ASSESSMENT OF COMMUNITY MOBILIZATION OF HEALTH EXTENSION PACKAGE AND ITS CHALLENGES AS PERCEIVED BY HEALTH EXTENSION WORKERS:

The Case of Bereh Aleltu Woredas' Of Oromia Region

By: SIYUM KEBEDE

A Thesis Submitted to the Department of Psychology, Addis Ababa University, in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Social Psychology.

June, 2009

Acknowledgements

I would like to give a special thank to Prof. Habtamu Wondimu, my advisor and lecturer who I admire for his enthusiasm, dedication and humour- for all his help and support. I would like to thank my friends Kasu Wagaye, Alemayehu Tenkolu and especially to Anteneh Wagaye, Kassahun Gebremariam and Fikadu Tullu with out whom my success would have not materialized. Thanks also go to Chimdi from Bereh Aleltu Health Office. I could not forget to thank all health extension workers and community leaders for making me feel so welcome during my fieldwork and especially to all the people that participated in the interviews.

Table of Contents

Contents in Brief Page

Chapter Five

List of Tables

Page

Acronyms

HEP	Health Extension Package
HEW	Health Extension Workers
RHEW	Rural Health Extension Workers
FMOH	Federal Ministry Health
MOH	Ministry of Health

Abstract

The Ethiopian government introduced the HEP in 2003, to achieve one of the millennium development goals and solve the countries short fall in health. However, since its implementation there is very fragmented information on its status and achievement. This thesis was conducted with the purpose of assessing the community mobilization process and the challenges met to learn from experience of HEWs and give recommendations, to ensure the sustainability of the package. This research concludes that the HEP seems effective and been accepted by the communities in the study area. A significant correlation was found when scores of social asset were correlated with scores of community participation and perceived local support for both HEWs and community leaders. The reasons for the acceptance were found to be; Issue awareness of the community, HEWs sense of usefulness, and sense of community between HEWs and the community are some. Currently community's attempts to improve their health is witnessed in family planning, pit latrine construction, vaccination, abrogation of harmful practices according to the interviewed HEWs. The main hampering factors found were lack of *community support and participation from certain parts of the society at the early stage, community members' negative attitudes towards specific issues (cultural), the difficulty of mobilizing individuals in economically disadvantaged communities, lack of training and reward system and technical support, and felt inadequacy. Bearing in mind the successful results yet registered; to further higher the implementations of HEP. It is important to use community development approach that treat community as full partners in improving their health of rather than being passive recipients or consumers of health services. Intensive awareness creation should be targeted to incorporate schools, religious institutions, community leaders in the mobilization process so as to build social networks to widen support, commitment, and changes in social norms and behavior. In order to mitigate some the of the barriers timely responses should be given to social and psychological needs of HEWs through arrangements of up grading programs, refresher courses based on HEWs performance and years served are recommended.*

Chapter One

1.1 Background of the study

In the face of extreme poverty and inequality in Ethiopia, community mobilization interventions represent an important way in which people can be empowered and sensitized to improve their healthy life. But successfully conducting community mobilization requires anticipating and addressing a number of potential barriers in order to maximize the chance of promoting healthy behavior and interventions. In light of these premises, it is widely acknowledged that Ethiopia has inadequate health services as a whole and with the most of the rural, nomadic pastoralist and fringe areas calling for the need of effective community mobilization that can mitigate the problem.

Moreover in developing countries where millions of people are without basic health care, government efforts alone cannot ensure that people will be able to lead healthy and socially productive lives. Moreover, the impact of programs that target individual behavior change is often transient and diluted unless efforts are also undertaken to bring about systematic change at multiple levels of society (Braithwaite et al., 1994). Hence, increased efforts are needed to involve communities. Through active involvement in delivery, maintaining and utilization of health services it is hoped that equity in distribution of health services can be realized.

In September 2000, 189 member countries of the UN endorsed and committed themselves to eight millennium development goals. Of these goals, one is aimed at solving health related problems of the poor through promoting healthy behavior by creating awareness at

community level by mobilizing their potential. To accomplish this task in 2003, the Ethiopian Federal Ministry of Health (FMOH) launched a new health care plan, the *"Accelerated Expansion of Primary Health Care Coverage," (MOH, 2003) page 6* through a comprehensive Health Extension Program (HEP). Recognizing the huge gap between need and health care services available, the FMOH has focused on providing quality promotive, preventive, and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children. The policy places particular emphasis on establishing an effective and responsive health care delivery system for those who live in rural areas. The HEP draws on the same principles as Primary Health Care, but focuses on the improvement of prevention skills and behaviors within the household, and involves fewer facility-based services. This program is an innovative approach to address the shortfall in health by training, after one year post secondary school, a new cadre of health extension workers who are charged with mobilizing and providing the rural community health and hygiene promotion and prevention of communicable diseases.

The Government of Ethiopia (GOE) plans to train 30,000 HEWs by 2010. All HEWs are women, at least 18 years of age, with a minimum of 10th grade education and recruited from the communities in which they will work. HEWs must complete a one-year course of instruction and field training, provided by Technical and Vocational Education Training Schools (TVETs), and operated by the Ministry of Education. Upon completion of training, HEWs are assigned, in pairs, to rural kebeles where they would be assigned at health posts and work directly with individual families. Health posts, therefore, are becoming the first level of healthcare service providers for the community, emphasizing preventive care. As a preventive health program, the HEP promotes four areas of care: Disease Prevention and Control, Family Health, Hygiene and

Environmental Sanitation, and Health Education and Communication. HEWs spend 75 percent of their time visiting families in their homes and performing outreach activities in the community. The remaining 25 percent is spent providing services at the health posts, including immunizations and injectable contraceptives, among mothers. To address strong community demands for basic curative care, HEWs are trained to provide first aid; treat malaria, dysentery, intestinal parasites, and other ailments; and to refer cases to the nearest health center when more complicated care is needed(MOH, 2003).

Oromia is one of the biggest regional states of Ethiopia and has implemented this program by its regional health bureau in an effort to fulfill the health care needs of its population through decentralization of health care delivery to the community level. According to the annual performance report for 2007/8, thus far more than 8300 health extension workers were trained and deployed in rural kebeles of Oromia. More than 4500 HE package students were also entered the workforce by the middle of this year after a one year training in order to achieve 100% coverage at all rural kebeles.

1.2 Statement of the problem

The rapidly growing number of the poorest; most vulnerable communities with the highest mortality rate are demonstrating that the need to develop and implement culturally appropriate solutions to improve and develop home based life saving skills. To this end, now days, health programs are using community mobilization as a primary strategy (Libonet and Robertson, 1996). Although this strategy can be applied to any aspect of community development this paper focuses on community mobilization to improve the health condition of rural community. Its primary actors include community members, women, families,

households, neighborhoods and their respective links to the external source. This is because communities have a critical role as central players in this process. This type of intervention encompasses the concept of helping communities to help themselves through capacity building; skill and knowledge development and empowerment (McNeely, 1999; Santiago-river, Morse and Hunt, 1998).

Since the implementation of health extension program (HEP), has begun though there is a growing literature in community mobilization the experience here in Ethiopia is frustrating. However, according to a study conducted in Wolkait, Tigrai with an objective of assessing the impact of health extension workers indicated that despite many challenges HEWs were broadly seen as helpful and as improving the general health service provision. Here also the study has gaps in showing how these health extension workers improved the general health of the rural community.

Misganaw and Getu (2000) found out that though the government policy insists on preventive and promotive type of disease control still the rural community gives priority to treatment which is not the task of rural extension health workers. From this, one can understand that misunderstanding exists between the rural community and the workers, hampering full community participation which is the bedrock of community mobilization. Because as community participation increases or exists community ownership and capacity increase with the result that community action continuous improvement in the quality of community life (Kegler M., Steckler A. Mechlory; and Malek, S, 1998).

According to the annual performance report of 2007/8 of Oromia Health Bureau, there are health extension workers of Zones who have registered a remarkable achievement than others citing Arsi zone as good performer, particularly in expansion of immunization, house to house

visit and community actions through community mobilization. While, zones such as Guji, Ilubabor, Bale, East shoa, East Hararghe, and West Wollega achieving below 50% of their annual plans. From this it is possible to deduce that there is varying result at different places of Oromiya due to different challenges that the HEWs face.

The earlier mentioned researches also noted that given the well established difficulties of communicating health information to poorly educated people; it may be that more attention should be paid during training of HE students to the process of imparting information and to villagers' preparedness to assimilate such information.

*In general despite many challenges, it is very clear that broadly speaking HEWs are seen as helpful. But to enable these workers perform their level best requires a need to conduct a research that explores their experiences thus far and better pointing out the need for locally appropriate comprehensive health care plans that maximize the skills of HEWs and rural community. Since achieving high quality, sustainable program on a large scale is challenging regardless of what strategy is used. It can be done most effectively when it is integrated into a broader national health plan; when there is political, financial, technical commitment, support, and when there is clear vision and implementation strategy that respects and builds on local structures, relationships and resources.

Many scholars argue that community mobilization, at its best does not merely raise community awareness about an issue or persuade people to participate in activities that have been prioritized and planned by others, rather it is comprehensive strategies that include carrying out careful formative research to understand the community context and design the process involving the community; how to work with community leaders

and others to invite and organize participation of those most affected. But thus far few publications have been found reflecting on what practical research base that health extension package program were implemented; what challenges have been encountered thus far and how the HEWs and the stakeholders are reacting to the challenges. Particularly with respect to the down to earth implementers of the package ie HEWs.

In addition to knowledge gap on HEP due to many challenging contexts in which the RHEWs live that jeopardize proper community mobilization towards inculcating healthy behavior. Though across the board mortality rate is lower in urban areas of the country mortality rate is high particularly infant and child mortality rate is at a standstill high being nearly first from the last. Hence, it calls the need for conducting sound research on rural extension health workers who are charged with the task of mitigating this problem.

1.3 General Objective of the Study

It is well documented that community mobilization is one of the building blocks of community change. That is why the researcher got interested in the exploration of the mobilization process and possible challenges of rural extension health workers face in disseminating preventive and basic curative skills as its general objectives.

1.3.1 Specific Objectives

i) To see the correlation among the building blocks of community mobilization (social asset and community participation, perceived local support) so as to determine the mobilization status.

ii) To identify barriers/challenges that rural extension health workers face in an effort to mobilize rural community on the HEP.

iii) To see the utilization of HEP in the study area based on the perspective of REHWs

iv) To check how the rural community is sensitized and engaging to solve health problem.

v) To recommend for further study in the area.

