, 1975:17). To enhance their professional knowledge and skills, CHWs with limited basic education require basic refreshment courses. But usually they do not receive them (WHO, 1975:17). Training of community health workers may take different forms i.e. as pre-service and in-service (Demene, 1989:11). Training of the CHW may face various problems like scarcity of qualified trainers and lack of interest in combination with lack of clarity of the training policy (Demene, 1989:12).

2.2.4. Remuneration

Community health workers program needs support in terms of working facilities, remuneration and supervision from health system and community's interest in carrying out PHC activities (WHO, 1999:157). In many program, remuneration may take a form of either in cash or in kind or both or intrinsic satisfaction after effective work. Thus, this implies that remuneration is an important motivator of CHWs to keep on working. Studies uncovered that in case of HEWs were un-paid volunteers exercising the basic health care services, the CHWs themselves and the community feel of low quality service (Demene, 1989:19). As another study else where pointed out, unpaid workers may not spent much time and put full hearted effort to there work as they would do otherwise (Baum and HaileMariam, 1999: 102). Thus unpaid volunteers may not spent much time and put full hearted effort to their work as they would do otherwise. This in turn contributes to high turn over of the volunteers.

Community health workers remuneration might be in the form of salary or exemption from some community work as in Tanzania (WHO, 1999); and intrinsic satisfaction as

VMWs in South Oromia Region, Ethiopia (Gezahagn and Daud, 2005:15). Mostly in many countries remuneration source for CHW is government (e.g. in Botswana and Liberia). Nevertheless, as pointed out in many studies it is evident that community supported CHWs are more dedicated and committed to their community than those paid by government and also community commitment is high in the former case (Gezahagne and Daud, 2005:9; Damene, 1989).

In sum, low remuneration has frequently been cited as a cause for attrition rate in many countries.

2.2.5. Supplies and Equipments

Here greater emphasis still centers on reviewing the influence of shortage and lack of essential drugs and equipments on the CHWs program and the overall health system effectiveness. CHWs' program success is partly related to the availability of essential drugs, necessary equipments and the personal competence of CHWs to diagnostic knowledge and skill as well as providing appropriate drugs (OCED and WHO, 2003:40). In the delivery of basic health care services, one of the prominent constraints is a shortage of essential drugs in all institutions, predominantly at the health post level, which provides outreach health services (Bichman and Chaulagai, C.N, 1999: 55; Chaulagai, C.N, 1995: 93).

Shortage and lack of drugs in the health posts is frequently cited to cause underutilization (Bhuiya, et al., 2004: 23), mainly because it leads people to feel low quality of the services. For instance, the patient who received proper treatment for his curable disease would be more enthusiastic to listen the health education offered by CHW about prevention (Demene, 1989: 8). The inability of the CHWs to deal with community on disease like (malaria, diarrhea, etc.) to be treated at health- post level due to lack of essential drugs may reduce their reputation (Akenzua, et al., 1994: 311).

Large number of health workers appeared to leave their posts due to shortage of medicines and the instruments to keep on working, though lack of support could be another instance. In Bolivia, of nearly 200 health workers trained from 1986-1989, only 20 percent were found to exist functioning by 1994 for the same reasons above (Oakley, 1999:45). From same country's experience, the Palos Altos health district continued to function better than other areas in the district's catchments area owing to available resources for running the work in 1994. The experience from the Obadan project in Nigeria have shown that the project sustained among others owing to available and adequate drugs supplies by donation and the community contribution (Akenzua, et al., 1994:311).

Bolivia faced resource shortfall to sustain a nation wide district level health service (Oakley, 1999:48).

In cases, when the health posts fail to provide appropriate intervention and refer them to hospitals or refer patients with prescription to nearby pharmacies, it should not surprise that many patient are no more interested to visit their respective health posts altogether. Similarly, the study in Sudan uncovered that communities have shown more interest on curative services of health posts than other complementary services (Bichmann and Chauylagai, C.N, 1999: 60).

2.2.6. Supportive Supervision

Supervision is an important tool of maintaining and correcting the CHWs activities and the basic health care services. Obviously, the performance of health workers along with others depends largely on the quality of supervision regardless of its variation from place to place due to some related factors (Demene, 1989). If weak, inactive and poorly organized district health system exists, this inevitably leads to lack of basic health care for the needy people within catchments area as a whole. Experiences from case studies in many countries have shown that health workers cannot carry out function in a sustainable

and purposeful manner in the absence of effective district level support and regular supervision from higher levels (WHO, 1999:14).

Supervision can be administrative (by local community leaders) and technical (by the health institution). Thus supervision is indispensable on-job training which all staff with supervisory responsibilities should do on a regular basis (MOH, 1997:58; Challi, et al., 2004:58-74).

Supervision is a means to ensure staff competence, effectiveness and efficiency through observation, discussion, support and guidance of the overall health system. Thus supervision is very important tool which pinpoints the difficulties facing health workers at various levels in the system (is it lack of material, financial, manpower or the appropriate skills knowledge and understanding about their respective job?), and hints the required type of corrective measure to maintain the system.

In Senegal, it was cited that though there was well organized and objective-oriented supervision on regular basis which even involved telephone networked communication, health workers were frequently confronted with unknown tasks as to CIH management due to lack of appropriate training (Bichmann and Diallo, 1999:86). Thus supervision is indispensable that all staff with supervisory responsibilities should do on a regular basis (MOH, 1997:58; Challi, et al., 2004:58-74). Many Evidences have been documented as supportive supervision and training are likely to contribute to proper functioning of the overall health system, particularly at the health posts' which provide outreach services.

On the other hand, poor supervision is likely to contribute to low performance of HEWs. For instance in Bolivia, irregular/sporadic/ contact between health service staff and the health workers often contributed to the attrition of health workers (Oakley, 1996). The same study in Bolivia, cited that district health system experienced rapid turn over of health workers, which was partly due to lack of staff training and supervision, which in turn made continuity impossible (Oakley, et al., 1999:129).

The role of supervision on the effectiveness of basic health care delivery systems is widely mentioned in literature. The misconception and wrong attitude of health staff attitudes within the health system and about the community they serve may emanate from lack of appropriate professional staff training and formal supervision (Oakley, 1999:29).

In the whole, health workers cannot function in a sustained and purposeful manner without effective district level support and regular supervision from higher levels (Oakley and Hailemariam, 1999:14).

2.3. Ethiopian Experience

2.3.1. Pre-Derge Regime

Program to deliver basic health care service was started in 1960s, in Ethiopia. But it became unsuccessful mainly due to lack of support from the health institutions and community (Demene, 1989: 13).

Later on in 1976, CHSs as part of the Basic Health Services Program under UNICEF were attempted again though the program was left to be restarted in 1979 (MOH, 1978), due to the same constraints as before

2.3.2. During Derge Regime

The health policy which got its root in the 1974's socialist revolution and the 1976's National Democratic Revolution (NDR) program declaration, emphasis on preventive and disease control with high priority to rural areas. The policy has further been consolidated by adopting the PHC strategy of Alma-Ata declaration in 1978. The comprehensive 10 year perspective health sector plan has set a target of training 32,000 CHAs and an equal number of TBAs too by the end of the plan period (Mechiel, et al., 1984; Borgat M.V.D, 1983).

The need for CHA training and using was based on the principles of self-reliance and promotion of community participation along with providing more access to health services and increasing coverage. To this end, the curriculum for trainees was developed in 1978 (MOH, 1977). The trainees had to be selected by the community with guidance and assistance of the health institution around the kebele based on their full interest to serve their respective community, and preferably those with age of above 45 and who can read and write (MOH, 1979:54).

The CHAs, job description was clearly stated in the curriculum ,the main activities performed by CHAs were giving health education, improving environmental sanitation and water supply, providing first aid and referring patients to the nearest health institutions, performing maternal and child health care at their level, participation in the control of endemic and epidemic diseases, registering vital events (births and deaths occurrence in the community) and collecting and reporting data to health service unit at the immediate higher level (Demen, 1989:12).

To realize these effort was made and partly this was reflected through total figure of trained local personnel up to 1988 (i.e.13, 085 CHAs and 11, 762 TBAs). However, the 1985 PHC review has shown that nearly 4/5th of the CHAs have been poorly supported by the government or the local communities. The review result pointed out that only limited proportion of the health institutions did have satisfactory knowledge and information about the CHAs and TBAs in their respective catchment areas. Another similar study elsewhere has shown that 38% attrition rate of CHAs was mainly due to lack of community support (MOH, 1985).

The training duration for CHAs in Ethiopia was conducted in health centers for 3 months and 5-6 months at Agarfa (MOH, 1985).

2.3.3. Post- Derge Regime (the current regime)

One year after a change in political power, task force for the preparation of the new health policy was mandated to evaluate the status of health service, identify the major health problems and developed a health policy within the framework of the overall governmental policy of good governance and development. Thus, in September 1993, the current government approved Ethiopia's national health policy was adopted (FMOH, 1993 cited in Tesfaye, 2004:42).

The current health policy is the result of critical examination of the nature, magnitude and root causes of the prevailing problems of the country. It pays especial emphasis to the needs of less privileged rural population. The government has formulated a twenty year health sector development program (strategy), which will be implemented through a series of five year programs.

The health sector development program is the first of all investment programs. HSDP comprises eight components, namely, service delivery and quality of care, health facility rehabilitation and expansion, human resource development, pharmaceutical services, information, education and communication, health sector management and information systems, monitoring and evaluation, and health care financing (FMOH, 1993 cited in Tesfaye, 2004:42 - 43).

Establishing an effective and responsive health delivery system is an integral part of the overall development that aims at reducing poverty and achieving economic growth. Ethiopia has begun to embark on health sector development program, which is designed to translate government's new health policy statement into action (FMOH, 2005:1).

The country still remains one of the poorest nations in the world, with very low income compared to even the sub-Saharan African countries. This resulted in relatively low life expectancy which will further decline if present health problems are not mitigated. Infant and under-five mortality rates are still among the highest in the world. The health system

was under developed and able to provide health care only to limited segment of privileged urban population, though much of the rural population has still limited access to modern health care(MOH, 2006:1).

Environmental health problems, are still contributing to 60-80 percent of communicable diseases. In the country, preventable diseases are still high. Proportion of the rural mass and urban population has still limited access to adequate water supply. National sanitation coverage is very low. Nearly 80 percent of the health problems in the country are related to communicable diseases which can be easily prevented and controlled by applying basic hygiene and environmental sanitation measures (FMOH, 2005: 1).

Based on critical reviews of and challenges in the implementation of the first phase HSDP (1997-2000/2001), it became evident the necessary basic health services have not reached the people at the grass-root levels as envisaged. The government of Ethiopia has therefore decided to introduce an innovative community based approach aimed at improving the health status of the population. Accordingly, HSEP was introduced as a sub-component of health sector development program II (HSDPII 2002-2005). This program's main objective is aimed at promoting equitable access to essential preventive health intervention through community-based health services with strong focus on sustained preventive health actions and increased health awareness (MOH, 2005:4). As a study in Southern Oromia revealed that the recently introduced and deployed village malaria workers (VMWs) for malaria treatment in selected rural malarious areas appeared to be effective through promoting the participation of the community in effort to malaria control (Gezehagne and Dadd, 2005:9).

Proper implementation of basic health care programs requires training of the PHWs in their particular fields of activity (WHO, 1987:49). Consequently, they will be useful means of dissemination of knowledge, health education, improvement of hygienic condition and (WHO, 1987, 26). This approach led many countries to dispatch larger number of CHWs to underserved areas to provide basic health care services with low cost to the poor (Carra, 2004:20).

2.4. Conceptual Framework

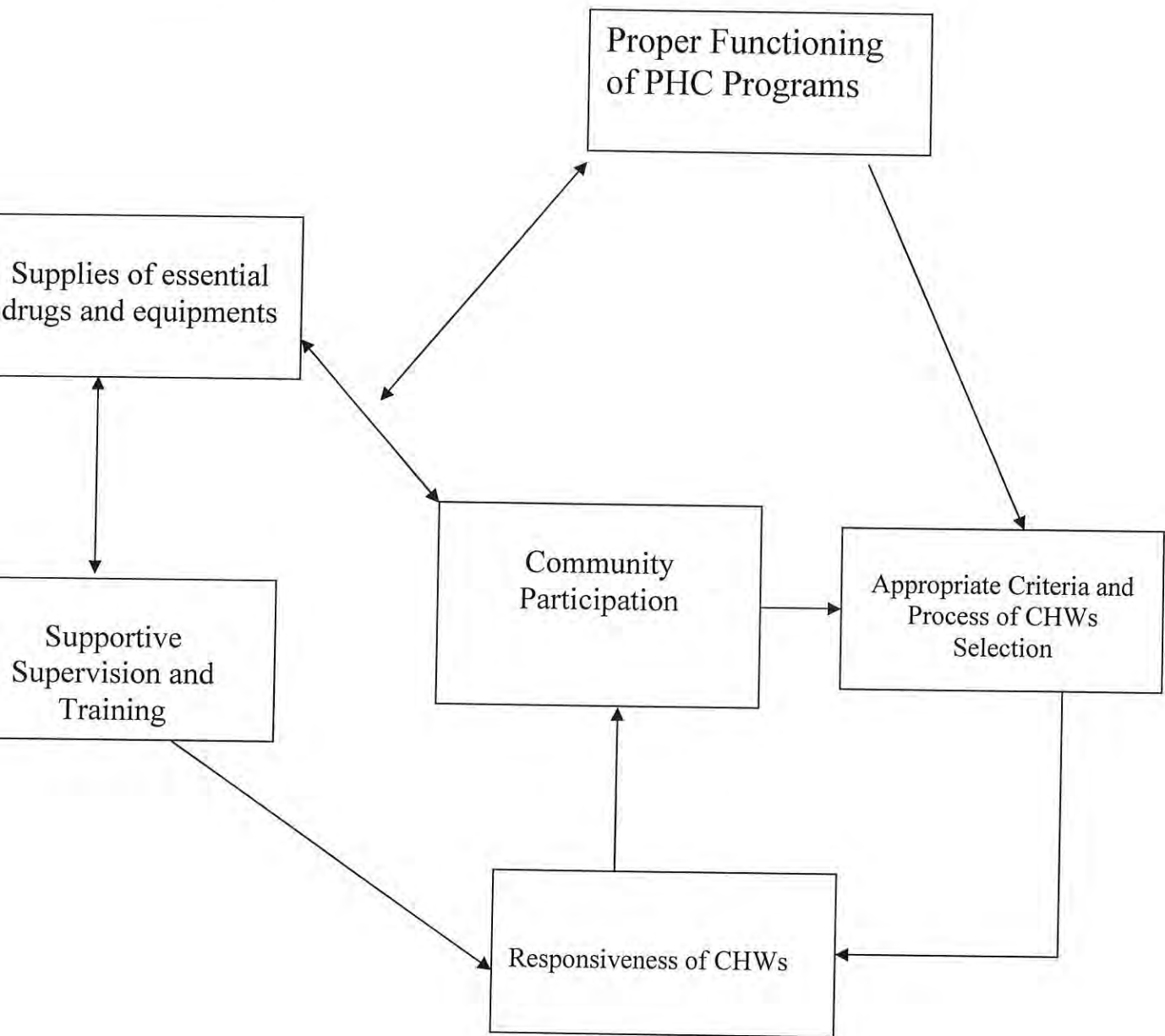
Establishing an effective and responsible health service delivery system is an important component of the overall development effort as it contributes to the healthy life of citizens, so as to ensure their productivity in all spheres of development. This requires inclusive health care delivery system which addresses the need and wants of the underserved rural majority in the developing countries where majority of people are either underserved or completely devoid of such services. In cognizant of this many developing countries in the world have been practicing PHC program since Alma-Ata Declaration in 1978, as a means to meet the health needs of their rural majority.

