



**ADDIS ABABA UNIVERSITY  
COLLEGE OF HEALTH SCIENCE  
SCHOOL OF PUBLIC HEALTH**

**ASSESSMENT OF URBAN HEALTH EXTENSION PROGRAM  
PACKAGES UTILIZATION AND HEALTHCARE- SEEKING  
BEHAVIORS AMONG MODEL AND NON-MODEL HOUSEHOLDS IN  
THE COMMUNITY OF BOLE SUB CITY, ADDIS ABABA, ETHIOPIA:  
A COMPARATIVE CROSS-SECTIONAL STUDY**

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES SCHOOL OF PUBLIC HEALTH AS PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTERS IN PUBLIC HEALTH.

**FEBRUARY, 2021  
ADDIS ABABA, ETHIOPIA**

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**ADDIS ABABA UNIVERSITY**  
**SCHOOL OF GRADUATE STUDIES**

Assessment of urban health extension program packages utilization and healthcare seeking behaviors among model and non-model households in the community of Bole sub-city, Addis Ababa, Ethiopia: A Comparative cross-sectional study

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### **Acknowledgments**

My deepest gratitude first goes to my advisors Dr. Mesfin Addisie and Mr. Gashaye Asrat for their continuous guidance, support, and providing constructive comments to this thesis paper. Secondly, I would like to thank Addis Ababa University School of Public Health for giving me this opportunity to carry out this thesis work as part of the requirements of a Master's degree in public health.

I also extend my appreciation to AAHB, Bole sub-city, and woredas health office for providing necessary information, materials, and showing a willingness to support.

Next, special appreciation is given to all data collectors and Supervisors for their time and patience under the current pandemic disease Covid 19 situation without them this would not happen. Eventually, thank you very much to almighty God for everything.

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**List of Acronyms and Abbreviations**

AA.....	Addis Ababa
AAHB.....	Addis Ababa Health Bureau
AOR.....	Adjusted odds Ratio
CI .....	Confidence Interval
COR.....	Crude Odd Ratio
CSA.....	Central Statistical Agency
EDHS.....	Ethiopia Demography and Health Survey
EMDHS.....	Ethiopia Mini Demography and Health Survey
ETB.....	Ethiopia Birr
FMHACA.....	Food, Medicine and Health care Administration and Control Authority
HEP.....	Health extension program
HF.....	Health Facilities
HH.....	Households
HP.....	Health Professionals
HSB.....	Healthcare seeking behaviors
HSDP.....	Health Sector Development Program
HSTP.....	Health Sector Transformation Plan
JSI.....	John Snow, Inc
MOH.....	Ministry of Health
SEUHP.....	Strengthening Ethiopia's Urban Health Program
SPSS.....	Statistical Package for Social Science
SRS.....	Simple Random Sampling
UHEP.....	Urban Health Extension Program
UHEPa.....	Urban Health Extension Program Packages
UHE-Ps.....	Urban Health Extension Professionals
UHES.....	Urban Health Extension Service
WASH.....	Water, hygiene and sanitation
WHO.....	World Health organization

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### Abstract

**Background:** Ethiopia has implemented urban health extension programs at the community level since 2009. The program was a pro-poor and cost-effective policy it aims to improve the utilization of urban health extension program packages and empower healthcare-seeking behaviors of the community mainly model households. Model households are households that attend at least 75% of model training implement and use at least 75% of the packages.

**Objective:** To compare the urban health extension packages utilization and health care seeking behaviors of a model and non-model households in Bole sub-city, Addis Ababa.

**Methods:** A community based comparative cross-sectional study design was conducted using a quantitative method. To collect data simple random sampling method was used to select the first household from registration listed by the name of the model and non-model female household heads and then a systematic random sampling method was applied until 594 sample sizes obtain. Data first entered into Epi info version 7.2.1.0, then exported into SPSS version 23 computer software for data analysis. P-values less than 0.05 and a 95% confidence interval was used to detect statistical significance and determine the association between independent and dependant variables.

**Result:** 228 (77.6%) model and 105(64.2%) non-model female household heads were utilizing urban health extension packages. Model(AOR=3.135, 95% CI, 0.429-4.470), and non-model female HH (AOR=1.088, 95% CI, 0.533-2.224) heads who understand packages were significantly associated with urban health extension packages utilization than those HH heads who did not understand the packages. 139(75.5%) model and 131(65.2%) non-model female household heads had appropriate healthcare-seeking behavior.