1.4 Research Questions

The study gives answer for the following research questions at the end of the analysis.

i. Is there a significant correlation among scores of social asset, community participation and perceived local support of community mobilization?
ii. Is there a difference in the correlation between the responses of HEWs and community leaders?
iii. How is the rural community reacting to/utilizing HEP?
iv. What are the activities the rural community under taking to solve their health problem as a result of behavioral change brought by HEWs?

1.5 Purpose of a Research

The purpose of this research is partly is to be used to advance the existing theoretical knowledge of the functioning and sustainability of health extension package in the selected sites and to be used as the base for an applied research. As an applied this research has a purpose of identifying existing barriers in the functioning of effective community mobilization of rural community on health extension package and

propose solutions to solve specific problems i.e. sustainability of the program and efficiency). It intends to address how the HEP is run by mobilizing the rural community.

1.6 Significance of the Study

Community mobilization is a very important issue for the success of community based interventions and where its success is affected by many variables. In Ethiopia the Minister of Health has begun implementing the HEP in 2003. Thus this study will supplement the existing knowledge and would instigate further research in the area where it is still infant in Ethiopian context. It would also try to find out some barriers that could hamper the implementation of the package so as to make the package in the hands of the rural community. Finally findings of the study may provide information for other researchers who are interested to make further investigation in similar area.

1.7 Scope of the Study

The study is delimited to only Bereh Aleltu Woreda of north Showa zone of Oromia region. This was done because of the familiarity of the rural inhabitants in the area by the researcher. The research focused on HEWs and community leaders chiefly in the area under investigation. Furthermore, the research is delimited to the use of questionnaire and interview guide due to the shortage of resource and time.

1.8 Limitations of The Study

Due to financial and time constraints the study does not cover all stakeholders of the package such as worede health officers, mothers,

children and the elders. This may have limitation of generalization about the whole population.

1.9 Operational Definitions

i) **Community** = in this study communities are people residing in rural kebeles or the smallest administrative unit

ii) **Community mobilization** = for the purpose of this study community mobilization is capacity building through which community members, (groups) plan, carry out and evaluate activities on participatory and sustained bases to improve their health conditions stimulated by RHEWs.

iii) **Challenges** = are barriers that jeopardize effective community mobilization on the health extension package.

iv) **Social Asset** = In this study is a measure of social networks in a community on HEP with indicators such as volunteerism, government performance, and capacity for cooperation.

v) **Community Participation** = For the purpose of this study, it is the extent to which communities are working collaboratively with and through groups to address health issues affecting their well-being initiated by HEWs

vi) **Perceived Local Support** = In this study refers to the extent to which individuals perceive that all stakeholders encourage and contribute to the success of HEP.

CHAPTER TWO

2.1. Reviews of Related Literature

2.1.1 Theoretical Framework of Community Mobilization

Community mobilization is a planned effort to mobilize a community or groups within a community toward positive social change (May, Miller, Wallerstein 1993). During the past two decades, though still too young, researchers have provided evidence to support that community mobilization is one of the building blocks of community change. This is because for community to be successful in any endeavor each individual has its role and is an asset.

In ecological view healthy communities are those communities, who are well integrated, interdependent and share responsibility to resolve problems and enhance the well being of the community. Hence, it is increasingly recognized that to successfully address a community's complex problems and quality of life, it is necessary to promote better integration, collaboration and coordination of resources.

Community mobilization as a strategy involves a capacity building process through which community members (groups) plan, carry out and evaluate activities on participatory and sustained bases to improve their health and other conditions either on their own initiative or stimulated by others. Corroborating the above idea Lewine (1936), in ecological principles of practice in community psychology, indicated that to effectively address a given community problem help has to be located strategically. The goals and values of the helping agent or service must be consistent with the goals and values of the setting. The form of help

should have a potential for being established on a systematic bases using the natural resources of the setting or through introducing resources which can become institutionalized as part of the setting. May, Miller, and Wallerstein, (1993) indicated that as community mobilization models often fall in two categories, top-down and community driven. The top down approach is typically expert-driven and is not sensitive to community needs strategic plans, while eloquent, often are designed apart from their target audience with an emphasis on delivering services instead of involving local community members (May, Miller and Wallerstein 1993). The community driven approach on the other hand requires local development, a committed interest in both the process and out come and motivational issues. In the community driven approach a key element is to encourage people, to care enough to improve their life conditions by addressing their emotional concerns and thereby engage in an on going interplay of self-interest and social concerns.

WHO also demonstrated that community mobilization come into being from the premises that communities cannot be rebuilt or improved by focusing only on their needs, problems and deficiencies (pathologies). Rather community building starts with the process of locating the assets, skills and capacities of residents. In light of these developments members of diseases prevention and health promotion communities have expanded their efforts to create positive environment and strong community action and to use public policy in new ways that support community collaboration (WHO 1986, Hanson, 1998). This thinking about public health is an outgrowth of the social change movements of earlier decades and more recently reemerging as a dominant notion. It stresses the importance of engaging community in health decision making and improving community participation in health promotion, health protection, and diseases prevention effort (Fawcett et al, 1993). As a result of this renewed emphasis in public health efforts, health

professionals and community leaders can envision many new opportunities to mobilize people.

Hence clearly to bring the massive gap in human resource need to treat rural people do not have to wait the lengthy education of medical doctor and nurses; should rather concentrate on briefly trained community based workers having close attachment to the rural dwellers: solution that has been demonstrably effective in Africa and else where (Chen, and Hanvorangovich, 2004) even though some argue that the evidence base for primary health care is at best questionable. The reason is clear that community based interventions allow for the maximization of scarce resources, the rationalization of a fragmented service delivery station across geographic areas and levels of intervention, the increase of a critical mass behind a project the development of trust among individuals with diverse expertise, knowledge and skill transfer and the involvement of citizen participation in program planning and implementing (Mc'Leroy et al 1988). For one to see mobilization level of a given community on a certain problem and observe a change process many necessary building blocks of community mobilization become apparent. These are level of community participation/engagement; perceived local support and the social asset (Jakes, Lisa and Shannon, 2002).

2.1.2 The Role of Community Participation for Effective Community Mobilization

It is well acknowledged that community participation is critical to community success and it is an indication of effective community mobilization on a certain community project. Different studies on community health promotion have been conducted on the effectiveness of

community based health prevention and promotion of healthy behavior to better health of the community through mobilization (Kegler, et al; 1998; Parker et al; 1998; Butterfoss et al; 1996). These researchers have provided initial evidence that community members' participation, specific organizational characteristics (e.g., shared decision making; formalized rules and procedures, frequent communication with community leaders' and members') (Butterfoss et al., 1996; Gottlieb, Brink, & Gingiss, 1993; Kegler, et al;1998; Kumpfer et al., 1993; Parker et al., 1998; Taylor, Elliott, Robinson, 1998) had an impact on effectiveness of the program. Lack of community participation, a major barrier to community based interventions effectiveness (Gottlieb et al., 1993; Herman, Wolsfon, & Forster, 1993; Kegler, et al,1998; Taylor et al., 1998), can be fostered by different factors, including competing priorities, staff turnover, lack of interest in the issues at stake, turf 'wars', and the lack of available staff and/or community volunteers. The above mentioned studies further have documented that communities that engage their citizens and partners deeply in the work of community development, realize more resources, achieve more results and develop in a more holistic and ultimately more beneficial way. Herman, Woston and Forster (1993) indicated that lack of community participation is one of a major barrier for effective community mobilization for attainment of community based health interventions. Hansan (1988-89) pointed out that a population can achieve long term health improvements when people became involved in their community and work together to effect change. In addition Fawcett et al, (1995) suggested that participation of community is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It involves partners will and coalitions that help mobilize resources and influences systems, change relationships among community. All the above contentions entail that participation is one of the building block of community mobilization. Studies of participation in voluntary or initiated

by other have allowed social scientists and other researchers to develop organizing concepts about communities and the ways in which they are mobilized (Floring etal 1990, Hanson, 1988-89).

Moreover, asserting the above notion Braithwaite et al, (1994) indicated that the real value of participation stems from entire community rather than engaging people on an individualized basis or not engaging them at all. Simply stated change:

"- - - is more likely to be successful and permanent when the people it affects are involved initiating and promoting it." Page, 126.

In other words a crucial element of community mobilization is participation by the individuals, community based organizations and institutions that will be affected by the effort.

It is hard to get resources regarding community participation in Ethiopia. The health extension package was introduced by the Ministry of Health to curb the short fall in health by training after, one year post secondary school. The health Extension Workers were charged with mobilizing the rural community for promotion of hygiene and prevention of communicable diseases by creating awareness through total participation of the community. It is with this sentiment that the health extension workers are deployed to the rural community since the implementation of the package in 2003. Though there is no sufficient resource indicating how this package is running.studies of Yayehyirad, et al (2007) revealed that communities are in general reportedly well disposed to HEWrs. Fifty percent of the Health Extension Workers indicated that kebele officials are highly supportive of the program. However there is very little participation of communities in planning and programming and management of health extension package in general.

Many researchers claim that it is unthinkable to bring change without full community participation particularly with respect to community based interventions of prevention and promotion of health. This is because community health workers thrive in an empowered community with respect to decision making, and a key challenge lies in getting the community members to participate effectively with them using the community members in programs run by health out lets. i.e awareness programs to promote other community members to use health services and to participate in decision making about health service and their management.

2.1.3 Theoretical ground of Health Extension Package and Reason for Implementation

Now a days health programs are using community mobilization as a primary strategy (Libonet, and Robertson, 1996). Although this strategy can be applied to any aspect of community development this paper focuses on community mobilization to improve the health condition of rural community by health extension package. Its primary actors include community members, women, families, household, neighborhoods and their respective links to the external source. This is because communities have a critical role as central players in this process. This type of intervention encompasses the concept of helping communities to help themselves through capacity building; skill, knowledge development and empowerment (McNeely, 1999, Santiago-river, Morse and Hunt, 1998).

The health extension package is grounded in the social ecological paradigm. Social-ecological thinking infers to a belief that efforts to promote well-being should be based on the understanding of the interplay among diverse environmental and personal factors. Such

thinking, based on the work of Lewin (1936), Barker (1968), and Bronfenbrenner (1977, 1979) has been applied by McLeroy, et al, (1988) to health promotion, and is receiving recognition as a viable health promotion strategy. According to McLeroy et al. (1988), health-related behaviors are influenced by five determinants: (a) intrapersonal factors which comprise individuals' personal characteristics (e.g., knowledge, skills, self-concept, attitudes), (b) interpersonal processes (e.g., formal and informal groups and networks within which individuals evolve), (c) institutional factors (e.g., social institutions with organizational characteristics, formal and informal rules of operations), (d) community factors (e.g., norms, beliefs and values that regulate the relationships and boundaries among organizations, institutions, formal and informal networks), and (e) public policy. McLeroy et al. (1988) and other proponents of social ecological models (Kegler, et al, 1995) advocate that health promotion interventions are most effective when they use these channels of influence via multi-level strategies of change involving hcommunity partnerships. The health extension program fit well with a social ecological perspective of health promotion since the community based new cadres of health extension workers work at multiple.

