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Addis Ababa University

School of Graduate Studies

ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF THE IMPLEMENTATION OF HEALTH EXTENSION PROGRAM: THE COMPARATIVE STUDY OF GORO AND WELISO WOREDAS.

Milkiyas Ayele

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List of Acronyms

CBHW Community Based Health Workers

CHA Community Health Agents

E. C Ethiopian Calendar

FP Family Planning

GIPRO Goro Information and Public Relations Office

HBM Health Belief Model

HC Health Center

HEP Health Extension Program

HEWs Health Extension Workers

HIV/AIDS Human Immune Deficiency Virus /Acquired Immune Deficiency Syndrome

HSDP Health Sector Development Program

HSEP Health Service Extension Program

IEC Information, Education and Communication

ITNs Insecticide Treated Mosquito Nets

LLITN Long Lasting Insecticide Treated Net

MDGs Millennium Development Goals

MoH Ministry of Health

NGOs Non- Governmental Organizations

QC Quality Care

PASDEP Plan for Accelerated and Sustained Development to End Poverty

PHC Primary Health Care

STIs Sexually Transmitted Infections

TB Tuberculosis

TTBA Trained Traditional Birth Attendants

WHO World Health Organization

WIPRO Weliso Information and Public Relations Office

Explanatory notes

- All years in this thesis are written in Gregorian calendar unless otherwise stated in Ethiopian calendar (E.C).

- Where the years are skipped or not considered or given zero (0) values in the figures drawn indicate that there are no available data for those particular years.

Abstract

Ethiopian government has developed and implemented Health Extension Programme to improve the health status of communities particularly those who reside in rural areas of the country since 2004/5. The thesis focuses on the assessment of achievements and challenges of the implementation of Health Extension Program. The objective of the study is to assess the achievements and challenges of Health Extension Program in Goro and Weliso woredas.

As to the research methodology, descriptive method was used. Stratified multi- stage cluster sampling was employed to select sample households. Six (6) kebeles were randomly selected from the two woredas. From these kebeles a total of 150 households were randomly chosen. Simple random sampling was used to select Health Extension Workers (HEWs) and Supervisors. Purposive sampling was utilised to select woreda health administrators. Schedule questionnaire, observations and interview were applied to obtain first-hand information.

Regarding the findings, the study shows that there have been poor performances in the execution of Health Extension Programme. In the malaria prevention and control package, the findings show that the Insecticide Treated Mosquito Nets (ITNs) is not adequate to protect households being caught by malaria. It has been also widely observed that people utilise ITNs for different unintended purposes in the study areas. As to the family planning services, households resist to use family planning methods for a number of reasons such as religion matter. Moreover, evidences show that the current family planning fall short of communities' needs and expectations. Health posts and basic health service kits have been lacking for Health Extension Workers to fully serve the communities. On the other hand, Health Extension Workers also lack basic skills and knowledge to render quality health services. In the implementation of health education and communication package, sufficient time has not been allocated for it in study areas.

Facilities such as construction of health posts and supply of equipments, medicines and supplies, strong health education and communication, alternative finance rising instruments to supplement operational budget, integrated refreshing trainings for Health Extension Workers, development of guidelines on the promotion, transfer, continuing education, salary increment are some of the major recommendations put forwarded.

Chapter One

1. Introduction

1.1. Background of the Study

Ethiopia is an ancient country with diverse cultures and people but it has remained backward in social-economic, technological and political development. Conventional heath parameters such as infant and maternal mortality and morbidity from communicable diseases, malnutrition and average life expectancy place Ethiopia among least privileged nations in the world (MoH, 1993: 21).

Ethiopia has extremely poor health status relative to other low-income countries, even within sub-Saharan Africa. This is largely attributed to preventable infectious ailments and nutritional deficiencies. Widespread poverty along with general low income levels of the population, low education levels (especially among women), inadequate access to clean water and sanitation facilities, a high rate of migration, and poor access to health services have contributed to the high burden of ill-health in the country. This situation is further aggravated by the high population growth (MoH, 2002: 4).

Towards the end of the Imperial period a comprehensive health services policy was adopted through initiatives from the world health organization (WHO). However, the dawn fall of the regime precluded the possibility of putting this scheme to the test. The 'Derg' regime that came into power in the mid seventies formulated a more elaborate health policy that give emphasis to disease prevention and control, priority to rural areas in health service and promotion of self reliance and community involvement. But in practice the totalitarian political system lacked the commitment and leadership quality to address and maintain active popular participation in translating the formulated policy into action. Therefore, in health as in most other sectors, in both of the previous regimes there was no meeting ground between declaration of intent and demonstrable performance (Ibid: 21-22).

It seems being cognizant of these prevailing health problems and their consequences that the present Ethiopian government has developed and implemented a comprehensive health policy just after its seizure of power. Since then, encouraging changes have been observed in terms of heath posts, health centres, number of health professional graduates, etc in the country though there have been a number of recorded challenges during the implementation of health sector reform programmes (MoH, 2004).

Having recognised the severity of prevailing health problems and emerging diseases, Ethiopia government has developed and implemented Health Sector Development Programme (HSDP) since 1997/8 (1990 E.C). The first phase of HSDP was completed in 2002(MOH, 2005). Despite the gains that were made in the implementation of HSDP I, it became clear that basic health services had not reached those in need, owing to lack of primary health care (PHC) services at the community level. In the past, public health financing gave priority to the curative sector. This led to a considerable increase in the number and health facilities, but with limited rates of utilization, partly because of lack and physical access. Therefore, in response to the country's health problem that government introduces "Accelerated Expansion of Primary Health Care Coverage" and Health Extension Programme (HEP). The new health policy focuses on providing quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach all segments of population, with special attention to mothers and children. The policy has a particular emphasis on establishing an effective and responsive health delivery system for those who live in rural areas (MoH, 2007: 2).

[Health] extension programme (HEP) is a defined as a package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of PHC, it is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom (Ibid: 3).

The main objective of HEP is to improve access and equity to preventive essential health interventions provided at village and household levels with focus on sustained preventive health actions and increased health awareness. It also serves as effective mechanism for shifting health care resources from being dominantly urban to the rural areas where the majority of the country's population resides. Therefore, HEP is considered as the most important institutional

framework for achieving the MDGs in health sector (http://cnhde.ei.columbia.edu/files/, accessed on 12 December 2009).

Accordingly, Goro and Weliso woredas have been executing HEP as per the national HEP implementation guide prepared by ministry of health. There are some indications in the front compound of health offices witnessing that the woredas health offices have strived to render quality health services to the public. For instance, each woreda's health office has bulletin board at their gate with vision and mission written on it. The woredas' health offices have written the statement 'creating healthy and productive citizens' as their vision. Their mission statement has included major activities to be discharged being collaboration with stakeholders or not in the due course of health service delivery process such undertaking research, modernising health service delivery system through strengthening the supply of medicines and equipments, giving concerted on time responses to communities' needs, etc. The mission statement has also included principles of good governance in provision of health services to bring tangible improvements in the health status of their respective communities albeit their efforts have been constrained by a range of factors.

An innovative programme, health service extension programme (HSEP) is introduced as one of the key components in Ethiopian's health sector development programme (HSDP II). Health extension programme has the following major packages and in turn each package has other sub-packages. The main packages are Diseases Prevention and Control; Family Health; Hygiene and Environmental Sanitation; and Health Education and Communication. Diseases prevention and control consists of HIV/AIDS and other sexual transmitted infections (STIs) and TB prevention and control; family health is composed of maternal and child health, family planning, immunization, nutrition and adolescent reproductive health. Excreta disposal, solid and liquid waste disposal, water supply and safety measures, health home environment, control of insects and rodents and personal hygiene constitute hygiene and environmental sanitation package of health extension programme (MoH, 2005).

1.2. Problem Statement

Government has been mobilising much resources for the development and implementation of health sector reform policies. Thus, the design and execution of health extension programmes aimed at improving the health conditions of the citizens especially those residing in rural areas has become a timely issue and been given priority in the health sector development agenda(MoH, 2005).

From the outset of the implementation of health sector development programme particularly health extension programme, there have been a range of hurdles impeding the effectiveness and efficiency of HEP. Generally, a number of challenges have been encountered from the beginning of HEP implementation in the country:

- The practical training of health extension workers (HEWs) particularly on skilled delivery and key clinical skills had deficiency due to limited facilities for large number of trainees.
- There are no clear guidelines for working relationship between HEWs and other community based health workers (CBHW) trained previously such as Community Health Agents (CHA) and Trained Traditional Birth Attendants (TTBA).
- Guidelines were not ready from the beginning on transfer, leave of absence and career structure (http://cnhde.ei.columbia.edu/files/, Accessed on 12 December 2009). Health extension workers had lower competence in interventions related to skilled delivery and some curative services including malaria control and acute respiratory infection (Argaw, 2007).

Government objective is to attain users' satisfaction in delivering health services by making health service close to the households and families. The implementation of HEP in the areas of the study however has been constrained by a number of obstacles which have been discussed as follows:

In the study areas, a variety of problems have been observed in the execution of HEP such as complaints from the clients i.e. they have complained that they have not been given adequate Insecticide Treated Mosquito Nets (ITNs), HEWs have not treated clients fairly, for instance,

they have selected few households with a criteria that most of people did not know and they have spent much of their time serving these households. HEWs have lived in urban areas due to the fact that there were no housing facilities in their working places and this affects their long stay in the kebele they have been assigned to. Unavailability of furnished working centres/health posts/, absence of transportation means and other health service equipments and supplies were other problems noticed.

Maximising communities' involvement through intensive health education and communication has been given much emphasis in the due course of HEP implementation. However, observations show that households have used ITNs cutting it into different pieces for covering hairs, cereals, making rope, etc. In addition, households have not welcomed well family planning for various reasons such as spread of misperceptions about family planning and religious matters.

There has been a mismatch between the number of HEWs and the number of households they are supposed to serve. This is to say that HEWs have been so overloaded that they could not reach each and every households going house to house on foot given the scattered settlements of people in the locality (interview conducted with HEWs).

In the two woredas, there have been irrigation facility and manmade ponds constructed for agricultural development but unfortunately they have been found challenging in time of malaria prevention and control endeavors. There have been also identified wide marshy areas in woredas posing difficulties in clearing mosquito breeding sites.

In addition, transportation problems, remoteness of some kebeles to reach, logistic and supplies problems and shortage of skilled manpower were identified challenges in the implementation of HEP (Goro woreda health office, Annual report, 2000 and Weliso woreda health office, annual report, 2001).

In spite of the prevailing problems, no reliable and consistent research has been conducted in the woredas except some assessments undertaken at national level. Therefore, assessing and analyzing the status of health extension programme, achievements recorded, monitoring and evaluation instruments used, changes in clients' knowledge, skills, and behavior, challenges encountered in the two woredas by comparison is found to be timely and critical.

1.3. Objectives of the study

1.3.1. General Objectives

The general objective of the study is to assess the challenges and achievements of HEP and to suggest possible courses of action to be taken to improve the performance of the programme.

1.3.2. Specific Objectives

- To examine the fulfillment of necessary conditions by scrutinizing the construction of health posts, supply of required equipments and supplies, transportation and communication means
- To assess the comparative achievements of goals and targets by the HEP in the woredas
- To identify and analyze obstacles/challenges faced in the implementation of HEP in the woredas
- To measure the extent to which HEWs are committed and competent to assist the clients in the woredas in the comparative view
- To examine the monitoring and controlling mechanisms to improve the programme and
- To suggest feasible remedies that can be taken based on the findings of the research.

1.4. Research questions

The following questions shall guide the research:

- What necessary conditions have been fulfilled? What achievements have been gained by the implementation of HEP in the woredas?
- What challenges have been encountered in the implementation of the packages in the two woredas?
- To what extent HEWs are committed and qualified to provide quality health services in the areas?

- What means/mechanisms/ are available to get better the performance of HEP in the woredas?

1.5. Significance of the study

This research plays important roles as it gives better information about the performance and challenges encountered during the execution packages concerned. The followings are some justifications for the significance of the research:

- The findings would give better insights into the performance of the packages and existing and potential problems of the packages
- The results would help politicians, administrations, NGOs. health offices and other parties concerned with health extension programme in making decisions to improve the future performance of the packages
- The research would be used as an input for further scientific research in the field
- The findings would be reviewed to make generalizations as to the performance of HEP in other districts having similar social, cultural and economic backgrounds.

1.6. The scope of the study

Scope of the study entails demarcating the research so that the researcher deals with particular things within the boundary not with those outside the boundary. Health extension programme is composed of a number of packages within it. But because of financial, time, manpower resources constraints, the researcher has focused on examining the achievements and challenges of packages of the programme - malaria prevention and control, family planning, and health extension education and communication packages. The research has been conducted at two woredas of South West Shoa Zone of Oromia Regional State i.e. Goro and Weliso woredas. The period of study covered from the year 2004/5 onwards (the beginning of the implementation of the programme).The research took one year for the study, i.e. the 2009/10.

1.7. Limitations of the study

In the due course of the study, in one way or another way, multi faceted problems have been encountered. The problems have been presented as follows:

- Some households had low understanding to articulate what they experienced with the programme implementation and this affects the quality and adequacy of the data given.
- It was found difficult to get HEWs, supervisors and health office administrators as per appointment schedule and some were also reluctant to cooperate. Thus, gathering data took much time than what was planned.
- It was also problematic to obtain sufficient recorded secondary data on the performance of the programme in the study areas.
- The study focused only a few components of HEP. However, Better insights into the implementation of HEP could be gained if the overall components of HEP were considered.

However, all efforts and measures were taken to minimise the effects of these variables on the quality of the research.

1.8. Justifications of the selection of the study areas

Goro and Weliso woredas were purposely selected for the research case study. The reasons are:

- The two woredas have been implementing HEP but their own limitations
- The researcher has living experience that would help in acquiring relevant data
- The woredas are adjacent in location which was convenient for the researcher

1. 9. Research Methodology

This part describes and justifies type of research methods used, sources of data, and instruments of data collection and methods of data analysis.

1.9.1. Research Methods

The research has aimed at evaluating the program, identifying and describing challenges encountered in the due course of HEP implementation, the adequacy of the packages and achievements recorded measured in terms of goals, objectives and targets predetermined.

Based on the above stated aims of the research, the researcher employed predominately descriptive and evaluative research methods for they were more appropriate than other methods at addressing the goals of the research.

1.9.2. Study Population

Study population is the aggregation of elements from which the sample is actually selected. The study population included residents of the two woredas, health extension workers, health extension programme supervisors and the two woredas' health office administrators.

1.9.3. Sampling Frame

It is the actual list of sampling units from which the sample is selected. The sampling frame for the residents is the list of households from health extension workers/health posts considered for the study. The sample frame for heath extension workers is their list from woreda heath office. The sample frame for health extension programme supervisors is their list from their respective woreda health office. The sample frame for woreda health office administrators is their list from his/ her respective unit of administration.

1.9.4. Sampling Design

Because of some constraints such as manpower and cost, it is difficult to reach all elements of the study population. Therefore, it is necessary to use appropriate sampling technique/s to ensure the requisite size of sample is selected so that the selected sample will be sufficiently representative of the population about which generalizations to be made. Because it was found difficult to get the accurate size of the population and list of elements for service customers (residents), the researcher has employed stratified multi- stage cluster sampling.

The kebeles of Weliso and Goro woredas have been stratified into 37 and 19 rural kebeles respectively based on the administrative division of the two woredas. At the first stage, three (3) rural kebeles have been selected randomly using lottery system. Secondly, 25 households have been selected randomly from the six (6) kebeles chosen at the first stage irrespective of the kebele's population size. In all, 150 households have been considered as a unit of observation for both woredas.

Because of their important role in the implementation of HEP, all HEWs operating in the selected six (6) rural kebeles have been considered and additionally randomly selected six (6) HEWs from both woredas have become units of data collection. A total of 24 HEWs have been included in the sample.

Purposive or judgmental sampling has been utilised to select woreda health office administrators. At the end, Five (5) HEP supervisors have been randomly selected, one (1) from Goro and four (4) from Weliso woreda because of their unique position.

1.9.5. Sample Size

The sample representatives are categorized as follow in accordance with the study population.

No	Group	Sample size
1	Households	150
2	Health extension workers	24
3	Health office administrators	2
4	HEP supervisors	5
Total		181

1.9.6. Sources of Data

In search of pertinent information that answer research questions both primary and secondary data sources were identified and used.

1) Primary sources

The primary data sources are those sources that provide the researcher with first hand data. Those sources were the residents, health extension workers, health extension programme supervisors, and health office administrators. Moreover, direct observation by the researcher is put in use.

2) Secondary Sources

Second hand data has been sourced from both published and unpublished sources. Sources such as service reports, charts, survey report, letters, magazines, journals, books have been reviewed.

1.9.7. Instruments of Data Collection

1) Schedule/interview questionnaire

Based on the objectives/ purposes of the research and the fact that most of the residents were illiterate, semi-structured - schedule questionnaires were found to be reliable and valid instrument for obtaining original data from primary sources. The same instrument was put in use to obtain data from HEWs. A questionnaire consisting both close and open ended questions covering the demographic profile, the achievements and challenges of HEP execution was presented for client respondents. Similarly, a questionnaire including open and close ended questions focusing on the performance of the HEP was distributed to HEWs. It also covered demographic back ground of respondents. This instrument would also improve the return rate of the questionnaire.

2) Field Observations

Field observation was another important, reliable and valid instrument used for obtaining primary data. The researcher has made field visits to observe some manifestations such as construction of health posts, distribution of insecticide treated mosquito nets, etc.

3) Interview

Structured and non structured interview was conducted with health office administrators and HEP supervisors to get information to supplement and complement the data acquired through other instruments (Appendix three).

4) Document Review

Review of service report, charts, survey report, letters, magazines, journals, books was conducted.

1.9.8. Data Analysis Instrument

The collected data was edited, coded, classified and tabulated for making meaningful analysis. Since the purpose of the research was primarily to describe the performance of government intervention i.e. HEP achievements and challenges, descriptive methods have been employed. Descriptive methods such as tables, diagrams and percentages were extensively employed to describe the patterns observed in the collected data and for making appropriate interpretation. Qualitative analysis was also put in use for analyzing and interpreting qualitative data.

1.10. Organisation of the Thesis

The thesis has been logically arranged into five chapters. The first chapter has covered the introduction part which included background of the study, problem statement, objectives of the study, research methodology, data analysis, etc. The second chapter has consisted of related literature review as to health extension program. The third chapter has dealt with data discussion of respondents' response based on response categories made. In chapter four, data interpretation and analysis on the performance of HEP in the study areas have been made. The finally, major findings, conclusions and recommendations are found in chapter five.

Chapter Two

2. Literature Review of the Theoretical Framework on the Implementation Contexts of Health Extension Programme

The literature review part covers the literature studies involving the theoretical frameworks by which the overall research tasks governed and other researchers' work in the area.

The literature studies address the conceptual and operational definitions of basic concepts and terms, the review of intervention areas of health extension programme packages, objectives and targets of the programme and implementation strategies. Heath extension programme component, principles, progress indicators and heath sector development programme will also be thoroughly and critically studied. Moreover, the chapter covers other researchers' work in the field. All the materials to be reviewed are relevant for the research on hand.

2.1. Definitions of Basic Concepts and Terms

The Ethiopian government has been exerting much effort to the health sector performance. To upgrade its citizens' health status, it has developed and is implementing a series of health sector development programme (HSDP). And it introduced health extension programme as a part of HSDP to ensure accelerated expansion of health care which has focused on health promotion, preventive and curative health care services. Definitions of some basic concept and terms are given as follows:

- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (www.who.int, Accessed on 13 December 2009).
- Health extension programme (HEP) is defined [as] package of basic and essential promotive, preventive and selected high impact curative health services targeting households --- (MoH, 2007: 3).
- Health promotion is the process of enabling people to increase control over, and improve their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions (www.who.int/topics, Accessed on 13 December 2009).

- Health education is the profession of educating people about health. Areas within this profession encompass environmental health, physical health, social health, emotional health, intellectual health, and spiritual health (en.wikipedia.org, Accessed on 13 December 2009).
- Malaria is a serious, infections disease spread by certain mosquitoes (www.answers .com, Accessed on 13 December 2009).
- Family planning is --- the use of various methods of fertility control that will help individuals or couples to have the number of children they desire an at a planned time interval in order to ascertain the well being of the children, parents and communities at large (MoH, 2004: 7).

2.2. Health Policy and Health Sector Development Programme (HSDP)

Having undertaken a critical examination of the nature, magnitude and root causes of the prevailing health problems of the country and awareness of newly emerging health problems, the transitional government of Ethiopia developed a comprehensive health policy (MoH, 1993: 22-23). It is founded on commitment to democracy and the rights and powers of the people that they derive from it and to decentralization as the most appropriate system of government for the full exercise of these rights and powers in our pluralistic society. It accords appropriate emphasis to the needs of the less privileged rural population which constitute the overwhelming majority of the population and the major productive force of the nation. It proposes realistic goals and the means for attaining them based on the fundamental principles that health, constituting physical, mental and social well-being, is a prerequisite for the enjoyment of life and for optimal productively (Ibid: 23).

2.2.1. General Policy

The policy includes the following broad areas:

- Democratization and decentralization of health service system
- Development of the preventive and promotive components of health care
- Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources

- Promoting and strengthening of intersectoral activities
- Assurance of accessibility of health care for all segments of the population
- Development of appropriate capacity building based on assessed needs
- Provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay
- Promotion of the participation of the private sector and nongovernmental organisations in health care (Ibid: 24-25).