**Conclusion:** Providing training, household visit, frequent non-model household visits, and giving more attention to disease prevention and control packages are very important for the utilization of urban health extension packages. Accessibility and availability of government health centers in some woreda, providing training and health institution visits like Pharmacy, and drug shops are crucial to avoid inappropriate healthcare-seeking behaviors.

**Keywords:** Health care-seeking behavior, urban health extension packages utilization, model households, and non-model households.

# 1. INTRODUCTION

## 1.1. Background

Globally, urban health and healthcare-seeking behaviors (HSB) underutilized, neglected, and health inequalities exist particularly in low and middle-income countries and there is also rapid urbanization and high population growth(1). By 2050, nearly 60% of the population of the continent is expected to be living in urban areas and 35–40% of children and adolescents globally projected to be living in Africa(1). UN-habitat reports the proportion of the urban population in slums in the developing country declined from 39.4% in 2000 to 29.7% in 2014, but the absolute numbers have grown at an incredible 881 million people (1).

In Ethiopia, urban health extension program (UHEP) was adopted and deployment of specially trained urban health extension professionals (UHE-Ps) was started in 2009; to create health equity and access to health service through the provision of health information to increasing urban health extension packages (UHEPa) utilization and healthcare-seeking behavior (HSB) of the households (2, 3).

Urban health extension professionals(UHE-Ps) more than 75% of time spends in the community to provide health education, community mobilization, and house to house visit to implement 15 packages and identify and train model households(HHs) on the four core preventive health areas family health, hygiene, and environmental sanitation, disease prevention and control, injury prevention and control first aid and referral services(3, 4).Model households are those who take at least 75%( 60 hours) training on packages and implement and use at least 75% of packages at household levels (3, 4).Model households mean households acquiring the necessary knowledge, skills, and behavior change that help them have better control over their health(5).According to the health sector transformational plan, the health extension program was one of the government priority areas to address equal access, utilization of essential health service, to increase HSB and health service utilization, and provide equal quality of care in the community(6).

A systematic review conducted in Ethiopia on the health extension program successes and challenges of primary healthcare services from 2003-2018 indicated that significant improvements were achieved in the knowledge, healthcare-seeking, maternal and child health, and hygiene and sanitation(7).Evidence showed that 59.2 % and 72.8% of participants utilize the UHEPa in the community of west Gojjam zone, Amhara and Bishoftu town, Oromia region, Ethiopia(8, 9).Health service utilization in Addis Ababa was 47.6% of

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women use any modern contraceptive method, 81.8 % of received antenatal care, and 73.5% postnatal care service (10).UHEPa utilization affected by different factors such as socio demographic and economic, UHE-Ps and HH factors like occupation, HH income, frequency of home visit, model HH training and being graduated model HH (8, 11, 12).

Healthcare-seeking behavior(HSB) is the action of individuals visiting any health facilities for modern treatment instead of traditional therapy(13). Evidence in Sub-Saharan Africa indicated that 45.9%(western Africa),34.8%(Central Africa),41.6%(Eastern Africa), and 44.1%(Sub-Saharan Africa) of participants sought health care(14).

The other study in the urban area shown that 35% of HHs had self-treatment practices, 81% seek health care, and 19.3% did not seek health care due to lack of money(29.3%), long distance to health facility(26.9%), and symptoms were not severe(26.4%) (15).Another study in southern Ethiopia also reported that inappropriate HSB and knowledge gaps were present of which 37% of HHs had self-treatment,17.4% traditional healer, and 45.6% did not know where to go(16). In addition Literacy, educational status, perceived illness, income, and treatment costs are some of the predictor factors for Health seeking behaviors (17, 18). Even early health care utilization and adherence to effective treatment can reduce morbidity, disability, and mortality(19).

Moreover, health care policies and programs' planning requires knowledge about healthcare-seeking behavior for early diagnosis, effective treatment, and appropriate intervention(20).Thus, this study intends to compare urban health extension program package utilization and healthcare-seeking behaviors of model and non-model female HH heads.