It is widely acknowledged that 85% of Ethiopia's population is living in country side getting inadequate health services as a whole and with most of the rural, nomadic pastoralist and fringe areas calling for the need of effective community based interventions that can mitigate the problem. In addition the rapidly growing number of the poorest; most vulnerable communities with the highest mortality rate are demonstrate the need to develop and implement culturally appropriate solutions to improve and develop home based life saving skills.

Realizing the impossibility of providing curative medical service to the rural communities of the third world country to address maternal and

child mortality rate in September 2000, 189 member countries of the UN endorsed and committed themselves to eight millennium development goals. Of these goals one is aimed at solving health related problems of the poor through promoting healthy behavior by creating alertness at community level by mobilizing their potential.

Acknowledging the impossibility of providing curative medical service to the rural community and coupled with the reality that low income countries like Ethiopia have limited resources for training health care professionals and the migration of those who are trained have forced the government to depend on new health cadres who are charged with mobilizing and change rural communities knowledge of basic home based life skills that enable them to lead a healthy life.

2.1.4 Community Mobilization and Health Extension Workers in Ethiopia

According to different reports, Ethiopia is found at low status in health measures. This is because the country is suffering from a health problems primarily due to communicable diseases, poor nutrition and lack of access to health services. Since 47% of the population lives below the poverty line and income per capita is only around USD 100, most people cannot afford health care, and consequently the average life expectancy at birth remains only 46yrs. The main modern health care provider is the government which manages most of the country is health stations, posts, centers and hospitals (Kitaw, et al 2006).

Modern health services only cover about 60% of the population with little access for most of the rural, nomadic-pastoralists and fringe areas. Even

these limited services are under-utilized due to economic and social barriers. Recent initiatives (Millennium development goal, sustainable development and poverty reduction program) have accelerated the anticipations in development and the related requirements to upscale health services have amplified the underlying human resources crises for health. The HEP is an innovative health services delivery program that aims for universal coverage of primary health care by 2009. At the hub of this program there are new health cadres which are expected to better the rural communities' health just residing in the rural kebeles. They act as professionals who provide services in a community and urge for social change regarding the communities' basic life saving skills.

The health extension workers strive for community betterment, where community members or residents are invited to join the process, but professionals retain primary influence. Betterment efforts often proceed by identifying needs or deficits in a community. Then planning and implementing services to meet those needs (Kretzman and McKnight 1993 cited in Community Psychology (2000).

The health extension workers are expected to mobilize the community for effective dissemination of the services. McLeroy et al. (1998) and other proponents of social ecological model advocate that health promotion interventions are most effective when they use community partnerships. In addition Kumpfers, et al 1993 indicated that community mobilization is a formal multi purpose and long term alliances of community promoting the adaptation of healthy behavior and community change. The reason is clear that community mobilization allow for the maximization of scarce resources, the rationalization of a fragmented services delivery, increase of a critical mass behind a project, the development of trust among individuals with diverse expertise, skill transfer and the involvement of citizen participation. Hence for HEWS to

effectively mobilize the rural community need to understand the complex community psychology, culture and other social factors to connect health care skills to the community. Their role is not only involving rural people in the provision, monitoring and control of basic health services but also to place health in people's hand. Essentially important are community education and awareness programs that have positive influence changing health related behaviors and increase reception of preventive and promotive health care.

In light of the above notion though it is hardly possible to get a single article or written documents depicting how the rural communities are mobilized and to what extent they have brought behavioral change some journals with different objectives have tried to illustrate the conditions of the health extension package and how community is reacting to the program. For example studies conducted by Yayehyirad, et al in (2007) indicated that trainee's express high commitment and willingness to work in rural kebeles.

The importance of active participation is one of the building blocks of community change in its own development including the choice of objectives, priorities and actions to be taken. The health extension package emphasized establishing kebele health committees and mobilizing the people for all types of activities. But this has in practice remained illusive (MOH, 2003, Awash, 2005). Study of the working conditions of health extension workers in Ethiopia conducted by (Awash, et al in 2005) illustrated that though kebele officials are very highly supportive of the program; there was little or poor cooperation in most kebeles of research area. The aforementioned research acknowledged that as there is very little participation of communities in planning and prioritizing what is to be done. This study also illustrated that the effectiveness of HEW will hinge on their relationship with the community.

Experiences elsewhere shows that the greater the participation of the community the greater the acceptance of and use of services and the lesser demand for expensive curative services.

Overwhelming evidences urge that community participation in the design and implementation of health sector and inter-sectoral activities have a significant impact on success and sustainability of community development programs. According to community driven model motivation of the community to participate in a community driven project comes either through an invitation of professionals to work within a community or through a widespread literally and dialogue process in synergy with community members and leaders, who must ultimately direct the community mobilization (May, Miller, and Wallerstein 1993).

CHAPTER THREE

3.1. METHODOLOGY

3.1.1 Study Design

In order to study the community mobilization with respect to the health extension package in Bereh Aleltu Woreda North Showa Zone of Oromia region a quantitative survey method as well as qualitative methods were employed. The subjects of this study are health extension workers who are the main actors of the mobilization process and the community leaders. In the process the researcher took into account the underlying assumption that participants would provide accurate and reliable information about themselves and the health extension package.

3.1.2 Study Population

The study was conducted in Oromia Regional State on a total of 95 rural health extension workers residing in 47 rural kebeles of Bereh Aleltu woreda and 86 community leaders selected from the aforementioned kebeles. As stated above there are 47 kebeles in the Woreda. Geographically, the Woreda is found about 40km north east of Addis Ababa on the main road to Mekele hosting more than 200,000 people. It is one of the developing Woreda since it is near the vicinity of Addis Ababa. As the Woreda is in Oromia Regional state, most of its inhabitants are Oromo people.

3.1.3 Sample and Sampling Technique

The subjects of the study were RHEWs living in the rural communities and community leaders living in 47 rural kebeles. HEWs were selected using availability sampling techniques from all rural kebeles. And community leaders were selected using purposive sampling procedure after selecting 10 kebeles using simple random sampling technique. The selected kebeles were (Dirre Sokorru, Burra Maru, Burra Dibdibe, Laga Hola, Girar, Awajo, Gomman Ager, Tukkuyye, Warra and Sire Goyyo) of Bereh Aleltu Woreda. Participants for interview in the study were also selected from the ten selected kebeles employing availability sampling method.

3.1.4 Source of Data

3.1.4.1 Rural Health Extension Workers and Community Leaders

During data collection, a total of 95 rural health extension workers have participated. These health extension workers were living in 47 rural kebeles of Bereh Aleltu woreda

In addition 86 known dwellers or community leaders who were selected from the ten randomly selected kebeles also participated in the study.
The rationale behind focusing on HEWs and community leaders was two fold. One is as the purpose of the study is to investigate the mobilization processes from the perspective of ecological perspective all the participants had their own share in the success of the package i.e. as initiator or promoter to reach the target population. Second particularly the HEWs were selected because they are the main actors living and driving a livelihood within the community but are not necessarily born

there and are capable of persuading or attracting good health practices through teaching, visiting, organizing and demonstration in the process of carrying out their task to publicize health care skills in the community.

Table 3.1 Sampled Populations by Sex, Age and Experience

Sex	Fre	**Age**	Fre	**Experience**	Fre
Male	86	15-20	38	1-3	84
		20-25	71		
female	95	25-30	32	3 -7	40
		Above 30	40		
				Above 7	54
Total	181		181		181

3.1.5 Instruments

The instruments included self-administered questionnaire which was intended to measure different aspects of community mobilization and interview guide. The tools could also measure changes in the personal or collective assets and capacities resulting from opportunities afforded by health extension workers.

The scales and questions were translated from English to Afan Oromo and retranslated into English by experts from Addis Ababa University from the department of Ethiopian Languages and Literature and Foreign Languages – Afan Oromo and English streams. Moreover, minor modification (of terms) was done to the scales. All the items of the

instruments were made as relevant as possible to the research problem. The self administered questionnaires were adopted from Shanon, Lisa, Jakes and Suzan 2002 mobilization scales. These scales consisted of 27 five point likert scale intended to check the significance level of community mobilization and 10 items intended to assess the would be barriers. Some items were developed by the researcher. The questionnaire comprises of four parts. From the first part four items were intended to gather background information of the research participants. The next part having 11 items were about to see the social asset of the community. The following part having, 10 items were about the level of community participation on the HEP, and the next 6 items were to see the perceived local support of community.

3.1.6 Pre-test/Piloting

The purpose of the testing was to collect information that would be used for screening and selecting the items. It was also to find out, if wording and instruction of the instrument as a whole were clear and comprehensive to respondents and community representatives. All the instruments used in the study were written and developed first in English. After extensive and repetitive revision, a copy of the final version of English questionnaire and unstructured interview guide were given to my advisor and two post graduate students of social psychology. They were asked to give their reaction on each item of the instruments. Using relevant comments and suggestions from the professionals, some adjustments were made. The scale filled by participants and interview guide translated to Afan Oromo version in collaboration with first year Ethiopian language post – graduate students. Finally, my advisor evaluated the last English version of all the instruments and pretest was conducted.

Respondents, who took part in the pre–test, were taken through convenient sampling method. Twenty five health extension workers and 15 community leaders were given the questionnaire to read and give their own response during the visit to Woreda administrative town. Mean-while they were told to ask any question that is not clear or ambiguous. Based on their feedback, some items were discarded and few of them were modified. In order to assess the validity of the two questionnaires they were given to two instructors in the Department of Psychology. Except very few modifications, their feedbacks were positive towards the tool in general. Moreover by using SPSS version 15 the chi square value was calculated for each item. A total of 3 items were eliminated. From the analysis of test try out and the reliability of the instrument was found to be 0.673. Taking the multidimensionality of community mobilization questions reliability coefficient of 0.673 was accepted after further modification. Finally, after the important correction was made the final items were prepared and implemented.

3.1.7 Procedure of Data Collection for the Main Study

The procedure followed to collect data for the main study was different from the pre – test. Before administering the final instruments for data collection in the selected kebeles, one day training was given to two research assistants on how to administer the questionnaire.