However, there exists disparity among developing countries in their PHC approach towards their respective health related problems. Some pursued the comprehensive health package, whilst some others the more selective approach. This also remained the point of debate among various professional groups, politicians and activists who tried to reflect their influence on PHC (Rafkin and Walter, 1986:561; Walsh and Warten, 1979:313). Regardless of the difference among countries, the PHC program has widely been accepted and put in place differently. Thus positive experiences and challenges faced many countries in terms of their PHC program has widely been documented in the literature.

The basic concept of PHC largely depends upon the participation of the community where greater emphasis is given on treating minor ailments, preventive and promotive activities which can better be achieved through the provision of health education.

Attaining the goals and objectives of PHC program also largely depends among others, on personal attributes of the CHWs who are at the front line, community participation, selection criteria used for HEWs supplies of drugs and equipments, and supportive supervision and training. The interface between these variables and the PHC program is shown in the schematic diagram hereunder.

Schematic diagram of proper functioning of PHC programs: Adapted by Researcher.



Primary health care is assumed to be the function of the variables in the schematic diagram. It is often evident that proper selection criteria which involves community participation leads to the right, trusted, competent and willing people to be selected and trained for the post of CHWs. Even this is believed to enhance the interest of the community to undertake PHC activities. After once CHWs are chosen in proper way, they need to receive appropriate training which suits to what they do in the community.

As CHWs are the link between the community and the PHC program, their attitude and committed ness towards their community as well as their job is indispensable for promoting community participation. There might be instances where the CHWs might have limited knowledge, skills, and understanding to manage their usual activities. Supervision hints the appropriate type of training for CHWs. To this end, the supervision team consisting of personnel with necessary skills, knowledge and understanding for supervision is very much important. In addition, supervision on regular basis an important tool to identify the problems facing the program in terms of basic drugs, equipments, etc, and thereby to ensure the provision of basic health care services at community level.

The HPs are the basic units of basic health care services which outreach to the community. Community usually gives greater attention to the curative services at HPs, without which the whole system cannot maintain its credibility within the community. In the absence of basic drugs at HPs, the clients would be ignorant of the health education which is believed to be important for promotive and preventive activities. This implies that curative service at HP level stimulates people's participation in attending preventive and promotive activities. Even curative service at HPs promotes the community support to HPs in different ways such as in the form of cash, labor and kind. This in turn levers room for the community to take care its own health matter, ultimately ensures the program's sustainability and community's self-reliance. Hence, in general community participation is a central element for realizing effective implementation and continuity of the PHC program even in instances of lacking external support. This implies that all factors constraining community participation need to be critically treated in the implementation of HSEP.

Therefore, he researcher used these variables as a framework for this assessment study on HSEP in the study area.

Chapter Three

3.1. Study Area and Population

Kembata Kembaro Zone is one of the 13 zones in SNNPR, Ethiopia; bordering with Hadiya Zone in the north, Dawuro Zone in the west, Hadiya and Wolaita Zones in the south, and Alaba Special Woreda in the east. The zone covers an area of 15,236, sq.km (KTZFED, 2000:2). It has a population density of 504 persons per square kilometer, with a total population of 856,548(see map of the area in Annex VII.

As to the profile of health infrastructure, the zone has one hospital and seven health centers. At the time of the study, there were 157 HEWs who have been delivering health services at community level.

The zone has poor transport and communication networking, particularly to link health centers with the rural mass. Hence, a large proportion of the people in each Woreda live outside the catchments area of the respective health centers. In addition, health centers are unevenly distributed across woredas.

3.2. Methodology.

A combination of both qualitative and quantitative methods is used to obtain the data needed to arrive at anticipated results of the study.

3.2.1. Conceptualization and Operationalization of core Variables.

I. Definition of core concepts

1. Level of performance: the extent to which individual health post has Performed on the long list of activities set up by MOH to be done at health posts.
2. Recognition: community's knowledge about the existence of HSEP.
3. Appreciation: community's view of and emotional reactions towards HSE-

P indicated by community's satisfaction in services

4. Selection criteria: the ways in which individual HEW was selected for the post of HEW as indicated by level of community's involvement and knowledge about criteria used in the selection process.
5. Community support: the extent to which community is found to support health posts as indicated by the form of support in labor, kind and cash.
6. Availability of basic drug supplies: the presence and procurement of essential drugs to be available at health post.
7. Supportive supervision: the quality of supervision as indicated by frequency of supervise on visits, supervision checklist guides, plan of action for supervision and the presence of supervision team consisting of persons/ people/ with necessary skills for supervision.
8. Personal attributes: the attributes of HEW's as indicated by community perceived (client-perceived) conduct having activity plan and ability to discharge their responsibilities.
9. Training: the extent to which trainings /basic training and refresher courses/ offered to HEWs are perceived to be sufficient in light of their usual activities.

II. Operationalization of core Variables

The operationalization of variables that are central to the study are given in the table follows. Following the rows in the table, it is possible to see how concepts are transformed in to variables that are measured through their single or multiple indicator/s

Concepts	Variables	Indicator/s
Performance	- Composite score of achieved performance result in each health activity (in quartile categories, in nominal scale).	- If health post is actually performing the health activities to be performed at it (see the list of activities in the Annex I:5).
Recognition and	- Composite score of: -Recognition (nominal-scale).	- If community know about the existence of HSEP - Community's perception about the

appreciation	-Community feeling about the prominent health services at health post (in quartile categories, in ordinal scale)	following health services: curative, MCH, sanitation, health education, family planning, immunization, diseases control and nutrition.
Selection criteria	- Composite score of community's involvement in and knowledge about the selection process (in quartile categories, in ordinal scale)	- If community was involved in and knew about the selection criteria and process.
Community support	- Composite of forms of community support (in quartile categories, in ordinal scale)	- If community's support is available in the form of labor, kind and cash
Drugs supplies	- Composite score of HEWs response to the availability of basic drugs and their supplies arrangement (in quartile categories, in ordinal scale)	- Availability of a standard drugs list - If drugs reaching to HEWs in time - Availability of first aid kits, ORS, quatum, drugs for skin itching and Tetracycline ointment.
Supportive supervision	- Composite score of supervision frequency, and aggregate quality of supervision (in quartile categories, in ordinal scale).	- The number of supervision visits as per the recommended frequencies. - Availability of annual plan of action for supervision - Availability of supervision team consisting of persons trained with the necessary supervisory and management skills. - Availability of developed standard supervision checklists. - Feed back and benefits to HEW
HEWS personal	- Composite score of personal	- Community perceived social conduct of

attributes	attributes (in quartile categories, in ordinal scales)	HEW - Availability of activity plan - HEWS be in being found in discharging their assigned responsibilities
Training	- Composite score of HEWs' response to whether the basic and the supportive trainings they received are sufficient or not (in quartile categories).	- If the basic training is perceived to be adequate. - If HEW received any refresher courses or not - If the supportive trainings are perceived to be sufficient.

3.3. Survey Design

First and foremost, it must be borne in mind that each health post is part of one and the same study with the objective of determining the performance of HSEP and the influence of some assumed factors on it in the study zone. Though the surveys in each health post have shared the same research and sampling designs, they slightly differed as regards their performance level that was actually measured-arising from different factors that may influence performance of individual health post. Hence, approximating longitudinal survey through cross-sectional survey design was used. According to this procedure, a cross-sectional survey design which only permits the collection of data from a sample at one point in time in order to describe the large population at that time is enhanced by employing 'approximating devices' that would allow it to handle (to a certain extent) change over-time as if it were a longitudinal survey. Such approximating device to be commonly used /employed/ is to ask respondents to furnish data that refer to the post, and this was the strategy that was followed /pursued/ in this survey. Thus not only were data relevant to the objectives of the survey were gathered from respondents but also the qualitative data on prevailing situations were furnished. In addition, key respondents with relevant inputs for the study were also interviewed as source of data.

3.4. Limitations of Survey Design

Employment of the approximating device of asking respondents to furnish data referring to the past, obviously place limits on the validity of the data and the conclusions drawn thereof. Respondents' memory is not always reliable and their reflections of the past are to some extent influenced by their current views and attributes. However, this validity threats need not be exaggerated, since the researcher still has the two group comparison to rely on and as the conclusions arrived at through the survey are counter-checked and backed by the data obtained through the qualitative method.

3.5. Techniques of Data Generation and Processing

3.5.1. Sampling

In the study, stratified random sampling techniques were used. Thus all health posts in each Woreda were stratified to form their respective stratum. From each Woreda/stratum/ an equal number of health posts selected disproportionably. Owing to the homogeneity of the sample units/health posts/ in terms of their work description, HEWs operating them, and their need for different support from stakeholders, the sample size is determined at 11.4%. That is, 14 health posts were chosen from a total of 123 health posts.

Table 2. Sampling and sample distribution by Woreda

Woreda	Number of sample population	Sample size	Sample health posts
Angecha	17	2	- Kerekich - Bondena
Kadida gamela	17	2	-Bezena Benara - Teza Agerra
Damboya	19	2	-Bonga - Heggo
Tembarro	20	2	-Belela -Bachura

Hadero Tunto Zuria	14	2	-Mugunja - Ajora
Doyegenena	15	2	- Ancha - Dinnika
Kachabirra	21	2	- Wonko - Buge
Total	123	14	14

3.5.2. Instruments of Data Collection

Semi-structured interview guides were prepared in English and translated into Amharic (see Annex I-V). Both qualitative and quantitative data could be gathered simultaneously. Each interview questionnaire contains two types of items: some designed as survey type to collect quantitative data and some others designed as supplementary to the survey items and to collect qualitative data.

To understand the factors presumably influencing performance, data were collected in a cross-sectional survey of 28 community members, 7 HSEP coordinators, 7 Woreda health office staff, and 14 HEWs. In the mean time, qualitative data with the objectives of supplementing survey data were collected from same respondents. The researcher and three research assistants conducted the interviews. The three assistants with proven mastery of both the local languages (*Tembarisa* and *Kembatisa*) as well as Amharic were trained, recruited, and thereafter undertook data collection. In each health post catchment's area, focus group discussion guide was administered to a group of 4-6 participants from the community. A total of 56 people participated in the discussions. The researcher has facilitated the meetings with community members through HEWS. The discussions were conducted by the researcher in all cases, except two where two of the assistants were engaged in. In the mean while, recording of the observational results and informal respondents' reflections were also done to supplement aforementioned tools.

For the presumed /assumed/ influencing factors variables, operational definitions, measurement scales and indicators were defined in advance to standardize the result and

to ensure systematic interpretation and analysis of data. Pre-testing of the interviews, the checklists and the focus group discussion guidelines was done in one area by the investigator. Thereafter, some changes were made. To carry out the study, permission was requested from Kambata Tembaro Zone health management Team. The researcher also assured confidentiality and avoided injuring any of respondents.

3.5.3. Field work Itinerary

Field work for the collection of data was carried out in Kedida Woreda from 1-10 March 2008, in Kachabira Woreda from 11-19 March 2008, in Doyegena woreda from 19-26 March 2008, in Hadero and Tunto Zuria Woreda from 1-12 April 2008, in Damboya Woreda, from 13-18 April 2008, in Angecha Woreda from 20-27 April 2008, in Tembaro woreda from 1-4 May 2008.

3.5.4. Data Processing and Analysis

The data were processed and analyzed manually. The survey items as part of the semi-structured interviews were meant to serve the secondary functions of identification and the prompting of more important contingency questions, most of them were meant to measure variables relevant to the study/ or to be used in creating new ‘categorical variables’ as well as developing new composite measure variables. Almost all new composite measure variables were further transformed into ordinal-level category variables.

The creation of composite measure variables has permitted the bringing together of several related variables into fewer and more tangible measures, and this has in turn made the analysis and presentation of the data more coherent and systematic. The data from all sample health posts were analyzed and presented in the same chapter, as the main objective of the study is to determine the level of HPs’ performance which is dependent of several ‘program-internal’ and ‘program-external’ factors (independent variables) that may vary among health posts. In other words, as the main objective of the study was to determine whether health posts (.i.e. the basic units of HSE) are performing or not, and

whereby determine the worthiness of the HSEP. However, to the extent that it was found necessary, a kind of comparative analysis between the 'high performing' group and the 'low performing' group has been made and presented with an objective of identifying some factors presumably influencing performance. It should also be noted such comparison is made possible since both groups (the 'high' and the 'less' performing) used in the analysis of the data were consistently based on the aggregate of the total 14 cases, and not the two data sets of each of the 'high performing' and 'less performing' groups separately.

Since almost all of the variables were measured at/ or later on categorized in to/nominal and ordinal levels, contingency table/ cross-tabulation/ was employed as the main analytical device. Moreover, since the main dependent variable (performance) is a 'nominal' one, the chi-square test of independence (at 95% confidence level) was regularly used to determine the existence and level of the significance of associations between this (dependent variable) and each of the independent variables that are listed in the Table 1, operationalization of core variables.

Chapter Four

4. Presentation and Discussion of Findings

4.1. Profile of Respondents

The study has generated data on many of the attributes of the respondents that would allow a description of their profile. Accordingly, 35% of the respondents were females and 65% were males. As for their age distribution, 25% were under 25 years old, 52% were 26 to 35, 18% were 36 to 55, and only 5% were found to be over 56 years. Regarding marital status, 71% of the respondents were married and 29% were single based on assigned activities to be performed at health posts.