## 1.2. Statement of the problem

**UHEP is a community-based health approach that is intended to improve the health of the community through promoting, preventing, increasing the healthcare-seeking behaviors (HSB) and urban health extension program packages (UHEPa) utilization(3, 4).In this program the minister of health (MOH) give more attention to the model HHs than non-model HHs in providing model HH training, and conducting frequent home visits(3).**

**Even though the government of Ethiopia plan80% of kebeles graduated as model and all HHs utilize the health extension packages by 2020 (5),there were major gaps on the UHEPa utilization and HSB in the community of Addis Ababa(AA)only 29.6% of HHs utilize UHEPa and 55.4%use only environmental and health package(21, 22),besides 18.2% and 70.8% of HHs seek consultation during illness (22, 23).**

**Even if many researches were conducted on the UHEPa utilization and HSB of HHs, serious problems and gaps exist to compare and know the utilization of packages and HSB of model and non-model HH heads. There was evidences in AA showed that, packages like solid and liquid waste disposal, Immunization, and latrine utilization were more utilized by HHs where as first aid, mental health and malaria prevention were poorly utilized (22, 24, 25).**

Another studies in AA indicated that majority of HHs sought health care at health center level still the community had inappropriate HSB like self treatment, visiting traditional healers and holy water during illness (23, 24).Thus, the literatures reviewed so far all literatures was not be address the UHEPa utilization and HSB of model and non-model HHs and comparative study was uncommon.

MOH design UHEP to qualified all HHs (model and non-model) to utilize packages and improve HSB within three years of the program since 2009 (3). However, the expected chances it takes more than three years, this might not be due to lack of training, social and community mobilization and supportive supervision instead due to absence of identifying the gaps and knowing the current status of model and non-model HHs on urban health extension program packages utilization and healthcare seeking behaviors.

Therefore, identifying the gaps, and having regular and current data on model and non-model HHs were important for evidence-based decision making and baseline data for any

stakeholders to take action. Eventually, this study points out some of the problems encountered in the extant research.

### **1.3. Significance of the Study**

It is important to assess and compare urban health extension program packages utilization and healthcare-seeking behaviors of the model and non-model female HH heads.

Based on the gap, the households and community need to give health education and create awareness about determinant factors of the urban health extension program packages utilization and health care seeking behaviors of HHs.

Besides, it will give clues for AAHB, sub-city, woreda health office, and UHE-Ps to review the activity based on the findings and recommendations of this study.

Hopefully, the main findings of this study will contribute to MOH, NGO, policy, and decision-makers to take corrective action and measures in the health sector. And also, used as baseline data for further studies/researchers in this area.

### **1.4. Research question**

1. What are the components of urban health extension packages and knowledge status on urban health extension program?
2. Where do you visit health care consultation during illness? What are the possible reasons for not seeking healthcare consultation during ill?
3. How do you see and compare urban health extension packages utilization among model and non-model HHs? Which components of urban health extension packages utilize more and less? What are the possible reasons for not utilizing urban health extension packages?

## 2. LITERATURE REVIEW

The purpose of this literature review was to review the urban health extension program packages utilization and healthcare-seeking behaviors of the model and non-model HHs. The literature reviewed so far there was no study carried out not only comparative study on UHEPa utilization and healthcare-seeking behaviors of the model and non-model HHs but also UHEPa utilization and healthcare-seeking behaviors in the non-model HHs. Therefore, this literature review should provide a simple summary of prior work since there was no direct literature addressing UHEPa utilization and healthcare-seeking behaviors of model and non-model HHs.

### 2.1. Socio-demographic and economic related factors

There was evidence that showed that monthly HH income, marital status, educational status, occupation, and family size of the households were significantly associated with healthcare-seeking behaviors of the households. A study from Esera district, Dawuro zone and Dale district, Sidama zone, South Ethiopia indicated that monthly HH income more than 1170ETB (AOR=5.6, 95% CI, 2.044-15.409), marital status being married (AOR=11.3, 95% CI, 1.162-110.204) and family size less than five (AOR=2.29, 95% CI, 1.64-3.19), income more than 1170ETB (AOR=2.98, 95% CI, 1.37-5.68), and educational high school and above (AOR=4.26, 95% CI, 2.16-8.43) were more likely to seek health care than their comparatively (15, 16), respectively. In the other study carried out in Addis Ababa, HH income 50\$ and above, mothers occupation not housewives and educational status being literate were 2.9, 2.6 and 2.4 times more likely to seek health care than their comparable (23), respectively.