The researcher also advised research assistants to establish an appropriate rapport with the subjects to facilitate situations for the research activities. All the respondents were informed about the purpose of the study and how to complete the questionnaire. During the administration of the questionnaire chances for clarification of any question were given. The assistant researchers were in a face-to-face contact situation in the kebeles when the residents completed the

questionnaire and read out the questions for those who had difficulty in reading.

With respect to interview the data collection through the interview was conducted by talking with the HEWs in face to face. Before conducting the interview, for getting a representative sample of the population of the different villages' simple random sampling was used. This involves just by listing the rural kebele's to randomly select the representative kebele. As a result 10 kebeles are selected and since two health extension workers are stationed in those kebeles the researcher took one HEW from each selected kebele and a total of 10 HEW are interviewed where the chosen members share a similar characteristic. The short time available for this research was not enough to gain a good understanding of the communities studied and therefore, a representative sample could not be assured.

The interviews started by empowering the interviewees by explaining to them that the researcher was new in the area and that the information they could provide was very valuable. Necessary rapport was established with the HEW by creating conducive atmosphere and explaining clearly to them what the purpose of the interview was. The respondent was also assured that responses would be kept in absolute confidentiality. This procedure was applied successfully by many social researchers. Permission to take notes during the interviews was requested. The author explained the purpose of the interviews to them so that they did not live out any important piece of information while the interview session. The questions were checked in each site in order to ensure local sensitivities were not hurt. All the participants in the interviews participated actively during the entire sessions.

The interviews were started by acquiring background information, and subsequently, became more focused in a semi-structured manner. The guidelines of the interviews are presented in Appendix.

3.1.8 Method of Data Analysis

The data collected from the participants of the study were analyzed and interpreted using both quantitative and qualitative research methods. The matrixes for the data collected were computed using SPSS version 15 after loading all the questionnaires collected by coding each. Specifically, correlation was used in order to see the relationships between social asset, community participation and the perceived local support which enables the researcher to see the mobilization process. Frequencies and percentages were also used for the proportion of responses gained from the participants. The data gathered through interview and focus group discussion questions were analyzed qualitatively.

CHAPTER FOUR

4.1 RESULTS

In this section description of findings are presented. The analysis involves different parts. The first part deals with description of the characteristics and background of participants in the study. Which is followed by a descriptive statistical summarizing with means and standard deviation of the scores on each themes of community mobilization of HEWs and community leaders? Next the research questions were tested using correlation separately for HEWs and community leaders. This was done to check whether there may be difference the results of HEWs and community leaders. Finally the aggregate correlation was tested. In the course of analysis description of data were also reported with tabular and graphic presentation. Finally, the data's collected through interview are presented.

4.1.1 Demographic Characteristics of Respondents

Table.4.1 Sex, Age and Experience of Respondents

Sex	Fre	Per	**Age**	Fre	per	**Experience**	Fre	Per
Male	86	47.5	15-20	38	21.2	1-3	84	46.4
			20-25	71	39			
Female	95	52.5	25-30	32	17.7	3 -7	40	22.1
			Above 30	40	21.1			
						Above 7	54	31.5
Total	181	100		181	100		181	100

The table above depict that the total participants of the study were 181 people out of these 86(47.5%) were male while the remaining 95(52.5%) were female.

As the table shows the age of the respondent were mostly adults whose age composition ranges from 20 - 25 with the majority 71(39%), while the next larger group were in the age of above 30 years accounting 40(21.1%) followed by 25 – 30 being very few participant and 15 – 20 taking second from the last constituting 17% and 38% respectively of the total sample population.

When the other characteristics worth noting; the experiences of the participants were investigated the above data indicated that the greatest proportion 84(46.4%) of the participants have work experience of 1-3 years and the remaining two groups fall in the ranges between 3-7 years and above 7 years accounting for 40(22.1%) and 54(31.5%), respectively.

4.1.2 Response Analysis of Scores

4.1.2.1 Descriptive Analysis of Responses of HEWs

Table 4.2 Descriptive Statistics of HEWs scores on Social Asset, Community Participation and perceived local support

Variable	Mean	Std. Deviation	N
Social Asset	37.8000	8.05777	95
Community participation	34.3895	6.42683	95
Perceived Local Support	22.3579	3.32276	95

From the community mobilization questionnaire the expected minimum and maximum scores were 11 and 55, 10 and 50, 6 and 30 for each community mobilization themes respectively. The average scores for each community mobilization scales found to be 37.8, 34.39 and 22.36 for social asset, community participation, and perceived local support in that order. Where as the standard deviations were 8.0577, 6.42683 and 3.32276 by the same order for the mean.

4.1.2.2 Correlation Analysis for Responses of HEWS

Table 4.3. Correlation Matrix for HEWs on Scores of Social Asset and Community Participation, Perceived Local Support

Variables	Person correlation	Social asset
Community Participation	Pearson Correlation	.206(*)
	Significance 2 tailed	.045
	N	95
Perceived Local Support	Pearson Correlation	.260(*)
	Significance 2 tailed	.011
	N	95

*Correlation is significant at the 0.05 level (2-tailed).

From the correlation matrix computed for HEWs participants it was found that there is a positive relationship (r = 0 .206) between social asset and community participation. While, on the other hand the correlation between for social asset and perceived local support was found to be (r = 0 .26). In both instances the computed correlation matrix reveals existence of positive significant relationships. This according to Jakes, Susan and Shanon, Lisa, (2002) entail that the community is mobilized on the project.

4.1.2.3 Descriptive Statistics for Responses Community Leaders

Table. 4. 4 Descriptive Statistics of Community Leaders on scores Social Asset, Community Participation and Perceived Local Support

Variable	Mean	Std. Deviation	N
Social Asset	37.6395	8.27457	86
Community participation	34.5581	6.51984	86
Perceived Local Support	22.1163	3.31634	86

Here also the summary of means and standard deviations of scores on community mobilization among the three themes of community mobilization for community leaders was presented in the table above. As can be seen from the results the mean for social asset was 37.64 and the standard deviation was 8.28 where as for community participation as it is indicated in the table it was 34.5581, mean and 6.51984, standard deviation for the scores. The data in the table also depict that the mean and standard deviation for perceived local support was 22.1163 and 3.31634 respectively. When compared with that of the HEWs no significant difference was observed as the data reveals.

4.1.2.4 Correlation Analysis for Response of Community Leaders

Table 4.5 Correlation Matrix Computed for Community Leaders on scores of Social Asset, Community Participation and Perceived Local Support

Variables	Person correlation	Social asset
Community Participation	Pearson Correlation	.254(*)
	Significance 2 tailed	.018
	N	86
Perceived Local Support	Pearson Correlation	.414(*)
	Significance 2 tailed	.000
	N	86

*Correlation is significant at the 0.05 level (2-tailed).

For the community leaders also the computed correlation matrix indicate that as there is significant positive correlation between the social asset and community participation and perceived local support being r = 0.254 and r = 0.414, respectively. The results computed here also seem very similar with that of health extension workers except minor difference of computed correlation values.

4.1.2.5 Aggregate (HEWs and Community Leaders) Response Analysis

Table 4.6 Aggregate Descriptive Statistics of Responses on Social Asset, Community Participation and Perceived Local Support

Variable	Mean	Std. Deviation	N
Social Asset	37.8785	6.80822	181
Community participation	34.4917	7.45700	181
Perceived Local Support	22.6464	3.41839	181

The summery of aggregate means and standard deviations of scores among the three components of community mobilizations (HEWs and community leaders) is presented in the table above. As can be seen from the descriptive statistics the total mean score for social asset was found to be 37.8785 and the standard deviation was 6.80822. The data in the figure also depicts that the mean for community participation was 34.4917 with standard deviation 7.45700. Finally the results of the figure reflect the mean score on perceived local support was 22.6464 and standard deviation 3.41839. If one compare the overall means and standard deviations with the scores of community leaders and HEWs very little difference is observed. The fact that the inexistence, of big difference may reflect the similarity of feelings with respect to the health extension program and both groups are sharing the same experience.

4.1.2.6 Aggregate correlation Matrix Computed on Scales of Community Mobilization

Table.4.7. Aggregate Correlation Matrix between Social Asset and Community Participation, Perceived Local Support

Variables	Person correlation	Social asset
Community Participation	Pearson Correlation	.159(*)
	Significance 2 tailed	.032
	N	181
Perceived Local Support	Pearson Correlation	.287(**)
	Significance 2 tailed	.000
	N	181

*Correlation is significant at the 0.05 level (2-tailed).

As indicated in the above table the outcome of aggregate (both HEWs and Community leaders) Pearson moment correlation between the building blocks of community mobilization scores of the participant; that is scores of social asset and scores of community participation reveals significant positive correlation r = 0.159. In addition the table shows significant positive correlation between scores of social asset and perceived local support being r = 0.287. This implies there is a possibility by which an increase or decrease in the level of social asset is associated with level of community participation and perceived local support.

4.1.3 Rank Orders On Factors that Hinder effective Community Mobilizations on Health Extension Package

Table 4.8 Rank Orders of some would be Barriers

No	**Would be barrier**	Freq	%	Rank
1	Lack of knowledge from the side of the community	4	4.21	7
2	Lack resource needed for the program	31	32.63	1
3	Lack of commitment from all the stakeholders	5	5.26	6
4	Lack of clear policy direction about the program	7	7.368	5
5	Disorganization of the woreda and kebele leaders	2	2.105	9
6	Absence of committed and trusted leader in the community	10	10.526	4
7	Suspicions of the community on the effectiveness of the program in bringing change	1	1.053	10
8	Lack of support and participation from the side of the community	3	3.158	8
9	Community members' negative attitudes towards the program	18	18.947	2
10	Role overload, and felt inadequacy (i.e., lack of training and/or experience with community programs and technical support	14	14.737	3
Total		95	100%	

The participants of the study were asked to rate in ranks some of would be the barriers for effective community mobilization. As the table above depicts the participants rated that lack of resource needed for the program, community members' negative attitudes towards the program, role overload, and felt inadequacy (i.e., lack of training and/or experience with community programs and technical support took the three leading positions being 31(32.63), 18(18.947) and 14(14.737), respectively. While absence of committed and trusted leader in the community, Lack of clear policy direction about the program and Lack of commitment from all the stakeholders are the other barriers being 10(10.526), 7(7.368) and 5(5.26) in that order. The participant indicated that lack of knowledge from the side of the community, lack of support and participation from

the side of the community, disorganization of the woreda and kebele leaders and suspicions of the community on the effectiveness of the program in bringing change have been ranked from 7-10 being 4(4.21), 3(3.158), 2(2.105) and 1(1.053). Survey studies conducted on the implementations of health extension package in different regions of the country such as Tigray and SNNP of Wolayita also share majority of this barriers (Worku, 2007, Aregay, 2005).