4.2. Determining the Performance

A standard measure was developed on the basis of activities assigned to health posts to determine performance. Based on the assumption that variation is likely to exist in the level of performance among health posts, the survey has attempted to measure and determine their performance level.

Table 3: Performance table: frequency and percentage distribution of health posts by 'composite score of performance' (in quartile categories).

Composite score of performance.	Categories of performance	Frequency	Percent	Cumulative percent
<60	Low	-	-	-
60-74.5	Somewhat low	1	7.14%	7.14%
75-80	Somewhat high	4	28.5%	35.71%
>80	High	9	64.29%	100%
Total		14	100%	

Table 3 shows that 64.29% of health posts fell in the 'high' category, leaving only 35.71% to be split up between the middle categories in the quartile classification scheme of performance level that was on the aggregate data from all sample health posts. It

means that exactly more than half of the health posts fell in the upper most quartile category and appeared to perform over four-fifth of their assigned activities.

A checklist was also used to evaluate the availability of commodities logistic supplies at health posts. Elements of the logistic supplies checklist are shown in the table bellow.

Table 4: checklist on the availability of commodities logistic supplies at health posts.

Items	Present at	Percent	Absent	Percent
Contraceptives	13	93%	1	7%
Child and adult scales	14	100%	-	-
Vaccines, ice boxes	14	100%	-	-
ORS	12	85%	-	15%
Malaria drugs	10	75%	-	29%
Blood pressure apparatus	14	100%	-	-
First aid kits	14	100%	-	-
Delivery kits	14	100%	-	-
Educational materials	14	100%	-	-
Thermometers	14	100%	-	-
Female gowns	14	100%	-	-
Scissors and forceps	14	100%	-	-
Stationeries	14	100	-	-
Detergents	11	79%	3	21%
Cotton, bandage and plasters	14	100%	-	-
Female bicycle	-	-	14	100%
Stethoscope and sterilizer	14	100%	-	-
Delivery bed and hand torch	14	100%	-	-
EPI cards	14	100%	-	-

Apart from bicycle, which was absent in all cases, and malaria drugs and detergents which were absent, in 29% and in 21% of cases respectively, all other items were present at the majority of checked health posts.

From the above results, it follows that the HSEP is performing properly in the study area. The performance of each health post is determined by the composite score percentage in a standard performance measure containing the list of 17 activities assigned to be performed at health posts (Annex I: 5). To identify, the influence of some assumed factors on performance, all health posts were divided into two groups i.e. those health posts which scored below 80% are assigned as a group of ‘less performance’ level and

those which scored above 80% are assigned as a group of ‘high performance’ level in this particular study. Initially, though it was expected that some health posts would exist to show low performance (below 60%), this became non-existent at all. Hence, almost all health posts are managed to score well above 75% and only one health post scored below 75% i.e.73% (See Table 3). Thus, nearly 93% of health posts have shown relatively high performance (above 75%). Due to this, the researcher preferred to use the term ‘less’ instead of ‘low’, just to make a distinction between the two groups. Therefore, these two terms are consistently used through out the forthcoming section of the paper. The factors influencing performance are described in the following section.

4.3. Factors Influencing Performance

4.3.1. Recognition and Appreciation

The recognition and appreciation of community is a necessary condition for the effectiveness of basic health care services delivered at community level. Thus, both recognition and appreciation are important determinant factors among others in the success of HSEP as pointed out in similar studies elsewhere.

According to respondents from community members, in all cases, communities do recognize the existence and importance of HSEP in promoting their overall health status. The appreciation of community towards most services, except the curative ones, is still high. Respondents from community members confirmed better performance of HSEP, in all cases.

Table 5: Recognition and appreciation in relation to performance.

Recognition and appreciation (in quartile categories)	Performance				Total	
	High		Less			
	Count	Percent	Count	Percent	Count	Percent
High	9	64%	5	36%	14	100%
Total	9	64%	5	36%	14	100%

The absence of any statistically significant relation combined with quick visualization of the frequency and percentage distribution in Table 5 indicate a certain consistency in

perception or perhaps prevailing conditions, across geographical boundaries. Though depicting real picture of the program's impact in the community was not the concern of this study, as mentioned by community members, positive improvements have been witnessed in many aspects like, delivery services, pre-natal and post-natal care, malaria treatment and prevention, family planning services, sanitation, growth monitoring and frequency of ease contact with health services, immunization, etc. These findings were also further confirmed by focus group discussion. In some cases, recognition and appreciation further advanced to the stage that social capital and traditional institutions like 'idir'* ensuring their enforcement through the imposition of sanctions and passing judgment on their members who have no latrine on individual family basis. This means that social capital is already being in exploitation to ensure the implementation of HSEP in the study area. This implies, therefore, that proper use of traditional institutions as form of social capital likely contributes to effective implementation of HSEP and subsequently to high performance.

However, still community appeared to complain about unavailability of drugs as needed at health post, in all cases. That means community is dissatisfied in the status quo of and showed great interest in curative services. In contrast, some personnel in the health system have misconception that as if no curative services to be delivered other than preventive and promotive services at health post. These two findings show that over-expectations (in the side of community) and under-expectations (in the side of health personnel) exist and likely to have negative impact on the potential success of the program.

4.3.2. Selection Criteria.

During the study an attempt was made to assess community's knowledge about the selection criteria used for choosing candidates to be trained for the post of HEW and to determine community's involvement in the selection process

Table 6: Cross-tabulation of selection process in relation to performance.

Selection criteria (in quartile categories)	Performance				Total	
	High		Less			
	Count	percent	Count	Percent	Count	percent
Proper	-	-	-	-	-	-
Improper	9	64%	5	36%	14	100%
Total	9	64%	5	36%	14	100%

It was found that in all cases, community did not know the selection criteria as well as who selected HEWs. In 8% and 92% of cases, HEWs were selected by the kebele administrative council staff and the woreda health office staff respectively. Moreover, in nearly 50% of cases, HEWs were identified to be non-residents in the community they serve. These three results combined, possibly indicate that the criteria used and the selection process including persons who selected HEWs were not known by community. The accuracy of the selection process and believing that proper selection criteria were followed is doubtful.

In the literature it is a widely held view that improper selection criteria likely to contribute to low performance of HSEP (Oakley, 1999:40; Stekehenburg, et al., 2002:1). However, as Table 3 and 10 paint different pictures as compared to Table 5. That is, almost all health posts appeared to perform well above three-fourth (75%) of their assigned activities despite sharing improper selection criteria of HEWs in common. Moreover, in all cases, HEWs are identified to possess good personal attributes. It means, therefore, paradoxically, poor (improper) selection criteria which did not respect community's empowerment and participation does not have any significant influence on performance in the study zone. The reasons for improper selection to have no significant influence on performance may be related to indifference of culture, social and linguistics between the HEWs and the community they serve. Good personal attributes of HEWs could be another. This is similar to the findings of other studies (PAHO, 1996:96; Demene'1989:6).

4.3.3. Community Support

Community support is one of the basic factors which contribute to the proper functioning of PHC program (WHO, 1999:7; Oakley, 1999:48).

Table 7: Cross- tabulation of community support in relation to performance.

Selection criteria	Performance				Total	
	High		Less			
	Count	Percent	Count	percent	Count	Percent
Somewhat adequate	9	64%	4	29%	13	93%
Inadequate	-	-	1	7%	1	7%
Total	9	64%	5	36%	14	100%

Chi-square=1.937

Table 7 bears out that community support to health posts fell in ‘somewhat adequate’ category, in almost all (93% of) cases. Community support is inadequate (no support at all) in 8% of cases, while in 93% of cases, it is ‘some what adequate’. Even in ‘somewhat adequate’ category, the form of support is limited to contribution of labor and materials. None of the cases, in both high performing and in less performing group, fell in ‘adequate’ category, showing that support in the form of cash is non- existent at all. The glaring similarity between the high performing and less performing groups in terms of community support is also borne out by chi-square result, establishing the absence of significant association between the community support and performance. Though cash unavailability in the community might be a probable reason, community’s full participation in labor and in kind in both groups implies that little /or no effort was made by the concerned bodies (i.e. Woreda health office and Woreda administrative councils) to enhance the range of community support to HESP and to promote community’s self-reliance (which is amongst the underlying basic principles of PHC program). Thus maintaining the sustainability of the program seems difficult in the absence of community support in cash, at least to fill the resource gap from the government and at most to keep the program functioning in case the resource from the national/ regional level is cut altogether

The above findings, therefore, hint that lack of community support in cash likely threatens the sustainability of HSEP and also it crimples/ hampers/ community's potential of self- reliance in Kembata Temparo Zone. This is similar to the findings of studies elsewhere (Bauma and Hailemariam, 1999:102; Oakley and Hailemariam, 1999:147; Oakley, 1999:27).

4.3.4. Basic Drugs Supplies

A standard measure was developed and used to assess the availability of basic drugs and the reliability of supplies arrangements.

Table 8: Cross-tabulation of drugs availability in relation to performance.

Composite score of drugs availability (in quartile categories)	Performance				Total	
	High		Less			
	Count	Percent	Count	percent	Count	percent
Somewhat high	6	42.8%	2	14.2%	8	57%
Somewhat low	3	21.5%	3	21.5%	6	43%
Total	9	64.3%	5	35.7%	14	100%

Chi-square = 1.0452

According to respondents from HEWs, roughly in 64% of cases, drugs reach HEWs in time and in the amount needed. However, some drugs like oral malaria drugs (e.g. quatem) roughly in 36% of cases and ORS in 15% of cases fail to reach in time and in the amount needed, and were found to be unavailable at health posts during the study as well. This implies that there is low reliability and inconsistency in terms of drugs supplies. In this regard, different but some what interrelated factors were mentioned. As HEWs, the unavailability of such drugs at health posts was related to different factors, mostly the complete absence of drugs at health centers and imbalance between demand and supply for such drugs are prominent. In the same issue, the more prevalently mentioned reason / factor/ was budget shortage, as respondents from woreda health office staff. Sometimes, it was also related to the unavailability of personnel at dispensary of health center for many reasons; such as failure to delegate other persons when individuals in dispensary leave for short / or long term trainings. It means, believing that consistent

and reliable supplies arrangement is set, may be doubtful even if basic drugs are available at health center.

In all cases, there was no standard list for basic drugs to be available at health posts, as HEWs. Despite the absence of some drugs like tetracycline ointment and drugs for skin itching that are recommended in the implementation guide to be available at health posts (MOH, 2006:49,50), 71.43% of HEWs and 82% of woreda health office staff mentioned that drugs that should be available at health post has been adequately supplied on regular basis. Based on these grounds, it may not be exaggeration to say that the local implementers have limited understanding and recognition in basic drugs to be available at health posts and curative services to be delivered thereof. This combined together with the finding under 'recognition and appreciation' (i.e. under- expectation of health system personnel about curative services) may be the probable cause factors for communities' dissatisfaction in curative services. In addition to this, as Table 8 revealed, all cases fell in the two middle categories but none of them in the 'high' category. Hence, based on results from the above discussions, it is possible to perceive that the availability and procurement of basic drugs at health posts is inconsistent, not reliable and below the expectation in light of the implementation guide. It means, therefore, HSEP which integrates curative, preventive and promotive services in a way that they reinforce each other is not properly followed in the study area. In this regard, statistically no significant relationship is obtained between availability of drugs and performance.

4.3.5. Supportive Supervision

An attempt was made to assess the existence and frequency of supervision, supervisors' knowledge and understanding in relation to supervisory skills including benefits of supervision for HEWs.

According to respondents from the HEWs and health system staff, in all cases, supervision visits were aimed at improving the performance of HEWs. According to some respondents, in nearly 17% of cases, supervision visits had been by health centre staff and in 83% of cases, by woreda health office staff. According to respondents from

health office staff personal observation, supervision was hardly guided by standard checklists.

Table 9: Cross-tabulation of supportive supervision in relation to performance.

Supportive supervision (in the quartile categories).	Performance				Total	
	High		Less			
	Count	percent	Count	percent	Count	percent
Some what poor	1	7%	-	-	1	7%
Poor	8	57.3%	5	35.7%	13	92%
Total	9	64%	5	37.5%	14	100%

The quick visualization of the frequency and percentage distribution in Table 8 reveals that supportive supervision was poor, in all cases. That is, all cases split up into the two lowest categories. As respondents from HEWs, in 25%, 37.5% and 37% of cases, supervision was found to be received bi-annually, tri-annually and quarterly bases respectively. It means that supervision was characterized by irregularities and inconsistencies in the study zone. The widely mentioned factor was lack of vehicles specifically assigned for HSEP supervision tasks of woreda health office staff. In addition to this, there is lack of supervision teams that do supervision in organized, planned, uniform, and coordinated manner.

As a whole, those who involved in supervision visits were found to have insufficient knowledge and understanding in supervision. According to respondents from health system staff, in all cases, there was no well organized task sharing and responsibilities for supervision team at any of woredas under investigation during the study period. The situation was described by a respondent who was involved in the supervision visits as follow:

There is no formally established, autonomous supervision team for HSEP. In our case, however, we are nurses/public and clinical one each/ who were, assigned for supervision tasks. None of us had sufficient knowledge, understanding and necessary skills of the

tasks for which we are assigned nor received any supportive training. Despite such grounds, we were given the responsibility. Accordingly, we managed to date regard less our limited capacity. In addition to this, the responsibility of supervision tasks was supplementary to our usual tasks (responsibilities) at health center the above mentioned factors combined with others like staff shortage, lack of sufficient budget, transport facilities specifically for the purpose of supervision tasks are deterring the consistency, regularity and effectiveness of supervision..

Based on the above findings, it holds true that believing the supervision visits taken by people having limited/or no appropriate supervisory and management skills for supervisions and without annual plan and a standard checklists to be effective is doubtful. Given this, it is incredible that even if the supervision visits were/are adequate, HEWs do experience reasonable benefits from such visits.

Based on the above quantitative and qualitative finding, it follows that poor and loose supportive supervision are likely to be insignificant to maintain the proper functioning of the program in Kembata Tembaro Zone. This is similar studies elsewhere (Oakley, 1996; Oakley, 1999; Hailemariam, 1999:14). In this regard statistically no significant relationship was found between supportive supervision and performance.

4.3.6. HEWs' Personal Attributes

Assessment was made on community perceived conduct of HEWs and their competence (having activity schedule and whether performing the assigned activities or not).