To combat the serious health problems the nation has been facing, the government has given priorities for Information, Education and Communication (I.E.C to enhance health awareness and to propagate the important concepts and practices of self-responsibility in health, the control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions, provision of essential medicines, medical supplies and equipment shall be strengthened, etc (Ibid: 26-27).

2.2.2. Health Sector Development Programme (HSDP)

The Ethiopian government has formulated a series of health sector development programmes (HSDP I, II 1997-2010) in line with the plan for accelerated and sustained development to end poverty (PASDEP) and to achieve the health related millennium development Goals (MDGs) (MoH, 2007: 1).

The Health Sector Development Programme (HSDP), like the national health policy, is the result of a critical examination and an awareness of newly emerging health problems. Founded on commitment to democracy and to decentralization, it accords appropriate emphasis to the needs of the less privileged rural population which constitute the over whelming majority of the population and it proposes realistic goals and the means for attaining them --- (MoH, 1998: 1).

Health Sector Development Programme I (HSDPI) (1998-2003)

The health sector development programme was launched in 1998 in response to prevailing and newly emerging health problems in Ethiopia and in recognition of weaknesses in the existing health delivery system (MoH, 2002: 9).

HSDP was made up of eight components for budgeting and implementation purposes of which health delivery and quality of care with the objective of increasing the coverage and quality of promotive, preventive and curative activities was one (MoH, 1998: 15-20).

Despite the gains that were made in the implementation of HSDP I, it became clear that basic health services had not reached those in need, owing to lack of primary health care (PHC) services at the community level. In the post, public health financing gave priority to the curative sector. This led to a considerable increase in the number of health facilities, but with limited rates of utilisation, partly because of lack of physical access. Evaluation of HSDP I also revealed constraints in the availability of trained, high-level health professionals (MoH, 2007: 1-2).

Health Sector Development Programme (HSDP II) (2002/03 -2004/05) and HSDP III (2005/6-2009/10)

As in phase 1 of HSDP, the components of HSDP II remain the same except under HSDP II; there is one additional component, the health extension programme. The overall objectives remains the same to increase the coverage and quality of promotive, preventive, curative and rehabilitative services and the design aims to address the problems and challenges identified during the evaluation of HSDPI (MoH, 2002: 25).

Having considered the past gains and challenges in the process of the phase I HSDP implementation, the sector has realized that essential health services have not reached the people at the grass-root levels as envisaged in phase I of the HSDP. The government of Ethiopia has therefore decided to introduce an innovative community based approach aimed at creating healthy environment as well as healthful living by introducing a health service delivery and quality of care (HSD &QC) (Ibid: 25). The Health Extension Programme (HEP) is innovative community based programme introduced [and] started in 2003 during HSDP II (Aregaw, 2007: 7).

The main objective of health extension programme is to improve equitable access to preventive essential health intervention through community/ kebeles/ based health services with strong focus on sustained preventive health actions and increased health awareness (MoH, 2005: 2).

Health care is one of the crucial components of basic social services that have a direct linkage to the growth and development of a country as well as to the welfare of a society. Effective planning and implementation of health services requires mobilisation of the collective efforts of the relevant national and international organisations. One of the mechanisms to ensure this collaboration is harmonisation of health policies, strategies and implementation modalities with national and global perspectives of health service delivery. As a result, HSDP III has been developed and implemented in sector wide approaches within the context of the national and international policy environments (MoH, 2005: 35).

HSDP is the main medium of translating the health component of the PASDEP with minimum targets more or less similar with the millennium development goals (MDGS). As three of eight MDGS are directly related with health sector i.e. reduction of under -5 mortality by two third and maternal mortality ratio by three-fourth as well as halting and reversing the spread of HIV/AIDS and other epidemics such as malaria by 2015.

The formulation of HSDP III needs to focus on the prevention and control of poverty related diseases through the adoption of innovative and practical strategies to enhance the achievement of the MDGS. The analysis of the current health situation in Ethiopia clearly shows that reaching the MDGS implies not only a dramatic scaling up of key services, but also implementation of mechanisms to ensure adequate and efficient utilisation of the mechanisms to ensure adequate and efficient utilisation of the services by the whole community particularly by the rural population, the poor women and children. In order to materialise this, high impact and community based health interventions like the Health Service Extension Programme (HSEP), accelerated expansion of primary health care facilities and health service package became important (Ibid: 36).

2.3. Health Extension Programme (HEP)

Based on the concept and principles of primary health care (PHC), it is designed to improve the health status of families, with their full participation, using local technologies and the communities' skill and wisdom. HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facility- based services. The

philosophy of HEP is that if the right knowledge and skills are transferred to households they can take responsibility for producing and maintaining their own health (MoH, 2004).

To provide coverage for the whole country, the government has decided to accelerate the implementation of the HEP by training and deploying 30000 health extension workers (HEWs) and it was planned that by 2009, each kebele would have a health post which would be the operational centre for two HEWs, who would be responsible for providing outreach services. Construction of health posts and training of HEWs are being accelerated to reach these targets (MoH, 2007: 3-4). At community level, in addition to HEWs, there are community based reproductive health agents to supplement government health workers' outreach by providing primary health services, increasing community knowledge and offering immediate access to reproductive health services, including HIV/AIDS prevention and care. Community- based reproductive health agents are recognised to be the ' backbone' of the reproductive health system in Ethiopia particularly given recent arrangement of being they are supervised by newly deployed health extension workers. ...currently, community-based reproductive health agents (CBRHAs) are an integral part of the health delivery system in Ethiopia, a predominantly rural country with limited health service access (Andreea et al., 2007).

HEWs are responsible for explaining and promoting health extension components such as disease prevention and control, family health, hygiene and environmental sanitation and health education and communication at community level (MoH, 2000: 11).

2.3.1. Malaria Prevention and Control

Literature review reveals that malaria is the number of one public health problem in Ethiopia and accounts for major cause of illness and hospitalization (Wakgari et al., 2006).

Malaria in Ethiopia has different names in different languages. This obviously indicates the extent of the spread of the deadful disease that had long lived with people. Malaria is an old and long standing disease in Ethiopia. Seventy five percent of the land area of the country is considered to be either malarious or potentially malarious, and about sixty five percent of the populations in these areas are at risk of infection (MoH, 2004). Moreover, Since malaria is a killing disease and rampant in highly endemic areas, parents desire to have more children to

replace the ones they lose, or to guarantee atleast one surviving heir or one surviving child into the parents' old age(18). Based on these assumptions, it is possible to be accompanied with high population growth rate in epidemic –prone and intense malaria transmission areas (Wakgari et al., 2006).

Malaria is a disease caused by a parasite known as plasmodium that lives and feeds on red blood and liver cells. The parasites are identified by microscope. There are four types of malaria plasmodium species that develop and proliferated in human body and cause the disease. These are: Plasmodium Falciparum, Plasmodium Vivax,Plasmodium Malariae, Plasmodium Ovale. [These] different malaria plasmodium species have different physical shapes, development processes and life cycles, life span, level of severity, specific nature of frequency of relapses of the disease, varied level of effectiveness of anti-malaria drugs and the degree of disability they cause. Plasmodium falciparum and plasmodium vivax are the most commonly encountered human parasites in Ethiopia (ibid). Plasmodium vivax malaria is the most geographically wide-spread and the second prevalent cause of malaria globally. Ethiopia has the highest proportion of plasmodium vivax malaria on the continent, accounting for approximately 40%of all infection in the country. Chloroquine is the first treatment for confirmed plasmodium vivax malaria in the country. Nevertheless, chloroquine – resistant plasmodium vivax parasites are emerging in Debre Zeit, Ethiopia. This indicates a need for regular monitoring of the pattern of resistance to ant malaria drugs in the country (Hiwot et al., 2008).

Malaria is transmitted from man to man only through the bite of female anopheles mosquito. The female anopheles mosquito needs blood for the development of its eggs. When the female anopheles mosquito bites a malaria sick person it draws blood and with it the malaria plasmodium species. These species develop and mature in its stomach in 10-12 days. The malaria mosquito often breeds and develops after the rainy seasons in stagnant water in ponds, ditches and collections on the ground. --- The malaria mosquito has the capacity to fly about two kilometers distance from its breeding place to bite human beings (Ibid: 9-10).

2.3.1.1. Objectives and Indicators for Progress of Malaria Prevention and Control Package

Objectives

To increase awareness, knowledge and skills of the communities on the transmission, prevention, and control of malaria, to motivate, enhance, and promote participation of the communities in the prevention, control of malaria and suppress malaria epidemics, to reduce the number of cases and deaths due to malaria, to motivate and educate the communities for examination and treatment of malaria are major objectives to be realised through the execution of malaria prevention and control package and the performance (progress) of the package gauged in terms of :

Number of people who participated in health education session, number of mosquito breeding sites clearing sessions planned and implemented, total number of unit structures sprayed and re-plastered before six months after spraying, Number of households in village with one, two or more Insecticide Treated Mosquito Nets (ITNs) and percentage of pregnant women and children under five years sleeping under ITNs (MoH, 2005: 35).

2.3.1.2. Malaria Vector Control Methods

The effects of land use comprising of water impoundment schemes, irrigation schemes, deforestation, agricultural development, road and hydro-electric power construction in malarious areas result in ecological disturbances that exert considerable influence on the proliferation of breeding sites, resulting in high malaria transmission. Changes in land use followed by variations in climatic conditions singly or in combination have been incriminated by increase in morbidity and mortality from a number of parasitic diseases like malaria (Wakgari et al., 2006). Malaria transmission varies among communities largely due to environmental factors, such as proximity to breeding sites. Many water resources development and management projects result in local outbreaks of malaria ... These outbreaks can be attributed to an increase in the number of breeding sites for mosquitoes, an extended breeding season and longevity of mosquitoes,

relocation of local populations to high-risk reservoir shorelines and the arrival of migrant populations seeking a livelihood around the newly created reservoirs (Yewhalaw et al., 2009).

A. Environmental Management

Water is essential for the breeding of malaria mosquitoes. To ensure the prevention and control of malaria, it is important that all temporary or permanent breeding sites with water are identified and eliminated through active participation of communities. This can be achieved in areas where only limited number and fully identified breeding sites exist. The Following measures can be implemented in potential mosquito breeding sites to prevent and control sites:

- Clearing of water bodies, filling and leveling burrows and pits
- Drying up swampy and marshy areas by making drainage and planting trees
- Clearing grass or weeds in irrigation ditches
- Water containers inside and outside the households such as pots, wells, etc shoved be covered
- Cleaning and clearing ditches (MoH, 2004: 33).

B. Larvicides

Water collections that cannot be managed by environmental control measures can be dealt with larvicides. The success of larvicides depends on the identification of all mosquito breeding sites and their distribution in the entire potential areas and followed by weekly spray of chemicals.

The most common water soluble chemical used in our country is temephos (Abate). Temephos is safe for human and therefore it can also be applied to drinking water. Considering the expensiveness of the chemical , the need of spray equipment and human resource it should be applied only for small breeding sites and only if control measures are inapplicable in places such as cities, low lands and agriculture development with irrigation system (MoH, 2004).

C- **Indoor Residual House Spraying**

In door residual house spraying is the most widely and commonly used chemical method for vector control in anti malarial programme. The aim of the residual house spraying is to spray the sprayable surface of all individual houses (e.g. walls, floors, etc). when the mosquitoes rest on the sprayed walls, the chemical enters their body through the surface of their legs and intoxicate them, there by drastically shortening their longevity, This way the mosquitoes will not able to live long in frequently sprayed walls to transmit the malaria parasites to human beings. The chemical spraying operation can be conducted once or more times in a year depending on the seriousness of the malaria epidemics; the intensity of the transmission and period; the length of the lasting period of the effect of the chemical etc. In door residual house spraying is conducted in many parts of Ethiopia before the small and big rains usually in February and June. The rational for selecting these periods is to prevent potential malaria epidemics that occur immediately after the rains as it is likely that a wide spread and numerous suitable mosquitoes breeding sites will exist (ibid).

D. Insecticide Treated Mosquito Nets (ITNs)

Many Countries have recently introduced Insecticide Treated Mosquito Nets (ITNs) as malaria prevention and Control Measure. It has been found to be very effective in the reduction of malaria and mortality in several of these countries. The INTs Protect from mosquito bites through repellent and knocking down effect of the insecticide used to impregnate the nets. In Ethiopia this method of control is new and there is limited experience and know how in the utilisation of ITNs, but promotive efforts are being made to create the necessary awareness in the Communities to use ITNs. Consequently, ITNs are available (e.g. size, shape, color, quality etc) in different types (MoH, 2004: 38). The African region south of the Saharan is heavily affected by malaria. Ethiopia is among the 30 high burden countries in malaria infection and contributed to 6% of the malaria cases in Africa. The use of Long- Lasting Insecticide Treated Net (LLITN) is one the major components of selective vector control strategy in Ethiopia. LLITN distribution in Ethiopia primarily focuses on households with children less than five years of age and pregnant women in targeted areas. Low awareness about malaria and utilisation of the preventive methods are the serious challenges of malaria control programme in Africa and Ethiopia. The

level of knowledge and the use of LLITN in Ethiopia is a very low. According a research conducted in Gilgel Gibe, south-west Ethiopia, only 25%of under –five children slept under LLITN the night before the survey. It was observed that many mothers in the study area had used LLITN for scarves and bed sheets to prevent louses and fleas (Deribew et al., 2010).

2.3.2. Family Planning Extension Package

Family planning is --- the use of various methods of fertility control that will help individuals or couples to have the number of children they desire at a planned time interval in order to ascertain the well being of the children, parents and communities at large (MoH, 2004: 7). With a population of about 77 million in mid 2007, Ethiopia is the second most populous country in sub- Saharan Africa. The population is increasing at a rate of about 2.5% per annum while the fertility rate is 5.4% per woman. Like many other African countries, Ethiopia has so far shown little change in fertility. Among the nine regional states and two city council administrators under the Federal Government of Ethiopia, Oromia Region has the highest fertility rate of about 6.2% children per woman while Addis Ababa has a below replacement level of fertility of 1.4% children per woman (Yohannes, 2009).

After the National Population Policy was officially launched in 1993, the National Population Information, Education and Communication (IEC) and Advocacy strategy was also adopted and has been implemented since 2000. However, in the due course of implementation, evidences of monitoring and evaluation have indicated that application of strategy is inadequate and in some cases need updating. In the due course of population communication strategy, audience segmentation and multimedia approach have to be practised by implementing partners in the treatment and dissemination of population messages. It is through this approach that one could develop relevant materials to target audience and be able to change attitude and behaviours in the course of intervention (Ministry of Finance and Economic Development, 2009).

2.3.2.1. Benefits of Family Planning Services

Family planning has many benefits for mothers, children, family and the country at large. It would enable mother or family to have desired number of children, prevent serious illness and deaths that occur during delivery, opens for mother opportunities to participate in development

activities. Children also benefit from family planning by the way of that they get adequate care and affection from their families; they would have better chance of getting basic social services such as education and health services. Moreover, country's development would be fostered. If the utilisation of family planning services is increased, excessive population growth is prevented, women participation in the development endeavors would be realised. Government shall also have better capacity to make basic services accessible the whole segments of the population (MoH, 2004).

2.3.2.2. Objectives and Indicators for Progress of Family Planning

Objectives

In the execution of family planning package, increasing the awareness, knowledge and skills on the use of family planning, motivating and helping women to increase utilisation of family planning services, ensuring community opinion and religious leaders and promoting active participation of males in the use of family planning programme are the major objectives identified where as number of community members who received information on the family planning services and can tell the potential risks of unsafe abortion, number of households who became user of the family planning programme, number of women who use contraceptives, number of males who participate in the family planning programme, number of family defaulters and motivation and mobilization of opinion leaders to promote the use of family planning set as indicators for progress (MoH, 2005: 33).

2.3.2.3. Types of Family Planning Services

I. Natural /Traditional/ Contraceptive Methods

Natural /traditional/ method which prevents pregnancy includes breast feeding, calendar method, abstinence method and withdrawal of [male's genital/ penis before ejaculation]. The uses of these natural methods do not implicate medicines or prevent mechanical devices (MoH, 2004).

II. Modern Contraceptive Methods

Demographic research has shown that socio- economic and cultural factors influence fertility through biological and behavioural mechanisms such as the use of contraception, which has a direct effect on fertility. But contraceptive use, which plays the major role in influencing fertility is very low in Ethiopia. As of 2005, only 14.7% of married women in the country and 13.6% in Oromia Regional State used any method of contraception. As a result, of the low contraceptive prevalence, many women of reproductive age who want to stop or postpone child bearing are not able to do so; and hence there is a high unmet need for contraception in Oromia Regional State estimated at 41.5% in 2005. Women fertility intentions are influenced by various demographic, socio-economic and programme factors such as the age of women, number of living children, place of residence, education and exposure to media as well as by couple's experiences with child mortality and expectations about child survival conditions and their preferences for a single sex usually son (Yohannes, 2009).

Combined oral contraceptive pills

Combined oral contraceptive is prepared from two hormones namely estrogen and progestin. This contraceptive is the first among the most commonly used methods in Ethiopia. Combined oral contraceptive prevents pregnancy by preventing ovulation; thickening cervical mucus making it difficult for the sperm to pass through; making the lining of the uterus too thin for the fertilized egg to implant itself making it difficult for further development. The effectiveness in preventing pregnancy is high with the exception that, the pill needs to be taken every day and inconsistent or incorrect use raises risk; it is not also used for preventing sexually transmitted diseases including HIV/AIDS (MoH, 2004).

Emergency contraception is a combined oral contraceptive pills that women can use to prevent pregnancy expected from unprotected sexual intercourse, [when a woman is rapped or forced for sexual intercourse]. However, it should be underlined that the use of such method is only limited to unprotected sexual intercourse, but is never for regular usage. Emergency contraceptive pills inhibit or delay to prevent fertilisation (ibid).

Single drug oral contraceptives

These are oral contraceptives pills that are formulated only from progestin. The content of progestin in the contraceptive pills is less than what is contained in the combined oral contraceptive pills. It has the advantages that it has more advantage for breast feeding mothers; it prevents infection of the uterus; it does not aggravate blood pressure although it has some problems such as irregularity of menstrual cycles, more menstrual bleeding, and stops the running of the usual menstrual cycles (MoH, 2004).

Male condom

Condom is plastic material that men wear over the erect penis just before sexual intercourse in order to hold the sperm and prevent it from spilling in the vagina. Condom is made from thin plastic called latex. Condom prevents pregnancy as well as sexually transmitted diseases including HIV/AIDS. Condoms are often lubricated inside and on the surface and contain sperm cides that kill sperm cells in order to prevent possibility of pregnancy in the case the condom breaks or semen escapes or leaks by accident. Similarly, bacteria and viruses do not escape through the condom unless it is broken, but if it breaks the sperm cides will kill them as well. Condom is effective to prevent pregnancy and sexually transmitted diseases if it is used properly, not exposed to sun, or other type of heat (MoH, 2004).

Female condom

Female condom is one method to prevent pregnancy. The condom is inserted into the vagina and is only used for one time sexual intercourse. It is made from plastic material and has flexible rings at both ends. The condom serves as a physical barrier to prevent sperms from meeting the woman's eggs. It is one of effective alternatives for preventing pregnancy with one major drawback i.e. its cost is very expensive (ibid).

Injectable contraceptive

This contraceptive is injected deep into the muscle and its formulation is a single inject able contraceptive. The contraceptive contains progestin. In Ethiopia the commonly used contraceptive is the one injected every three months.

The method has strong sides as it unlike oral contraceptives, there is no risk of users forgetting the contraceptive; it is a better option for users that do not want permanent prevention from pregnancy as well as do not want to have more children albeit the method has some weaknesses such as it initiates prolonged heavy vaginal bleeding; increases weight; delays return to fertility for about 6-12 months after stopping (MoH, 2004: 48).

All the above briefly mentioned traditional and modern contraceptives are those that can be provided by health extension workers (HEWs).

2.3.3. Health Education and Communication

Ethiopian people suffer from many health problems, the major ones being infectious diseases, which emanate from poor sanitary conditions, nutritional deficiencies, harmful health practices, etc. These health problems are caused by [inappropriate] lifestyle, harm full health behavior, attitude and practice (MoH, 2004: 2). These situations indicate that sufficient and relevant information, education and communication must be given high attention to bring about positive changes in the knowledge, attitude and behavior of the communities.

Information, education and communication (I.E.C) of health [has] been given appropriate prominence to enhance health awareness and to propagate the important concepts and practices of self-responsibility in health (MoH, 1993: 26). Health education is an important component of health work that enables people to have right concept; develop positive attitude to bring about behavior change voluntarily, and consequently to be able to solve own health problems by own effort (Ibid: 7).

Health communication aims to improve health outcomes by sharing health-related information. The Centres for Disease Control and Prevention (CDC), 2000 and U.S department of health and

human services, 2005 cited in Schiavo (2007: 5) define health communication as "the study and use of communication strategies to inform and influence individual and community decisions that enhance health."

2.3.3.1. Principles of Health Education and Communication

In designing and implementing communication strategies and behavior change interventions, it is advisable to look into and apply certain principles, to enhance the effectiveness of communication intervention (MoH, 2004: 14):

- **Health education is not a onetime affair**: It is a continuing process based on planned and organized activities (MoH, 2004: 11). Heath communication is long term process that begins and ends with the audience's desires and needs. In health communication, the audience is not merely a target --- but an active participant in the process of analyzing the health issues and finding culturally appropriate and cost effective solution (Schiavo, 2007: 8).