4.1.4 Analysis of Data's Gathered Using Interview

This part of the study discusses data gathered through the interview held with HEWs. Knowledge and experience in the area of study were very limited and virtually none existence on the subject. The study was therefore exploratory and essentially qualitative to pave the way for future more systematic (representative sample based) studies. In depth interview was carried out on 10 individually interviewed HEWs. The interview was held using/employing prearranged interview guide by visiting the sites where rural health extension workers are residing. Regarding their characteristics only 3 HEWs were not born in the kebeles of their current assignment and rather were from neighbor kebeles. The majority 5 were born in the place where they are working now. The remaining 2 were born in woreda administrative town. By the request of the interviewee themselves their name were made anonymous.

4.1.4.1 Factors that encouraged the rural community to get mobilized

The major factors that motivated majority of the community according to the interviewed HEWs, are processed below.

4.1.4.1.1 Issue awareness

Respondents' awareness of health issues in the community had been fostered by 3 key factors as is indicated by the HEW. First, the fact that HEWs were selected from the rural community themselves that helps to develop trust and sense of belongingness have facilitated the people to involve or get easily mobilized on various health issues that had affected the children, mothers etc as part of their agendas existed in the community, which fostered community readiness to address these issues.

Secondly, earlier the rural communities were forced to travel long kilometers in order to get treatment particularly to woreda towns there many of the nurses teach them to follow the works of HEWs to protect themselves from diseases. As a result the community recognized links between high rate of attending and practicing healthy life saving skills taught by HEWs and the extent of getting illness, especially among its mother, children and old people encouraged the need for intervention. Susceptibility to different disease called for a wake up call to the community.

Thirdly, the fact that the communities (adults and adolescents) personally saw or knew of the model families graduating after following by the wake up teaching of the health extension workers, at different times which was facilitated by the small size of the community, boosted their desire to get involved in the mobilization process. As one informant noted:

When I went to the community first, many of the people teased at my teaching, and things haven't changed that much, so I wanted to use figure and respected families by my side and taught them to keep their health by their own knowledge (sensitized them how their health is in their hand). Having these families accepted my purpose of being here started to put in to real what I told them. One day I arranged conditions to show the good works of these families to many of the villagers at the presence of woreda administrators and health workers and acknowledged their commitment and its benefit. After wards many people become involved and started to do something about that.

4.1.4.1.2 HEWs' feelings of usefulness

HEWs' beliefs that their contributions would empower the rural community to make a difference to mothers, children's' health also motivated them to contribute/commit themselves for their own community. According to the interviewees such feelings of efficacy were generated by the informants' training and/or experience in health issues, with the targeted audience, and/or by the respondents' knowledge of the community and/or key people residing there.

I felt [that] my experience would be useful to my community. I have worked in this community for 3 years and I know all the key players, what's happening in the county, how to access people, who to access, who to talk to, etc... I was also already familiar with many of the issues... and most of my work has been geared toward the communities' health.

Informants' involvement in the project was described as "very valuable learning experience" that enhanced their personal and professional feelings of efficacy and their self-concept. One respondent summarized the above by emphasizing:

"It has been a learning experience. I have personally grown a lot... It has broadened my whole perspective on people's role in the community, and I also believe I have become a better teacher because of that experience".

Further the multiple partnerships strengthened the informants' feelings of actualization because they allowed for skill and knowledge transfer. Participants increased their knowledge in community activation, the formation and implementation of collaborative initiatives, the functioning, and specific leadership skills.

Finally, the informants' feelings of affiliation and their satisfaction at working collaboratively with the community further reinforced their feelings of success and enhanced their positive attitude toward the package and its members. As one participant pointed out:

"We like and we trust each other... there is a bonding that has developed, with the community and it's really nice.

4.1.4.1.3 **Sense of community**

There were several dimensions to the respondents' sense of community. Among these were a sense of connection with the place (many respondents were born and/or had lived in the village for many years), a sense of shared history, and a high empathy for the targeted audience. Participants reported that their altruistic concerns for their own community predisposed them to exert their effort in the HEP, as illustrated in the following comments:

"I knew it [the project] would touch the communities' health problem, and I wanted to help;" "I wanted to do something that would benefit and save the life of my community and I felt that I could do that"

In general the interviewed HEWs showed high commitment and willingness to work in rural areas; indicating as there is little or no attrition in spite of the various problems trainees are facing. Most say they are committed to work in kebeles and change the life of villagers. Even trainees who were recruited from the towns believe they have adapted themselves easily to rural community life. Yayehyirad, Kitaw, Yemane, Ye-Ebiyo and et al. (2007) disclosed that based on study of first batch of HEWs, despite many grievances the HEWs face and problems of implementations there is high degree of commitment from the side of HEWs.

As a whole interestingly enough, many of the factors that fostered community mobilization and continuous involvement in this study are similar to those reported by others (Butterfoss, Goodman, & Wandersman, 1996; Gottlieb et al., 1993; Kegler, et al, 1998; Kumpfer et al, 1993; Parker et al., 1998; Wandersman, et al, 1996) fostering the effectiveness of community mobilization.

4.1.4.2 Factors Inhibiting/Challenging Effective Community Mobilization

4.1.4.2.1 Culture

Many literatures suggests that culture serves as deterring factor people from engaging into some activities that they feel that it is not pro their culture and stay resistant. This is because health behaviors for a certain community are influenced directly by elements of one's culture. Hence imparting information on promotion of healthy behavior is a challenging task for the HEWs as one respondent put it in her own words:

> *Soon I was deployed to the rural kebeles, I started to teach mothers to vaccinate their children, to built toilet, to use family planning and all what I have learned during the one year training. Many of the mothers refused me. When children's are sick they prefer to take first to traditional healers whom they call 'kallu'. Moreover, the problem was aggravated since majority of the rural dwellers are uneducated there was a well established difficulty of communicating health issues to the community since most of them highly adhere to their culture.*
>
> *In one instance what I don't forget in my life while I was teaching them to use family Planning almost all strongly challenged me by saying how we be come against did of God how we interfere in the works of God. This is really sin you need to be blessed; how dare you say this. I took too much time to convince them, once they were convinced they always expect things should be at hand/require immediate service, but it was difficult for me to make things at hand, because logistics come from Woreda health center or from other places. But because I tolerated all those difficulties in my day to day activities currently, no one like me in my village the community respect like a priest and evangelist. These all negative*

attitude have been changed after a hard resistance by involving the respected community leaders.

This tells that before conducting any community based intervention the importance of first engaging the elders, traditional leaders in the process of dialogue and negotiation in order to gain consent, access and cooperation as one HEW noted:

"Recently I had access to the target community by involving community leaders or the gatekeepers, who are respected in the community. This have facilitated my acceptance and helped me to draw many people behind the program"

From this one can note, how culture of the community become barrier for the effective disseminations of the health extension package. This recalls that those who wish to work with community members should carefully examine the differences and similarities in cultural perceptions so that community health intervention activities are appropriate for that particular cultural context. Since individual's culture influences his/her attitude toward various health issues, including perceptions of what is and is not a healthy problem, methods, disease prevention, treatment for illness, and use of health providers (Steckler, Malek, & McLeroy, 1998).

4.1.4.2.2 Problem with Respect to Shelter

Housing is very important in motivating workers and in possibly lengthening their stay in the communities for commitment in work. Though, the trend in this respect is encouraging for the majority of the interviewees there are some HEWs who are living in house rented from farmers. One informant described the condition:

"I am now living in the house of farmers which is remote from the working station. In that remote area I sometimes, fear since I am a girl, I am afraid at night. I suspect if thieves robe my home. This is one of the great challenge I face not do my work effectively".

This insecurity of shelter and other basic facilities could have a negative effect on the quality of work and motivation of HEWs. Kinde, and Kenso, (1996 EC) also acknowledged this and elaborated further that good health service performance depends not only on the location, skills, and motivation of the worker but also on the buildings, equipment and materials the HEWs require doing their job. It is, therefore, important to fulfill the necessary facilities before the arrival of the HEWs or at least as soon as possible there after since, it could have impact on effective community mobilization by eroding motivation to work.

4.1.4.2.3 Lack of Training and Reward System

Continuing education and training is a critical to the success of HEP. Yet many of the respondent unanimously replied that except very conditional trainings there is no room for upgrading yet stretched as one of the interviewee summarized the condition:

> *While, I was in training many of the HEWs believe that after a yearsof service we could get a chance to upgrade ourselves and possibly become a nurse. But I have worked for more than five years, I am from the first batch there is no promising futurity that make me stay in this work. Moreover I hear that there are many new drugs of malaria coming recently, but I didn't know its names. I hear that some NGOs are giving trainings on methods of conducting community mobilization such as how to run community*

conversation or dialogue but no NGOs are found in our woreda except occasional workshops given to us by our supervisors. In fact before two years ago there was no any reward system even for the best performers. But currently there is a modest recognition of the out performers of HEWs regularly at the Woreda, Zonal and Regional level even including model families that have effectively used the HEP and brought behavioral change. This acknowledgment of work encourages me to stay and commit myself to achieve the objectives of HEP.

Lack of training and continued education may create feelings of inadequacy developed as a result of workers felt lack of expertise with health issues, how to address the target audiences. This could hinder workers interest for continued involvement in the project. Therefore there should be a need for continuing education as well as remedial measures for some of the HEWs deficiencies imparting/ challenging the proper implementation of the package. Awash, et al, (2007), and Yemane, et al (2007) have also disclosed this fact remarking that as there should be mechanisms to develop the HEWs skills that enable them to effectively communicate with the rural community and curb the country's shortfall in health.

4.1.4.2.4 Difficulty of Mobilizing Economically Weak People

It is well documented that majority of the Ethiopian population lead a subsistence life. Particularly the conditions get worsened with the rural community. Many of these people stretched out in terms of financial resources. Hence it is very tough task to involve people who only give so much of their time to feed themselves and their children rather than worrying about their health. As one respondent suggested:

Many of the community consume their time to feed their children. Therefore, it is hardly possible to get them involve in community dialogue. During my home visit I have asked them why they are not participating with the model families most of them told me that had they got ample time, they would have engaged actively at all sessions of community dialogue on health issue. However, they say "as you see we have nothing to feed our children we pass all days running here and there. Sometimes burn charcoal to sell to the market, at times we look for our children. So how could you imagine that we had not attended on issues that is intended to keep our health had we not lead a subsistence life".