Table 10: Cross-tabulation of personal attributes in relation to performance.

Personal attributes(in quartile categories)	Performance				Total	
	High		Less			
	Count	Percent	Count	Percent	Count	Percent
Good	9	64%	2	14.0%	11	78%
Somewhat good	-	-	3	22%	3	22%
Total	9	64%	5	36%	14	100%

Chi- square = 6.78

According to respondents from community members in all cases, HEWs, were found to possess good conduct/ manner. This finding was also confirmed by focus group discussion. An interview held with HEWs and personal observation revealed that in 78.6% of cases, HEWs appeared to be competent (i.e. performing most of their assigned activities). In addition to this, the conclusion that emerges from Table 10 is a straight forward one. In both 'high performing' and 'less performing' group combined together, the overwhelming majority of HEWs possess good personal attributes. Only 21% of cases, from 'less performing' group claimed to possess 'somewhat good' personal attributes. It means, therefore on aggregate, all HEWs were found to own (possess) acceptable personal attributes. Pooled result from the above findings shows that the largest proportion of HEWs characterizes good personal attributes. In this regard, statistically no significant difference is found. In the overwhelming majority of cases, where HEWs confirmed to possess good personal attributes, HEWs able to win the attention of the community not in curative services alone, but also in preventive and promotive activities as well. Subsequently, they achieved high credibility; thereby high performance of the HSEP was also realized. This is similar to the findings of similar studies elsewhere (WHO, 1999:39; Buama and Hailemariam, 1999:107). This condition was also qualitatively described further by respondents from the community members on one side and HEWs on the other side in related ways.

A respondent from the community members described as follows:

I can say that the health HEW at our health post is committed to us. She usually posts her weekly activity schedule containing site, duration and types of activities on a notice board at health post. I see her always working on our health related activities. In addition to this, as I heard, delivery attended by her often found to be convenient and safe. She is so tuff that in case of complications, she often identifies before late and refers pregnant women when needed without any dalliances. It is not with out reason that I say so. ...now I don't remember the exact date. To guess, some eight or nine months ago, our Mutual Self-help Group carried on shoulder and took my elder brother's wife (who was pregnant) to deliver at health post. In the moment we expected that she would deliver at

health post. But, we faced unexpected. Thus the HEW attempted to help but she couldn't attend the delivery. Hence she told us that the case was so complicated and need t be attended at the health center. Unfortunately, we/the women's family/ were not financially prepare for the referred case. So, we were in trouble. The HEW felt sorrow with our trouble and subsequently she gave us money of her own for referral. Thereafter, we took the women to and she delivered at health center safely

A respondent from HEWs also described the situation as hereunder:

You know that here I am a responsible person for basic health care services to be delivered at the community level. Thus when I go to different villages for preventive and promotive activities, the community accepts in a miraculous way not only me but also the activities that I order. Particularly, those malaria patients whom I treated and got recovered including pregnant women I attended whose delivery, often appeared to be more attentive for health education, practice, etc. For instance, after teaching people about certain basic health care issue and showing them how to do it practically, I often order them to do accordingly. In second visit, I often find it being done. Apart from this, while visiting homes, I find lunch prepared for me. These are conditions motivating me to be committed to this community. Thus still, it is the community's reputation and obedience that I always consider as a great remuneration to keep on working rather than the salary that I earn (a HEW aged 22).

The above findings show that good personal attributes of HEWs likely contribute to high performance in Kembata Tembaro Zone by way of creating close relationship between the community and the program, promoting people to support the program and enhancing the community's confidence in services at community level

4.3.7. Training

An attempt was made to assess whether the trainings (basic and supportive/or refresher courses) received by HEWs are sufficient or not in light of activities they perform

Table 11: Cross-tabulation of training in relation to performance.

Training(in categories)	Performance level				Total	
	High		Less			
	Count	Percent	Count	Percent	Count	Percent
Somewhat sufficient	7	50%	-	-	7	50%
Somewhat insufficient	-	-	4	28.6%	4	28.6%
Insufficient	2	14.3%	1	7.1%	3	21.4%
Total	9	64.3%	5	35.7	14	100%

Chi square 11.096

The chi-square test result for Table 11 shows the existence of highly significant association between the variables ‘training’ and ‘performance’ or the existence of significant difference between the two groups(‘high performance’ and ‘less performance’) regarding training that HEWs have received. This shows that in majority of the cases where HEWs have received ‘somewhat sufficient’ training, better performance of HESP is realized.

However, in the whole, the relevance of the chi-square test result ought to be taken with a pinch of salt. Thus there are good grounds for not relying solely on the test result. As the chi-square test of independence has well known limitation in such small cases (i.e. 14), a visual inspection of the frequency and percentage distribution in the table and the support of results from the qualitative data are in order. Hence, once again, by examining the test result in relation with the frequency and percentage distribution in Table 11, one observes the following. Firstly, none of the cases in both groups (‘high performance’ and ‘less performance’) has claimed to receive ‘sufficient training’. Besides, nearly 79% of all cases fell in the two middle categories. Secondly, the reason for the association is that in the ‘high performance’ group 7(77.8%) and 2(22.2%) of cases have claimed to receive ‘somewhat sufficient’ and ‘insufficient’ training respectively; but none of cases in this group has claimed to receive ‘somewhat insufficient’ training. In contrast, 4(80%) and only 1(20%) of cases in the ‘less performance’ group have claimed to receive ‘somewhat insufficient’ and ‘insufficient’ training respectively; but none the cases in this group has claimed to receive even ‘somewhat sufficient’ training. Thus on the bases of these

additional observations, it is safe to conclude that as a whole, HEWs have received inadequate training.

According to respondents from HEWs, only in 25% of cases basic training offered to HEWs was perceived to be adequate whereas in the great majority (75%) of cases perceived to be inadequate. Similarly, HEWs who received refresher courses/ supportive trainings still perceived them to be insufficient, in 87% of cases. But in 17% of cases HEWs received no supportive training at all. Subsequent to this, they all mentioned areas in which they need refresher courses. Hence, 87.5%, 37%, 25% and 12.5% of HEWs need supportive training on delivery, Expanded Program of Immunization and growth monitoring chart, malaria diagnosis and treatment, first aid and Acute Watery Diarrhea respectively. It means, therefore, there are areas in which HEWs are performing, despite they have insufficient knowledge understanding and self-confidence.

According to respondents, there were cases in which some HEWs appeared to have insufficient knowledge and understanding of performing routine activities. It was uncovered that a given HEW appeared to immunize a child by assuming as if he has to complete his last immunization series at age of 9 months. A respondent described the situation as follows:

I was a member of Epidemic Management Team in Kachebira woreda (one among the seven woredas in the study zone) health center. The team has been in field for malaria epidemic assessment at health post of a given malarious kebele on 07/08/2000 E.C. On same day, there was a HEW working on routine EPI activities at health post. On the spot, I picked the immunization card of a child to whom BCG and OPVo was given on 12/01/2000 E.C, in the first visit. After consecutive visits, he was appointed for measles vaccination on 07/08/2000 E.C, the final visit. That is, 7 months after the first visit, despite it should normally be completed 9 months later from the first visit (two months deviation from the normal schedule).

From the above quantitative and qualitative finding, it follows that HEWs are performing some activities for which they had insufficient knowledge and understanding. This implies that as long as HEWs' Capacity which gives the community greater confidence in services at community level is not maintained, it would inspire negative perception about and dissatisfaction in those services. Gradually, this may lead to increased by-passing of services at health post and threat on the creation of an effective multi-layered referral system, as (WHO, 1975:20). Therefore, the perceived low capacity of HEWs likely undermines the success of the HSEP in the study zone.

Chapter Five

5. Summary, Conclusions and Recommendations

5.1. Summary of key Findings

In summary, the HSEP has shown better performance in Kembata Tembaro Zone. In majority of cases, the program is appeared to be active showing that it has high priority both at woreda, zonal and national level

A summary of the key findings is presented below by way of providing glimpses in to the content of the study.

5.1.1. Recognition and Appreciation

After the launch of the program, which encouraged an integration of curative, preventive and promotive services, a noticeable increase has taken place in community awareness and understanding about the existence and components of the HSEP. Thus eagerness is on the rise among users those reached by the extension effect not to remain underserved any longer. Hence, demand for access to health services is also on an apparently steady increase, presumably as a result of community's better knowledge and appreciation of the program's practical usefulness. It is more surprising that community's appreciation and recognition, though in few cases, progressed to the stage where traditional institutions like '*Idir*' can be harnessed for the purpose of translating into practice the consensus and resolutions reached at health education and communication events (preventive and promotive activities). In addition, improvements witnessed after the program was put in place have gained increasing amount of recognition and appreciation in the community. Communities thoughts, expressed in slightly different languages, sounded are largely optimistic. These all imply that reasonable degree of knowledge currently exists in community showing peoples' acceptance of the program.

In contrast, however, community insisted on complaining curative services at health posts. This may be mainly related to failure to procure basic drugs as per recommended in HSEP implementation guide. Inconsistency and low reliability in drugs supply could be another.

5.1.2. Selection Criteria

In all cases, community had no/or little knowledge about the selection process including the selection criteria used. This implies that community involvement (participation) in the selection process was so poor; and no support from woreda health office existed to empower community organization to facilitate the selection process. In nearly 50% of cases, HEWs are not local inhabitants. This shows that the selection criteria did not remain open to community, i.e. poor selection criteria are evident.

Though poor selection criteria denied community's empowerment, its negative contribution to low performance of HSEP seemed to be over shadowed. The probable reasons may be indifference in culture, social and linguistics between the HEWs and the community they serve. Good personal attributes of HEWs could be another.

5.1.3. Community Support

In all cases, community support was inadequate. Regardless of its level varying from community to community, community support was limited to in kind and in labor; but no support was appeared in cash. It means, therefore, that lack of support in cash likely threatens the sustainability of the program, particularly when support from the national level remains to be inadequate and it also crimples community's potential of self-reliance.

5.1.4. Basic Drug Supplies

In KTZ, the availability and procurement of basic drugs at HPs is found to be inconsistent, not reliable and below the expected in the light of the program's implementation guide. Therefore, HSEP which integrates curative, preventive and promotive services in a way they reinforce each other is not properly followed in the study area.

5.1.5. Supportive Supervision

Supportive supervision of HSEP in the study zone was identified to be with erratic / inconsistent/ supervision visits and inferior /poor/ quality, in majority of cases. The poor quality is manifested through the unavailability of well organized and responsible

supervision team, personnel with supervisory skills, and standard supervision checklists. This implies that even if the number of supervision visits is adequate, it is doubtful to expect HEWs receiving it do experience reasonable benefit from such visits. This means also that the nomination of supervisors and the visits they take seemingly exist just only to report to the concerned bodies that the activities are fully visited, regardless of real benefits accrued in the course of supervision.

5.1.6. HEWs' Personal Attributes.

The quantitative and qualitative data revealed that in Kembata Tembaro Zone HEWs characterized good personal attributes, in almost all cases; and subsequently they achieved high credibility. HEWs who are with good conduct, competence and commitment to community's health care, appeared to win community's attention in curative, preventive and promotive services. This implies that good personal attributes of HEWs in the study zone promoted close relationship between the HSEP and the community. A HEW in one of the study cases stated that "... malaria patients whom I treated and got recovered, including ... appeared to be more attentive for health education, practices, etc.". Community's positive feed back on HEWs' attributes is prevalently mentioned. Therefore, this shows that good personal attributes of HEWs likely contribute to high performance of HSEP in the study zone.

5.1.7. Training

In Kembata Tembaro Zone, almost all HEWs felt both basic training and supportive training inadequate in light of their usual activities. Thus in 87.5%, 37.0%, 25.0%, 12.0% of HEWs need refresher courses on delivery, Expanded Program of Immunization and growth monitoring, malaria diagnosis and treatment, and Acute Watery Diarrhea, respectively. This shows that they have been performing some activities for which they had insufficient knowledge, understanding and self- confidence. This means also that when HEWs' capacity which gives the community greater confidence is low, it leads to negative perception and dissatisfaction on services they deliver; and subsequently, increased by-passing of services and threats on the creation of an effective multi-layered referral system appears/ emerges/ soon. Thus, insufficient knowledge, understanding and

low self- confidence related to inadequate training likely lead to low client-perceived service quality and ultimately to low performance of HSEP in the study area.

5.2. Conclusions and Recommendations

The quantitative and qualitative findings of this assessment study on the performance of HSEP and factors affecting it, in KTZ, have shown that the program is performing to the encouraging level. Since the program's commencement, many progresses have been perceived in the community. In spite of the marked difference in the levels of performance attained across health posts, important changes have been witnessed in distinct aspects of the community in regard to knowledge, attitude and practices since the implementation of HSEP.

In contrast, some factors like inadequate community support, poor drug supplies, poor supportive supervision, and low capacity of HEWs which is attributable to insufficient training are important to tackle in the study area.

Apart from the above loopholes, on the basis of the concrete results on the ground that have been verified by the findings of the study, the researcher can possibly conclude that the program is worthy. Thus the HSEP is the most realistic solution for attaining a high coverage with essential health care services (Tesfaye, 2004:2). Besides, it is affordable and sustainable method to achieve a situation of "equity of access to a cost-effective quality health care, as close to the family as possible". Hence it is the researcher's strong conviction that in KTZ which characterizes poor infrastructure, poor access to basic health care services (i.e. majority of the rural mass is living out side health centers' catchment areas and underserved for many reasons), HSEP is and will continue to be important element of zonal health care strategic plans.

Yet, any future efforts to realize far reaching impact of the program and maintaining its sustainability is advised to seriously consider the recommendations put forward here under.

1. Resource availability is very important among others for the sustainability of the program. Hence allocating adequate fund is needed. In countries like Ethiopia where scarcity of resource from the national level is evident,

extending the range of community support (i.e. initiating community to support in cash apart from the usual forms/in labor and in kind/) is viable. It is particularly important to maintain the program's sustainability by way of at least filling the resource gap from the national level and at most ensuring community's self-reliance in case the government is unable to run it altogether. Thus, harnessing local resource is of great importance. Future efforts to maintain available resource for the implementation of the program need to take into consideration community empowerment and set framework to create enabling environment to mobilize /tap/ local resources for health actions.