- **Audience segmentation**: It signifies the need to focus health communication messages for specific target groups; health communication could be designed in a way that it is understood by the target population and contributes to the intended changes in behavior at individual, group or community level. Audience segmentation signifies identifying and defining the primary as well as the secondary audience for a specific health message.

- **Multi- strategy and multiple methods:** An effective communication intervention programme uses different strategies that increase participation, collaboration and entertaining education. There are no readymade strategies and methods that could be effectively applied universally to achieve the goal of behavioral change.

Strategies and methods need to be designed and developed in a way that could easily address the needs and requirements of specific localities.

- **Technology and research evidence-base:** Health communication uses technologies depending on the task requirement and audience analysis. It is important to know

which technologies are appropriate, available and accessible for a specific target groups.

- **Participation and empowerment:** Empowerment is enabling individuals or groups to make informed decisions and informed choice of behaviors. Individuals or community participation is not only necessary for programme accomplishments, but are also means of creating partnership and collective responsibility. Empowering people, both women and men would facilitate partnerships in health communication interventions (MoH, 2004; 14-16).

- **Situation analysis**: Health communication success is based on a true understanding not only of the intended audiences but also of the situational environment. Situation analysis involves analysis of individual, social, political, and behavior related factors that affect attitudes, behaviors, social norms, and policies about health issue, key audiences' characteristics, demographics, needs, values, attitudes, and behavior (Ibid: 25).

- **Health education programme** should be prepared and delivered in such a way to be informative, recreating, and attractive (Ibid: 12).

2.3.3.2. Objectives and Indicators for Progress of Health Education and Communication

Objectives

Health education has been undertaken to enhance the achievements of the following objectives:

- Provide correct and right health information and develop skills to take informed decision
- Enable the community to assess the situation, identify and prioritize health problems
- Create Community dialogue, guide, motivate, encourage and mobilize Communities for health actions

- Enhance sect oral collaboration and coordination among government sectors and other stakeholders

- Disseminate and explain relevant health and health related issues to the public and all concerned sectors (MoH, 2005: 47).

- Create a receptive and favorable environment in which information can be shared, understood, absorbed, and discussed by the programme's intended audiences (Schiavo, 2007: 8).

- Inform and educate the community and concerned influential persons for implementing the government policies and guidelines

- To enable the people to find solutions for their own health problems, encourage people to discuss openly and frankly, advise the people to utilize fully the available health services (MoH, 2004: 9-10).

Indicators for progress

- Pattern of change in knowledge, attitude and behavior of the community members (HIV/AIDS, TB, Malaria, family planning, etc use)

- Participation/ involvement of the community in the health extension package

- Total number of the community members who were exposed to health information and education programme

- Number of seminars /workshops organized/ to community leaders, other sectors, women and youth groups, school community (MoH, 2005: 47).

2.3.3.3. Health Education Communication Methods

Communication methods are methods in which we exchange ideas, feeling and information. Therefore, it is essential for the success of communicating health education messages. The way messages are communicated should be well chosen. Using more than one communication

method is more acceptable by the audience. It will be more acceptable if the messages are communicated considering the audience's level of education, culture, tradition, economic level, audience's age, sex, ethnicity and the communication is two-way with eye contacts. Methods of communicating health education can be explaining, storytelling, giving examples using posters, pictures, printed matter, electronic media (Radio, TV.), songs, music drama, dialogue, films exhibiting during holidays, etc. The following are the major methods of communication (MoH, 2004).

A. Person to person health message communication

This is the method in which the health extension worker communicates in person with community members. Person to person communication is useful in rural areas where mass media is not available. When person to person communication method is not included, the message will end up by being passing information without community participation. This method of communication in which the health extension workers exchange ideas and information with the community and individual about health development programmes is preferable. The advantage of this method is that it enables the health extension worker visit house to house, villages, sanitation facilities etc to discuss, exchange ideas and to get feedback immediately. It also creates opportunity to exchange ideas and feelings, for reaching to a common step for action. This method involves group discussion in which health extension workers communicate with two or more people and communication at a large meeting where whole kebele, village and the area people participate ((MoH, 2004).

B. Peer learning method

This a learning process in which people of similar age, sex, occupation, living condition, religion of the same are etc acquire health information, concept, attitude, exchange experience (ibid).

C. Traditional methods of communicating messages

Traditional method of communicating messages are such as songs, poems, printings on cloth etc are useful for communicating messages, recreating and informative ways. Especially good for

those who cannot read or write to enable them to grasp messages that needed to be communicated (ibid).

2.3.3.4. Theoretical Influences in Health Communication

Health communication is influenced by different disciplines and theoretical approaches some of the most important theories can be divided into behavioral and social science theories, mass communications theories, marketing and social marketing and other theoretical influences, including medical models, sociology and anthropology. For this research purpose, the researcher likes discussing behavioral and social science theories.

Behavioral and social sciences theories seek to analyze and explain how change occurs at the individual, community, or social levels. The following are some selected behavioral and social sciences theories.

A. Diffusion of Innovation Theory

The diffusion of innovation theory addresses how new ideas, concepts or practices can spread within a community or "society or from one society to another" (National Cancer Institute and National Institutes of Health, 2002, p 226 as cited in Schiavo, 2007: 33). The theory identifies and defines five subgroups on the basis of audience's characteristics and propensity to accept and adopt innovation (Beal and Rogers, 1960 as cited by Schiavo, 2007: 33): Innovators, Early adopters, early majority, late majority, laggards.

The overall premise of this theory is that change occurs over time and is dependent on the following stages: awareness, knowledge and interest, decision, trial implementation, confirmation or rejection of the behaviour.

It also observes that innovators usually decide much faster than any other subgroup on whether to adopt new behaviors and social practices (Beal and Rogers, 1960 cited in Schiavo, 2007: 34).

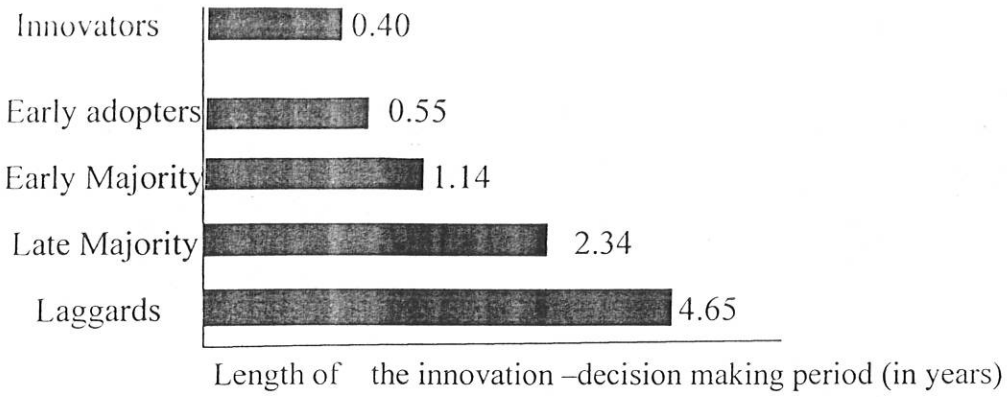

Figure 2.1: Attributes of the audience

Source: Schiavo, 2007: 34

The major contribution of the theory is its early audience segmentation model, which supports the importance of looking at intended audiences as a complex puzzle of different sub-groups, stages and needs that should be considered in developing communication messages and activities. The individual stage model provides a perspective on the time and the external conditions that are needed to achieve behavioral or social change.

A. Health Belief Model

The Health Belief Model (HBM) Stretcher and Rosen stock, 1997; Janz and Becker, 1984 cited in Schiavo (2007: 37) was originally intended to explain why people did not participate in programmes that could help them diagnose or prevent diseases. The major assumption of this model is that in order to engage in healthy behaviors, intended audiences need to be aware of their risk for severe or life threatening diseases and perceive that the benefits of behavior change outweigh potential barriers or other negative aspects of recommended action.

HBM has the following key components:

- **Perceived susceptibility:** The individual's perception on whether he/she is at risk for contracting a specific illness or health problem

- **Perceived severity**: The subjective feeling on whether the specific illness or health problems can be severe (For example, permanently impair physical or mental functions) or life threatening and therefore worthy of one's attention

- **Perceived benefits:** The individual's perceptions of the advantages of adopting recommended actions that would eventually reduce the risk for disease severity, morbidity, and mortality

- **Perceived barriers :** The individual's perceptions of the costs of and obstacles to adopting recommended actions(includes economic costs as well as other kinds of life style sacrifices)

- **Cues to action:** Public or social events that can signal the importance of taking action (for example, neighbor who is diagnosed with the same disease or a mass media campaign)

- **Self- efficacy**: The individual's confidence in his or her ability to perform and sustain the recommended behavior with little or no help from others (Schiavo, 2007: 38). The overall premise of the HBM is that knowledge will bring change. Knowledge is brought to target audiences through an educational approach that primarily focuses on messages, channels, and spokes people (Andereasen, 200: 1995 cited in Schiavo, 2007: 38). The major contribution of the HBM to the health Communication field is its emphasis on the importance of knowledge, a necessary but not sufficient step to change.

2.4. Health Extension Programme Implementation Strategy

As a major nationwide health Programme, HEP requires substantial investment in human resources, health infrastructure, and provision of equipment, supplies and commodities, as well as other operating costs.

I. Human Resources

Candidate of HEWs must be women aged 18 years or older with at least 10th grade education. HEWs will be selected from the communities in which they reside in order to ensure acceptance by community members. Selection committees are comprised of number nominated by the local community, representatives from the woreda health office, woreda capacity building office and woreda education office. Following selection, the HEW completes a one- year course of training

which includes coursework as well as field work to gain practical experience (MoH, 2007: 9). Health Extension review by Argaw (2007: 12) showed that HEWs being females, they could make a good role model for female children living in rural communities. Started in 2002/03; the plan was to train and deploy 30,000 HWEs and assign them in 15,000 kebeles by the end of 2000 E.C/ 2007/08) (Argaw, 2007: 11).

Assessment of HEWs training showed that the selection process was dominated by the Technical and vocational Education (TVE) sector with minimum involvement of the health sector, most trainees were selected from woreda towns (not rulal kebeles) and this could have a distortion effect in the future development of the HEP, the programme seems to have attracted trainees with much lower grades compared, for example, to those in the regular TVE programmes. Moreover, the teaching learning process suffers from the lack of text books, reference materials, inadequate practical demonstration facilities and a compromised apprenticeship programme with inadequate operational budget. Again, HEWs are bound to lack in a number of skills (http:// enhde.ei.columbia.edu/files/.

II. Construction of Health Posts

The operational centre of the HEP is the health post, which functions under the supervision of the woreda health office, kebele administration, with technical support from the nearest Health centre. Health posts are located at kebele level to serve a population of 5000 People (MoH, 2007: 10).

Health posts (HPs) will focus mainly on preventive and promotive aspects of health care i.e. promotion of healthful living and healthy environment; prevention of major infectious diseases and epidemics; mobilizing and empowering the community in health centres. Health centres (HCs) will focus on the provision of first line curative health care and technically support the HPs in their catchments area. Selected HCS will also provide emergency surgery service.

Hospitals will serve as the secondary and tertiary referral care centres to provide a wide range of services including surgery (district), specialists services (zonal hospitals) and sub specialists services (specialized hospitals they will also serve as higher training institutions for different categories of health works (MoH, 2005 : 42).

Assessment of Working Conditions of the First Batch of Health Extension Workers that conducted by Centre for National Health Development in Ethiopia at country level demonstrated that health posts were very far from administration supervisory bodies: Distance of health post (HP) kebeles visited varied from 1 hour to seven hours on foot from the woreda capital and therefore from the woreda health offices. Many HPs are accessible at least by dry weather roads while a number are only accessible on foot. Forty eight percent of the HPs were more than 10 km distance from the nearest HC/ clinic. In the context of poor transportation and communication systems, distance could have an important impact on logistic, monitoring supervision, referral and overall motivation of the HEW http://cnhde.ei.columbia.edu/files/, Accessed on 12 December 2009).

III. Procurement of Contraceptives, Medicine and Supplies

Health posts must be adequately provided with equipment materials and supplies required to deliver the different packages of essential services to the community. Medicines and supplies are procured and distributed to the health posts by the federal ministry of health, regional health bureaus and woreda health offices. Supplies are provided by health centres or woreda health offices to the heath posts (MoH, 207: 10).

Assessment of health extension conditions conducted by the Earth Institute at Columbia University national level shows that supplies situation seems erratic. Few HPs have no supplies at all. Where there are supplies: some major items drugs may be missing such as contraceptives, oral dehydration salt (ORS), anti- malaria, CoArtem in particular. Available drug may not be used by HEW because HEW do not feel competent to use them or are not allowed access to the drugs where there are senior health workers in the HP. Continuous availability of basic supplies, drugs and vaccine in particular, is defining criterion for the effectiveness, efficiency, acceptability and overall sustainability of health services extension programme (http://cnhde.ei.columbia.edu/files/, Accessed on 12 December 2009.

. IV. Monitoring and Evaluation

Monitoring and evaluation are integral and important components of the HEP and contain both technical and managerial purposes. Monitoring is the process of regularly reviewing

achievements and progress towards the goal. In this context, monitoring is the process of measuring, analyzing, and communicating information on the implementation of HEP for effective decision making at all levels. This helps to correct and improve the future planning process.

Monitoring and evaluation have to be built in to the programme from the outset as an integral part of planning process. Monitoring and evaluation requires health management information system to measure against objectives indicators and targets. The HEWs collect information with standardized reporting formats. The HEWs must keep accurate and timely records of their activities (MoH, 2007: 15-16).

Supportive Supervision

Supervision enhances to correct any constraints encountered in the implementation of the health service extension programme. Effective supervision requires team of experts with an appropriate skill mix, continuity among team members and strong management skills.

To ensure best quality of health service extension package programme, an ongoing in- service training, continuing education, regular supportive supervision; good supplies of materials are essential elements that are required. Supervision programmes shall be planned, scheduled, budgeted and conducted regularly.

The supervisory teams, whose members shall be drawn from several services units or professional expertise shall be designated from various organisation and administrative levels, in such a way that it is possible to see to the programme planning, implementation, monitoring le-vocation and fomentation of the health service extension programme(MoH, 2005: 12).

The steps for the work of HEWs [are] defined and starts by collection and documentation of basic data on the kebele. Besides addressing the whole public, the HEWs are expected to select model households and work with them. These are families considered to be innovative, and ready to change and influence community members.

The other function of the HEW is community package. This is regarding to the organisation of community for joint plans, and joint interventions related health such as environmental and water projects, drainage of swampy areas etc. The HEW uses all the available opportunity to educate and mobilize the community in this aspect. The HEW also mobilizes and uses other volunteers including Traditional Birth Attendant (TBA) and Community Health Agent (CHA) to deliver messages and to implement interventions. Also they are expected to train such volunteers and use them as assistants and promoters of health issues (Argaw, 2007: 9-10).

HEWs are required to spend seventy five percent of their time conducting outreach activities by going from house to house. During these visits, HEWs are expected to teach them by example (e.g. by helping mothers care for newborns, cook nutrition meals, construction of latrines and disposal of pits) (MoH, 2007: 12).

Conclusion

In this literature review part of this thesis, all possible relevant materials have been consulted so that the researcher has better understanding of the issues under study. To this end, in this section, an overview of health policy and health sector development programme of Ethiopia was made. Moreover, the theoretical foundations of health extension programme and its components have been dealt with. Finally, health extension programme implementation strategies such as human resource development, health post construction, monitoring and evaluation, supportive supervision, etc have been thoroughly discussed.

Chapter Three

3. Data Discussion on the Performance of Health Extension Programme

Chapter two briefed us with the theoretical aspects of the subject under study. In this chapter, background of respondents i.e. households, interviewees and HEWs have been presented. Again, the responses of households and HEWs on the issues raised have been discussed separately based on response categories established by the researcher. In other words, field surveys have been presented in brief.

3.1. Description of Study Areas

3.1.1. Description of Weliso Woreda

Weliso is one of the twelve woredas found in the south- west shoa zone. It is located at south west direction from Addis Ababa at the distance of 114 km on the way to Jimma or Wolkite. The woreda bordered by Bacho and Saden Soddo in the east, Wanchi and Amaya woredas in the west, Dawo and Dandi woredas in the north and Goro and Southern Nation and Nationalities in south (Weliso Information & Public Relations Office, WIPRO, 2010).

The woreda got the name 'Weliso' during the reign of Zewiditu in 1923 E.C from the leader called Aba Gada Weliso Liban of that locality.

The woreda has suiTable weather conditions for living and for the cultivation of variety of crops. Its dominant weather condition is 'Woyina Dega' which constitutes 91.7 percent while the remaining 8.3 percent is characterized by 'Dega' weather condition. It is found at the elevation of 2800m above the sea level. It gets an average of 270c temperature and 1600 mm rainfall annually.

The Weliso people like any other Oromo society had been governed by the 'Geda System' and still there is such practice on some parts of the woreda. The people of the woreda are followers of different religions. It is estimated that the number of Christian religion followers is 78.5 percent, Muslim is 21 percent and the remaining 0.5 percent is 'Wakefata'.

Administratively the woreda is divided into thirty seven (37) rural kebeles and one (1) town administration. According to survey conducted by Weliso health office, the size of the total

population was 153,578 in 2001 E.C out of which Oromo society takes the overwhelming proportion – 95.8 percent followed by Gurage which is 3.6 percent while Amhara and other nationalities make up 0.5 percent and 0.1 percent respectively.

Concerning languages spoken in the locality, Afan oromo, Guragigna, Amharic and other languages are widely spoken being Afan Oromo is the working and education language (WIPRO, 2010)

Figure 3.2a: Map of Weliso woreda

Source: WIPRO

3.1.2. Description of Goro Woreda

Goro is one of the twelve woredas found in the south- west shoa zone. It is located at south west direction from Addis Ababa at the distance of 135 km on the way to Jimma or Wolkite. The woreda bordered by Wonchi wereda in the north-west, Amaya woreda in the west, Weliso woreda in the north and Southern Nation and Nationalities in south (Goro Information & Public Relations Office, GIPRO, 2010).

The woreda has suitable weather conditions for living and for the cultivation of variety of crops. Its dominant weather condition is 'Bereha' which constitutes 85 percent while the remaining 15 percent is characterized by 'Weyina Dega' weather condition. It is found at the elevation of 950-1500m above the sea level. It gets an average of 1160 mm rainfall annually.

Figure 3.2b: Map of Weliso woreda

Source: GIPRO

Goro wereda consist of variety of nation and nationalities i.e. Oromo, Gurage, Qabena, Gumuz and Amhara nationalities reside at the woreda in harmony. Among these compositions Oromo

society make up 95 percent and above. In the same vein, different languages spoken in the area being Afan Oromo is the working and education language. With regard to religion, while the majority of people at the woreda are followers of Muslim there are also followers of Orthodox and protestant religions (GIPRO, 2010).

Administratively the woreda is divided into nineteen (19) rural kebeles and two (2) towns' administration. According to survey conducted by Goro health office, the size of the total population was 59,131 in 2001 E.C out of which Oromo society takes the overwhelming proportion – 95.8 percent (Goro woreda health office, 2001).

3.2. Background of Clients and HEWs respondents

Looking at the characteristics of respondents would help the readers appreciate the composition of the respondents. Thus, sex, religion, education status, ethnic groups and marital status are the basic features considered in this study. This back grounding information about the informants is a good indicator of the picture of the reality on the ground. Particularly, the education status of respondents is one of the strong determinants of the successful implementation of Health education programme. The educational level of employee sample populations would manifest whether there are qualified personnel in the sector or not. The education level attended by client respondents also affects the degree of acceptance of the programmes/ packages. Clients' religion is also seemed an important factor influencing the success of family planning package. Therefore, the background of client respondents is presented followed by employee sample populations for each woreda as follows:

Table 3.1: Sex, religion, ethnic group and educational level of client respondents of Goro woreda

	Category	Frequency	%
Sex	Male	35	46.67
	Female	40	53.33
Religion	Orthodox	14	18.67
	Muslim	58	77.33
	Protestant	3	4
	Other	0	0
Educational Level	0-5	62	82.67
	6-8	10	13.33
	9-12	3	4

Source: Own survey (primary data 2009/10)

When we closely see the different characteristic features of Goro's respondents, as illustrated in Table 3.1, among the households replied, around 46.67 percent were husband respondents while roughly 53.33 percent of informants were wife respondents. With respect to their religion, nearly 18.67 percent of households approached belonges to Orthodox religion, about 77.33 percent were Muslims whereas 4 percent were from Protestant religion.

The educational achievements of the respondents were not high. About 82.67 percent of respondents attended 0 - 5 grade levels, around 13.33 percent of them have achieved 6 – 8 grade levels whereas only 4 percent of informants have achieved grade 9 to 12. Sample respondents belonged to various ethnic categories.

Table 3.2: Sex, religion, ethnic group and educational level of client respondents of Weliso woreda.

	Category	Frequency	%
Sex	Male	27	36
	Female	48	64
Religion	Orthodox	51	68
	Muslim	8	10.67
	Protestant	16	21.33
	Other	0	0
Educational Level	0-5	58	77.33
	6-8	11	14.678
	9-12	6	8

Source: Own survey (primary data 2009/10)

At Weliso district, as put in the above Table 3.2, nearly 36 percent of sample households who filled the questionnaire were males i.e. husbands whereas about 64 percent of them were females/ wives. Regarding respondents' religion, majority of sample respondents were followers of Orthodox religion (68 percent), 10.67 percents of informants were among Muslim households whereas Protestant respondents constituted 21.33 percent.