This indicate that being economically disadvantaged have affected the some community members from participating in the package and would have brought a behavioral change in basic life saving skills. Studies on community health promotion have indicated that being economically disadvantaged would have impact on the effectiveness of community based health prevention and promotion of healthy behavior that can make the health of the community in their hand through mobilization (Kegler, et al, 1998 Parker et al. 1998,; Butterfoss et al, 1996)

Some of the participants' identified barriers to community's mobilization, including lack of community support and participation, felt lack of expertise and technical support, role overload, and felt inadequacy (i.e., lack of training and/or experience with community programs and specific issues). Some of these findings support the barriers of community mobilization to community health intervention and promotion identified by Cameron et al (1994) cited in community psychology by James, Dalton, Maurice and Abraham, (2007).

4.1.4.3 Community Attempts to Improve Communities' Health Problem

For community action/health promotion efforts to last it is important to create an environment from the out set that is conducive and open to change at all levels. This requires both the health agents and communities to work together, hand in hand to collectively identify barriers. Mutually determine suitable action through out the entire planned change process. Breslow, (1996) identified citizen participation as one of the most popular approaches used to facilitate change to day. The participants of this study were asked to picture out important characteristics of communities' effort made to solve their health problem as a result of wake up call conducted by health extension workers. Majority of interviewee share the same experience in current communities' endeavor and one has explained in this way:

> *In the past the rural communities get rid of their waste as he/she likes in the environment, where it made them predisposed to communicable disease. There was no concept of environmental sanitation. But today majority of them have built toilet. In some areas they have reached the extent of setting rules and regulation to control or punish community member who did not built toilet. Since, we work hand in hand with Iddirs (community organization) these Iddirs outcast people who are not working with us. For example in my kebele if one member of the community wants to marry both the couples have to check for HIV and show to traditional leaders. Because of the awakening program done the community has started to sensitively discourage harmful traditional practices such as female genital mutilation and childbearing. The other most important community action characteristics that make me proud of are their awareness in the*

use of family planning. Now a days many mothers use contraceptives to control unwanted pregnancy. Because the level of unmated need remains high a concentrated effort to make contraceptives available remains priority. Currently almost all communities immunize their children; the community collaborates in teaching to instigate pit latrines and improve house hold hygiene. This collaboration between the community and me has raised the status and enhance the impact in the entire community. What I forget not mentioning regarding communities activity is they have contributed community resources (time, labor, transport and money) to help compliment government resources.

Though, it is difficult to get local research corroborating or contradicting with this response the interviewee pointed out that the community has started to improve their health status by their own initiation; using their own skills in the study area which is the ultimate goal of HEP. However studies conducted by Awash Teklehymanot and his colleague (2007) reflected that communities participate in HEP actively except some reluctance during peak farming periods. The aforementioned researchers also disclosed that communities readily participate in HP construction even though there is some resistance in some places. During the data gathering the personal experience/observation of the researcher witnessed a variety of community initiatives very greatly though still not instigated at the broader level.

4.1.5 Discussion

Mobilization of community members and local communities are vital because this effort not only improve but also empower community with self reliance and control over the factors that affect the communities' health. Essentially, important are community education and awareness programs that have positive influence in changing health related behaviors and increase reception of preventive and promotive health care (Cameron et al. 1994) cited in community psychology by James, Dalton, Maurice and Abraham, 2007 . In this regard, this survey provides important information regarding the state of community mobilization in Bereh-Aleltu Woreda, North Showa of Oromiya regional state with respect to the health extension package. As clearly presented in the objective part of this study the researcher tried to test the relationship between building blocks of community mobilization scores that are apparent. To refine the result it have been tried to cross validate the response of HEWs and community leaders. The study revealed that there is significant level of positive correlation being r= 0.206 and r = 0. 260 when level of community participations perceived local support is paired with social asset for the response of HEWs. When one see the results of both health extension workers and community leaders there is no significant difference. This testifies that the HEWs encourage and make the rural community aware through existing mass organizations of the importance of involving themselves in decision making and implementation of health extension package as a means to accelerate the health service coverage. Though the study was conducted before the commencement of HEP, study of Mathiwos Wakbulcho (1988) indicated that community involvement in community health service is higher in rural community particularly in the planning and decision making process. Where as the 1975 UNICEF/WHO study showed that less than 20% of the rural

population in most developing countries receives basic health on regular base, admitting that in developing countries where millions of people are without basic health care and government effort alone cannot ensure people to lead healthy, socially productive lives. Thus, the studies of WHO reminds the need to grip the communities for active involvement in delivery, maintenance and utilization of health services, in order to realize equitable distribution of health services.

On the other hand regarding some of the factors that become barrier for effective community mobilization on the health extension package; the study found out that lack of community support and participation from certain parts of the society at the early stage, community members' negative attitudes towards specific issues (cultural), the difficulty of mobilizing individuals in economically disadvantaged, lack of training and reward system and technical support, and felt inadequacy (i.e., lack of training and/or experience with community programs and specific issues) were some of the barriers. Some of these barriers are similar to the barriers of community mobilization to community health intervention and promotion identified by Cameron et al (1994) cited in community psychology by James, Dalton, Maurice and Abraham, (2007). Similarly, when the participants of the study are requested to rank order on some of would be the inhibiting factors/challenges not conduct their work well they disclosed their opinion by ranking based on the intensity of the challenge. Hence, lack of resource needed for the program, community members' negative attitudes towards the program, role overload, and felt inadequacy (i.e., lack of training and/or experience with community programs and technical support, absence of committed and trusted leader in the community, lack of clear policy direction about the program, lack of commitment from all the stakeholders, lack of knowledge from the side of the community, lack of support and participation from the side of the community, disorganization of the

woreda and kebele leaders, and suspicions of the community on the effectiveness of the program in bringing change have been listed based on their percentage.

As described before studies conducted by Kegler, et al, (1998) Parker et al., (1998); Butterfoss et al, (1996) disclosed that healthy behaviors for a certain community are influenced directly by elements of once culture. As a result imparting information on promotion of healthy behavior is a challenging task. This was true for the HEWs as one respondent put it in the result part of the study. Those who wish to work with community members should carefully examine the differences and similarities in cultural perception; so that community health intervention activities are appropriate for that particular cultural context. The other challenging problem the study found out was problem of shelter for some HEWs. The insecurity of shelter and other basic need facilities could have a negative effect on the quality of work and motivation of HEWs. Kinde, and Kenso, (1996 EC) acknowledged this and elaborated that good health service performance depends not only on the location, skills, and motivation of the worker but also on the buildings, equipment and materials the HEWs require for doing their job. It is, therefore, important to fulfill the necessary facilities before the arrival of the HEWs or at least as soon as possible there after since it would have impact on effective community mobilization by eroding motivation to work. As disclosed in the interview part of this study, the other barriers for effective community mobilization in the area were difficulty of mobilizing economically weak people and lack of training and reward system. Lack of training and continued education may create feelings of inadequacy developed as a result of workers felt lack of expertise with health issues, how to address the target audiences. Awash, et al (2007) found out that the HEWs were very much worried about their future career, the possibility to transfer from one area to other area and the chance to continue their education. This

could hinder workers interest for continued involvement in the project. Therefore there should be a need for continuing education as well as remedial measures for some of the HEWs deficiencies imparting/ challenging the proper implementation of the package. Awash, et al (2007), and Yemane, et al (2007) have also disclosed this fact remarking that as there should be mechanisms that develop the HEWs skills to enable them effectively communicate with the rural community and tail them behind the project in order to curb the country's shortfall in health.

As reported by HEWs after very strong resistance from the side of the community involving community leaders in their work has assisted the community to work with health agents hand in hand to collectively identify barriers and mutually determine cultural harmful practices. As a result the community is showing encouraging results in environmental sanitation, family planning, pit latrine construction, vaccination and HIV/AIDS. Study conducted in Tigray Wolkite woreda has shown despite, many challenges noted the HEWs were broadly seen as helpful and improving the general health of community by engaging the community themselves. According to Braithwaite et al, (1994) the success or change in a certain community intervention is more likely to be successful and permanent when the people it affects are involved in initiating and promoting it. In other words a crucial element of community mobilization is participation by the individuals, community based organizations, and institutions that will be affected by the effort. The results of the above health extension workers interviewee reflect this fact.

In relation to what enhanced the mobilization of the community the interviewed HEWs indicated that awareness' of the community enhanced the mobilization process. These issues of awareness' were fostered by three factors according to the interviewed HEWs. These were the fact that majority of HEWs were selected from the rural community themselves

which helped to develop trust and sense of belongingness among the community and HEWs. This facilitated the people to get involved on various health issues. Secondly, the community started to recognize links between high rate of attending and practicing healthy basic life saving skills thought by HEWs and the probability of getting illness; especially, among mothers and children; though some community members still prefer curative treatment. The third factor reflected by the HEWs was observation of adults and adolescents the fact that model families graduating after attending and practicing basic healthy life saving skills at different times. This was started by small size of the community which boosted the desire to get involved in the mobilization process.

In the study it was also indicated that HEWs sense of usefulness and sense of community has contributed for their commitment in the work and mobilization process. According to the interviewees such feelings of usefulness were generated by the informants' training and/or experience in health issues, with the targeted audience, and/or by the respondents' knowledge of the community and/or key people residing there. Moreover informants' involvement in the project was described as "very valuable learning experience" that enhanced their personal and professional feelings of efficacy and success in the project. Furthermore, the HEWs sense of community which is developed as a result connection with the place (since many respondents were born and/or had lived in the village for many years), a sense of shared history, and a high empathy for the targeted audience have reinforced their commitment and facilitated the mobilization process. Regarding HEWs commitment to improve the health of rural community, Yayehyirad, et al (2007) in their study of assessment of working condition of first batch of HEWs disclosed that despite many grievances and problems of implementations it was found that there is high degree of commitment from the side of HEWs. Chavis

et al., (1990) also indicated that when people share a strong sense of community they are motivated and empowered to challenge problems they face, and are better able to mediate the negative effects over things which they have no control.

As a whole interestingly enough, many of the factors that fostered community mobilization and continuous involvement in this study are similar to those of other researchers (Butterfoss, Goodman, & Wandersman, 1996; Gottlieb et al., 1993; Kegler, et al 1998; Kumpfer et al, 1993; Parker et al., 1998; Wandersman, et al, 1996).