2. Effective supervision to correct any constraints encountered in the implementation of the HSEP is strongly needed. Effective supervision characterizing team of experts (i.e. consisting of public health officer, public health nurse, environmental health expert and health education expert depending on local context) with an appropriate skill mix, continuity among team members and strong management skills is strongly needed. Supervision programs should also be planned, scheduled, budgeted and conducted regularly. The quality and quantity of work need to have standard and should be in line with the general strategy directions and local conditions. Above all, members of the supervision team at woreda level should be trained on skills needed for supportive supervision (i.e. facilitation, inter-personal communication, problem solving and analytical skills to various tools and methods such as peer reviews, performance assessment tools) and frequently upgrade their skills.
3. Woreda health office has to develop a standard list for drugs to be available at health posts as per recommended in the HSEP implementation guide and make it available to all stake holders. Accordingly, the drugs have to be appropriately selected, procured and requested in time and have to reach the HEWs in time and in the amount needed. Apart from this, enabling arrangements need to be put in place either to delegate or substitute in cases when persons in the dispensary rooms are not available for short or long terms.

4. It is necessary to acknowledge that institutional arrangements exist in every community which can be harnessed and reoriented for the purpose of implementing HSEP effectively. What has been learned from some communities' experience in the course of implementation in the past is that the existing traditional structures and institutions can be utilized effectively as forms of social capital to ensure effective implementation of the HSEP. Therefore, future efforts in the implementation of HSEP should draw upon local potentials as a form of social capital for the realization the program's goals and objectives.
5. Delivery, Immunization, malaria diagnosis and treatment, and growth chart, are areas where a pronounced gap exists between HEWs' capacity and the related activities they perform. Hence, it must be predicted that the more HEWs provided with refresher courses, the greater the knowledge, understanding and self-confidence they endow will be, and thereby, there will be increased client-perceived quality of services and greater community confidence. With this anticipation, future efforts to improve the implementation of HSEP should include the necessary arrangements to offer refresher courses commensurate with the need identified through observing HEWs while carrying out activities and the demand created.

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3.5. Topics covered during basic training

- Control of communicable diseases
- Environmental health
- Nutrition
- Health education
- Maternal and child health care
- Diagnosis and treatment of diseases
- Handling of drugs and supplies
- Health information
- Traditional health care
-

Other topics (specify) _____

3.8. Did you receive basic training courses from the health system?

Yes No

If yes, for how long was the course? _____ Weeks/ months?

Yes No

3.9. Was the training adequate for your work? Yes No

If no, specify the area in which you have had insufficient or no training but included in your work

3.10. Have you participated in a refresher training course in the past 12 months?

Yes No

If yes, what was the latest course about?

Do you think that it is sufficient for your work? Yes No

3.11. In which areas do you feel that further training is necessary?

- a. _____
- b. _____
- c. _____
- d. No need for further training
- e. Don't know

3.6. When did you start working after training?

Never immediately after some time (specify) _____

3.7. For how long have you been working? _____ months

If yes, do you think that it is sufficient for your work?

4. Responsibilities of HEWs'

4.1. Recording all vital information? Yes No

4.2. Fulfilling by request and administering necessary supplies to health posts?

Yes No

4.3. Is the referral system strong? Yes No

Do you refer cases when needed? Yes No

4.4. Is your documentation system well organized? Yes No

4.5. Do you request basic drugs in proper time? Yes No

If yes, do you get them in time and in the amount needed? Yes No

If No, mention the

reasons _____

4.6. Do you handle basic supplies properly? Yes No

4.7. Do you inform to the woreda health office? Yes No

Mention if did so in the last 6

months _____

4.8. Do you to all concerned bodies regularly? Yes No

If yes, how often for last three months? _____

4.9. Working closely with TTBAS, CHAS (including training them if necessary)?

Yes No

Mention what you did in this regard in the last 3

months _____

4.10. Home visit on regular basis? Yes No

If yes, is it based on your plan? Yes No

4.11. Do you give treatment for diarrhea, trachoma and skin itching? Yes No

If yes, how often? Regularly Sometimes Not at all

5. Health services at health post level

Does the health post give the following services?

1. Health education? Yes No

If yes, how often? Regularly Sometimes

2. Home visits for antenatal, home deliveries and postal care? Yes No

If yes, how often in last months? Regularly Sometimes

How many days ago of last visit? _____

3. Treatment of common illnesses (diarrhea, trachoma, malaria etc), minor injuries and refer difficult cases? Yes No
If yes, how often in last months? Always sometimes
4. Give first aid to victims? Yes No
If yes, how often? a) always b) sometimes
5. Promoting and giving ORS to children with diarrhea? Yes No
If yes how often? Always sometimes
6. Immunization (against the six child hood diseases and TT immunization to all women of
Child bearing age? Yes No
if yes, how often? Regularly Sometimes
7. Giving vitamin A supplement along with promotion of nutrition?
Yes No
If yes, how often? Regularly Some times
8. Carrying out growth monitoring activities? Yes No
If yes, how often? Regularly Some times
9. Identifying vitamin A deficiency and sever malnutrition cases for referral?
Yes No
If yes, how often? Regularly sometimes
10. Providing counseling and family planning services?
Yes No
If yes, how often? Regularly sometimes
11. Providing hygiene education to the community? Yes No
If yes, how often? Regularly sometimes
12. Working closely with TTBA's. CHAs (including training them if necessary), and other
community-based health organization? Yes No
If yes, how often? Always sometimes
13. Malaria control and prevention? Yes No
If yes. how often? Always sometimes
14. Control and prevention of body itching? Yes No
If yes. how often? Always sometimes
15. Recording all community health activities organizing documentation and filling system and reporting? Yes No

If yes, how often? Regularly sometimes

16. Preparing relevant information in visual form/diagrammatically and posting on the wall?

Yes No

If yes, how often? Regularly sometimes

6. Support, supervision and working conditions

6.1. Have you ever been visited by any body from the health facility? Yes No

If yes, by whom? And what was his/her staff membership? _____

Did you know the purpose of the visit? Yes No

How long ago was the last visit?

Less than 1 month 1-3 months more than 3 months

Supply supervision training other

(specify) _____

Did you get any benefit from the supervision? Yes No

6.2. Do you receive any form of remuneration or reward? Yes No

If yes, specify in what form it is (i.e. Certificate, money, goods, etc)

Form whom? _____

6.3. How many patients have you referred to a health facility in the past 3 months?

6.4. Did the community arrange transport for the referrals?

Yes No

If yes, specify the arrangement _____

6.5. In what other ways does the community help you in your work? _____

If none, say so

7. MCH/FP/EPI/ health education.

7.1. Do you participate regularly in the MCH clinic that serves your community?

Yes No

If not, why not? Not invited

- The clinic is too far away

- Others (specify) _____

- don't know

7.2. How often are immunization services available in your area?

Daily Weekly Monthly

Every 2 months others (specify) _____

Not available don't know

7.3. What specific functions do you perform on a regular basis within the immunization program?

- Community promotion follow up defaulters

- Generally assist at sessions

- No active part at all

- Other (specify) _____

7.4. Do you have any health information materials to hand out to the community?

Yes No

If yes, specify what information you have given in the post 3 month's

8. Nutrition and diarrhea control.

8.1. Do you weigh the children yourself? Yes No

If yes, is your scale accurate? Yes No

8.2. Do you understand the growth chart used in this area?

Yes No

8.3. Up to what age do you believe that mothers should Brest-feed their babies?

Less than 3 months 3 months 6 months

12 months 24 months other (specify) _____

Don't know

8.4. Do you know how to prepare a sugar and salt solution for treatment of diarrhea?

Yes No

If yes, describe _____

8.5. What advice does the HEW (TBA) give to a mother whose child has diarrhoea?

(Tick another given –don't prompt)

- continue with breast-feeding _____

- stop breast-feeding _____

- give extra fluids _____

- Give ORS solution or sugar and salt solution _____

- give medicaments (specify) _____

- continue to feed child normally _____

- feed child more frequently _____
- stop solid feeding _____
- watch for signs of dehydration _____
- seek help if child not improving with sugar and salt solution _____
- Explain how to prevent diarrhoea in future _____
- Other (specify) _____
- Don't know _____

9. Supplies and equipments

9.1. Do you have a standard list for drugs you should have?

Yes _____ No _____

9.2 Are the following drugs available at the health post?

First aid kits Yes _____ No _____

ORS Yes _____ No _____

Oral malaria drugs Yes _____ No _____

Drugs for skin itching Yes _____ No _____

Tetracycline ointment for trachoma Yes _____ No _____

9.3. What is the arrangement for replenishing supplies?

9.4. Did you run out of supplies of basic drugs in the past 3 months?

Yes _____ No _____

If yes, which items have been out of stock during the pas 3 months and what were the reasons for the shortage?

<u>Items</u>	<u>Reasons</u>
a. _____	_____
b. _____	_____
c. _____	_____
d. _____	_____
e. _____	_____

Annex

An interview questionnaire for community members.

Date of interview _____

Name of interviewer _____

Name of community _____

Name of interviewee _____

1.1. Personal data

1.1. Age _____

1.2. Occupation _____

1.3. Marital status _____

2. Concerning to community's organization

2.1. Is there a village committee or similar mechanism for collective decision-making on the

community's health-related affairs? Yes No

If yes, who are the members (by categories of people and group they represent)?

If no, how are decision taken? _____

If yes, go to 1. 2

2.2. Is this committee's establishment statutory? Yes No

2.3. Does any health worker attend this committee? Yes No

If yes, what is his/ her status on committee (eg. Chairman secretary, treasurer, member,

invited advisor, consultant)?

3. Perception of health problems and health services.

3.1. What do you regard as the main health problems in the community? _____

3.2. What does the leader feel are the main causes of these problems?

3.3. Who are most affected? _____

Does the leader know these people personally? Yes No

3.4. What does the leader think the community should do about these problems, especially the

one that cause most suffering? _____

3.5. What has already been done? _____

3.6. Do you recognize/know HSEP and health services under it? Yes No

3.7. Do you consider that the HSEP has helped to reduce the community's health problem? Yes No

3.7. What information does the community collect on the health situation (eg., immunization,

birth, latrines, food supplies, measles incidence, etc)?

3.8. Which of the following health services are being provided at your health post?

Are you

satisfied with them? (tick as answered – ask one by one).

	Provided and Satisfactory	provided but unsatisfactory	not provided
i) Curative health Services	_____	_____	_____
ii) Maternal and child health services	_____	_____	_____
iii) Environmental health services	_____	_____	_____
iv) Health education	_____	_____	_____
v) Family planning	_____	_____	_____
vi) Immunization	_____	_____	_____
vii) Control of specific diseases	_____	_____	_____
viii) Nutrition education	_____	_____	_____

For each service with which you are not satisfied, give reason

4. Community resources and self-reliance

4.1. Can the community raise funds (local taxes)? Yes No

If yes, what does the community use the money for?

4.2. Has the community ever contributed to health post any (in labor, in cash or in kind)?

If yes, specify what for, how much, and when? _____

4.3. Enumerate communal health activities carried out during the past 6 months (Tick as answered do not prompt)

- Water supply
- Sanitation/ excreta disposal
- Village cleanness /solid waste disposal
- Transport of sick
- Promotion of nutrition
- Communal forming for health support

4.4. Are there any health projects (ongoing or proposed) planned by the community itself?

Yes No

If yes, is government or external support needed? _____

Describe the project/s and the type and quantity of assistance required _____

4.4. Has the community's health condition improved since HSEP was introduced?

Yes No

If yes, mention some _____

5. Community health workers' selection, conduct and performance

5.1. Who was selected HEW/s in your kebele?

a/ the whole community _____

b/ community leaders _____

c/ woreda health office staff

Others(specify) _____

5.2. Did you know the selection criteria? Yes No

If yes, mention some _____

5.3. Does/Do HEW/s perform the following health activities?

a/ preventive and promotive Yes No

b/ visiting home regularly Yes No

c/ prenatal, natal and postnatal care Yes No

d/ family planning Yes No

5.4. Does the community utilizes the services under 5.4? Yes No

If yes, is there any progress in the community

because of these services? Yes No

If there is/are perceived progress/es _____

An interview questionnaire for woreda health office staff.

1. Taking HSEP as a key responsibility? Yes---- No-----
2. Coordinating, implementing, following up evaluating HSEP activities at household community level? Yes----- No -----
3. Supportive supervision followed by feedback? Yes----- No -----
If yes, how often in 12 months?
4. Preparing and offering refresher courses for HEWs? Yes----- No -----
If yes, mention whom by, where and on what issues it was.-----
5. Procuring basic drug supplies for HSEP? Yes ----- No -----
If yes, do you think that these are adequate? Yes ----- No -----
If No, what are the main reasons for this? -----
6. Strengthening inter-sectoral collaboration in the implementation of HSEP?
Yes ----- No -----
7. Supporting and facilitating while HEWs are selected? Yes ---- No -----
If yes, mention the type of support given? -----
8. Strengthening referral system between health posts and higher level health institutions? Yes ----- No -----
9. Collecting, compiling and reporting activity report to the concerned bodies in time? Yes ---- No ----
If No, mention the reason/s. -----
10. Orienting HEWs about activities they perform before they start working at Health posts? Yes ---- No ----
11. Initiating, cooperating, and guiding the community to contribute to logistic supplies to health posts? Yes ---- No ----
12. If yes, what is the form of community's contribution (e.g. in cash, in kind, and in labor)? -----
13. Procuring and providing basic drugs to health posts in time and in the amount needed? Yes ---- No ----
If yes, is it reliable and consistent? Yes ---- No ----

5.5. Is the community satisfied with the work and behavior of the community health worker)? Yes No

If no, specify dissatisfaction _____

5.6. Has it been necessary during the last 6 months to remove or replace the HEW?

Yes No

If yes, specify the reasons _____

5.7. What remuneration or reward does the community provide for its community health worker (e.g. regular payment in cash, remuneration in kind, certificate, exemption

from other community duties)?

5.8. Has the community/committee managed to provide the remuneration without fail in the past 12 months? Yes No

5.9. What other services supports are given to CHWs?

An interview questionnaire for HSEP supervisors.