Concerning the education variable, the larger proportion of respondents i.e. roughly 77.33 percent have attended the class level from 0 to 5 grades, approximately, 14.67 percent of

respondents have achieved the educational level of 6 to 8 grades while only 8 percent of sample populations have attended grade 9 to 12 levels.

Table 3.3: Sex, religion and educational level of staff respondents of Goro woreda

	Category	Frequency	%
Sex	Male	0	0
	Female	12	100
Religion	Orthodox	3	25
	Muslim	6	50
	Protestant	3	25
	Other	0	0
Educational Level	10^{+1}	12	100
	10^{+2}	0	0
	Degree	0	0

Source: Own survey (primary data 2009/10)

As portrayed in the above Table 3.3, there are no male health extension workers in health sector. As a result, 100 percent of employee samples considered were feminine. Among the samples that filled the questionnaire, 25 percent were followers of Orthodox religion, 50 percent were among Muslim communities and 25 percent belonged to Protestant religion. Across the respondents, there is similar educational achievement attended i.e. 100 percent of respondents expressed their highest educational achievement was certificate ($10+^{1}$).

Table 3.4: Sex, religion and educational level of staff respondents of Weliso woreda

	Category	Frequency	%
Sex	Male	0	0
	Female	12	100
Religion	Orthodox	6	50
	Muslim	0	0
	Protestant	6	50
	Other	0	0
Educational Level	10^{+1}	12	100
	10^{+2}	0	0
	Degree	0	0

Source: Own survey (primary data 2009/10)

The characteristics of Weliso's respondents are presented in the above Table 3.4. Accordingly, by same analogy there were no male employee respondents. Therefore, 100 percent of employee informants were females. As far as their religion considered, Orthodox and Protestant religions were dominant ones. That means 50 percent of sample employees were followers of Orthodox religion whereas the remaining 50 percent were Protestants. As that of Goro case, all (100 percent) respondents were certificate holders ($10+^{1}$).

3.3. Background of interviewees

Interview was conducted to capture data that could not possible to obtain through questionnaire and observations. As a result, individuals who were supposed to have close contact with HEP in

the study areas were indentified and interviewed. Consequently, health office leaders of both woredas were included. Again, one supervisor from Goro woreda and four supervisors from Weliso woreda were incorporated in the interview. Since interview was employed to supplement other data collection instruments used, no separate analysis has been made for it.

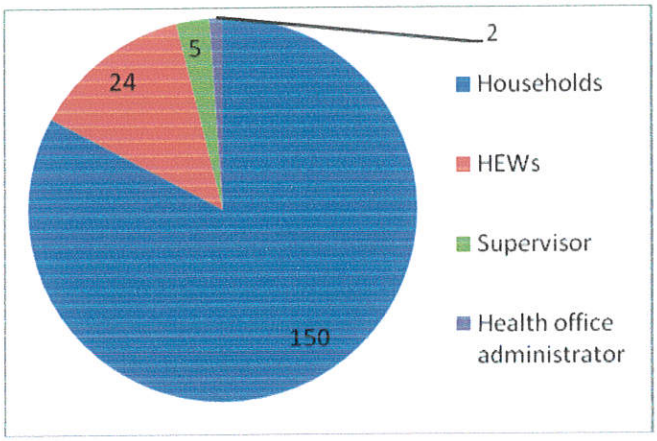

Figure 3.1: Composition of respondents

Source : Own computation

3.4. Discussion of clients' response on the achievements and challenges of HEP

Table 3.5: Client responses concerning clearance of mosquitoes breeding areas

Goro								Weliso							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
3	4	62	82.67	6	8	4	5.33	3	4	64	85.33	0	0	8	10.67

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

As depicted in the above Table 3.5, about 86.67 percent responded positively. They either strongly agree or agree while only the cumulative percent of 13.33 respondents either disagree or strongly disagree with the clearance of mosquitoes breeding areas at Goro woreda. At Weliso

woreda nearly 90 percent of respondents responded saying either they strongly agree or disagree whereas 10.67 0f the total respondents responded strongly disagree.

Table 3.6: Client respondents rating on their participation in health education

Goro Woreda						Weliso Woreda					
1		2		3		1		2		3	
No	%	no	%	no	%	no	%	no	%	no	%
12	16	56	74.67	7	9.33	0	0	62	82.67	13	17.33

1=very often 2= sometimes 3=never participated

Source: Own survey (Primary data) 2009/10

As one observes from Table 3.6, it asks how often clients participate in health education. Twelve (16 %) of the clients responded that they often participated in the health education delivered. Majority of the respondents i.e. 74.67 percent of respondents said they participated in health education sometimes. About 9.33 percent of the clients replied that they have never participated in health education given at Goro woreda. At the counter part of Weliso woreda, there is a deviation that one responded that they have participated in health education very often. Compared to Goro clients' response, the higher proportion of respondents replied i.e. about 82.67 responded they have participated in health education sometimes at Weliso woreda whereas 17.33 percent of clients asked responded they have never participated in health education.

Table 3.7: Clients' responses on the utilization of ITNs

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
4	5.33	62	82.67	6	8	3	4	2	2.67	66	88	3	4	4	5.33

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

For the question raised on the utilization of ITNs (Table3.7), positive responses sum up to 88 percent out of which 5.33 respondents said strongly agree and 82.67 percent of respondents agree that they have used the ITNs for the purposes intended whereas 12 percent of respondents either disagree or strongly disagree on the utilization of ITNs. This means because of different reasons, they have been using ITNs for different unintended purposes such as fetching water, carrying fire woods or other materials, etc. With respect to Weliso woreda, 2.67 and 88 percent of respondents said that they disagree and strongly disagree respectively in the utilization of ITNs whereas the remaining 9.33 percent of respondents disagree or strongly disagree on the appropriate use of ITNs by them.

Table 3.8: Responses of clients on whether their house is sprayed or not in this year

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
No	%	No	%	no	%	no	%
72	96	3	4	75	100	0	0

Source: Own survey (Primary data) 2009/10

Respondents were asked to tell whether their house is sprayed or not within this year. As the responses tabulated in the Table 3.8, there is a great similarity among the responses of the two woredas' respondents. All respondents at the Weliso woreda answered that their house got sprayed in within this year. But only 96 percent of respondents of Goro woreda responded positively compared to Weliso's respondents response. Three (4 percent) respondents of the total sample asked replied that their houses have not got sprayed in last one year. This variation may be attributable to emerging new households or those who immigrated from other localities.

Table 3.9: Respondents rating on how many months they cover house's wall after spraying

Goro Woreda						Weliso Woreda					
1		2		3		1		2		3	
No	%	no	%	No	%	no	%	no	%	no	%
6	8.33	34	44.45	35	47.22	5	6.67	34	45.33	36	48

1= ≤ 3 months 2=≤6 months 3= >6 months

Source: Own survey (Primary data) 2009/10

Respondents whose house got sprayed were asked derivative question i.e.in how many months they cover the sprayed wall with mud after spraying. The effectiveness of sprayed DDT depends among other things is the length of period within which the sprayed house get covered with mud after spraying. As it is observed in the above Table 3.9, majority of the respondents replied that they cover their house with mud after spraying either within 3 months or within 6 months (52.77 percent). The remaining 47.22 percent of respondents said they have got sprayed their house after 6 months after spraying which is advisable by professionals to improve the effectiveness of DDT at Goro woreda. Coming to Weliso case, about 52 percent of respondents told the researcher that they have got covered their house within either 3 months or 6 months. Like Goro's respondents, 48 percent of Weliso's respondents responded they have got their house covered with mud after spraying within 6 months. To get better the performance of DDT, the sprayed house should be covered with mud after 6 months of spraying.

Table 3.10: Respondents rating on early examination for malaria

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	No	%	no	%	no	%	no	%	no	%	no	%	no	%
20	26.67	50	66.67	5	6.67	0	0	24	32	48	64	0	0	3	4

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

Sample populations were asked to answer on their awareness for early examination. As put in the Table 3.10, respondents responded to the question favorably by saying either strongly agree or agree that constitutes 93.34 percent. Contrary to this, 6.67 percent of sample surveyed said they disagree with the statement at Goro woreda. At Weliso woreda the number of respondents who responded positively makes up 96 percent. Among this 32 percent replied they strongly agree while 64 percent of them selected the choice 'agree' at Weliso woreda.

Table 3.11: Respondents' knowledge as to the transmission routes of malaria

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
50	66.67	25	33.33	66	88	9	12

Source: Own survey (Primary data) 2009/10

Respondents were surveyed to measure their knowledge on the transmission routes of malaria. On comparative view, respondents of Weliso have better knowledge than Goro's respondents on the issue of transmissions means of malaria. As shown in Table 3.11, 50 (66.67 percent) respondents answered that they know how someone is caught by malaria. Twenty five (33.33 percent) respondents have spoken they do not know the transmission routes of malaria at Goro woreda. In relative term higher proportion of Weliso's respondents responded positively. Sixty six (88 percent) respondents answered by saying 'Yes' for the raised question while the remaining 9 (12 percent) respondents have chosen 'No' alternative.

Table 3.12: Respondents' knowledge of self prevention against malaria

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
No	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
8	10.67	58	77.33	0	0	9	12	4	5.33	66	88	2	2.67	3	4

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

Prevention is given priority in health extension programme and it is not exceptional in malaria prevention and control package. As depicted in the above Table 3.12, the positive responses counted to 88 percent. About 10.67 percent strongly agree and 77.33 percent agree with the statement saying I know how to prevent oneself from being caught by malaria while 12 percent responded by choosing an alternative 'strongly disagree' at Goro woreda. Seventy (93.33 percent) of Weliso's respondents reacted positively. They either said strongly agree or agree with the statements put forward. Nearly 2.67 percent of respondents disagreed with the positive statement while 4 percent of respondents replied they strongly disagree.

Table 3.13: Comparative respondents' knowledge of family planning methods in the two woredas

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	No	%
0	0	70	93.33	5	6.67	0	0	4	5.33	68	90.67	0	0	3	4

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

As tabulated in Table 3.13, respondents of the two woredas have been rated comparatively on their knowledge of contraceptives. Respondents of Goro woreda rated their knowledge on the contraceptive where 93.33 percent of them have selected 'agree' choice whereas 6.67 percent of respondents stated they disagree with the raised statement. Unlike respondents of Goro, 5.33 percent of respondents said they strongly agree as to their knowledge of contraceptives. The higher proportion of Weliso's respondents i.e. 90.67 percent of them replied they agree. The remaining 4 percent of respondents told they strongly disagree on their knowledge of contraceptives.

Table 3.14: Information sufficiency provided by HEWs concerning family planning methods

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
No	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
6	8	64	85.33	3	4	2	2.67	8	10.67	64	85.33	0	0	3	4

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

Awareness creation is one of the important areas of health extension workers' job. To bring about behavioral changes among households, provision of sufficient education or information is a requirement. Based on this fact, respondents were asked gauge the sufficiency of information provided by HEWs. Table 3.14 depicts the tabulated data. Accordingly, 93.33 percent of respondents reacted positively by either saying strongly agree or agree when 6.67 percent of informants said either disagree or strongly disagree in the case of Goro woreda. In the counter woreda, about 96 percent of respondents responded favorably to the question raised. 10.67 percent of the informants said they strongly agree while 85.33 percent of the sample asked replied they agree the statement put forward. Respondents who said they strongly disagree constitute 4 percent.

Table 3.15: Ratings made on the respondents' knowledge of where they get family planning they want

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
12	16	54	72	3	4	6	8	8	10.67	64	85.33	3	4	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

As presented in the above Table 3.15, informants were asked to measure their knowledge as to where family planning/contraceptives are provided. Consequent to this purpose in mind,

informants' responses were rated as shown in the above Table. Among the respondents of Goro's woreda, 88 percent of them have known where they can get the contraceptives they prefer. Out of those favorably responded, 16 percent strongly agree with the statement while 72 percent agreed with the question put forward. About 12 percent of respondents reacted either by saying strongly disagree or disagree. With respect to Weliso's respondents, the overwhelming majority i.e. 96 percent of respondents said they have well known from where they can get family planning method/s they need. Only 4 percent of respondents replied that they have no information concerning where contraceptives are available.

Table 3.16: Respondents' ratings on side effects of contraceptives

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
14	18.67	44	58.67	3	4	14	18.67	12	16	50	66.67	3	4	10	13.33

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

The perceptions the households hold has influences on the utilization of contraceptives by households. Households may perceive that using contraceptives adversely affect their health. And washing such misperceptions out of households' mind is an important and challenging task for health extension workers. It is obvious that misperception denotes that negative attitudes or behaviors would follow. The above Table 3.16 also depicts respondents' perception as to the side effects of contraceptives. Generally, about 77.34 percent respondents had the perception that using contraceptives has negative consequences on their health. They either strongly agree or agree with the statements raised. Households who have positive perception towards contraceptives make up 22.67 percent either by saying disagree or strongly disagree at Goro woreda. At Weliso district, it seemed misperception has spread more. Out of sample asked, about 82.67 percent have the beliefs that modern contraceptives have impact on health. From this percent, 16 percent strongly agreed that contraceptives have side effects while 66.67 percent have agreed that taking contraceptives would harm health. The remaining 17.33 percent of

informants either disagreed or strongly disagreed with the statement contraceptives have side effects on health.

Table 3.17: Clients' responses rating on whether he/she has used modern contraceptives

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
40	53.33	35	46.67	52	69.33	23	30.67

Source: Own survey (Primary data) 2009/10

One of important indicators of progress in family planning services is the number of households who become the users of family planning programme. Therefore, Table 3.17 measures this indicator of progress. As the data collected showed, 40 (53.33 percent) respondents said that they have utilised any of family planning method while 35 (46.67 percent) informants said that they have not ever used family planning services at Goro district. When we look at the data gathered from Weliso woreda, 52 (69.33 percent) respondents have had the experience of using contraceptives while 23 (30.67 percent) households have not ever used contraceptives.

Table 3.18: Clients' responses rating on whether he/she is currently using modern contraceptive

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
36	90	4	10	46	88.46	6	11.54

Source: Own survey (Primary data) 2009/10

Here respondents who said 'yes' in Table 3.17, were asked additional question to check whether they are using contraceptives at present. Data tabulated in the Table 3.18, presented that 36 (90 percent) households were taking family planning services and only 4 (10 percent) households were not using family planning services at the time of data collection at Goro woreda. By the

same token, about 46 (88.46 percent) households were utilizing family planning method/s while 6 (11.54 percent) respondents were not attending family planning services provided at the time of this data collection at Weliso woreda.

Table 3.19: Respondents rating on reasons for not using modern contraceptive

Goro Woreda												Weliso Woreda											
1		2		3		4		5		6		1		2		3		4		5		6	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
16	45.72	6	17.14	4	11.42	3	8.58	0	0	6	17.14	14	60.87	6	26.09	3	13.04	0	0	0	0	0	0

1=I do not know the use of contraceptive 2=contraceptive has major side effects 3=my religion does not allow 4= it is not available 5=it is very expensive 6= other reason

Source: Own survey (Primary data) 2009/10

Anyone can understand from Table 3.17 the number of households who have not ever used contraceptives is not underestimated at both woredas. Question was posed to know the possible reasons of not using family planning contraceptives. As it is depicted in Table 3.19, 45.71 percent respondents of Goro woreda uttered that they have not used modern contraceptives for the reason that they have no information/ knowledge as to the importance of family planning methods. About 17.14 percent of respondents replied they have not utilised contraceptives because they perceived contraceptives have adverse consequences on health. Those who do not use due to their religion are counted to 11.42 percent while 8.57 percent of respondents said they have not ever used family planning method/s because they could not get the methods they prefer at health posts. The remaining 6 (17.14 percent) respondents stated that they have not able to use modern contraceptive for various reasons such as they did not need to use it for no reason.

When it is looked at the counter district, Weliso district, households who have not used contraceptives because of lack of knowledge of family planning methods is larger than Goro's respondents. It constituted 60.87 percent who did not have the experience of using family planning method for they had no/ little information on the advantage of family planning services. The beliefs that using contraceptives bring complicated health problems have been noticed

more at Weliso district. About 26.09 percent of respondents have not used contraceptives for they perceived family planning method has adverse consequences on their well being. Those who did not use family planning method/s because their religion prevents them from doing so amounted to 13.04 percent.

Table 3.20: Respondents' responses on for what purposes they use contraceptives

Goro Woreda				Weliso Woreda			
1		2		1		2	
no	%	no	%	no	%	no	%
36	100	0	0	44	95.65	2	4.35

1= spacing 2= limiting

Source: Own survey (Primary data) 2009/10

Respondents who have been using contraceptive methods were requested to tell for what purposes they are you using contraceptives. Accordingly Table 3.20 attempts to show the same information in both woredas. In Goro woreda, all households who have been using contraceptives told they are using the family planning means for the purpose of widening the gap between births giving periods. At Weliso district, mixes of purposes have been put forward. Like that of Goro, larger proportion of respondents, 95.65 percent talked they have been using contraceptives for spacing among children to be born. Though the numbers is small i.e. 4.35 percent of respondents told the researcher they have been using contraceptives for permanently stopping giving birth to child.

Table 3.21: Clients' responses on sufficiency of malaria prevention and control measures

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
46	61.33	29	38.67	52	69.33	23	30.67

Source: Own survey (Primary data) 2009/10

As to the sufficiency of malaria prevention and control services, informants were requested to rate the same. Services in the area of malaria prevention and control may measured in terms of education delivered, ITNs distributed, DDT sprayed, etc. Depending on these criteria, respondents attempted to gauge the availability of services in these areas. As portrayed in the above Table 3.21, at Goro woreda, 46 (61.33 percent) households responded that services being given in the malaria prevention and control were sufficient while 29 (38.67 percent) households argued services being delivered had fallen short of their needs or expectations in many ways. In the case of Weliso district, among households who filled the questionnaire, 52 (69.33 percent) respondents responded positively that services being delivered were able to meet their needs well. Around 23(30.67 percent) respondents have expressed their dissatisfaction with services provided in the area of malaria prevention and control efforts.

Table 3.22: Clients' opinion towards HEWs being only females

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
19	25.33	56	74.67	15	20	60	80

Source: Own survey (Primary data) 2009/10

Government has recruited only female health extension workers for the implementation of health extension programme for the reason that programme has primarily targeted mothers and children. Respondents' opinions were surveyed to identify if there is any problem associated with HEWs being female. Consequent to this, 19 (25.33 percent) of respondents agreed that there were challenges in the implementation of the packages for HEWs being females while 56(74.67 percent) of the total sample surveyed said they had not experienced any constraint for HEWs being female at Goro woreda. At the counter woreda, 15 (20 percent) of households asked claimed HWEs being females had its own limitations in the implementation of the packages while 60 (80 percent) respondents replied they have not noticed any problems for health extension workers being females. These respondents' responses have been tabulated in the above Table 3.22.

Table 3.23: Clients' responses on residence place of HEWs

Goro Woreda						Weliso Woreda					
1		2		3		1		2		3	
no	%	no	%	no	%	no	%	no	%	no	%
8	10.67	58	77.33	9	12	32	42.67	36	48	7	9.33

1=in the working kebele 2=in the town 3= I do not know

Source: Own survey (Primary data) 2009/10

Government intended to make primary health service delivery near to where households are living. For this intention to be realized, health service providers namely health extension workers should reside in the kebele they are working. The above Table 23 shows us respondents' responses on the residence place of HEWs. Only 10.67 percent of households said health extension workers live the kebele they are working while the overwhelming portion of households replied HEWs come from the nearby town to render services. In figure nearly 77.33 percent of informants told health extension workers make their residence place at woreda's town or any other town. Other respondents that can be counted to 12 percent had no information as to the residence place of HEWs at Goro woreda. At Weliso woreda relatively as figure in Table 3.23 showed 42.67 percent of respondents answered HEWs live in the same kebele they are working. Thirty six (48 percent) of informants reported that primary health service providers live at town. The remaining 9.33 percent of respondents had no knowledge of where health service providers reside.

Table 3.24: Accessibility of HEWs to the community

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
40	53.33	35	46.67	50	66.67	25	33.33

Source: Own survey (Primary data) 2009/10

It is assumed that health extension workers are expected to spend 75 percent of their working time going home to home to provide services to households. In line with this general principle, respondents were asked to express their opinion on the availability of HEWs when they need them. Accordingly, Table 3.24 showed tabulated informants' responses for the two woredas. A little bit more than half of the respondents i.e. 40 (53.33 percent) said they have got HEWs at the time they looked for them. Nearly half of the respondents - 35 (46.67 percent) complained that they did not get services at the time they are in need of it at Goro woreda. At Weliso 50 (66.67percent) of respondents favorably reacted to the question raised. One third of respondents (33.33 percent) negatively responded i.e. they did not get provided the services needed at the time the services should be rendered.