Chapter Five

5.1 Conclusion and Recommendations

5.1.1 Conclusion

Even though it is hardly possible to generalize about the whole status of health extension program with this limited sample based on the result obtained in the study area, there was encouraging effort done by HEWs to provide health service and sensitize the rural community to the basic life saving skills through mobilizing them. This is testified in the current community activity effort such as contribution of their resources, devaluing harmful traditional practices, use of family planning, pit latrine construction etc.

All these changes have come about due to rural communities' awareness fostered by development of trust and sense of belongingness between community and HEWs, recognition of communities on the use of practicing what is told by HEWs and observation of model families graduating after attending and practicing the health extension package programs. The other contributing factors were HEWs sense of usefulness in changing the health of their community and their senses of belongingness which fostered commitment.

The inhibiting/ challenging factors that deter effective community mobilization with respect to health extension package were found to be negative attitudes/culture of the community/; absence of shelter, absence of additional trainings for the HEWs and inexistence of refresher trainings that can be a remedial for their current deficiencies. This is because majority of HEWs are highly concerned about in service training and their future carrier. Finally since majority of the community members are leading subsistence life, it becomes a tough task for the HEWs to involve such community members.

5.1.2 Recommendations

The following recommendations are forwarded for all stakeholders.

- All stakeholders should support mobilization process that aim for higher levels of community participation using community development approach that treat community members as full partners in improving health of the community members such as mothers and children rather than as passive recipients or consumers of health services. This shared responsibility between communities and health service providers promotes greater community ownership and more sustainable improvements over the long term.

- Building upon existing community resources is critical for successfully obtaining community support for focused initiatives in promoting healthy behavior. Groups wishing to promote preventive and promotive healthy behavior in a certain community should examine existing strengths and culture of that community.

- Encourage community and make them aware through existing mass organization of the importance of involving themselves in the planning, decision making and implementation of the package as a means to accelerate health mobilization process.

- Bearing in mind the good achievement yet registered, intensive awareness creation should be targeted to incorporate schools, religious institutions, community leaders in the mobilization process so as to build social networks to spread support, commitment, and changes in social norms and behavior.

- By preparing clear plans for the remedial continuing education of HEWs, establish a mechanism (such as a taskforce or committee) to study and plan upgrading (as appropriate) training and future training centers for HEWs.

- Timely responses should be set to mitigate social and psychological needs of HEWs based on their performance and years served. In addition, HEWs have to be introduced to new refresher courses towards improvements of skill (e.g. how to conduct community dialogue, prevention and control of HIV/AIDs) and changes in technology (e.g. new drugs) to effectively mobilize the community

- Doing further research is recommended to unravel the level of health awareness that come as a result of health extension package.

Reference

1. Awash, T., Yayehyirad, K., Asfawosen, G/Y., Samuel, G., Aklilu, S., Hailay, D. and Yemane, Y.(2007): ***Study of the Working Condition of Health Extension Workers in Ethiopia***. Ethiopian Journal of Health Development; 21(3):246-259.
2. Aregay W. (2005): ***Assessment of The Impact of Health Extension Package***; in Wolkite Tigray: Unpublished MSC Thesis; Addis Ababa University
3. Barker, R. G. (1968). ***Ecological sociology***. Stanford, CA: Stanford University Press.
4. Breslow, L. (1996). ***Social Ecological strategies for Promoting Healthy Lifestyles***. American Journal of Health Promotion, 10(4), 253-257.
5. Bronfenbrenner, U. (1977). ***Toward an Experimental Ecology of Human Developmen***t: Journal of American Psychologist Association, *32*, 513-553.
6. Bronfenbrenner, U. (1979). ***The Ecology of Human Development.*** Cambridge, Mass. Harvard University Press.
7. Butterfoss, F. D., Goodman, R. M., & Wandersman, A. (1993). ***Community Coalitions for Prevention and Health Promotion***. Journal of *Health Education Research, 8*(3), 315-330.
8. Florin, P., Mitchell, R., & Stevenson, J. (1993). ***Identifying Training and Technical Assistance needs in Community Coalitions***: A development approach. Journal of *Health Education Research, 8*(3), 417-432.
9. Francisco, V., Paine, A., & Fawcett, S. (1993). ***A Methodology for Monitoring and Evaluating Community Health Coalitions***. Journal of *Health* Education Research, *8*(3), 403-416.
10. Goodman, R. M., Speers, M. A., McLeeroy, K., Fawcett, S., Kegler, M., Parker, E., Rathgeb Smith, S., Sterling, S. D., & Wallerstein, N. (1998). ***Identifying and Defining the Dimensions of Community capacity to provide a basis for Measurement***. Journal of *Health* Education & Behavior, *25*(3), 258-278.
11. Hanson, P. (1988-89) ***Citizen Involvement in Community Health Promotion: A Role Application of CDC's PATCH model***. International quarterly of community health education,9(3):177-186
12. Jakes S, Lisa C and Shanon L.(2002): ***Community Change Survey***. USA
13. Kretzmann, J.P. and McKNIGHT, J.L. (1993) ***Building Communities from the Inside Out: a Path toward Finding and Mobilizing a Community's Assets***, Chicago University. USA.

14. Kegler, M. C., Steckler, A., Malek H. S., & McLeroy K. (1998). ***A Multiple Study of Implementation in 10 local project ASSIST coalitions in North Carolina***. Health Education Research, *13*(2), 225-238.

15. Kegler, M., Steckler, A., McLeroy, K., & Malek, S. H. (1998). ***Factors that contribute to effective community health promotion coalitions: A study of 10 Project ASSIST coalitions in North Carolina. American Stop Smoking Intervention Study for Cancer Prevention***. Journal of Health Education & Behavior, *25*(3), 338-353.

16. Kitaw Y. et al. (2006) ***Evolution of Public Health in Ethiopia***. EPHA, Addis Ababa

17. Kinde, K., and Kenso. H (1996): ***Demand and supply of health man power: Alternative scenarios, policy and human resource development*** **Project sponsored by the Ethiopian Government and World Bank**: Addis Ababa.

18. Lewin, K. (1936). ***Principles of Topological Psychology***. New York: McGraw-Hill.

19. Labonte R, Robertson A. (1996). ***Delivering the goods, showing our stuff: the case for a constructivist paradigm for health promotion research and practice***. Health Education Quarterly 1996:23(4):431-447.

20. May P, Miller,J and Wallerstein N, (1993): ***Motivation and Community Prevention of Substance Abuse:*** Journal of experimental and clinical pharmacology, vol 1 Nos 1-4 68-78 American Psychological Association.

21. McLeroy K., Bibeau, D., Steckler, A., & Glanz, K. (1988). ***An Ecological Perspective on Health Promotion Programs***. Health Education Quarterly, 15, 351-377.

22. MOH.(2003). ***Report of the Final Evaluation HSDP***, volume 1. Addis Ababa, March 2003

23. Misganaw, F., and Getu D. (2000) ***Health Utilization in Amhara Region of Ethiopia***: unpublished article Addis Ababa

24. Worku, C.,(2007). ***Factors Affecting the Implementations of Health Extension Package***: In Wolayita. Unpublished MSC Thesis, Addis Ababa University

25. Yayehyirad, K., Yemane, Y., Amir, S., Hailay, D and Awash, T. (2007). ***Assessment of the Training of the First Intake of Health Extension Workers***. Ethiopian Journal of Health Development; 21(3): 232-239

26. Yemane, Y., Yayehyirad, K., Asfawosen, G/Y., Samuel, G., Hailay, D., Aklilu, S., and Awash, T. (2007) ***Study on Health Extension Workers: Access to Information, Continuing Education and Reference Material***. Ethiopian Journal of health Development; 21(3): 240-245

Appendix I

ADDIS ABABA UNIVERSITY SHOOL OF GRADUATE STUDIES
DIPARTMENT OF PSYCHOLOGY

DEAR/SIR

You have been selected to supply information for a study designed to collect data on how rural communities are mobilized, to keep their well being. Below are community level mobilizations subscales that are appropriate for measuring levels of community mobilization. Hence I would like to request you to share your genuine opinion and experience there are no right or wrong answers be sure that your answers to this surveys will be grouped together and no single person's response will be made public and only used for purpose of this study.

Questionnaire to be filled by Health Extension Workers and Community Leaders

Thanks for sharing what you think!

I. Back ground information
Fill the blank space or circle the options below

1. Name of your Woreda _____ Kebele _____
2. Sex M ☐ F ☐
3. Age 15-20 ☐ 20-25 ☐ 26-30 ☐ above 30 ☐
4. Service year 1-3 ☐ 4-6☐ 7 and above ☐

ii. Social Assets

Indicate whether or not you agree with the following statements according to the scale below. SD = Strongly Disagree DS= Disagree
Agr = Agree SA = Strongly Agree

	SD	DS	Not Sure	Agr	SA
1. Individuals in this community Know how to develop a survey About health issue	☐	☐	☐	☐	☐
2. Individuals have developed Knowledge of how to work with Others on preventive health issue.	☐	☐	☐	☐	☐
3. The community have the communica Skills to influence each other on- their sanitation.	☐	☐	☐	☐	☐
4. The community know when important health issue takes place	☐	☐	☐	☐	☐
5. The community does not know how to gather information relevant to their	☐	☐	☐	☐	☐

health

6. The community have developed the Skills needed to make important decisions in their community ☐ ☐ ☐ ☐ ☐
7. The community know how to raise money to do community actions to keep their wellbeing ☐ ☐ ☐ ☐ ☐
8. The community are not leaders in their Community ☐ ☐ ☐ ☐ ☐
9. They know how to develop Leadership on health issues ☐ ☐ ☐ ☐ ☐
10. Local community groups do not Usually work together on Important health matters ☐ ☐ ☐ ☐ ☐
11. They often join together to Discuss and solve their health ☐ ☐ ☐ ☐ ☐

iii. Community participation

	SD	Dis	Not sure	Agr	STA
1. Only a few people participate in community health improvement	☐	☐	☐	☐	☐
2. People in this community generally Volunteer for community health	☐	☐	☐	☐	☐
3. Most people in this area take active role in the community health education.	☐	☐	☐	☐	☐
4. Community members usually do not Pitch in when there is work to be done For the importance of community	☐	☐	☐	☐	☐
5. When people in my community Try to create positive community Change community usually cooperates	☐	☐	☐	☐	☐
6. Most people are involved in discussions	☐	☐	☐	☐	☐
7. The leaders in the community					