The study carried out in the west Gojjam zone, Amhara region and Addis Ababa indicated that households income greater than 961ETB and sustainable source of income were 3.67 and 0.63 times more likely to utilize health extension packages than their counterpart (22, 26), respectively. Mothers who were in the reproductive age groups (18-49 years) were 1.74 times more likely to use health services than mothers above 49 years (22). The study carried out in Malawi indicated that, the age category from 37-53 years were 0.54 time more likely to seek health care than other age groups (27).

## 2.2. Health facilities related factors

Previous literature showed that, distance to the health facility and transport service from home to health facility significantly associated with healthcare-seeking behaviors and health service utilization of HHs. Evidence in Addis Ababa showed that, walking time from health facility less than 15 minutes were 3.3 times more likely to seek health care than walking time greater than 15 minutes(23). In the other study was done in Esera district, Dawuro zone, south Ethiopia, distance from health facility less than or equal to 10 km were 3 times more likely to seek health care than distance greater than 10km(15).

Study in the Tigray region, northern Ethiopia easy transport service from home to health facility were 0.57 times more likely to utilize skill delivery service, and walking time greater than or equal to 30 minutes were 0.53 times less likely to utilize skill delivery service(28). Due to the improvement of accessibility and availability of health facilities, the overall healthcare-seeking behavior of households was 58.4% (29).Evidence in Jimma ,Oromia region, Ethiopia showed that 26.9% of households were not seeking health services because of distance to functioning health centers (30).

Evidences in Africa showed that ,45% Kenya,23.5% Nigeria and 33.7% Tanzania women was not be attended delivery at health facility because of far distance and lack of transport(31).

### 1.3. Urban health extension professionals (UHE-Ps) related factors

To increase the healthcare seeking behaviors and utilization of the urban health extension program packages, UHE-Ps 75% of their time spent in visiting their outreach activities in the household(3, 4). There was evidence in the community of AA, and west Gojjam zone, Amhara region the frequency of home visits by UHE-Ps were 1.89, and 1.289 times more likely to utilize maternal and other health services (12, 22).The other study in Ambo town, Oromia region the frequency of home visits by UHE-Ps were11.6 times more likely to utilize maternal health services(32).Moreover, the prior research which was conducted in Bishoftu, Oromia region, and AA, showed that 72.8%, and 57.1% HHs were visited by the UHE-Ps(9, 22). Another study conducted in Hosanna town, Hadiya zone, South Ethiopia indicated that 61.7% of HHs was visited by UHE-Ps (11).

#### 1.4. Individual, household, and community-related factors

UHEP essential to increase community knowledge, and bring visible changes in the behavior of individuals, and communities to utilize different components of UHEPa(3).Evidence in Ethiopia showed that, being graduated model HHs were 2.12, 2.4,and 2.18 times more likely to utilize different components of UHEPa than non-model HHs (11, 22, 32),respectively. The other study carried out in Gondar, Amhara region ,Hosanna town Hadiya zone, South Ethiopia, and AA reported that the knowledge status of HHs on UHEPa was 4.37,2, and 1.5 times more likely to utilize packages as compared to those HHs who did not know(8, 11, 24), respectively. In another study conducted in the community of AA, HHs who heard about UHEP were 2.13 times more likely to utilize UHEPa than those HHs who did not heard(22). Thus, the existing research reported that 65.3% and 41.8% of HHs in the community of Gondar Amhara region , and Hosanna town Hadiya zone, South Ethiopia had good knowledge of the UHEPa(8, 11),respectively. There was other evidence in the community of AA,59.4% of the participants had poor knowledge, and only 65.5% of HHs knew the UHEPa component (21, 22) respectively.

Besides, evidence in Gondar Amhara region, Bishoftu Oromia region, and Hosanna town Hadiya zone South Ethiopia, indicated that only 59.5%, 14.3%,and 42%of HHs were graduated model HH and utilize the urban health extension packages (8, 9, 11),respectively.

On the one hand, community perception on quality of health service, perceived severity of the disease, and knowledge on danger sign significantly associated with the healthcare-seeking behaviors of HHs. The study was conducted in AA, having good knowledge of the danger sign of disease were 3.3 times more likely to sought care than their counterpart(23).