Table 3.25: Possible reasons for the absence of HEWs from work as rated by clients

Goro Woreda								Weliso Woreda							
1		2		3		4		1		2		3		4	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
60	80	0	0	0	0	15	20	66	88	0	0	0	0	9	12

1=She goes to town 2=she does not go to office 3= she goes for meeting 4=I do not know

Source: Own survey (Primary data) 2009/10

Respondents who selected 'no' response category in Table 3.24, were asked a derivative question that attempts to find out the possible reasons for the absence of health service providers at the time they needed. As put in the above Table 3.25, 80 percent of Goro's respondents uttered they did not get HEWs for they have gone to town frequently. About 20 percent of households could not get HEWs at the time they face health problems for the reasons they have not known. Also majority of weliso's respondents i.e. 88 percent said they did not get access to health services for HEWs were not available in the kebele they were working. The remaining 12 percent households claimed they did not find HEWs when they need them for the causes they did not know for their absence.

Table 3.26: Clients' ratings on the availability of family planning method/s of one's preference at health posts

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
8	10.67	50	66.67	7	9.33	10	13.33	10	13.33	60	80	0	0	5	6.67

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

To increase the utilization of family planning services and to broaden its benefits, as much as possible family planning services should be decentralized to health posts so that households would have access to wide range of choices without being exposed unnecessary costs. As observable in the above Table 3.26, 77.34 percent of informants responded favorably either by saying strongly agree or agree on the decentralization of family planning services whereas 22.66 percent of households reported that family planning services have not fully brought down near to households. At Weliso district, much more respondents i.e. 93.33 percent positively acknowledged the decentralization of family planning methods. 13.33 percent of respondents strongly agreed that family planning method is decentralized to kebele level while 80 percent of informants have chosen 'agree' response category. Households who strongly disagree with the devolution of family planning services make up 6.67 percent.

Table 3.27: Ratings of clients on the existence of effective referral system

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	No	%	no	%
58	77.33	17	22.67	68	90.67	7	9.33

Source: Own survey (Primary data) 2009/10

Health extension workers have been trained for giving primary health services which focused on preventive health care system with selected curative health services. They are also expected to

provide referral system for those patients whose cases are beyond the capacity of HEWs. As depicted in the above Table 3.27, respondents were asked to respond to referral system of health service. At Goro woreda, 58 (77.33 percent) of informants expressed their satisfaction with the present referral system while 17 (22.6 percent) of respondents had complaints with the present referral systems. At Weliso woreda, 68 (90.67 percent) of respondents measured the referral system as it was good while the remaining 7 (9.33 percent) of respondents gauged the referral system that it was unable to meet clients' needs.

3.5. Discussion of HEWs' responses on the achievements and challenges of HEP

Table 3.28: Respondents' responses on the reduction of malaria incidence

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	No	%	no	%	no	%	no	%
6	50	6	50	0	0	0	0	2	16.67	8	66.67	2	16.67	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

One of the objectives of malaria prevention and control package is to reduce the number of malaria cases. Malaria is among the leading causes of morbidity in these localities. Staff respondents of Goro district have positively responded that malaria cases have reduced. As presented in the above Table 3.28, 50 percent of respondents strongly agreed that malaria incidences got reduced while 50 percent of informants said they agree with the statement raised. In the case of Weliso woreda, higher proportion of respondents reacted favorably either saying strongly agree or agree, 16.67 percent strongly agreed while 66.67 said they agree that malaria cases have reduced after the implementation of health extension programme. But 16.67 percent of informants stated that morbidity due to malaria has not got reduced.

Table 3.29: Respondents' ratings on the reduction deaths due to malaria

Goro Woreda								Weliso Woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
6	50	6	50	0	0	0	0	4	33.33	6	50	2	16.67	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

Another objective of malaria prevention and control package is to reduce mortality that results from malaria. Government has been making efforts to minimize the number of deaths due to malaria. Health extension workers have provided reposes to the question posed. As the data put in the Table 3.29 showed, all the respondents acknowledged that deaths due to malaria have greatly reduced. Out of the sample population asked, 50 percent have strongly agreed while 50 percent have agreed to witness the reduction of deaths as a result of malaria at Goro woreda. When we come to Weliso's respondents, the following mixes of responses were found. Near to 83.33 percent of respondents positively responded. Out of this figure, 33.33 percent constituted those who have strongly agree the statement put forward while 50 percent of them have said they agree that loses of lives due to malaria has got declined. Just about 16.67 percent of sample contacted believed that casualties due to malaria have not dropped.

Table 3.30: Respondents' answers to the utilization of modern contraceptives

Goro woreda								Weliso woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
9	75	3	25	0	0	0	0	12	100	0	0	0	0	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

It is believed that one of the factors contributing to our poverty is the rapid population growth that cannot match with the available economic resources. As a result, concerted efforts have been

undertaken in family planning services to limit the population growth rate. The above Table 3.30 presented employees' responses to the question 'consumption of modern contraceptives' by households. As per the response of respondents, at Goro woreda, the largest part of respondents i.e. 75 percent rated consumption of contraceptives by households by choosing 'strongly agree' alternative while 25 percent also positively responded through the selection of 'agree' response category. With respect to Weliso, employees highly appreciated the using up of contraceptives by households in their locality. Entirely all sample surveyed- 100 percent strongly agreed that households have increased their contraceptive utilization.

Table 3.31: Responses of respondents on the participation of religious leaders

Goro woreda								Weliso woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
0	0	0	0	9	75	3	25	2	16.67	6	50	4	33.33	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

The fruits to be harvested in family planning services would increase if various religious leaders have involved in the promotion of uses of family planning. Followers of different religions have diverse attitudes towards family planning. Positive attitudes can be brought among various religion followers if the participation of opinion or religious leaders strengthened to promote the uses of family planning services. As shown the above Table 3.31, staff respondents rated the participation of religious leaders in the provision of family planning services. At Goro woreda, respondents said there was little or no participation of religious leaders. More or less 100 percent of informants reacted negatively either by saying they strongly disagree or disagree. At Weliso, data showed better participation of religious leaders in the provision of family planning services. Approximately, 66.67 percent of respondents replied that there were contributions from religious leaders. But 33.33 percent of employees argued that there were involvements in family planning services by religious leaders by circling on 'disagree' response category.

Table 3.32: Staff's ratings on the number of defaulter in family planning use

Goro woreda								Weliso woreda							
SA		A		DA		SD		SA		A		DA		SD	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
3	25	9	75	0	0	0	0	6	50	2	16.67	4	33.33	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

The success of family planning service provision depends on the continuity of households in using the methods and when they use it as per the instruction/ prescription provided otherwise it becomes difficult to reach the intended goals. Health extension workers were asked to rate their clients' commitment such as their compliance to the procedures/prescription. Thus, as depicted in the Table 3.32, 25 percent of respondents strongly asserted that family defaulters in the use of family planning service has fallen, 75 percent of employee respondents stated that households had been using family planning methods in accordance of the guidelines given to them. At Weliso woreda, respondents who strongly agreed amounted to 50 percent whilst 16.67 percent of respondents agree that their clients had been using family planning method without interruption. But around 33.33 percent of informants declared that their clients had not used the medicines in proper way, they might interrupt using, they did not use in the proper way, etc.

Table 3.33: Respondents' ratings on the cooperation between HEWs and other government agencies/workers

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
12	100	0	0	12	100	0	0

Source: Own survey (Primary data) 2009/10

The implementation of health extension programme does not fall on the shoulder of HEWs alone. Its efficient and effective execution of the programme needs the concerted and well coordinated efforts of many government development agents such as schools, agricultural

extension workers and kebele administration. Health extension workers were solicited to tell about the co operations they get from above mentioned government organisations. As one observes in Table 3.33, at both woredas, they positively responded. At the two cases, almost 100 percent of respondents have said 'yes' i.e. they assured assistances were extended in the discharge of their duties.

Table 3.34: Respondents' responses as to the participation of residents in the programme such as clearing water bodies

Goro woreda								Weliso woreda							
SA		A		DA		SA		SA		A		DA		SA	
No	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
9	75	3	25	0	0	0	0	2	16.67	6	50	4	33.33	0	0

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

Health extension programme is designed to improve the health status of families through the full participation of communities in the design and implementation of the programme. Cognizant of this fact, the researcher requested the respondents to judge the participation of their clients in the execution of the packages. Accordingly, as the above Table 3.34 shows almost all the employees of Goro i.e.100 percent responded favorably that they recognised the cooperation of residents in the accomplishment of their duties. But with respect to Weliso case, one third (33.33 percent) of employees selected 'disagree' response alternative. They articulated that clients' participations were not encouraging as such. Roughly 66.67 percent of respondents have said either they strongly agree or agree that residents' assistances were commendable.

Table 3.35: Respondents' ratings on the participation of NGOs or private organisation in the provision of family planning services

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
3	25	9	75	0	0	12	100

SA= strongly agree A= agree DA= disagree SD= strongly disagree

Source: Own survey (Primary data) 2009/10

Health extension programme's intervention strategies focuses on households and communities while their success call for the coordinated efforts of all sectors- NGOs and private organisations. Table 3.35 displays employees' responses on the presence of NGOs or private organisations helping the provision of family planning services. Consequently, 3 (25 percent) of informants confirmed the support of these sectors while about 9(75 percent) of them denied the participation of these organisation in the family planning service delivery at Goro. Regarding Weliso, all employees i.e. 100 percent of staffs approached uttered there were not any support from other sectors.

Table 3.36: Respondents' ratings on the participation of NGOs or private organisation in malaria prevention and control services

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
6	50	6	50	4	33.33	8	66.67

Source: Own survey (Primary data) 2009/10

Respondents also were asked on the participation of sectors other than government in the delivery of malaria prevention and control services. Employees evaluated the contribution of these nongovernmental organisations as displayed in the above Table 3.36. Therefore, 6 (50

percent) of sample staff contacted admitted the contributions of them in the provision of malaria prevention and control efforts while the remaining 6 (50 percent) declared that there were no supports from agents at Goro district. At counterpart of the district, 4 (33.33 percent) of respondents acknowledged their collaborations whereas 8(66.67percent) of respondents denied the involvements of NGOs or private organisations in the malaria prevention and control endeavors.

Table 3.37: Respondents' ratings on the participation of NGOs or private organisation in the provision of health education and information

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
0	0	12	100	0	0	12	100

Source: Own survey (Primary data) 2009/10

Contributions of NGOs or private organisations in health education or information is also demanded to maximize the benefits of health services. As presented in the Table 3.37, at both woredas, all employees i.e. 100 percent assured that no NGOs or private organisations have extended aids in the delivery of health education or information.

Table 3.38: Respondents' answers the question, the presence of community health workers

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
12	100	0	0	12	100	0	0

Source: Own survey (Primary data) 2009/10

At the community level, in addition to HEWs, there are voluntary community health workers to enhance their effectiveness in discharging their duties. The work of each group should support

the other's work. As put into the above Table 3.38, at both of the woredas, all employees surveyed expressed that they have had voluntary community health workers in their respective working kebeles.

Table 3.39: Respondents' responses to the presence of health post in the kebele

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
0	0	12	100	4	33.33	8	66.67

Source: Own survey (Primary data) 2009/10

The operational centres for health extension workers is the health post which is intended to serve about 5. 000 people. HEWs render health services at health post in addition to going house to house to serve households.As a result the existence of functional health post in the kebele is mandatory. Among the staff respondents discussed with, 100 percent of them replied that they did not have operational health posts at Goro woreda. As presented in the above Table 3.39, 4(33.33 percent) of respondents of Weliso asserted that they have health posts while the remaining 66.67 percent argued that they have no health posts.

Table 3.40: Respondents' ratings on the availability logistic supplies for health post

No		Goro Woreda			Weliso Woreda		
		Response	No	%	Response	no	%
40a	Disposable syringe and needle	Yes	12	100	Yes	12	100
		No	0	0	No	0	0
40b	Contraceptives (oral and inject able), condom, penis model, etc	Yes	12	100	Yes	12	100
		No	0	0	No	0	0

40c	Anti malaria drugs, abate, ITNs, spraying equipment, DDT	Yes	9	75	Yes	12	100
		No	3	25	No	0	0
40d	Blood pressure apparatus	Yes	9	75	Yes	6	50
		No	3	25	No	6	50
40e	Examination Table, chair, store shelf, stretcher	Yes	0	0	Yes	4	33.33
		No	12	100	No	8	66.67
40f	Malaria, family planning education materials	Yes	9	75	Yes	6	50
		No	3	25	No	6	50
40g	Dry batteries and megaphone	Yes	0	0	Yes	0	0
		No	12	100	No	12	100

Source: Own survey (Primary data) 2009/10

Health posts must adequately furnished with equipment and other necessary materials to delivery different health services to households or families. Consequently, employees were asked to tell about the supply of necessary materials for health posts. As organised in the Table 3.40, the entire respondents of the two woredas reacted positively that they have syringe and needle. As to the availability of contraceptives, again all employees replied favorably. Respondents have divergent views on the existence of necessary facilities for malaria prevention and control services. Roughly 75 percent of informants acknowledged the supply of such facilities to delivery health services smoothly whilst 25 percent of employees disagreed on the fulfillment of the needed facilities. Contrary to this, 100 percent of sample surveyed at Weliso have spoken that materials required for malaria prevention and control service procured. One fourth (25 percent) of respondents of Goro said they did not have blood pressure apparatus while 75 percent responded that they have been provided with it. With respect to Weliso district, half of the

respondents agreed that they have been furnished with blood pressure apparatus while the remaining 50 percent of employees disagreed as the availability of the instrument. All Sample employees of Goro district complained that they did not have examination Table, stretcher, chair, store shelf. At Weliso woreda, 33.33 percent of respondents admitted the availability of these facilities whereas 66.67 percent of them uttered that there were no such facilities. As to the availability of education materials, 75 percent of employees who filled the questionnaire said they have possessed sufficient teaching materials whereas 25 percent of sample replied they did not have enough education materials at Goro district. Concerning Weliso's situation, 50 percent of respondents recognised the availability of required teaching materials while 50 percent of the informants argued that there were not adequate education materials. The whole respondents of each woreda replied that they have not procured dry batteries and megaphone.

Table 3.41: Respondents' ratings on supply of stationery

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
No	%	no	%	no	%	no	%
0	0	12	100	8	66.67	4	33.33

Source: Own survey (Primary data) 2009/10

To smooth the operation of HEWs, there should be continuous supply of stationeries such as pen, paper, registration book, etc. Selected employees were requested to respond on availability of necessary stationery items to discharge essential health services. As presented in the Table 3.41, 100 percent of Goro's respondents declared that they have not provided with stationeries on time. Better performance has been observed at Weliso with this regard. About 66.67 percent of sample employees have given their testimony that there were supplies of stationeries on time while approximately 33.33 percent said no.

Table 3.42: Respondents' ratings on the presence of duties and responsibilities in writing

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
0	0	12	100	0	0	12	100

Source: Own survey (Primary data) 2009/10

Up on the employment of HEWs would have to be given a detail job description so that workers know the duties and responsibilities as the same time obligations expected of them without confusion. Job description stated in unequivocal terms also reduces supervision burden by letting HEWs identify their duties and responsibilities with little or no help from the management or supervisor. Surprisingly, as tabulated in the above Table 3.42, at both woredas all sample employees approached sadly asserted that they did not have job description.

Table 3.43: Respondents' ratings on the presence of work schedule for HEWs

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
12	100	0	0	12	100	0	0

Source: Own survey (Primary data) 2009/10

Effective implementation of any programme needs the preparation of work schedule that contributes to smooth execution of the packages. As the data collected from the respondents exhibited each employees had work schedule. One observes in the Table 3.43 that 100 percent respondents of each district told they had work schedule.

Table 3.44: Respondents' answers to the question –who prepare HEW's work schedule

Goro Woreda										Weliso Woreda									
1		2		3		4		5		1		2		3		4		5	
no	%	no	%	no	%	no	%	o	%	no	%	no	%	no	%	no	%	no	%
0	0	6	50	0	0	9	75	0	0	10	83.33	10	83.33	0	0	4	33.33	0	0

1= myself 2=woreda health office 3=health centre 4=HEW with kebele leaders 5= other

Source: Own survey (Primary data) 2009/10

Table 3.44 shows the multi responses for the question 'who prepare work schedule for HEWs'. As a result, 75 percent of sample population of Goro woreda replied that HEWs in collaboration with kebele leaders participate in the participation of work plan while 50 percent of them announced woreda health office prepare HEWs' work schedule. Approximately, 83.33 percent of Weliso's informants expressed that HEWs themselves engaged in the planning of their work while the same percent of respondents stated woreda health office took the responsibility to prepare work schedule. The remaining 33.33 percent of sample employees have spoken themselves involved the preparation of work schedule.

Table 3.45: Respondents' ratings on the availability of transportation facility

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
0	0	12	100	0	0	12	100

Source: Own survey (Primary data) 2009/10

In the rural settlements where kebeles scattered over wide geographical areas, the communication between HEWs and woreda health office or health centre becomes extremely ineffective. To ensure on time supply of medicines, to make timely report and to get immediate responses for the same, to strengthen the coordination among different levels, there should be

convenient transportation facilities. Unfortunately, in the areas where this research was conducted there was no transportation means for HEWs to go to health centre or woreda health office. To describe quantitatively as it is put in the above Table 3.45, almost 100 percent of sample employees of each woreda argued that there were no transportation facilities given for them.

Table 3.46: Respondents' ratings on availability of references

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	No	%	no	%
3	25	9	75	2	16.67	10	83.33

Source: Own survey (Primary data) 2009/10

Learning is not a onetime activity rather it is a continuous process. Therefore, in any profession where possible there should be ample reference materials in the working place to read. Such arrangement would help professionals to upgrade their knowledge in the area of their working. Moreover, accessibility of references would support health service providers to refer and find solutions for practical problems they face in the implementation of the programme. Having this reality in mind, the researcher has raised question to check the availability of references at their work place. As a result, 3 (25 percent) respondents informed that they have reading materials whereas 9 (75 percent) denied the existence of references at Goro woreda. Similarly, as presented in the Table 3.46, only 2 (16.67 percent) of respondents acknowledged the provision of reference materials whereas 10 (83.33 percent) of respondents did not at Weliso district.

Table 3.47: Respondents' ratings on the availability of educational or career development opportunity

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
No	%	no	%	no	%	no	%
0	0	12	100	0	0	12	100

Source: Own survey (Primary data) 2009/10

One of the potential sources of motivation for workers is the provision of career development or opportunity for further education. To adapt to the increasing changes in communities needs and technologies, education has irreplaceable role. Keeping this view at front, HEWs were asked to evaluate their condition with respect to promotion or career development. To the degree unbelievable, as portrayed in the above Table 3.47, all sample respondents of the study areas replied regretfully that they have been denied education opportunity.

Table 3.48: Respondents' ratings on the frequency of job evaluation by HEWs

Goro Woreda								Weliso Woreda							
1		2		3		4		1		2		3		4	
No	%	No	%	no	%	no	%	No	%	no	%	no	%	no	%
3	25	12	100	0	0	0	0	10	83.33	6	50	0	0	0	0

1=monthly 2=quarterly 3=semi-annually 4=annually

Source: Own survey (Primary data) 2009/10

Monitoring or evaluation should be there to assess achievements and progress towards predetermined goal. Consequently, respondents were asked to respond on the periodical evaluation of their job. As organised in the above Table 3.48, informants have given multiple responses for the question. At Goro woreda, 25 percent of the samples said they evaluate their work monthly whereas 100 percent of them told they have evaluated their tasks quarterly. In the

counterpart district, roughly 83.33 percent described they used to appraise their work monthly whilst 50 percent of employees said they have evaluated their work quarterly.

Table 3.49: Respondents' ratings on the presence of reporting format

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
12	100	0	0	12	100	0	0

Source: Own survey (Primary data) 2009/10

Sound supervision or controlling activity partly depends on the presence of clear reporting relationships. And effective reporting relationship in turn is influenced by the provision of clear and detailed reporting format. In case where there is no reporting format, management has little or no means for controlling and taking remedial measures to improve work performance. As put in the above Table 3.49, happily, the whole respondents i.e. 100 percent of respondents of both districts reported that they have reporting format.

Table 3.50: Respondents' ratings on reporting relationship

Goro Woreda								Weliso Woreda							
1		2		3		4		1		2		3		4	
No	%	No	%	no	%	no	%	no	%	no	%	no	%	no	%
9	75	12	100	3	25	0	0	0	0	8	66.67	0	0	4	33.33

1=health centre 2=woreda health office 3= kebele council 4=other

Source: Own survey (Primary data) 2009/10

As it is observable in the Table 3.50, sample populations were requested to speak on the reporting relationship of their work. The data collected demonstrated HEWs have been making work report for different individuals/offices. At Goro woreda, around 75 percent of respondents reacted they have made work report for health centre, 100 percent of them made report to woreda health office and 25 percent of respondents declared they reported to kebele council. Weliso'

respondents experience somewhat differ in that roughly 66.67 percent of sample employees asserted they have been making report to woreda health office whereas 33.33 percent of them told reported to other office/ individual such as supervisor.

The provision of immediate feedbacks for the reports made is a requirement to get HEWs informed about their strengths and weaknesses. The provision of immediate feedback would enable HEWs to make corrective measures for what they are doing on the spot.

Table 3.51: Respondents' ratings on provision of feedback for the report made

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
0	0	12	100	8	66.67	4	33.33

Source: Own survey (Primary data) 2009/10

Thus, sample employees were requested to express their opinions on the provision of feedback. Accordingly, as it is presented in the Table 3.51, almost 100 percent of Goro's respondents complained that they did not get immediate response for their report. By the same token, at Weliso 8(66.67 percent) respondents favorably responded that they have got immediate feedback for the reports they have made while around 4 (33.33 percent) of respondents talked that they were not provided with timely response/ feedback for the reports.