Do not encourage community Members to participate to Make decisions on health issue	☐	☐	☐	☐	☐
8. Local administrators support Community effort	☐	☐	☐	☐	☐
9. The community play active role When they are asked	☐	☐	☐	☐	☐
10. Each community member don not Feel a personal responsibility To participate in community	☐	☐	☐	☐	☐

iv. Perceived local support

1. Local policies support community Improve effort	☐	☐	☐	☐	☐
2. Local service agencies, school Health department etc support Efforts to make the community Health at a better place.	☐	☐	☐	☐	☐
3. When people in my community try to create positive community change, community leaders usually cooperate	☐	☐	☐	☐	☐
4. The community do not have developed Specific procedures in place to Help to a new community health Education	☐	☐	☐	☐	☐
5. The leaders in the community Do not lead community members to Participate in decision making of the HEP	☐	☐	☐	☐	☐
6. All stake holders of government and non government instauration support all Endeavors of community act.	☐	☐	☐	☐	☐

V. Ranking Items

Rank order the following factors which might become barriers for proper community mobilization (to achieve the goal of Health extension program)

No	**Factors (situation)**	Your rank (1,2,3----10)
1	Lack of knowledge from the side of the community	
2	Lack of appropriate resources needed to support the program	
3	Lack of commitment from all the stake holders	
4	Lack of clear policy direction about the program	
5	Disorganization of the Woreda and kebele leaders	
6	Absence of committed and trusted leader in the community	
7	Suspicions of the community on the effectiveness of the program on bringing change to them	
8	Lack of support and participation from the side of the community	
9	Community members' negative attitudes towards the program	
10	Role overload, and felt inadequacy (i.e., lack of training and/or experience with community programs and technical support	

Appendix II

ADDIS ABABA UNIVERSITY SHOOL OF GRADUATE STUDIES
DIPARTMENT OF PSYCHOLOGY

. Interview Guide

1. What do you believe are 2 or 3 most import characteristics of community in an attempt to solve their health problem? When you picture this community addressing these issues effectively what stands out at the forefront?
2. What makes you most proud of your community in how it currently addresses some selected issues?
3. What are some specific examples pyramids by people or groups working to improve communities' health around the selected health problems?
    i. How did these come about? Who was involved? How did they access needed resources what was accomplished?
    ii. What are the most important lessons you have learned form both successful and unsuccessful community effort.
4. If you could improve communities' health how do you go about it?
5. What are the most important challenges you faced in attempt to induce preventive and preventive behavior right you were employed
6. What do you believe is keeping the community from doing what needs to be done to improve their health what do you believe are the underlying causes or reasons for these barriers.
7. How can you build up on the assets and strengths of the community?

Thank you

Appendix III

YUUNIVARSIITII ADDIS ABABAATTII SAGANTAA

QO'ANNOOLEE EBBAA

MUUMMEE XIINSAMMUU (PSYCHOLOGY)

Gaafannoo Hojjeettoota Ekisteenshinii fi Hoggantoota Hawaasaan Fayyaan Guutamu

Kabajamoo/tuu

Isin kan filatamtaniif, akkaataa gurmaa'ina (mobilization) hawaasa baadiyyaa sagantaa Ekisteenshinii fayyaa ilaalchisee gurmichi itti fuufiinsa akka qabaatuu fi bu'aa ba'ii (challenge) mudatan irratti qo'annoo gaggeessuuf adeemu kanaaf odeeffannoo akka naa kennitaniif.

Isaan armaan gadii kutaalee sadarkaa gurmii hawaasaa kan bekuuf/safaruuf oolanii dha. Kanaafuu odeeffannoo dhugaa kan muuxannoo keessan irratti hundaa'e akka naa hirtan isin gaafadha. Yaadnii fi odeeffannoon isin naa kennitan fiixa bahiinsa qo'annoo kanaaf iddoo guddaa qaba.

Deebii fi yeroo keessaniif galatoomaa!

I. Odeeffannoo duraa

Bakka duwwaa guutuun ykn filannootti maruun deebisaa.

1. Maqaa Aanaa keetii ---------- Ganda/Araddaa ----------
2. Sadarkaa barumsaa ----------
3. Saala Dhi ☐ Dha ☐
4. Umurii 15-20 ☐ 20-25 ☐ 26-30 ☐ 30 olii ☐
5. Tajaajila (Waggaan) 1-3 ☐ 4-6 ☐ 7 olii ☐

II. Waa'ee Hawaasummaa (Social Asset)

Yaada deeggarsaa fi mormii qabdan haala armaan gadiitiin agarsiisaa.

BD – Baay'ee Deeggara
D – Ni Deeggara
KJR – Kana jechuuf rakkisaa dha (not sure)
M – Ni Morma
BM – Baay'ee Morma

	BD	D	KJR	M	B
1. Hawaasa kana keessatti namni akkaataa ittiin waa'ee fayyaa irratti rakkoolee mudatan hiiku ni beeka.	☐	☐	☐	☐	☐
2. Dhimma ittisa dhukkubaa irratti namootni akkaataa waliin hojjatan irratti hubannoo ni qabu.	☐	☐	☐	☐	☐
3. Hawaasni waa'ee qulqullinaa irratti waliigaltee cimaa gonfate..	☐	☐	☐	☐	☐
4. Waa'ee fayyaa irratti bu'a qabeessummaa narii ni beeku.	☐	☐	☐	☐	☐
5. Hawaasichi waa'ee fayyaa isaanii irratti akkaataa ittiin odeeffannoo argatu hin beeku.	☐	☐	☐	☐	☐
6. Hawaasni ogummaa murtee bu'a qabeessa dhimma fayyaa hawaasummaa keessatti kennuu dandeessisan dagaagfateera.	☐	☐	☐	☐	☐
7. Hawaasni akkaataa ittiin maallaqon sochiisaa cimsu irratti hubannoo ni qaba.	☐	☐	☐	☐	☐
8. Hawaasa keessatti miirri hooggantummaa hinjiruu.	☐	☐	☐	☐	☐
9. Hawaasichi akkaataa ittiin waa'ee fayyaa irratti hooggantummaa dagaagsan ni beeka.	☐	☐	☐	☐	☐
10. Qooda fudhattootni hawaasaa dhimmoota faayidaa fayyaa irratti hedduminaan waliin hin hojjatan.	☐	☐	☐	☐	☐

11. Hawaasichi yeroo hedduu gurmaa'uun mari'ata rakkoo waa'ee fayyaa ilaallatan fura. ☐ ☐ ☐ ☐ ☐

III. Hirmaannaa hawaasaa ilaalchisee (Community participation)

	BD	D	KJR	M	B
1. Namoota muraasa qofatu fayyaa hawaasaa dagaagsuu irratti hirmaata.	☐	☐	☐	☐	☐
2. Hawaasa kana keessatti namootni waa'ee fayyaa irratti hirmaachuuf guutumatti fedhii qabu.	☐	☐	☐	☐	☐
3. Namoonni naannoo kanaa harki caalu hubannoo waa'ee fayyaa laatamu irratti si'atoo dha.	☐	☐	☐	☐	☐
4. Miseensotni hawaasa hedduminaan waliin ta'anii waan barbaachisummaa fayyaa hawaasaaf hojjatamu tokko hin hojjatan.	☐	☐	☐	☐	☐
5. Yommu namootni hawaasa kiyya keessatti jijjiirama gaarii fidan hawaasichi ni gurmaa'a.	☐	☐	☐	☐	☐
6. Namootni baay'een marii waa'ee fayyaa irratti ni hirmaatu.	☐	☐	☐	☐	☐
7. Hooggantootni hawaasaa miseensota hawasichaa waa'ee fayyaa irratti murtee kennamu irratti hin hirmaachisan.	☐	☐	☐	☐	☐
8. Bulchiinsi araddaa sochii hawaasaa ni deeggara.	☐	☐	☐	☐	☐
9. Miseensotni hawaasaa gaaffii gaafatamaniif deebii kennuu irratti gahee olaanaa taphatu.	☐	☐	☐	☐	☐
10. Tokkoon tokkoon miseensa hawaasaa hirmaannaa hawaasa keessaatiin itti gaafatamummaan itti hin dhagahamu.	☐	☐	☐	☐	☐

IV. Hubannoo gargaarsaa ilaalchisee (Perceived local support)
(Sadarkaa Naannootti)

	BD	D	KJR	M	BM
1. Imaammaatichi carraaqqii hawaasaa ni deeggara.	☐	☐	☐	☐	☐
2. Qooda fudhattootni, muummeewwan fayyaa fi kkf sochii hawaasaaf bakka guddaa kennu.	☐	☐	☐	☐	☐
3. Yommuu namootni jijjiirama gaarii fidan, hooggantootni hawaasaa ni deeggaru.	☐	☐	☐	☐	☐
4. Hawaasichi barumsa fayyaa ilaalchisee hawaasa hubannoo hin qabne akkaataa ittiin calqabsiisu irratti hin qophoofne.	☐	☐	☐	☐	☐
5. Hooggantootni hawaasaa miseensota murtee sagantichaa kennamu irratti hin-hirmaachisan.	☐	☐	☐	☐	☐
6. Qooda fudhattootni dhaabbilee mootummaa fi mit-motummaa sochii cimaa hawaasni taasisu ni deeggaru.	☐	☐	☐	☐	☐

V) Qabxiilee Sadarkeessuu

Armaan gadittii sagantaa ekisteenshinii fayyaa irrattii hawaasnii akka hin gurmoofnee qabattootni guufuu ta'uu danda'an dhiyaatanii jiruu. Haala cimina isaanitiin sadarkeessaa

No	Haala/qabata	Sadarkaa(1,2,3…10)
1	Beekumsa dhabu gama hawaasaa.	
2	Hanqina leeccoolee barbaachisaa sagantaa ekisteenshinii fayyaa galmaan ga'uuf.	
3	Kutannoo dhabuu gama qooda fudhattootaatin.	
4	Qajeelfama ifaa/qajeelaa dhabuu imaammatichaa.	
5	Rakko qindoomona hoggantoota aanaa fi gandaa.	
6	Dhabiinsa hogganaa hawaasaa amanamaa fi kuutataa.	
7	Shakkii hawaasni jijjiirama fiduu fi bu'aa qabeessuummaa ekisteeshinii fayyaaf qabu .	
8	Hanqina deggarsaa fi hirmaannaa gama hawaasaa.	
9	Ilaalcha jallataa miseensii hawaasaa sagantaa ekisteenshinii fayyaaf qabu.	
10	Baay'ina gahee, hanqina leenjii ykn muxannoo sagantaa hawaasaa adeemsiisuuf.	

Declaration

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

Name Siyum Kebede

Signature_____

Place: Department of Psychology, Education faculty, Addis Ababa University

Date of submission 21. July 2009

This thesis has been submitted for examination with my approval as the university advisor.

Name: Professor Habtamu Wondimu

Signature_____

Date_____