Besides the study in Esera district, Dawuro zone South Ethiopia perceived severity of diseases were 6.6times more likely to seek health care than those who did not have severe cases (15).In the previous study, the overall healthcare-seeking behaviors of HHs in the community of AA and South Ethiopia were70.8% and 72.8% (16, 23)even in Malawi, 61% of caregivers sought health care (27).

The study was done in the urban slums in Malawi indicated that perceived severity of illness and home management of illness undertaken were 1.17 and 0.54 times more likely to seek healthcare(27).

**Conceptual Frame Work**

The conceptual framework of the study adopted from Andersen and Newman the initial behaviors model(33) and literature review with few modifications. UHEPa utilization and HSB can be directly and indirectly affected by multi-dimensional and multi-level factors. The framework shows multiple factors such as socio demographic and economic factors, UHE-Ps factors, health institution and individual and household factors can be the determinant factors for UHEPa utilization and HSB. Therefore, the conceptual framework saw as follow

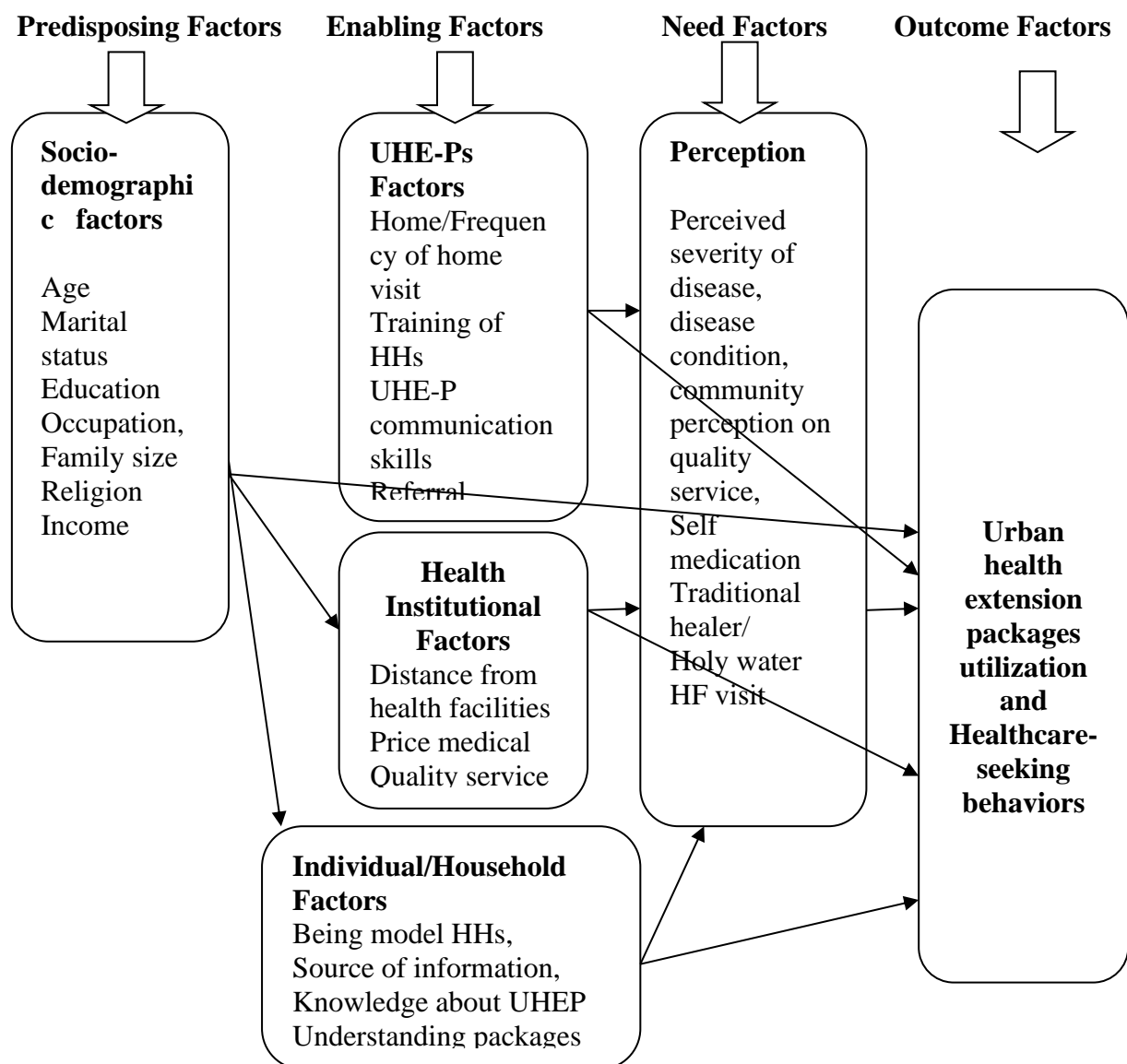


Figure1. Conceptual framework on the UHEPa utilization and HSB

### **3. OBJECTIVES**

#### **3.1. General objective**

To compare the urban health extension program packages utilization and healthcare-seeking behaviors of the model and non-model households in the community of Bole sub-city, Addis Ababa city, Ethiopia, 2020.

#### **3.2. Specific objectives**

3.2.1. To assess the knowledge status of the model and non-model households towards urban health extension program packages.

3.2.2. To identify the current healthcare-seeking behaviors of model and non-model households.

3.3.3. To compare urban health extension program packages utilization among model and non-model households.

## **4. METHODS AND MATERIALS**

### **4.1. Study area and period**

The study was carried out among model and non-model HHs from December 2019 to December 2020 in the Bole sub-city, Addis Ababa, Ethiopia. Bole sub-city is one of the 11th administrative sub-cities in AA and according to AAHB, it had a total population of 406,059 of which 194,908(48%) male and 211,151(52%) female and the total expected number of HHs was 99,039.

The sub-city has 122 trained urban health extension workers run by 29 supervisors and 1170 health professionals were provide health service at the health center level. According to the Bole sub-city health office report, 57307 (57.8%) of the households are model households. The ratio of UHE-Ps to the HHs was 1:812 even if the expected to be 1:500 and the ratio of supervisors to UHE-Ps was 1:5.