Table 3.52: HEWs 'satisfaction with their work

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
3	25	9	75	4	33.33	8	66.67

Source: Own survey (Primary data) 2009/10

Table 3.52 shows the responses of employee on their satisfaction with their work. Regarding their satisfaction, a mix of feelings was read on their face. While majority of them were happy for they have been making all their efforts to improve the health status of the communities. As one sees in the Table, 3 (25 percent) of respondents have chosen 'yes' response category while 9 (75 percent) asserted their dissatisfaction with what they are working at Goro woreda. In the case of Weliso district, 4 (33.33 percent) of sample employees have expressed that they are satisfied with their work whereas 8 (66.67 percent) of them said they have not satisfied with their job.

Table 3.53: Respondents' ratings on the sufficiency of ITNs distributed

Goro Woreda				Weliso Woreda			
Yes		No		Yes		No	
no	%	no	%	no	%	no	%
0	0	12	100	4	33.33	8	66.67

Source: Own survey (Primary data) 2009/10

One prevention technique of malaria is the distribution of impregnated ITNs for households at the appropriate time. As depicted in the Table 3.53, approximately 100 percent of Goro's respondents said the ITNs distributed were not enough in relation to family size. When we look at Weliso's case, 4 (33.33 percent) of respondents confirmed the sufficiency of ITNs distributed whereas 8 (66.67 percent) of approached employees argued that ITNs circulated were not enough compared to families' need.

Table 3.54: Respondents' ratings on where HEWs delivery health education

Goro Woreda										Weliso Woreda									
1		2		3		4		5		1		2		3		4		5	
no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%	no	%
6	50	12	100	12	100	0	0	0	0	10	83.33	12	100	12	100	0	0	0	0

1=at school 2= home to home 3= at public meeting 4= at public holidays 5= at health post

Source: Own survey (Primary data) 2009/10

Health education and communication is one of health extension packages which has given due attention in the implementation of HEP. Having considered this fact, the researcher has posed a question on the place where HEWs deliver health education. As presented in the Table 3.54, respondents ranked the place of health education delivery based on their frequent use. Thus, at Goro woreda, 50 percent of respondents replied that they have provided health education at school. 100 percent of sample populations reported they did deliver health education at public meetings and by going home to home. With respect to Weliso district, around 83.33 percent have delivered health education at school the whole staff respondents i.e. 100 percent of them stated they have given health education by going home to home and at public meetings.

Conclusion

For a researcher to make a meaningful analysis or interpretation of data, the data collected need to be logically organised and discussed. As a result, survey results of the two study areas have been presented in comparative view based on the responses of sample households and HEWs. In this chapter, the data collected has been tabulated and discussed on response categories established for each question.

Chapter Four

4. Data Analysis on the Implementation of Health Extension Programme

In chapter three, the data collected from client and employee respondents has been thoroughly discussed. In this chapter, the discussed data has been analyzed and evaluated. Indeed it is a difficult task to analyze and evaluate programme performance based on the criteria/ benchmarks upon which everybody agrees. Different stakeholders may have their own standards to measure health services delivery. In spite of these challenges of service delivery measurements, the researcher attempted to evaluate health services performances to arrive at sound conclusions based on respondents' response vis-a-vis with the objectives and indicators of progress mentioned for components under study. Thus data is analysed as follows.

4.1. Service delivery Performance in the area of malaria prevention and control package

Malaria prevention and control extension package is one of disease prevention and control components. Because of the topography and warm climate condition of the study area, malaria disease had been occurring so frequently that it took away the lives of large number of individuals. To make the situation worse the malaria usually outbreaks at peak of cultivation and harvesting period of the year resulting in reduced agricultural productivity. It seemed cognizant of this situation; government has planned and is implementing malaria prevention and control package to alleviate its repercussions on the economy and social (households).

Reduction of malaria cases and deaths

According to MoH (2005) one of the objectives of malaria prevention and control package is to reduce the number of malaria cases. Taking this goal as it is important, sample employees were requested to express their opinion on it. As respondents said, the cumulative positive impressions overweigh the negative ones. In the Goro district, respondents showed strong confirmation that malaria cases have got reduced. Half of respondents (50%) have said they strongly agree while the other 50 percent declared they agree with the statement. Similarly, majority of Weliso's employee respondents reacted favorably though there was a difference in figure with Goro's responses. Around 83.34 percent of respondents have positively responded i.e. either they said

they strongly agree or 'agree' while nearly 16.67 percent of them had disagreement with the statement.

But data from secondary source on malaria cases shows different figures. Particularly at the case of Goro woreda where sufficient secondary data has been obtained depicts in another way. The retrospective review of data from the year 1999-2001 has been organised as follows:

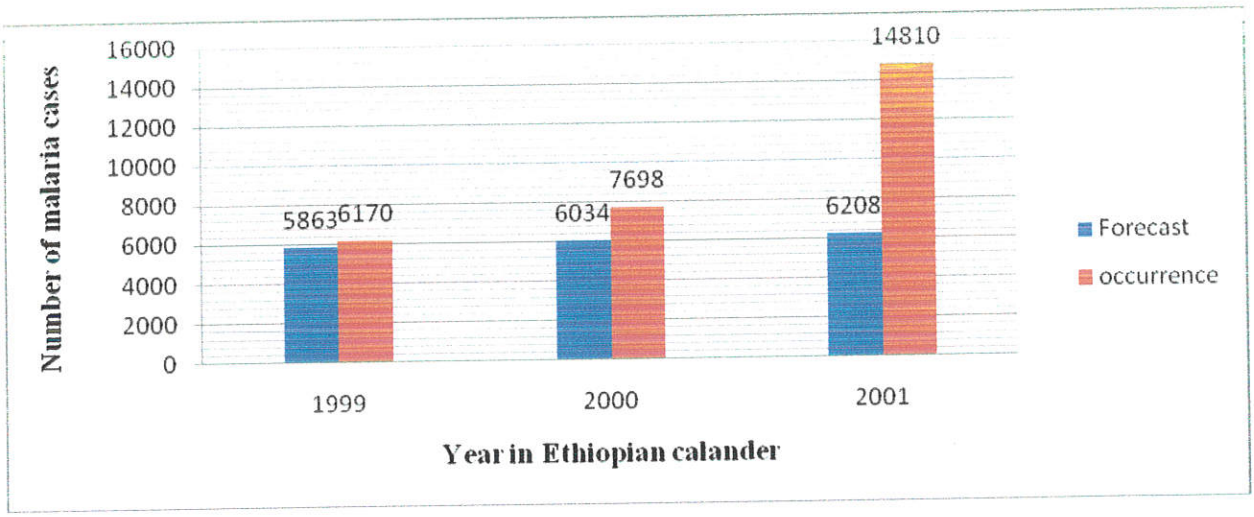

Figure 4.1a: Forecast and occurrence of malaria cases at Goro

Source: own computation (secondary source 2009/10)

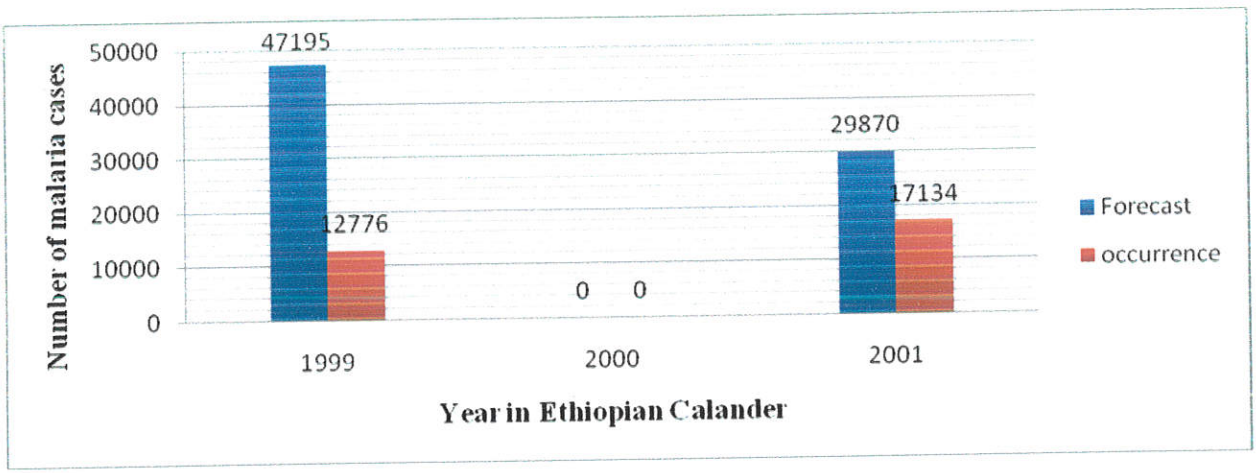

Figure 4.1b: Forecast and occurrence of malaria cases at Weliso

Source: own computation (secondary data 2009/10)

As portrayed through the chart, when one compare the plan and the occurrence of malaria cases in the last three years, malaria cases happened were greater than what expected to occur at Goro woreda. Whatsoever respondents replied favorably it may become fallacious to strongly argue that malaria cases have dropped at Goro woreda in the absence of strong evidence. Contrary to Goro's experience, fragmented performance report of Weliso supported staff respondents' opinion. In the preceding years except in the year 2000 E.C. in which secondary data was not found, the occurrence of malaria cases much lower than what were forecasted. Death due to malaria is an issue which cannot separately be seen from morbidity because of malaria. As respondents argued though there were prevalence of malaria diseases, because of extensive malaria control efforts by the government, casualties resulting from malaria has decreased. Almost100 percent of Goro woreda respondents replied they either strongly agree or 'agree' that deaths because of malaria have dropped where as only 16.67 percent of informants denied the decrease of mortalities due to malaria. Similarly, about 83.33 percent oe weliso's staff respondents have confirmed that mortalities due to malaria have dropped where as only 16.67 percent of informants denied the decrease of mortalities due to malaria.

Clearance of mosquitoes breading sites

Water collections, intermittent rivers and streams, swampy and marshy areas, slowly running shallow irrigation and manmade ponds are malaria mosquitoes breeding sites. Therefore, identification and clearance of such areas are very necessary. Effective environmental management should be implemented to ensure the interruption of malaria from breeding. To this end, through the mobilization of communities, measures have been undertaken to prevent and control malaria. Majority of client respondents of both woredas have positively replied that encouraging malaria vector control through the elimination of breeding sites has been made albeit there were some challenges in the implementation of measures for malaria prevention and control as reported by the respondents. But some percent of the respondents argued that mosquitoes breading sites have not been sufficiently cleared. Despite the commendable cooperative spirit of the communities in malaria vector control in the form of leveling and filling drainage, cleaning and clearing itches, challenges have been faced particularly at irrigation and marshy areas. HEP supervisors interviewed stated that it has been found very difficult to remove

water collections through the participation of communities in such large and marshy areas. In addition, they explained that challenges have been encountered around manmade ponds and water catchment and shallow irrigation systems built for agricultural developments. Undesirably, these water catchment areas have become suitable places for malaria to breed.

Distribution and utilization of ITNs

Recently Insecticide Treated Mosquito Nets (ITNs) has been introduced as malaria prevention and control measure. Sufficient distribution of ITNs in accordance of family size and its proper utilization by households determine the success in the endeavor of malaria vector prevention and control.

Adequate ITNs that takes into account the number of members who sleep under it have to be delivered periodically to supplement other malaria prevention and control measures. But the ITNs distributed fall short of the households need by a far margin. Almost 100 percent of staff respondents at Goro woreda reported that ITNs were distributed in 1998 E.C and then after no ITNs were distributed even the then distributed ITNs lacked proper administration such as lack of adequate information about family size, random distribution of ITNs for users without considering family size, etc. Respondents of Weliso also have similar experiences in their locality except there was additional ITNs distribution in1999 E.C. for selected kebeles. As to its utilization, about 88 and 90.67 percent of households of Goro and Weliso woredas respectively responded orally that they have using it for the intended purposes. But through the observations made at the households contacted, it was rare to find households utilizing ITNs properly for malaria prevention and control. Malpractices such as cutting ITNs into pieces for covering females' hair, carrying and covering cereals, imprudently putting it outside the home or in home were widely noticed.

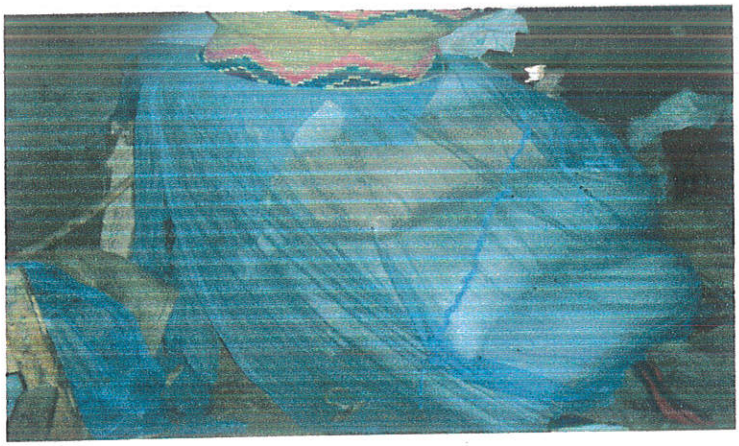

Figure 4.2: ITNs utilisation by households

Source: Photo from field visit

There are widespread misconceptions among households on how to use or for what purpose to use ITNs. These are manifestations of the existence of gaps in the delivery of education for households in the utilisation of

ITNs from beginning and the resistances of households to develop the desired and healthy behaviours (**quoted** from interview held with the head of Weliso health office).

Indoor residual house spraying

House spraying is another important and widely used malaria prevention and control measure in Ethiopia. In the woredas were this research conducted, almost all sample households reported that their houses have got sprayed periodically to the needed degree and only few households have not get their house sprayed. This probably happed because of such households might come from other localities or they might be newly emerging households. But respondents did not skip without telling the complaints they have on its execution. They complained that there were cases where spray men sell the chemicals budgeted to be sprayed. Such ill behaviors of spray men made the spraying less effective in the prevention and control of malaria for the chemical and water applied to mix is disproportional.

The spraying effectiveness at the prevention and control of malaria to a great extent depends on if the house sprayed re- plastered/ covered with mud/ after six month of the spray. But among the households who filled the questionnaire, about 52.77 and 52 percent respondents Goro and Weliso districts respectively said they covered the sprayed wall either within three months or before six months after spraying and only about 48 percent of respondents of the two woredas

replied that they covered walls after six months of the spray. Staff respondents including HEWs, supervisors and heads of health office added that there have been challenges after spraying on the side of clients (households). Households used to décor their houses at the time of religions holidays, when wedding ceremony come and for any other reasons before the recommended period to do so which highly impeded the success of spraying operation at the woredas.

Communities' knowledge and behaviors about malaria prevention and control

Active community participation in the malaria prevention and control campaign is mandatory for effective implementation of the programme. Therefore, awareness rising through health education has been given due attention by government. As the data collected reveals there have been positive trends among households at visiting HEWs or other health institutions earlier when they felt or observe symptoms of malaria. Also about 66.67 and 88 percent of respondents of Goro and Weliso woredas respectively reported that they well know the transmission routes of malaria. But it is not uncommon to hear/ observe/ the misperceptions households hold concerning the transmission routes of malaria. For instance, unpleasant smells at locality, unclean drinking water, eating roasted maize, etc are sources of malaria disease as reported by many client respondents. This misunderstanding of how one being caught by malaria is more dominant at Goro woreda. Such misperceptions among households are likely to be obstacles in the malaria prevention and control efforts. Again, ill-behaviors of households such as covering the sprayed wall with mud before the stipulated time, using ITNs for unintended purposes were very rampant at the woredas. HEWs on their part added that unhealthy practices have being noticed among families in using drugs. They said that for instance one of the family members may get sick and approach HEWs for treatment and then they are given medicines /drugs/ to be taken. But the patient may drop taking medicines the movement he/she started feeling better or they may give the medicines for other persons who become ill.

4.2. Family planning services delivery

Knowledge of modern family planning methods and its utilisation by households

The consumption of modern contraceptives is measured among other things in terms of the number of households using contraceptives and their sustainable use. Health workers namely

HEWs of the two woredas had strong confirmation that the number of households using modern contraceptives has increased while the number of family planning defaulters has kept on decreasing. About 75 and 25 percent of staff respondents of Goro said they 'strongly agree' and 'agree' respectively that family planning method utilization has risen up while roughly 100 percent of staff respondents of Weliso woreda uttered that they 'strongly agree' with the statement. Similarly, encouraging practices were noted among households. About 53.33 and 69.33 percent of Goro and Weliso woredas respondents respectively assured that they have become users of family planning services for either limiting the number of their children or spacing between the children to be born.

However, though it was very difficult to find recorded data across many years in the provision of family planning services in the woredas, the review of the last two years recorded data revealed the poor performance of family planning services delivery in relation to the projected performance. As presented in the below chart, the actual performance is lower than planned performance in the two years. With the absence of strong recorded evidence, it is found difficult to dare to say family planning method utilization increased.

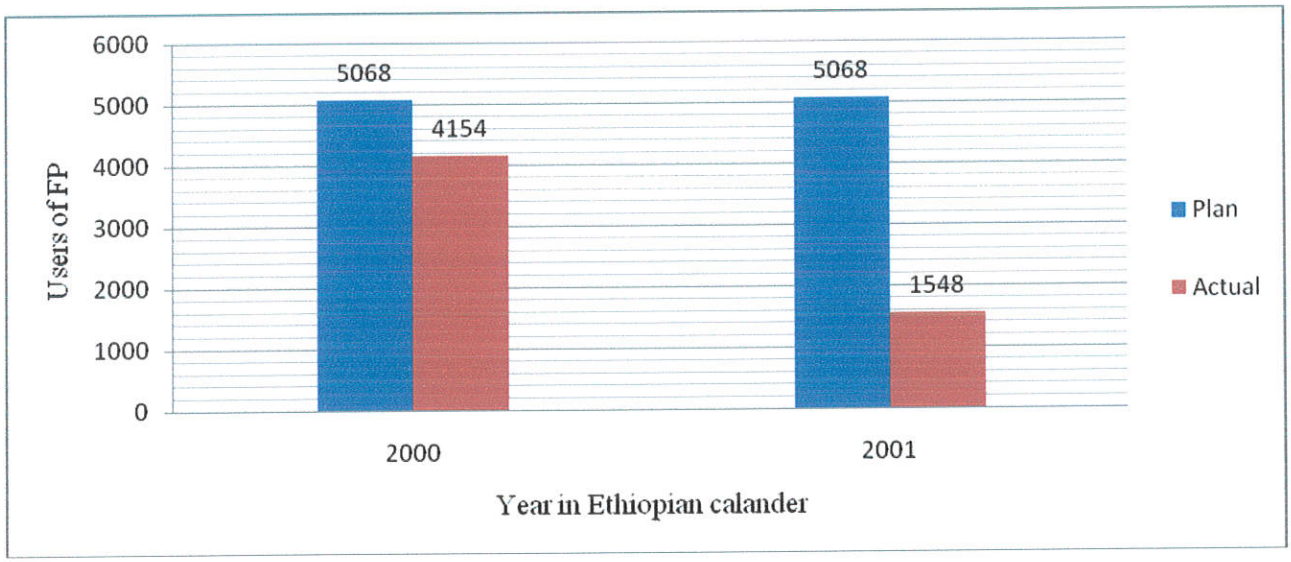

Figure 4.3a: Plan and actual performance of FP (Goro)

Source: own computation (secondary data 2009/10)

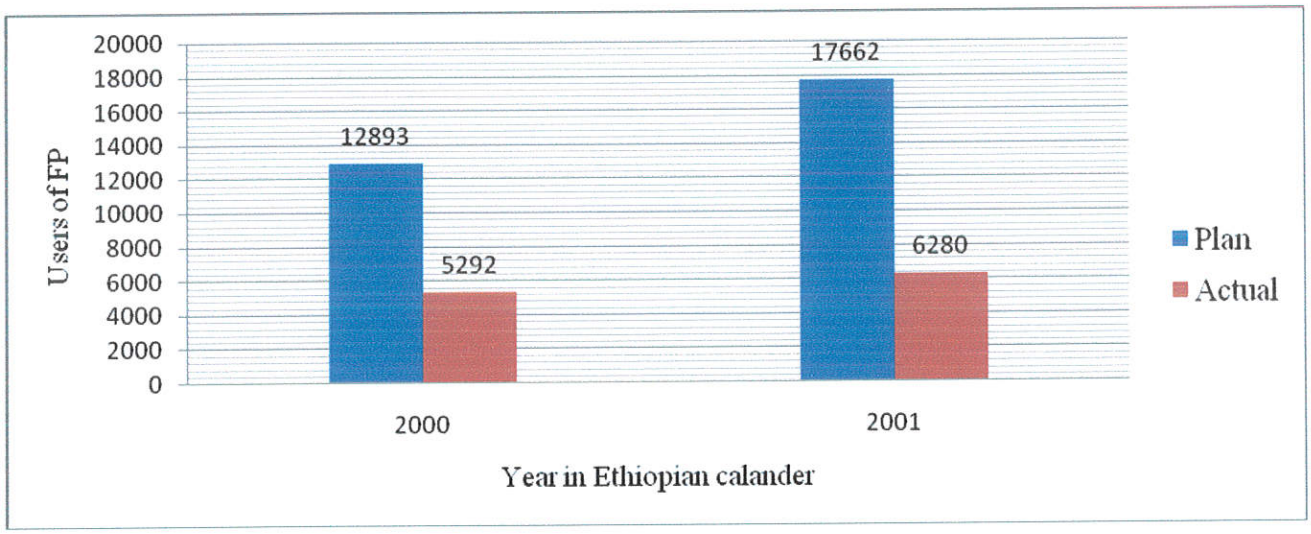

Figure 4.3b: Plan and actual performance of FP (Weliso)

Source: own computation (secondary data 2009/10)

Moreover, more than one third of households of Goro woreda have not ever used family planning services while nearly one fourth of respondents of Weliso district have not become users of family planning for various reasons. Lack of knowledge, religious matters, lack of

willing to use are the dominant factors that kept households not using family planning as reported by client respondents. Some households also had misunderstanding that one has to consume food adequately while using family planning drugs otherwise complicated health problems would happen to the user. This is also another fear creating factor to use as told by respondents. About 77.34 percent respondents of Goro and 82.67 percent of Weliso respondents have strong believed that contraceptives have side effects on health. Such belief bound to impact on contraceptives utilization. Among households who filled the questionnaire, there were households having up to 8 children. In such context, even among family planning users, almost all has been using it just to space between the children to be born not for limiting or stopping to born child. Here, measures such as education should be given to motivate households to shift the use of family planning to limiting family size.