Date of interview _____

Name of interviewer _____ Woreda _____

Name of interviewee _____

1. Personal data

1.1. Age _____

1.2. Sex _____

1.3. Educational status 12+2 12+4 10+3 12+3

1.4 . Field of specialization: Public nurse . Clinical nurse
Health officer Environmental health

2. Elements of supervision.

2.1. Is there supervision tea in your woreda? Yes No

If yes, was the team's establishment statutory? Yes No

Describe the team's establishment

criteria _____

2.2. Has/Have the team/you received any relevant training on skills needed for HSEP supervision? Yes No

If yes, specify where, when and by whom it was given

2.3. Do supervisory visits include the following? (use '+' if yes and '-' if not)

i) supervision plan/schedule _____

ii) supervision checklists _____

iii) supervising according to supervision scedule

iv) supervision feedback to HEW's _____

v) supplies and commodities _____

vi) day - to - day activities _____

vii) after competing the mission _____

2.4. Has the supervision plan met the objectives of each visit in the past 12 months?

Yes No

If yes, has it been uniform for all health posts of in the woreda? Yes No

If not, specify main reasons _____

2.5. What factors do you feel are mainly hindering the team not to discharge its responsibilities as expected?

በጤና ኤላ ስራተኛ የሚሞላ ቃለ መጠይቅ

1. አጠቃላይ መረጃ

- 1.1. የወረዳው ስም -----
- 1.2. የቀበሌው ስም -----
- 1.3. የቀበሌው ሕዝብ ብዛት -----
- 1.4. የሕዝቡ የመተዳደሪያ ግብር -----

2. የጤና ኤላ ስራተኛ የግል መረጃ

- 2.1. እድሜ -----
 - 2.2. ከጤና አገልግሎት በተረፈ ተጨማሪ ግብር:- ግብርና ሌላም ካለ ይገለጽ -----
 - 2.3. በሚሰሩበት አካባቢ የኖሩበት ጊዜ:- ከተወለዱበት ጊዜ ጀምሮ 5 ዓመትና ከዚያ በላይ ከ5 ዓመት በታች
 - 2.4. የጋብቻ ሁኔታ:- ያላገቡ ያገቡ አግብተው የፈቱ ሌላም ካለ ይገለጽ -----
 - 2.5. ያገቡ ከሆኑ የቤተሰብ ብዛት -----
 - 2.6. የትምህርት ደረጃ:- 10ኛ ክፍል ያጠናቀቁ 12ኛ ክፍል ያጠናቀቁ ሌላም ካለ ይገለጹ -----
 - 2.7. በአሁኑ ሰአት በጤንነት ላይ ያለ ችግር:- አለ የለም
 - 2.8. አሁን የቀበሌ ስራ አመራር አባል ናት ? አዎ አይደለም
- መልስዎ «አዎ» ከሆነ ኃላፊነቱ ይገለጽ -----

3. የሰራተኛ የምልመላ ሂደት ፣ መሰረታዊና የሙያ ማሻሻያ ስልጠና በተመለከተ

- 3.1. ለጤና ኤክስፔንሽን ስራተኝነት የመረጠዎት ኅብተሰቡ ነበር? አዎ አይደለም
 - መልስዎ «አዎ» ከሆነ እንዴት ተመለመሉ?
 - በመላው የቀበሌ ኅብረተሰብ ስብሰባ
 - በቀበሌ ኅብረተሰብ በተወከሉ የኮሚቴ አባላት
 - በኅብረተሰቡ በተወከሉ ሌት አባላት
 - በቀበሌ ስራ አመራር አባላት
- ሌላም ካለ ይገለጽ -----

- 3.2. የሰለጠኑበት ቦታ -----
 - 3.3 ስልጠና የጨረሰበት ዘመን -----
 - 3.4 የስልጠና ወጪ የሸፈነው አካል:- ኅብረተሰቡ ጤና ድርጅት
- ሌላም ካለ ይገለጽ -----

3.5. በስልጠናዎ ላይ የተማሯቸው ኮርሶች ይዘት ምን ምን ያካትት ነበር ?

- የተላላፊ በሽታዎችን ስለመቆጣጠር
- የእኩልነት ጤና አጠባበቅ
- ሥነ-ምግብ
- የጤና አጠባበቅ ትምህርት
- የእናቶችና ሕጻናት ጤና አጠባበቅ
- በሽተኛን መመርመርና ሕክምና አሰጣጥ
- የመድኃኒቶችና የሕክምና ቁሳቁሶች አያያዝ
- ስለ ጤና መረጃ አሰባሰብና አላላክ
- ስለባህላዊ ህክምና ጤና አጠባበቅ
- ሌላም ካለ ይገለጽ -----

3.6 የጤና ኤክስቴንሽን ስራ መቼ ጀመሩ? እስከ አሁን አልጀመርኩም ወዲያውኑ
ከተወሰነ ጊዜ በኋላ (ግዜው በውል ይገለጻል) -----

3.7 በዚህ ሥራ ላይ የቆዩበት ጊዜ ----- ወር

3.8 ከሰለጠኑበት የጤና ማሰልጠኛ ተቋም መሰረታዊ የስልጠና ኮርሶች አግኝተው ነበር?

አዎ አይደለም
መልስዎ «አዎ» ከሆነ ለምን ያህል ጊዜ ነበር? ----- ሳምንት/ወራት

3.9 ስልጠናው ለስራዎ በቂ ነው ብለው ያምናሉ? «አዎ» «አይደለም»
መልስዎ «አይደለም» ከሆነ በቂ ወይም ምንም ስልጠና ያላገኙበትን ነገር ካለ ይጥቀሱ

3.10 ባለፉት 12 ወራት ውስጥ በሙያ ማሻሻያ /ማነቃቃያ ስልጠና ላይ ተሳትፈው

ያውቃሉ? «አዎ» «አይደለም»

መልስዎ «አዎ» ከሆነ በቅርቡ የተከታተሉበት ስልጠና በምን ዙሪያ ነበር?

የሙያ ማሻሻያ ስልጠናው ለስራዎ በቂነው ብለው ያምናሉ?

አዎ አይደለም

3.11 በስራዎ ዙሪያ ተጨማሪ ስልጠና ያስፈልገኛል ብለው የሚያስቡበት ካለ ይግለጹ

ሀ. -----

ለ. -----

ሐ. -----

መ. ምንም ስልጠና አያስፈልገኝም

ሠ. አላውቅም

4. የጤና ኤክስቴንሽን ስራተኛ ተግባራት በተመለከተ

የሚከተሉትን ተግባራት ያከናውናሉ?

1. መሠረታዊ የዲሞክራሲና የጤና ነክ መረጃዎችን ማሰባሰብና መዝግቦ መያዝ

ሁልጊዜ አንዳንድ ጊዜ

2. ለጤና ኤክስቴንሽን ፕሮግራም ተግባራት የሚያስፈልጉ ግብአቶችን ማሟላትና ማስተዳደር

አዎ አይደለም

3. የህሙማን አላላክና አቀባበል ስርአቱ የተጠናከረ ነው? አዎ አይደለም

መልስዎ (አዎ) ከሆነ ሃደቱን ይግለጹ -----

4. የመረጃ ማጠናቀሪያ መዝገቦችና ሰነዶች በሚፈለገው መጠን አሉ? አዎ አይደለም

መልስዎ (አይደለም) ከሆነ ምክንያቱን ይግለጹ -----

5. የዶክመንቲቸን ስርአቱና የፋይል አያያዙ የተጠናከረ ነው? አዎ አይደለም

መልስዎ (አይደለም) ከሆነ ምክንያቱን ይግለጹ -----

መልስዎ (አዎ) ከሆነ ሃደቱን ይግለጹ -----

6. የሚያስፈልጉ መድኃኒቶችንና የሕክምና መገልገያዎችን በወቅቱ ይጠይቃሉ?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ የጠየቁትን ግብአቶች በሚያስፈልገው መጠን በወቅቱ ያገኛሉ?

አዎ አይደለም

በሚፈለገው መጠን በወቅቱ የማያገኙ ከሆነ ምክንያቱን ይግለጹ -----

8. መድኃኒቶችና የሕክምና መገልገያዎችን ብልሽት እንዳይደርስባቸው በአግባቡ ይይዛሉ?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ ሃደቱን ይግለጹ -----

9. ጊዜ ያለፈባቸውና የማይፈለጉ ሲኖሩ ለወረዳው ጤና ጥበቃ ጽ/ቤት ያሳውቃሉ?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ ላለፉት 7 ወራት ያሳወቁት ካለ ይግለጹ -----

10. በየወቅቱ ሪፖርት በማዘጋጀት ለቀበሌ ምክር ቤት ፣ ለወረዳ ጤና ጥበቃ ጽ/ቤትና ለጤና ጣቢያ ይልካሉ?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ ላለፉት 3 ወራት ስንት ጊዜ ላኩ?

11. የበጎ ፈቃድ የሕብረተሰብ ጤና ሰራተኞችን ማደራጀት፣ ማሰልጠንና ማስተባበሩ

አዎ አይደለም

መልስዎ (አዎ) ከሆነ ላለፉት 3 ወራት የተደረገ ካለ ይግለጹ -----

12. መደበኛ የቤት ለቤት ጉብኝት ያደርጋሉ? አዎ አይደለም

መልስዎ (አዎ) ከሆነ ጉብኝቱ በእቅድ የጊዜ ሰሌዳን መሰረት ያደረገ ነው? አዎ አይደለም

13. ቅማጥ፣ የሆድ ትላትል፣ ትራኮማና እከክ ለመሰላሰሉት ህመሞች ህክምና ይሰጣሉ?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ አሰጣጡ እንዴት ነው? ሁልጊዜ አንዳንድ ጊዜ

5. የጤና ኬላውን አገልግሎት በተመለከተ

5.1. የጤና ኬላው የሚከተሉትን የጤና አገልግሎቶች ይሰጣል? በስራ ዕቅድ መሠረት ከሆነ ሁልጊዜ ምታች ከሆነ አንድ ጊዜ እና የማይሰጥ ከሆነ የለም ጎን ባለው ሳጥን በ (✓) ምልክት ያሳይዩ

1. የጤና አጠባበቅ ትምህርት፡- (ሁልጊዜም) አንዳንድ ጊዜ

2. የክትባት አገልግሎት ለሕጻናትና እናቶች፡- ሁልጊዜም አንዳንድ ጊዜ

3. የቤተሰብ እቅድ አገልግሎት፡- ሁልጊዜም አንዳንድ ጊዜ

4. የቅድመ ወለድ ክትትልና ምክር፡- ሁልጊዜ አንዳንድ ጊዜ

5. የወሊድና ድህረ ወለድ አገልግሎትና ምክር፡- ሁልጊዜ አንዳንድ ጊዜ

3. የህሙማን አላላክና አቀባበል ስርአቱ የተጠናከረ ነው? አዎ አይደለም
 መልስዎ (አዎ, ከሆነ ሃደቱን ይግለጹ -----
 4. የመረጃ ማጠናቀሪያ መዝገቦችና ሰነዶች በሚፈለገው መጠን አሉ? አዎ አይደለም
 መልስዎ (አይደለም, ከሆነ ምክንያቱን ይግለጹ -----

5. የዶክመንቱሽን ስርአቱና የፋይል አያያዙ የተጠናከረ ነው? አዎ አይደለም
 መልስዎ (አይደለም, ከሆነ ምክንያቱን ይግለጹ -----
 መልስዎ (አዎ, ከሆነ ሃደቱን ይግለጹ -----

6. የሚያስፈልጉ መድኃኒቶችንና የሕክምና መገልገያዎችን በወቅቱ ይጠይቃሉ?
 አዎ አይደለም
 መልስዎ (አዎ, ከሆነ የጠየቁትን ግብአቶች በሚያስፈልገው መጠን በወቅቱ ያገኛሉ?
 አዎ አይደለም
 በሚፈለገው መጠን በወቅቱ የማያገኙ ከሆነ ምክንያቱን ይግለጹ -----

8. መድኃኒቶችና የሕክምና መገልገያዎችን ብልሽት እንዳይደርስባቸው በአግባቡ ይይዛሉ?
 አዎ አይደለም
 መልስዎ (አዎ, ከሆነ ሃደቱን ይግለጹ -----

9. ጊዜ ያለፈባቸውና የማይፈለጉ ሲኖሩ ለወረዳው ጤና ጥበቃ ጽ/ቤት ያሳውቃሉ?
 አዎ አይደለም
 መልስዎ (አዎ, ከሆነ ላለፉት 7 ወራት ያሳወቁት ካለ ይግለጹ -----

10. በየወቅቱ ሪፖርት በማዘጋጀት ለቀበሌ ምክር ቤት ፣ ለወረዳ ጤና ጥበቃ ጽ/ቤትና ለጤና ጣቢያ ይልካሉ?
 አዎ አይደለም
 መልስዎ (አዎ, ከሆነ ላለፉት 3 ወራት ስንት ጊዜ ላኩ?

11. የበጎ ፈቃድ የሕብረተሰብ ጤና ሰራተኞችን ማደራጀት፣ ማሰልጠንና ማስተባበሩ
 አዎ አይደለም
 መልስዎ (አዎ, ከሆነ ላለፉት 3 ወራት የተደረገ ካለ ይግለጹ -----

12. መደበኛ የቤት ለቤት ጉብኝት ያደርጋሉ? አዎ አይደለም

መልስዎ (አዎ, ከሆነ ጉብኝቱ በኋቅድ የጊዜ ሰሌዳን መሰረት ያደረገ ነው? አዎ አይደለም

13. ቅማጥ፣ የሆድ ትላትል፣ ትራኮማና እከክ ለመሰላሰሉት ህመሞች ህክምና ይሰጣሉ?
 አዎ አይደለም
 መልስዎ (አዎ, ከሆነ እሰጣጡ እንዴት ነው? ሁልጊዜ አንዳንድ ጊዜ

5. የጤና ኬላውን አገልግሎት በተመለከተ
 5.1. የጤና ኬላው የሚከተሉትን የጤና አገልግሎቶች ይሰጣል? በስራ ዕቅድ መሠረት ከሆነ ሁልጊዜ ምታች ከሆነ አንድ ጊዜ እና የማይሰጥ ከሆነ የለም ጎን ባለው ሳጥን በ (✓) ምልክት ያሳይዩ

1. የጤና አጠባበቅ ትምህርት:- ሁልጊዜም አንዳንድ ጊዜ
2. የክትባት አገልግሎት ለሕጻናትና እናቶች:- ሁልጊዜም አንዳንድ ጊዜ
3. የቤተሰብ እቅድ አገልግሎት:- ሁልጊዜም አንዳንድ ጊዜ
4. የቅድመ ወለድ ክትትልና ምክር:- ሁልጊዜ አንዳንድ ጊዜ
5. የወለድና ድሀሪ ወለድ አገልግሎትና ምክር:- ሁልጊዜ አንዳንድ ጊዜ