Sample households reported that they have knowledge on family planning services. Most of client respondents do know the negative consequences of having unplanned family size. Majority of households have recognised the available family planning methods that women can use but they have little or no knowledge about family planning methods that men can utilise to limit the number of their children. Male respondents replied that they have been given family planning education on the contraceptives to be used by females but not on family planning methods employed by males. The households got surprised when they were asked about male family planning methods. They added that, the information /education/ they got from different media such as TV, Radio has enhanced their knowledge of family planning methods and where they can get them. Generally, the cumulative positive responses of respondents overweigh the negative responses by a great margin concerning their knowledge on family planning methods. But the knowledge or awareness about family planning is not an end by itself rather it might be a requirement to bring positive behaviors among households to use family planning.

In addition, households have complained about the current family planning services delivery for a range of reasons. Households especially females told that the current family planning services delivery targeted only females. This can be explained in terms of the currently available family planning drugs which are only used by females, the education has entirely focused on women. In such context, the participation of males in family planning wound likely to be very weak as

explained by women respondents. Some respondents also added that they were limited choices of family planning services. In other words family planning methods have not been fully decentralised to the grass root level to meet the diverse needs of the households.

On the other hand, HEWs told the researcher that there are problems to ensure sustainable utilization of family planning services albeit there are some hope giving trends among households. Some females tended to drop using contraceptives because they might say it has brought health complications to her, or her partner warned her to stop using, or they forget taking it regularly as prescribed which lessens the effectiveness of family planning services.

Participation of religious leaders in the mobilization and motivation of their respective followers to use family planning services contributes much to the success of the execution of the package. The total sample HEWs of Goro who answered the questionnaire have had negative impressions that there were no contributions at all from various religious leaders in the implementation of the package. But at the counter part of the district, health sector much better mobilised religious leaders to promote the use of family planning. However, much need to be done to mobilise religious leaders particularly that of Muslim religion to inculcate the use of family planning in their followers' mind to speed up their acceptance as told by HEWs.

4.3. Participation of NGOs and private sector in the implementation of HEP

The general health policy of Ethiopia promotes the participation of the private sector and nongovernmental organisations in health care (MoH, 1993). Successful execution of HEP needs the concerted efforts of different sectors such as NGOs. As a result, local and international NGOs have extended supports to the effective implementation of HEP in a variety of forms. They have provided materials and finance support for the construction of health posts or health centre particularly at Weliso woreda, they have engaged in home to home DDT spray by allocating the chemicals and spray men themselves, etc. Moreover, they have provided refreshing and skill development trainings on different topics of HEP for health extension workers. But much needs to be done to strengthen the continuous participation of NGOs. As HEWs have spoken, NGOs used to come to give them support infrequently and to provide them with trainings or other forms of supports for a few days and then after they went back. They added that to bring genuine changes, NGOs should be encouraged to directly provide health

services to the communities and to extend sustainable supports in addition to the trainings they have been offering or direct engagement in a campaign form.

4.4. Health education delivery performance

Information, education and communication (I.E.C) of health shall be given appropriate prominence to enhance health awareness and to propagate the important concepts and practices of self responsibility in health (MoH, 1993). Accordingly, health education has been implemented as one component of HEP. HEWs have been delivering health education across all components of HEP to promote and motivate households so that they develop positive behavioral changes. Majority of client respondents have acknowledged the efforts of HEWs in health education delivery. To inculcate the desired attitudinal and behavioral changes, HEWs have to segment the communities into different groups based on some similarities such as needs, age, sex or any other relevant background and employ various education delivery approaches based on their availability and necessities. In addition, they need to identify and select appropriate and conducive places to deliver health education. But HEWs answered that they were constraints such as teaching materials, lack of manpower and knowledge and skill to extensively offer health education. It seemed there was no segmentation of customers in the due course of health education delivery that would have probably improve the effectiveness of health education or communication. Further, HEWs explained that they have not been given special consideration for health education during their training at college. This has its own bearings on the delivery of health education. A research conducted by Centre for National Health Development in Ethiopia has analyzed training time allocation of the HEP curriculum. It shows that only 30hrs was allocated for health education out of total 1392 hours budgeted for HEP curriculum (http://cnhde.ei.columbia.edu/files/assessed on 12 December 2009.

On the top of that, HEWs have stated that they offer health education most often by going house to house. In the condition where houses scattered/ sparsely populated households/, it has been very challenging to reach every houses at the time needed. They also argued that health education has not been given due attention it deserves as it is a cross cutting element in the execution of HEP. At the end, they mentioned that communities' participation at health

education was less. They said that the communities did not attend meeting called by HEWs for health education very often. Generally, there was poor performance in the area of health education. For instance, Goro woreda health office has planned to give health education for 50261 individuals in 2000 E.C. but they reached only 15863 individuals (31.60%) (Goro Health office, Annual report,2000 E.C).

On the other hand, clients have explained the concerns they have on the health education delivery. Some respondents have informed that HEWs sometime used to speak other languages that they could not understand, use words which are against the culture and norm of the locality. One respondent told the researcher what he encountered during health education delivery by one of HEWs working in his kebele. He explained that HEW started giving education standing in front of the gathered female and male individuals. In the mid of her speaking, she used very offensive words. Surprisingly, almost all audiences remaining the stage and went having felt great shame soon after she has spoken that word. By the same token, head of Weliso health office has shared the researcher similar experiences he has faced at different kebeles. Furthermore, he described that such problems have emanated due to absence of extensive ethical education provision during their stay at college or after their graduation as refreshing skill while on their work.

4.5. Communities acceptance of HEWs being female

Majority of respondents reported that they have no problems for HEWs being females at Goro and Weliso woredas (74.67% and 80%) respectively. They mentioned that HEWs create very close relationship with wives and girls in the household and women discuss all their problems with HEWs openly for they are being females. But some households claimed that they are certain problems since all HEWs being female. These households said male clients could not create effective communication with HEWs as they feel shame to expose their secrets to female HEWs. They also added other problem to rise for HEWs being female. One respondent stated that assume you may face urgent problems in the night and you may need HEWs to come home to give treatment but she fears to come in the night. However, if they were male, they could come at the time you need. In the same vein, HEWs themselves have discussed some of the problems related with for they are being female. They declared that there are backward thinking i.e.

communities undermine females performance which would result in resistance among individuals to accept what HEWs said. Further, they told that they fear while they go long distance across rives. forest to provide health services at home and they also go for hours alone to report and get supplies and other materials from woreda health on their foot. Therefore, if male HEWs were involved might solve these and other problems as described by HEWs.

4.6. Work relationships between health extension workers and other sectors

Regarding work relationship almost all respondents (100 %) of the two woredas approved the existence of cooperative relationships with schools, DAs and kebele leaders. School administrators help HEWs in the operation of health services such as health education delivery at school through establishing and organizing different clubs where HEWs deliver health education. They also support them in selecting students from the school for the preparation and presentation of entertaining and informative dramas, poet, etc to be used in health education delivery. Kebele administrators on their behalf, they call and organise public meetings for them, they mobilise and motivate the communities to contribute physical, material and intellectual resources for efficient and effective health service delivery as presented by HEWs. They also acknowledged the support from Agricultural extension workers particularly their help at liquid and solid wastes management measures.

On the other hand, some HEWs criticised that kebele administrators have not extended heartfelt supports for the reason they are not paid for their contribution in the execution of HEP. They added that kebele administrators are not cooperative enough. For instance they invite HEWs to discharge their duties at the end of public meeting when people start departing and at time of exhaustion.

Regarding voluntary community health workers, HEWs have recognised the supports extended to them in the form of promoting and motivating people in order to make communities fully participate in the operation of HEP. But HEWs have the doubt that these voluntary community workers are not given sufficient practical attention by woreda health office. To capitalise on their contribution and to sustain their support, woreda health office has to arrange some sorts of benefits such as pocket money otherwise is bound to be fool to expect much commitment and durable contribution from them as said by HEWs.

4.7. Referral system performance

Among the duties and responsibilities of HEWs, giving referral for patients beyond their knowledge at health post is one. HEWs are supposed to have good knowledge and skills about what cases to refer what cases not to refer. About 73.33 and 90.67 percent household respondents of Goro and Weliso woreda respectively have appreciated that they have been given on time refer to higher health institution. But roughly 22.6 and 9.33 percent respondents of Goro and Weliso woreda have denied that there was not satisfactory referral system currently. And these individuals complained that HEWs refer simple cases to health centre or to other higher institutions which could possibly get solutions at health post. Some households argued that HEWs provide very little curative health services. Thus, they prefer to go to higher health centre in the nearby town by passing HEWs. By the same analogy, both Goro and Weliso health office administrators explained the challenges prevailing in the current referral system. They discussed that there are physical decentralization i.e. construction of health posts and health centres are underway in their respective districts but all these institutes are not providing health services in their full capacity for a number of constraints such as lack of skilled manpower. As a result, HEWs could not perform much on curative aspect at health posts. They added that there are problems with HEWs in identifying justified and unjustified referrals, failure to refer cases on time. On the top of this, there are rural kebeles which are considered as "out of reach," in these kebeles it has been found very difficult to establish good referral system particularly in the rainy seasons.

4.8. Working conditions of HEWs

Availability of health posts and residences for HEWs

Availability of functional health posts i.e. health posts well furnished to render services what they are supposed to provide is one of defining criterion for efficient and effective operation of health extension programme. Health posts are operational centres for HEWs in the kebele they are working. As it was observed during the field survey, there were no health posts in anyone of kebeles at Goro woreda except some were under construction while there were some constructed but with no necessary equipments and supplies at Weliso woreda. The health posts are

constructed or being constructed with mud and wood while their door and windows are made of steel.

Figure 4.4: Health post under construction

Source: Photo from field visit

Consequently, HEWs have offered health services by going home to home or at her residence home if she lives in the kebele. In some kebeles, HEWs were found rendering services at kebele administration office or agricultural extension workers office. HEWs reported with frustration that they have encountered a number of challenges while delivering health services in the absence of health posts. HEWs explained that clients could not get them for there was no defined common place to offer services, in the case where they use other sectors' office, clients lose privacy to openly discuss with them since kebele administrators or agricultural workers serve their respective clients in the same office and probably at the same time. Availability of residences for HEWs in the kebele they are working contributes a lot to the successful execution of HEP. The presence of residence would prolong the stay of HEWs in the place they are working there by improving their easy accessibility to the communities. Roughly 77.33 and 48 percent respondents of Goro and Weliso have witnessed that HEWs do reside in at the nearby town and this could highly affect HEWs accessibility to the communities. As client respondents said absence of housing facility for HEWs has influence on their continuous stay in the kebele. Despite HEWs live in the nearby town, 53.3 percent of Goro and 66.67 percent of Weliso respondents declared that they have got HEWs at the time they needed them. Not few households from both districts argued that they could not get HEWs when they need to meet them. One informant attempted to describe the situation by saying that, HEWs come every morning from the town they reside in and by the time they reach in the kebele, most

households go out to fields for work. Again when households come back from field, HEWs depart for town around 4:00 pm. And he concluded that HEWs kill their time coming from and going to town every day. He added that, HEWs frequently go woreda capital for meeting or other reason he does not know. Moreover, HEWs do not got to work on the weekend when majority of the people can be available. Similarly, HEWs themselves have described why they do not live in the kebele they are working. Among 12 HEWs in the Goro woreda who were interviewed, ten of them have made their residence place in the nearby town. Most of them told that they started living in the kebele earlier but they found difficult to live there because there were no clean drinkable water, comfortable and enjoyable living conditions.

Procurement of equipment, medicines, contraceptives supplies and references

Health posts should be furnished with necessary equipments and other necessary materials to enable health extension workers provide the essential health services. Generally the distribution of required medicines or equipments seemed erratic in the two woredas. For instance in some kebeles HEWs have had blood pressure apparatus while in other kebeles HEWs do not have it at all. Generally speaking, basic required materials for health posts have not yet procured. For example some HEWs reported that they provide malaria drugs based on the symptoms the patient show without any examination because of the absence of blood test machine. Most HEWs described their working conditions that they do not have examination table, chair, store shelves, etc. They used to store medicines or contraceptives in carton or plastic basket they bought. As a result, medicines or necessary documents were haphazardly placed at a given corner of the house in which they were working.

Regarding stationeries supply, HEWs claimed that there was problem with supply of stationeries such as recording books, writing paper and the like. About 100 percent of Goro and 33.33 percent of Weliso's respondents witnessed the same.

Figure 4.5: HEW looking for medicine

Source: Photo from field visit

HEWs have also described other problematic areas. They said that here were shortages of basic necessities such as anti- malaria drugs especially when malaria epidemic breaks out, megaphone is required to deliver health education at large people gatherings but it is missing. These are some signs of lack of commitment on the side of woreda council or health office not able to fill health posts with necessary facilities. It is clear that immediate measures have to be taken to furnish health posts with the needed materials.

Concerning the construction of health posts and supply of equipment materials, Weliso and Goro health officers stated that there has been budget constraint to hurry up the construction of health posts and fill them with the required equipments. As a result, they could not have completed the construction of health posts and fulfillment of basic materials that were planned to be accomplished in the year 2000 E.C.

With respect to reference and reading materials, all HEWs interviewed have had reference materials prepared by Ministry of Health of which most were written in Afan Oromo language and others reading materials which were given ~~during~~ their study at college. There are practically no other references for HEWs. They do not get news paper, news letter or any ~~other professional~~

journals to upgrade their knowledge of the profession. Reference materials are important and efforts need to be made to improve the availability of reference materials in the form of news letter, leaflets, magazine or journal.

Transportation facility

None of HEWs have means of transport to go to health centre or woreda health office. HEWs used to travel on foot home to home for serving households and to go to health centre or woreda health office. The distances from woreda health office bound to be great. There are kebeles so far from the woreda capital that takes up to 5 hours on foot. Also the distances among households in which HEW are considerable in most kebeles particularly in sparsely populated kebeles. As a result, it has been become a painful activity going around each household on foot to serve them.

Moreover, in such circumstances, it is difficult to create effective reporting relationship and supervision systems. Thus, the need of transportation means for HEWs is legitimate. Consequent to this reality, government has to search out for feasible solutions to overcome the problem. However, still some kebeles because of its geographical locations are only accessible on foot until some time to come.

Job satisfaction/ motivation, promotion, transfer and continuing education

A mix of feelings was noticed on the faces of HEWs regarding their work. They reported that they are glad about their efforts of improving the health standards of communities, the commencement of HEP has provided them with job opportunities otherwise they would have been unemployed. Nevertheless, HEWs have demonstrated complaints on the above basic issues. They explained that they were promised at the time of training and when they joined health sector as HEWs that there would be arrangements for upgrading, promotion, transfer after two years services but none of the promises have been fulfilled. HEWs who were recruited at the inception of the programme still they are working on the same position, in the same kebele with no salary increment. One HEW told with great embarrassment that she has worked for five years in the same kebele and within these years she has got no promotion, transfer and she is paid the same amount of salary that new employee is paid. She added that since there has been no practical further education opportunity except promises, she started nurse education herself at

private college but at the time woreda health office heard that it suspended her salary until she brought confirmation letter from the college showing that she has quitted her education and she did the same. Another HEW being awkward said that she bother much when she thinks for how long she lives in the kebele she working now. She said that she worries much when she recognises that there are no promotion, transfer and opportunity to upgrade her knowledge or skill. Again, transfer requests by HEWs are considerable but no single HEW got permission as reported by HEWs.

Besides, HEWs mentioned that other development workers such as DAs have been given boats, rainy coats and umbrellas but no such facilities have been arranged including uniform i.e. field and health post uniforms for them. At the end, they reported that all these embarrassing situations force them not to concentrate on their activities and look for other job opportunities in the market. In other words, these have bearings on the motivation and performance of HEWs. For example, they are HEWs who quitted this work and start their own private work such as opening small grocery for selling 'Tela' and other local alcohol drinks. These situations reflect loopholes on the government and management aspect of HEP.

Supervision /monitoring/ and reporting relationship

Supervision is an important management tool as it helps to detect constraints encountered in the execution of HEP. Effective supervision requires team of experts with appropriate mix of knowledge and skills of both technical and management aspects. Except one kebele, others have not have supervisors at the time of visit at Goro woreda. Head of Goro health office also told the same. He described that they have lack of supervisors (skilled manpower) to run supervision activity. During the field work at the woreda, there was only one supervisor who is nurse graduate in diploma supervising the works of HEWs in five kebeles. He explained the challenges existing while supervising. He said that he has never been given training on supervision; he works in five rural kebeles going on foot across long distances. Relatively speaking, supervisors at Weliso woreda are almost degree graduates most of them in environmental health but with no trainings on supervision and management. They have spoken that zonal health office has sent them to woreda health office and woreda health office has assigned them randomly without giving them without pre-job trainings into different kebeles. Supervisors told that they monitor

HEWs performance in line with progress indicators (checklist) prepared for each component of HEWs given down by zonal or regional health office. Concerning their work relationship with HEWs, supervisors said that they give HEWs advice, share them knowledge and solve problems encountered in their operation if there are found under the jurisdiction of supervisors otherwise they pass on them to the higher office. They also explained their observations in their work that most HEWs lacked high commitment, and basic knowledge and skills for delivering health services as planned. They speculated that HEWs were selected from low grade achievers at grade ten and adequate education and trainings were not given at college level and these realities made HEWs less competent in the render of health services. They also mentioned that woreda health office management has not provided them with means of transport, there are work overloads i.e. one supervisor oversees works done in five kebeles. These events highly hamper effective and efficient supervision. It seemed a lot of attention has not been given to supervision. Generally, supervision has not been carefully considered lacking a lot of technical competencies, limited learning process, supports from higher health offices.

Regarding reporting relationship, there was no uniform reporting system across sample respondents. All HEWs have reporting format prepared by woreda health office or higher health office. They told that they evaluate their progress in the implementation of more often monthly and quarterly. However, their evaluation varies according to the component of HEP concerned. There are some variation concerning to whom HEWs report their performance. In some kebeles, they only reported to woreda health office, in the other time, HEWs make reports to different bodies such as kebele council, health centre and supervisors simultaneously. But the current reporting suffered from lack of appropriate record keeping /information management/ at health post. During the field surrey it was observed that there was no adequate documented data except some found haphazardly placed in any place. Reporting is an important management tool if it used effectively particularly for controlling. Again, HEWs complained that they have not ever relieved written feedback for their report or they were only told orally at meeting after six or more months of the report. HEWs added that they were not given positive feedback what every they performed well. They said that people who are working in health centre or woreda health office have no positive attitudes towards them. They consider HEWs as they are working for different goal, these people highly undermine the importance of HEWs in the operation of the

programme as reported by some HEWs. Thus, there was flawed reporting relationship that could possibly emanate from ill relationship between HEWs and other health workers.

With respect to work schedule, all HEWs replied that they have had work schedule for a day, week and month. Woreda health often prepares annual work schedule in terms major objectives to be accomplished and activities to be undertaken. Then after HEWs in collaboration with either kebele council or woreda health office, they break down woreda's annual plan into semiannual, quarter or month plans. However, some HEWs denied that the contribution from kebele council or leader was so meager that HEWs were forced to prepare work schedule alone. They also answered on the execution programmes in accordance with work schedule. They explained that sometimes they underperformed for various reasons such as they may be called for meetings at woreda capital that could last for many days, the period of accomplishment set by woreda health office for a particular component task did not commensurate with the realities prevailing on the ground. For instance they were told to graduate model families in two months on all seventy components of HEP but practically it was eventually impossible given many constraints such as time, low understanding level of households, they also do political works as reported by HEWs. The situation got worsened due to scarce men power as all duties of executing all components of HEP surfaced on the shoulder of only two HEWs in each kebele.

In line with this, no HEW has had job description in writing. HEWs reported that upon their graduation, they were called to sign a contract on their respective woreda health office and then they were given only a letter announcing that they are employed on the position of health extension. Consequently, no one of HEWs knows the duties and responsibilities expected of them and the privileges and rights to claim.

Conclusion

In this section of the thesis, data analysis on the achievements and challenges of health extension programme has presented. Though it is difficult to have a consensus on the performance of HEP among different stakeholders at least on the degree of performance, efforts have been made by the researcher to rate the performance of the programme having classified the data discussed into eight (8) sub topics suitable for making interpretation. Service delivery performance in malaria

prevention and control, family planning service delivery, participation of NGOs and private organisations, health education delivery performance are among the major variables which have been dealt with in depth.

Chapter Five

5. Major Findings, Conclusions and Recommendations

In chapter four, attempts have been made to analyse and present data collected through interview and questionnaire as well as observation and review of available secondary data in relation to basic research questions set.

In this chapter, key findings would be identified based on data analysis made in the previous chapter. All possible data sources i.e. primary and secondary have been considered to arrive at major findings encountered in the study of the assessment of health service delivery (HEP) at Goro and Weliso woreda followed by conclusion and recommendations put forward by the researcher.

5.1. Summary of Major Findings

Assessment of health service delivery was made primarily based on standards, indicators of progress, basic requirements need to be satisfied to efficiently and effectively implement health extension programme (HEP). As a result, key findings in line with the objectives and research questions set to guide the study have been identified and discussed as follows:

- One of the guiding principles in the implementation of HEP is to ensure the participation of communities in the design and implementation of HEP. Equally important, HEWs' duty is to educate and promote people so that communities would develop healthy behavior to improve their living standards. However, the findings of the study indicated the behavior of households has not yet changed well in keeping their health, they are reluctant to use family planning methods, and they are not much concerned and committed in the execution of HEP.
- For efficient and effective implementation of HEP to be undertaken, early construction of health posts is a basic requirement to host basic health services benefiting the mass population. The findings drawn, however, showed that this requirement i.e. functional health posts almost missing out of which rendering quality health services become hope rather than reality.

- It is stated in implementation guide that sound supervision is an essential input in the execution of HEP. However, in the study areas due attention has not been given to the supervision aspect of HEP. It is discernible that there is high deficit of skilled supervisors. For instance, there was only one supervisor at Goro woreda at the time of visit otherwise they were not well equipped with multi-disciplinary skills that reliable supervision needs coupled with over loaded works.
- The most front desk health service renders in the implementation of HEP are HEWs. These individuals have a very close contact than any other body with communities and they are primary agents of HEP implementation. One could deduce from this fact that HEWs have to be competent enough to serve communities as well they have to advance ethical behaviors in service rendering process. The findings of study showed that the implementation of HEP addressing the needs of various segments of the communities could not adequately be undertaken by the current manpower. It is also apparent that only two female HEWs could not fully discharge the duty of HEP execution.
- For health posts or HEWs to serve the communities in their full capacity, they have to be provided with necessary facilities such as equipments, medicine and any other vital kits. Regarding this, the findings of the study clearly demonstrated the under supply of HEWs or health posts with required equipment materials to provide services. Most of sample HEWs reported that there were high shortage of even basic kits such as gloves, blood test instruments, etc. Additionally, logistic problems have been vividly observed predominantly at furnishing kebeles considered as "out of rich."
- Working being HEW is an awkward profession that a person who does not have other alternative joins it as phrased by HEWs. To elaborate it the working conditions of HEWs were not pleasant. Rights such as transfer, promotion, continuing education that they are supposed to gain have become inaccessible to them. The finding in the study has highlighted the ramifications of the decisions on the performance of HEWs or their long stay in the profession.

- Provision of appropriate and timely feedback for the reports made help HEWs to keep track of their progress and make corrective measures as fast as possible. Unfortunately, findings of the research reflected the weak reporting relationship in the execution of HEP. It was reported that either health centre or woreda health office has not ever provided written feedback to HEWs.
- At the end, the findings of the study reflected that there has been financial constraint to construct health posts and to ensure on time supply of equipments and materials that would enable the provision of quality health services.

5.2. Conclusions

Multiple data collection instruments were employed to gather data from different actors involved in the implementation of HEP. Appropriate analysis instruments were put in place to look into the patterns of data collected which have been summarized in the paragraphs to follow.

To start from the achievement recorded, findings of the study indicated that HEWs have been providing primary health services down at village level to improve the health standards of the rural communities. Among the achievements registered, the distribution of ITNs to households, encouraging starts in the utilization of family planning services at woredas, provision of health education by HEWs at kebele level, relative reduction of deaths due to malaria, a few constructed and under construction of health posts and health centres, etc have been identified as major harvests of the execution of HEP.

On the other hand, the findings of the study showed many poor performance areas in the execution of the packages. In the malaria prevention and control campaign, the finding indicated the inadequacy of ITNs distributed to enable households protect themselves from malaria, undesired households behaviors in utilising ITNs i.e. households have been utilizing ITNs for different unintended purposes. It also highlighted that there have been challenges in clearing and drying wide marshy areas which are a suitable areas for mosquitoes to breed. Moreover, the result of the study has proven that the higher proportion of households have covered sprayed house before advised period that lessen the effectiveness of anti malaria chemical spray.

Regarding family planning services provision, resistance of households to use family planning methods mostly in Muslim communities was high that they have perceived limiting family size is against god work. Generally, evidences have showed health office of the study areas have also under performed address households need for family planning methods.

Decentralization of health service delivery to lower level has been written in implementation guide of HEP. However, preventive and promotive health services have been rendered with little emphasis given to the curative aspect. Physical decentralization i.e. construction of health posts and health centre have been undertaken or planned to be done at kebele level but lack of skilled man power and other facilities hindered to provide wide range of health services. But households have also needed the curative health care at health posts.

Construction of health posts and furnishing them with the required equipments and medicines are the defining criteria for successful execution of health services. Equally, housing services should be in place that would lengthen the stay of HEWs in the kebele they are assigned. Nonetheless, the findings showed up that health posts and basic health service kits have been lacking for HEWs to serve communities as intended.

The educational background of HEWs another factor that impacts on the success of the programme. As reported by supervisors and heads of heath office, health extension workers lacked basic skills and knowledge in some aspects of HEP. As evidenced by the data collected, all HEWs were certificate holders (10+1) and ethical education has not been adequately given at college that have minimized the achievements of HEP. And no strengthened refreshing education has been arranged to upgrade HEWs knowledge and skills by the woreda health office.

Supervision is an important management tool to ensure effective and efficient management of HEP. In the study areas, the findings reflected that generally there has been weak supervision. Findings showed that supervisors lack a mix of skills such as technical competency, management skills that are basic for sound supervision to exist. In addition, there was no transportation facility for supervisors to smoothly coordinate and supervise the performance of HEWs in five kebeles.

HEWs are expected to provide primary health services and refer patients with chronic illness those cannot be treated at health posts to higher health institutions i.e. health centre or hospital. But evidences have witnessed that there have been problems in identifying justified and unjustified referrals, delays for referral and lack of feedback from health centres or hospitals to which patient has been referred.

Government has trained and deployed two female HEWs in each kebele to deliver basic health services for all segments of the communities. Nevertheless, the finding underscored that female HEWs were not in a position to meet the needs of male population. Respondents replied that male clients have not discussed with HEWs freely about the problems they have encountered. Moreover, in some places communities undermine HEWs for being female. Consequently, such situation has proved the resistance of households to participate in the design and implementation of HEP.

A cross – cutting issue in the implementation of HEP is health education and Communication. Heath education and communication has been given priority in HEP by government. Despite this fact, the result of the study showed that sufficient time has not been allocated for health education in health service delivery. It was discernible from the interview made with heads of health office that health education was not given due attention at the time of trainings and after their deployment. As a result, it was noticed that HEWs could not impart the basic information and knowledge to households to bring positive behavioral changes among households to be self reliant in keeping their health.

As to the participation of NGOs or private organisation in the execution of HEP, it seemed that government has recognised the irreplaceable role of such sectors for the success of the programme. However, in the study area, the findings mirrored that the participation of NGOs or private organisations was not as such high except some helped in giving trainings for HEWs and the construction of health posts at Weliso woreda.

Lastly, the working conditions of HEWs such transfer, career development, continuing education and salary are the primary factors influencing the motivation of HEWs. As deducible from the results of the study, HEWs have attached much value to these variables in carrying out their

duties. Nevertheless, these conditions absolutely have not been fulfilled that could otherwise inspire them to be active and hopeful in discharging their responsibilities.

5.3. Recommendations

Based on the findings of the study, recommendations having options for policy implications and practical interventions to improve health service delivery performance (HEP) are forwarded. The recommendations have mentioned as follows.

- Facilities needed for the provision of quality health services should be strengthened. It is important to complete the operational centre of HEWs on time. By the same token, health service delivery kits, gloves, and supply of family planning drugs and anti malaria drugs, ITNs, etc should be improved to guarantee sustainable provision of health services.
- As presented in this thesis, adequate positive changes in the knowledge, attitude and behavior of individuals were almost absent. Thus, health education and communication should be reinforced to inculcate receptive spirit among households so that their full involvement would be realized that could be a potential assurance for the success of the programme.
- The current supervision should be immediately improved. It is vivid that the present supervision is very weak that it induces changes in terms of improving the managerial and technical skills of supervisors. In the same vein, sound information management system should be in place so that sufficient data would be available for keeping track and making informed decisions about the programme.
- Further study should be conducted to solicit feasible and sustainable transportation facilities for HEWs. For supervisors transport facility such as motor cycle should be used to smooth supervision activity.
- Integrated refreshing trainings have to be arranged to fill the gaps noticed in the practical skills of HEWs so that HEWs could undertake their current job more effectively and efficiently.

- Study should be initiated to consider whether male health extension workers need to be included to meet male population needs and help female HEWs in the programme implementation.
- Like any other sector staff, arrangements have to be made to address the increasing needs of HEWs. Among the arrangements, the salary increments, availability of transfer, continuing education are the major ones. Similarly, housing facilities near health posts should be arranged for HEWs.
- Communities have had high needs for the curative aspect of health services and wide range of health services at health posts. Consequently, further analysis has to be made to decide about to what extents health services be decentralized given the constraints prevailing.
- Improve the future selection and recruitment of candidates to be trained as HEW by ways of scaling up entrance grade, conducting entrance examinations and so forth.
- To share the burden of health services delivery, favorable working environment has to be created to attract NGOs or private organisations to the locality. NGOs or private organisations' experiences, knowledge or education should be tapped to improve the present health service delivery.
- Woreda health office should solicit for alternative finance rising instruments to back up operational budget allocated by the government. Cost – recovery mechanism such as fee-for- service or other community based financing should be discovered that could be used to accelerate the construction of health institutions and supply of required facilities and thereby it improves sense of ownership among households over health centres or health posts.

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Appendix One: Questionnaire for Residents

Addis Ababa University

Business and Economics Faculty

Public Administration and Development Management

Masters of Public Administration

Guidelines for interviewers/ enumerators

When you reach the selected individual/household, introduce yourself as you come from Addis Ababa University to collect data to conduct scientific research regarding the performance of health extension program. Then explain the purpose of the research.

After explanation, identify the presence of preferably husband or wife otherwise any household member who aged 18 years and above. If you meet more than one person who are 18 years old and above in the identified household, give them number and then select one individual by lottery method.

If there is no individual in the identified household age group, thank them and go to the next household.

Questionnaire to be filled

Dear informant, I came from Addis Ababa University, post graduate school. I came to collect information from you to undertake a research entitled **'assessment of the achievements and challenges of health extension program'**. The information is collected for academic purpose, to suggest remedial actions to improve the program and in no ways has political implications. Moreover, the information obtained is kept confidential and never affects your personal life. You are also not required to tell me your name. Therefore, you are cordially requested to give your genuine answers to the questions raised in accordance with the instructions. I thank you in advance for all co operations extended to me. You are supposed to give your answer according to the general and specific instruction.

Part I: Demographic profile of service customer respondents (residents)

Dear enumerator put tick mark (√) in the box correspondent to respondents' response and writes their response on the space provided for open ended questions.

Age _____ Ethnic group _____ Your religion _____ Marital status _____

No of children _____ Educational status _____ Sex _____

Occupation _____ Years of residence _____

Part II: Questions regarding main achievements recorded for service customer respondents (residents).

1. Mosquitoes breeding sites have been cleared.

☐ Strongly agree ☐ Agree ☐ isagree ☐ ngly disagree

2. How often you have participated in health education program/ sessions.

☐ Very Often ☐ Sometimes ☐ ve not ever participated

3. I have properly used Insecticide Treated Mosquito Nets (ITNs) (visit way of use)

☐ Strongly agree ☐ gree ☐ sagree ☐ ngly disagree

4. Has your house got sprayed within this year?

☐ Yes ——→ go to question 5

☐ No

5. Within how many months you cover your house's wall with mud after spraying?

☐ ≤ 3 months

☐ ≤ 6 months

☐ After 6 months

6. I get early examination or treatment for malaria.

☐ Strongly agree ☐ gree ☐ sagree ☐ ngly disagree

7. Do you know the transmission routes of malaria?

☐ Yes ——→ go to question no. 8

☐ No

8. If your answer to question no. 8 is yes, what are/is the transmission route of malaria?

_____

_____

9. I know how to prevent from being caught by malaria.

☐ Strongly agree ☐ gree ☐ sagree ☐ ngly disagree

10. I know family planning methods that women or men use to avoid pregnancy.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

11. Health extension workers give me sufficient information about family planning methods.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

12. I know where I can get family planning method/s I need.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

13. What are the advantages of family planning? Please mention at least three of such advantages.

_____

_____

_____

14. Contraceptive methods have side effects on health.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

15. What are the negative consequences of unplanned family size? Please mention three of them.

_____

_____

_____

16. Have you ever used modern contraceptive?

☐ Yes ⟶ go to question 21

☐ No ⟶ go to question 22

17. Are you currently using contraceptive methods?

☐ Yes ⟶ go to question 23

☐ No

18. Why you have not used modern contraceptives? (More than one choice is possible)

☐ I do not know about the use of contraceptive methods

☐ It has major side effects on my health

☐ My religion does not allow me to use

☐ It is not easily available

☐ The methods are expensive
☐ If other, specify _____

19. For what purpose are you using the contraceptive method?

☐ For Spacing
☐ For limiting

20. Do you think services currently provided are sufficient in the areas of malaria prevention and control?

☐ Yes
☐ No ——→got to question 25

21. What improvements need to be made to get better the services?

Part III: Questions regarding challenges of the packages for service customer respondents (residents).

22. Do you think there are problems for health extension workers being female?

☐ Yes ——→go to question 28
☐ No

23. What problems exist with health extension workers being female? Please explain them

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24. Where do health extension worker live?

☐ In the same kebele
☐ In the town
☐ I do not know

25. Do you get health extension worker at the time you need her?

☐ Yes
☐ No ——→go to question 32

26. Why did you not get her?

☐ She goes to town
☐ She does not go to office
☐ She goes for meeting
☐ I do not know

27. Family planning methods are available at health post as one prefers.

☐ Strongly agree ☐ Agree ☐ Disagree ☐ ongly disagree

28. Do you get referral system on time?

☐ Yes

☐ No

29. What measures do you suggest to be taken to improve family planning services?

_____

_____

_____

Appendix Two: Questionnaire for Health Extension Workers

Addis Ababa University

Business and Economics Faculty

Public Administration and Development Management

Masters of Public Administration

Questionnaire to be filled

Dear informant, I came from Addis Ababa University, post graduate school. I came to collect information from you to undertake a research entitled **'assessment of the achievements and challenges of health extension program'**. The information is collected for academic purpose, to suggest remedial actions to improve the program and in no ways has political implications. Moreover, the information obtained is kept confidential and never affects your personal life. You are also not required to tell me your name. Therefore, you are cordially requested to give your genuine answers to the questions raised in accordance with the instructions. I thank you in advance for all co operations extended to me. You are supposed to give your answer according to the general and specific instruction.

Questions regarding main achievements recorded for health extension worker respondents.

Part I: Demographic profile of health extension worker respondents.

Dear enumerator put tick mark (√) in the box correspondent to respondents' response and writes their response on the space provided for open ended questions.

Age _____ Ethnic group _____ Your religion _____ Marital status _____

No of children _____ Educational status _____ Sex _____ Service year _____

Part II: Questions regarding main achievements recorded for health extension worker respondents.

1. The number of malaria cases has reduced.(visit recorded data)

☐ Strongly agree ☐ Agree ☐ isagree ☐ ngly disagree

2. The number of deaths due to malaria has decreased. (Visit recorded data)

☐ Strongly agree ☐ gree ☐ sagree ☐ ngly disagree

3. Modern contraceptive methods utilization has increased. (Visit recorded data)

☐ Strongly agree ☐ Agree ☐ isagree ☐ ngly disagree

4. Religious leaders are participating in community mobilization for family planning services use.

☐ Strongly agree ☐ gree ☐ agree ☐ ngly disagree

5. The number of family defaulters in family planning service use has decreased.

☐ Strongly agree ☐ gree ☐ agree ☐ gly disagree

Part III: Questions regarding challenges of the packages for health extension worker respondents.

6. Is there cooperation between health extension workers and schools, kebele administrator, agricultural extension workers?

☐ Yes ——→ go to question 7
☐ No

7. On what issues do you work together? Please list at least three areas of co operations.

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8. The residents are cooperative enough with health extension workers in areas such as clearing of water bodies, drying swampy areas at local level.

☐ Strongly agree ☐ gree ☐ agree ☐ gly disagree

9. Do private organizations or NGOs participate in the provision of family planning services in your locality?

☐ Yes
☐ No

10. Do private organizations or NGOs participate in the provision of malaria prevention and control service in your locality?

☐ Yes
☐ No

11. Do private organizations or NGOs participate in the provision of health education or information service in your locality?

☐ Yes
☐ No

12. Is there community health workers in your village?

☐ Yes ☐ No

13. Is there health post in your kebele?

☐ Yes
☐ No ——→ go to question14

14. Where do you provide health services?

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15. Do you have the needed logistic supplies for the health post?
    1. Disposable syringe and needle ☐ s ☐
    2. Contraceptives (oral and inject able), condom, penis model, etc
       ☐ Yes ☐ No
    3. Anti malaria drugs, abate, ITNs, spraying equipment, DDT

Yes No

4. Blood pressure apparatus
5. Examination table, chair, store shelf, stretcher
6. Malaria ,family planning education materials
7. Dry batteries and megaphone Yes

16. Do you get stationery on time (pen, pencil, registration books, folders, family planning cards, etc)?
    Yes No
17. Do you have a detail description of duties and responsibilities in writing?
    Yes ——→(observe for existence)
    No
18. Do you have work schedule?
    Yes ——→(observe for existence) ——→go to question 19
    No
19. Who prepare your work schedule?
    I myself
    Woreda health office
    Health center
    In collaboration with kebele leaders
    Other, specify----------
20. Do you have means of transportation to go to woreda health office or health center?
    Yes
    No
21. How long does it take from health post to health center?
    ---------- Hours
22. How long does it take from health post to woreda health office?
    ---------- Hours
23. Do you have books, newsletter or leaflet to refer?
    Yes
    No
24. Are their opportunities for promotion or further education?
    Yes
    No
25. How often do you evaluate your activities?
    Monthly
    Quarterly
    Semi annually
    Annually
26. Do you have reporting format?
    Yes ——→(observe for existence)
    No
27. To who do you report?
    to health center head
    to woreda health office
    to kebele council
    If other, specify ----------
28. Do you get feedback for your report on time?
    Yes

☐ No

29. How do you explain the performance of your supervisor while supervising your activities?

_____

_____

_____

30. What measures have been undertaken to improve the performance in malaria prevention and control?

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31. What measures have been undertaken to improve the family planning services?

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32. Are you satisfied with your work?

☐ Yes

☐ No ——→ go to question 33

33. What are your sources of dissatisfaction?

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34. Do you think the ITN delivered was sufficient in relation with household's members size?

☐ Yes

☐ No

35. Where do you provide health education or information? Prioritize in accordance with their frequent use by you.

☐ At school

☐ Going home to home

☐ At public meeting

☐ At public holidays such as saint holiday

☐ At health post

36. What methods do you employ in health education delivery? List the first three methods you have used.

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37. What are your major emphasis areas in the implementation of health extension program? List three of the packages in order of importance.

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38. How many days do you work per a week?

_____

39. What measures do you suggest to improve the performance of health extension services?

_____

_____

_____

40. What measures do you suggest to improve malaria prevention and control services?

_____

_____

_____

41. What measures should be taken to get better family planning services?

_____

_____

_____

42. What activities have you undertaken to increase model families?

_____

_____

_____

Appendix Three: Interview Questions

Interview questions for woreda health office administrators and Supervisors

1. Tell me, what measures and activities are being carried out with regard to family panning in the health extension program?
2. What challenges have been encountered in the area of malaria prevention and control?
3. How do you gauge the progress of family planning package?
4. Do you think that necessary conditions have been fulfilled such provision of contraceptives, living condition of health extension workers, etc.?
5. What mechanisms do you use to evaluate health extension workers' performance?
6. How do you explain other stakeholders' participations in the provision of malaria prevention or family planning services?
7. What resource constraints have you experienced such as lack of finance (budget), skilled manpower, etc while implementing health extension program?
8. What kinds of arrangements have been made to upgrade the knowledge or skills of health extension workers?
9. How do you explain referral system between health posts and other higher health service providers?
10. Tell me, what activities and measures have been undertaken regarding health education and communication?
11. To what extent health service with regard to malaria prevention and control and family planning have been decentralized?

DECLARATION

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

Declared by:

Name: Milkiyas Ayele

Signature: _____

Date: 13/07/2010

Confirmed by Advisor:

Name: Mulugeta Abebe (PhD)

Signature: _____

Date: 13 July 2010