6. የሕጻናት እድገት ክትትል መስራትና መምከር፡- ሁልጊዜ አንዳንድ ጊዜ

7. የሕጻናትና የነፍሰ ጡር እናቶች የሥነ-ምግብ እጥረት ልዩታና የምክር አገልግሎት

ሁል ጊዜ አንዳንድ ጊዜ

8. ወባን የመከላከልና የመቆጣጠር ተግባር፡- ሁልጊዜ አንዳንድ ጊዜ

9. በተቅማጥ በሽታ ለተያዙ ኢ.አር.ኤስ መስጠት፡- ሁልጊዜ አንዳንድ ጊዜ

10. የቴትራሲይክሊን ቅባትን በመጠቀም የትራኮማ በሽታን ማከምና ስለፊት መታጠብ

ማስተማር፡- ሁልጊዜ አንዳንድ ጊዜ

11. የእኩክ በሽታን መከላከልና መቆጣጠር፡- ሁልጊዜ አንዳንድ ጊዜ

12. ለታመሙት ሕጻናት ወይም ለሌሎች የኅብረተሰብ ክፍሎች አስፈላጊ እርዳታ

ማድረግ ፣ ከአቅም በላይ ሆኖ ሲገኝ ወደ ቀጣዩ የጤና ተቋም መላክ

ሁልጊዜ አንዳንድ ጊዜ

13. ቫይታሚን ሌሎች ለማይሰፈሩባቸው መስጠት፡- ሁልጊዜ አንዳንድ ጊዜ

14. የመጀመሪያ ህክምና እርዳታ ማድረግ፡- ሁልጊዜ አንዳንድ ጊዜ

15. ከበጎ ፈቃድ የኅብረተሰብ ጤና ሰራተኞች ጋር ቋሚ የሆነ መደበኛ ስብሰባ

ማካሄድ፣ እንደአስፈላጊነቱ ስልጠና መስጠት፡- ሁልጊዜ አንዳንድ ጊዜ

16. የተከናወኑ ስራዎችን መመዘገብ ፣ ፋይል ማደራጀት ፣ መረጃን ማጠናቀርና

ሪፖርት ማቅረብ፡- ሁልጊዜ አንዳንድ ጊዜ

17. አስፈላጊ መረጃዎችን በግራፍና በቻርት በመስራት ግድግዳ ላይ መለጠፍ፡-

ሁልጊዜ አንዳንድ ጊዜ

6. ድጋፍ፣ ሱፐርቪዥንና የሥራ ሁኔታ

6.1. የጤና ኤክስፔንሽን ሰራተኛዎ በየበላይ የጤና ሰራተኛ ተጎብኝተው ያውቃሉ?

አዎን አይደለም

- መልስዎ ለአዎ ከሆነ በማን?
- ላለፉት 12 ወራት ምን ያህል ጊዜ ሱፐርቪዥ ተደረገ?
- የቅርብ ጊዜው ምን ያህል ጊዜ ሆነው?
 - ከአንድ ወር በታች
 - ከ 1-3 ወር
 - ከ3 ወር በላይ

የጉብኝቱን አላማ ያውቁ ነበር? አዎ አይደለም

መልስዎ አዎ ከሆነ አላማዎን ይግለጹ

የጉብኝቱን ግብረ መልስ አግኝተው ነበር? አዎ አይደለም

ከግብረ መልሱ ያገኙት ፋይዳ ነበር? አዎ አይደለም

አዎ ከሆነ ፋይዳውን ይግለጹ

- አቅራቢት
- ሱፐርቪዥን
- ስልጠና
- ሌላም ካለ ይገለጹ
- አላውቅም

6.2 የጤና ኤክስፔንሽን ሰራተኛዎ ማንኛውንም ማበረታቻ ያገኛሉ? አዎ አይደለም

መልስዎ ለአዎ ከሆነ የማበረታቻው አይነት ይገለጹ (ለምሳሌ የምስክር ወረቀት፣ ገንዘብ ፣ ቁሳቁስ ፣ ወዘተ) ከማን?

6.3. ላለፉት 3 ወራት ምን ያህል በሽተኛ ወደ ጤና ጣቢያ /ሆስፒታል ተላኩ?

6.4. ወደ ጤና ጣቢያ /ሆስፒታል ለሚላኩ በሽተኞች ማንንኑ ኅብረተሰቡ ያመቻች ነበር?

አዎ አይደለም

መልስዎ ለአዎ ሆነ ይግለጹ

6.5. ኅብረተሰቡ የጤና ኤክስቴንሽን ሰራተኛዎን የሚደግፍባቸው ሌሎች መንገዶች ምን ምን ናቸው?

ምንም ከሌላ ምክንያቱ ምንድን ነው?

7. የእናቶችና ሕፃናት ጤና አጠባበቅ የቤተሰብ ምጣኔ ትምህርት

7.1 የጤና ኤክስቴንሽን ሰራተኛዎ ኅብረተሰቡን እያገለገለ በሚገኛው የእናቶችና ሕፃናት ጤና

አጠባበቅ ማእከል መደበኛ ተሳትፎ ያደርጋሉ? አዎ አይደለም

መልስዎ (አይደለም) ከሆነ ለምን?

- አልተጋበዝኩም
- ማእከሉ በጣም ስለሚርቅብኝ
- ሌላም ካለ ይገለጹ
- አላውቅም

7.2 የክትባት አገልግሎት አሰጣጥ በአከባቢዎ እንዴት ነው?

- በየቀኑ
- በየሳምንቱ
- በየወሩ
- በየ ሁለት ወር
- የለም
- አላውቅም

7.3 በክትባት ፕሮግራም ጊዜ በኅብረተሰቡ ውስጥ የጤና ኤክስቴንሽን ሰራተኛዎ መደበኛ ተግባራት ምንድን ናቸው?

- ኅብረተሰቡን መቀስቀስ
- ፕሮግራሙን ማገዝ
- ያልተከተቡትን ክትትል ማድረግ
- ምንም ቋሚ ተግባር የለም
- ሌላም ካለ ይገለጹ

7.4 ለህብረተሰቡ የሚሰጥ የጤና ትምህርት መረጃ ቀሳቀሶች አሉን?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ ባለፉት ሶስት ወራት የተሰጠ መረጃ ካለ ይገለጹ

8. ሥነ-ምግብና የተቅማጥ ቁጥጥር

8.1 የጤና ኤክስቴንሽን ሰራተኛዎ የሕፃናትን ክብደት ይለዛል?

መልስዎ (አዎ) ከሆነ ልክቱ ትክክለኛ ነው?

አዎ አይደለም

8.2 የእድገት ግራፍ እውቀቱና ግንዛቤ አሉት? አዎ አይደለም

8.3 እናቶች ልጆቻቸውን ማጥባት ያሰባቸው የእድሜ ገደብ ምን ያህል ነው?

- ከ3 ወር በታች
- 3 ወር - 24 ወር
- 6 ወር - ሌላም ካለ ይገለጹ
- 12 ወር - አላውቅም

8.4 ተቅማጥን ለማከም ውሃና ጨው በራሳሽ መልክ እንዴት መዘጋጀት እንዳለበት

ያውቃሉ? አዎ አይደለም

መልስዎ አዎ ከሆነ አዘገጃጀቱን ይገለጹ

9. አቅርቦትና የሕክምና ቁሳቁሶች

9.1. የሚያስፈልግዎት የመድኃኒትና የህክምና ቁሳቁሶች ዝርዝር አልዎት? አዎ

አይደለም

በጤና ኩላው የሚከተሉት መድሃኒቶች አሉን?

ሀ. የመጀመሪያ ህክምና እርዳታ ቁሳቁሶች

ለ. ኦ አር ኤስ

ሐ. የወባ መድሃኒት

መ. የእከክ መድሃኒት

ሠ. የቴትራሳይክሊን ቅባት

9.2. ስያልቅቦት እንዴት ስያልቅቦት እንዴት ነው የሚያሟሉት? _____

9.3. ባለፉት ሶስት ወራት ያለ አስፈላጊ ግባቶች ሰርተው ያውቃሉ?

አዎ አይደለም

መልስዎ (አዎ) ከሆነ የትኛው የግብአት አይነት ነበር ያስተብዎት? ምክንያቱ/ቶቹ ምንድን ነበር/ሩ

የግብአቱ አይነት

ምክንያቱ/ቶቹ

ሀ. _____

ለ. _____

ሐ. _____

ቀን

ቀን ላይ የሚከናወኑ ስራዎች

I የሥራ ስራዎች

ቀን

ቀን

የሥራ ስራዎች

ቀን

2. የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

2.1 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

2.2 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

2.3 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3. የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.1 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.2 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.3 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.4 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.5 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.6 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.7 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.8 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

3.9 የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

የሥራ ስራዎች ላይ የሚከናወኑ ስራዎች

በአጥጋቢ ሁኔታ ተሰጥቷል ነገር ግን አልተሰጠም

	<u>ተሰጥቷል</u>	<u>አጥጋቢ አይደለም</u>
ሀ. ከሕመም የመፈወስ አገልግሎት	-----	-----
ለ. የእናቶችና ሕጻናት ጤና አጠባበቅ	-----	-----
ሐ. የአካባቢ ጤና አጠባበቅ	-----	-----
መ. የጤና አጠባበቅ ትምህርት	-----	-----
ሠ. የቤተሰብ እቅድ አገልግሎት	-----	-----
ረ. ክትባት	-----	-----
ሰ. የበሽታዎች ቁጥጥር	-----	-----
ሸ. የሥነ-ምግብ ትምህርት	-----	-----

3.10. ከላይ ከተዘረዘሩት ባልረኩበት በእያንዳንዱ አገልግሎት ዙሪያ የአለመርካትዎን ምክንያት/ቶች/ ይግለጹ -----

4. በኅብረተሰቡ የጤና ግብአቶችና ራስ መቻል ዙሪያ

4.1. ኅብረተሰቡ ገቢ ያሰባስባልን? አዎ አይደለም
 መልስዎ ላይ ከሆነ ገንዘቡ በየትኛው ተግባር ይውላል? -----

4.2. ላለፉት 7 ወራት ኅብረተሰቡ ክራሱ በቀጥታም ሆነ በተዘዋዋሪ ጠይቆ ያደረገ ማንኛውም የጤና ድጋፍ አለን (በገንዘብ አሊያም በቁሳቁስ መልክ)?
 አዎ አይደለም
 መልስዎ ላይ ከሆነ ለምን ተግባር ምን ያህል እና ከየት እንደሆነ ይግለጹ -----

4.3 ባለፉት 12 ወራት በኅብረተሰቡ የተደረጉ የጤና ተግባራት ካሉ የሚከተለውን መረጃ ይስጡ:: (✓) ምልክት በመጠቀም ምላሹን ያሳዩ)

- የውሃ አቅርቦት
- የሽንትና የእይነ ምድር አወጋገድ
- የደረቅና የፈሳሽ ቆሻሻ አወጋገድ
- ሕመማንን ማጓጓዝ
- የሥነ-ምግብ ማበረታታት
- የጤናን ዘርፍ ለመደገፍ በኅብረት ማረስ
- ሱላም ካለ ይገለጽ

4.4 በኅብረተሰቡ የታቀደ የጤና ፕሮጀክት (ተግባራዊ የሆነ ወይም የታሰበ) አለን?
 አዎ አይደለም

መልስዎ ላይ ከሆነ ፕሮጀክቱ የመንግስት ወይም የሌላም አካል ድጋፍ የሚያስፈልገው ነው? አዎ አይደለም
 ድጋፍ የሚያስፈልገው ከሆነ የፕሮጀክቱን አይነት፣ የድጋፉን አይነትና መጠን ይግለጹ::
 መልስዎ ላይ ከሆነ ተግባሩ/ራቱ ይግለጹ/ጹ -----

4.5 ክቅርብ አመታት ወዲህ የኅብረተሰቡ አጠቃላይ የጤና ተሻሻሏል ብለው ያምናሉ?
 አዎ አይደለም

መልስዎ ሕዎ ከሆነ የተወሰኑትን ይጥቀሱ -----

5. የጤና ኤክስቴንሽን ሰራተኞችን የምልመላ ሂደት የሰራና ባህሪ ሁኔታ በተመለከተ

5.1 የጤና ኤክስቴንሽን ሰራተኛዎ ነለዚህ ስራ በማን ተመረጠች

ሀ. በመላው የቀበሌ ህብረተሰብ

ለ. በቀበሌው የስራ አመራር አባላት

ሐ. በወረዳው ጤና ጥበቃ ጽ/ቤት አባላት

መ. ሌላም ካለ

ስራና ባህሪዎ ጎብረተሰቡ የሚያረካ ነው?

አዎ አይደለም

መልስዎ አይደለም ከሆነ ያልረካቸው ሁኔታዎች ይግለጹ -----

5.2 የምልመላ መስፈርቱስ ምን እንደነበር ያውቃሉ?

አዎ አይደለም

መልስዎ አዎ ከሆነ የተወሰኑትን ይጥቀሱ

5.3 የጤና ኤክስቴንሽን ሰራተኛዎ በሚከተሉት የጤና አገልግሎቶችን ለህብረተሰቡ ትሰጣለች/ ይሰጣሉ?

ሀ. የበሽታዎች መከላከልና የጤና ማሻሻል ስራ

አዎ አይደለም

መልስዎ አዎ ከሆነ ላለፉት ስድስት ወራት ከተደረጉት የበሽታ መከላከል ተግባራት የተወሰኑትን ይግለጹ

ለ. የቤት ለቤት ጉብኝት

አዎ አይደለም

ሐ. የቅድመ ወሊድ ፣ የወሊድ እና ድህረ ወሊድ አገልግሎት እና ምክር

አዎ አይደለም

መ. የቤተሰብ ምጣኔ አገልግሎት

አዎ አይደለም

5.4 ከላይ በ5.3 ስር የተዘረዘሩትን የጤና አገልግሎቶች አጠቃቀም በህብረተሰቡ ዘንድ ምን ይመስላል? የሚታዩትስ እበረታች ለውጦች አሉ?

አዎ አይደለም

5.5 የጤና ኤክስቴንሽን ሰራተኛዎ/ኞች ሥራና ባህሪ ህብረተሰቡን የሚያረካ ነው?

አዎ አይደለም

መልስዎ አይደለም ከሆነ ያልረካቸው ሁኔታዎች ይግለጹ

5.6 ባለፉት 6 ወራት የጤና ኤክስቴንሽን ሰራተኛዎችን ከስራ ማስወገድ አልያም በሌላ መተካት አስፈላጊ ነበር?

አዎ አይደለም

መልስዎ ሕዎ ከሆነ ምክንያቶቹ ይግለጹ -----

5.7 ለጤና ኤክስቴንሽን ፕሮግራም ህብረተሰቡ የሚሰጠው የማበረታቻ ድጋፍ ምንድን ነው (በገንዘብ ፣ በቀሳፍስ ወዘተ)?

መልስዎ አዎ ከሆነ የድጋፍ አይነት ይግለጹ

5.8 ለጤና ኤክስቴንሽን ህብረተሰቡ የሚያደርገው ሌላ የድጋፍ አይነት ካለ ይግለጹ

በወረዳ ጤና ጥበቃ ጽ/ቤት ኃላፊዎች የሚሞላ ቃለ-መጠይቅ

ቀን _____

የወረዳው ስም _____

ቃለ መጠይቅ የተደረገለት ሰው ስም _____

ሀላፊነቱ _____

ዕድሜ _____ ያታ _____ የት/ደረጃ _____ ... የጋብቻ ሁኔታ _____

የወረዳው ጤና ጥበቃ ጽ/ቤት የሚከተሉትን ተግባራት ያከናውናልን?

1. የጤና ኤክስቴንሽን ፕሮግራምን ቁልፍ ተግባር አድርጎ መንቀሳቀስ?

አዎ አይደለም

2. የጤና ኤክስቴንሽን ስራዎችን በቤተሰብና በሕብረተሰብ ደረጃ ማስተባበር ፣ ተግባራዊ ማድረግ፣

መከታተል እና መገምገም « አዎ አይደለም

3. ድጋፍዎ የመስክ ክትትልና የሥራ ግምገማ በማድረግ ተገቢውን ግብር መልስ መስጠት?

አዎ አይደለም

መልስዎ (አዎ)፣ ከሆነ ላለፉት 12 ወራት ለስንት ጤና ኤላዎች ምን ያህል ጊዜ እንደሆነ ይግለጹ

4. ለጤና ኤክስቴንሽን ሰራተኞች የሥራ ላይ የሙያ ማሻሻያ ስልጠናዎች ማዘጋጀትና መስጠት

አዎ አይደለም

መልስዎ (አዎ)፣ ከሆነ በማን መቼና የት እንደሆነ ይግለጹ _____

5. ለፕሮግራሙ የሚያስፈልጉ የተለያዩ የጤና አገልግሎት ግብአቶችን ፣ ቅጾችን፣ መመሪያዎችን

፣ ፎርምዎችን ወዘተ ማሟላት? አዎ አይደለም

መልስዎ (አዎ)፣ ከሆነ አቅርቦቱ በቂ ነው ብለው ያናሉ? አዎ አይደለም

በቂ ካልሆነ ምክንያቶቹ ምን እንደሆኑ ይግለጹ _____

6. ከተለያዩ የሥራ ዘርፎችና አጋር ድርጅቶች ጋር ቅንጅታዊ አሰራርን ማጠናከር?

አዎ አይደለም

መልስዎ (አዎ)፣ ከሆነ ምሳሌ ይጥቀሱ _____

7. በጤና ኤክስቴንሽን ሰልጣኞች ምልመላ ወቅት ለቀበሌዎች ድጋፍ ማድረግ?

አዎ አይደለም መልስዎ (አዎ)፣ ከሆነ የድጋፍ አይነት ይግለጹ _____

8. ሕብረተሰቡንና አጋር ድርጅቶች በማስተባበር የጤና ኤላ ግንባታን ማስፋፋት?

አዎ አይደለም

መልስዎ (አዎ)፣ ከሆነ ሕብረተሰቡ የሚያደርገውን የትብብር ዓይነት ይግለጹ (ለምሳሌ _____

ገንዘብ፣ ጉልበት፣ ወዘተ)

9. በወረዳው ውስጥ በኤክስቴንሽን ፕሮግራምና ባሉት የጤና ተቋማት የሕመማን አሰላጠን አተባባይ

ሥርዓት በማጠናከር ለጤና ኤክስቴንሽን ፕሮግራም አራዓም አገዥና አመቺ ማድረግ?

አዎ አይደለም መልስዎ አዎ ከሆነ ሁኔታውን ይግለጹ _____

10. የሥራ ሪፖርቶችን ማሰባሰብና ማጠናከር፣ በየወቅቱ ለሚመለከተው አካል ማቅረብ

አዎ አይደለም

መልስዎ (አይደለም)፣ ከሆነ ምክንያቱን ይግለጹ _____

11. ለአዲስ ተመራቂዎች ወይ ሥራ ከመሰማራታቸው በፊት ለሥራቸው ስለሚገባ የሥራ እንቅስቃሴ፣

የመረጃ አያያዝ፣ ሪፖርት አደራረግና ከሕብረተሰብና ከበጎ ፈቃድ የጤና ሰራተኞች ጋር እንደሆነ

መስራት እንደሚገባቸው ስልጠና መስጠት

አዎ አይደለም

12. ሕብረተሰቡ በአጠቃላይ ለግብአት አቅርቦቱ የበኩሉን አስተዋጽኦ እንዲያደርግ ማስተግበርና አመራር መስጠት

አዎ አይደለም

መልስዎ አዎ ከሆነ ለዚህ የሕብረተሰቡ ምላሽ ምን ይመስል ነበር? ያደረገውን አስተዋጽኦ አለን (ለምሳሌ ገንዘብ፣ ቁሳቁስ ፣ ጉልበት ፣ ወዘተ)?

13. ለጤና ኤላ የሚያስፈልጉ የክትባትና የህክምና ቁሳቁሶች እንዲሁም መድኃኒቶች በአቅራቢያ ወደ

ሚገኘው ጤና ጣቢያ በተገቢ ጊዜ ማድረስ? አዎ አይደለም

መልስዎ አዎ ከሆነ ላለፉት 7 ወራት ስንት ጊዜ ----- በዚህ ሃይትስ ያጋጠማችሁ ችግር ነበር?

የፎካል ግሩፕ ፎክሊስት

መግቢያ

1. ደህና አደራችሁ፣ ደህና ዋላችሁ፣ (እንደአስፈላጊነቱ) ሰላምታ በመለዋወጥ የውይይቱ መሪ ራሱንና አብረውት ያሉትን ጓደኞቹን ያስተዋውቃል
2. ለውይይቱ ተሳታፊዎች እንኳን ደህና መጣችሁ በማለት ተሳታፊዎቹ ራሳቸውን እንዲያስተዋውቁ ማድረግ
3. ተሳታፊዎቹን ውድ ጊዜያቸውን መስዋዕት በማድረግ በውይይቱ ለመሳተፍ በመምጣታቸው በማመስገንና በውይይቱም ላይ በነፃነት በመሳተፍ የበኩላቸውን እንዲያበረክቱ ማስገንዘብ
4. ተሳታፊዎቹ በፕሮግራሙ ዙሪያ ያላቸውን ሀሳብ፣ ግንዛቤና ዕውቀት ከአስተባባሪዎቹ ጋር በመሆን ለውይይቱ በተዘጋጁ ጥያቄዎች መሠረት የመለዋወጥና የማያውቁት አሊያም ያልገባቸው ነገር ሲኖር መጠየቅ እንዲችሉ ማስገንዘብ
5. ተሳታፊዎቹ በውይይት መልክ በፕሮግራሙ ዙሪያ የሚሰጡት መረጃ ተጨባጭ እውነታን የሚያስገንዝብና የመፍትሄ አቅጣጫ ጠቋሚ በመሆኑ ጠቀሜታው የጎላ መሆኑን መግለጽ
6. በውይይቱ ላይ የሚንፀባረቅ ማንኛውም ሀሳብ ወይም ግብረ-መልስ ትክክለኛና የሚመዘገብ መሆኑን በማስገንዘብ ወደ ውይይቱ ርዕሶች ማምራት።

የውይይቱ ርዕሶች

ሀ. የፕሮግራሙ ዕውቅና እና አድናቆት

1. በዚህ አካባቢ ሕብረተሰቡ በፕሮግራሙ ላይ ያለው ግንዛቤና ዕውቀት ምን ይመስላል?
2. ሕብረተሰቡ የፕሮግራሙን ጠቀሜታ /ፋይዳ/ እንዴት ያየዋል?
3. ጠቀሜታውንስ የሚያንፀባርቁ ነገሮች ምን ምን ናቸው?
4. ማህበራዊ ተቋማት/ዕድር ፣ መረዳጃ ፣ ሀይማኖት ወዘተ/ ሆነው ለፕሮግራሙ አተገባበር ዕገዛ የሚያደርጉ አሉን?
5. ካሉ ስማቸውንና እያበረከቱ ያሉት ዕገዛ ጭምር ይገለጽ።

ለ. የጤና ኤክስቴንሽን ሠራተኞች የመልመላ ሂደት

1. የጤና ኤክስቴንሽን ሠራተኛዎች/ኞቹ ሲመለሙ የሚያስታውሱት አሊያም ያደረጉት ተሳትፎ ምንድን ነበር?
2. ማን ነበር የመረጣት/ቸው?
3. መስፈርቶቹስ ምንድን ነበሩ?

ሐ. የጤና ኤክስፔንሽን ሠራተኞችን በተመለከተ

1. ባሕሪይ/ያቸው ምን ይመስላል?

2. በሕብረተሰቡ የጤና ችግሮች ዙሪያ የሚያደርጉት እንቅስቃሴ ምን ይመስላል?

መ. ለፕሮግራሙ ሕብረተሰቡ የሚያደርገው ድጋፍ

1. ሕብረተሰቡ የጤና ኬላውን አሊያም ሠራተኛዎ/ኞቹን የሚደግፍባቸው መንገዶች ምን ምን ናቸው?

2. ካለስ ድጋፍ በቂ ነው ብለው ያምናሉ?

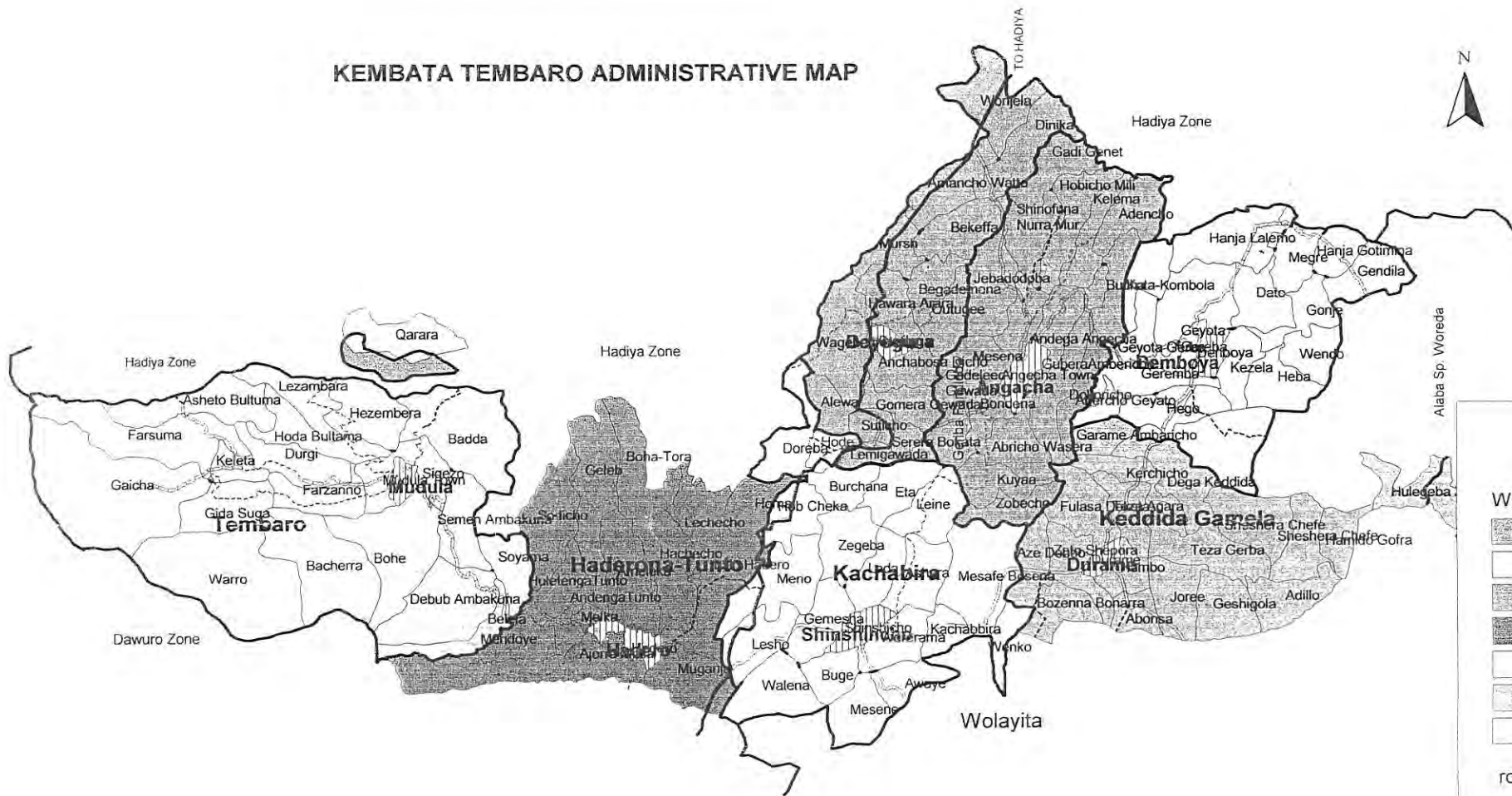
3. ለመደገፍስ ይፈልጋሉ? ከሆነ መቼና በምን መልኩ ልደግፉ እንደምፈልጉ ይግለጹ።

Annex - VI

A CHECKLIST for LOGISTICAL SUPPLIES at health PLANTS

Items	Present at	Absent
Contraceptives		
Child and adult scales		
Vaccines, ice boxes		
ORS		
Malaria drugs		
Blood pressure apparatus		
First aid kits		
Delivery kits		
Educational materials		
Thermometers		
Female gowns		
Scissors and forceps		
Stationeries		
Detergents		
Cotton, bandage and plasters		
Female bicycle		
Stethoscope and sterilizer		
Delivery bed and hand torch		
EPI cards		

KEMBATA TEMBARO ADMINISTRATIVE MAP



LEGEND

Woredas

	Angecha
	Demboya
	Doyogena
	Haderona-Tun
	Kachabira
	Keddida Game/a
	Tembaro

roads.

	Asphalt
	Earth
	Earth Track
	Gravel
	Gravel-Federal
	Towns

Scale 1:250000

Caution : All boundaries in this map are not authoritative

Declaration

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

Declared by:

Candidate

Confirmed by:



Advisor