### **4.2. Study design**

A community-based comparative cross-sectional study design using; quantitative method was conducted.

### **4.3. Population**

#### **4.3.1. Source and Study Population**

The source population was all female households' heads who live within the sub-city. According to the 2009 FMOH UHEP implementation guideline, most of the packages implemented and used by a female, so female were selected as study participants. Therefore, the study populations model and non-model female HH heads that live among the selected ketenas within 4 woredas were as a part of the study.

### **4.4. Eligibility criteria**

#### **4.4.1. Inclusion criteria**

Female model and non-model HH heads aged above 18 years old and those who lived in the study area for more than one year were included in the study.

#### **4.4.2. Exclusion criteria**

Those who had hearing loss, severely ill, unable to communicate, and Female HH heads less than 18 years old were excluded from the study.

#### 4.5. Sample size determination

The sample size for each specific objective was calculated using the two population proportion formula by applying Epi-Info versions 7.2.1.0. For all specific objectives take the same assumption of 95% confidence interval, a 5% significance level, a margin of error of 5%, power of 80%, 1:1 model to non-model ratio, design effect of 2, and non-response rate 10%. Let model HH P1 and non-model HH P2.

In the study conducted in Ethiopia, 88.4% knowledge (24), 80.7% healthcare-seeking behavior (15), and UHEPa utilization 66.6% taken from AAHB 2018 unpublished annual performance report. Since studies conducted only on model HHs there is no literature done on non-model HHs, assumed 50% of the proportions of non-model HH for knowledge, healthcare-seeking behavior, and UHEPa utilization. Therefore, based on a study finding, the sample size calculated using two population proportion formulas as following:

$$n = \frac{(Z_{\alpha/2} + Z_{\beta})^2 \times (P_1(1-P_1) + P_2(1-P_2))}{(P_1 - P_2)^2}$$

Table 1. The sample size for each specific objective

No.	specific objective	95% CI	Pow er80 (%)	P1	P2	N	Desi gn effec t2	Non respo nse rate10%	Tot al sam ple size (n)
1	Assess knowledge status	1.96	0.84	0.88	0.5	19	38	3.8	42
2	To determine health seeking behaviors	1.96	0.84	0.81	0.5	34	68	6.8	75

3	To compare UHEPa	1.9 6	0.84	0.6 7	0.5	13 5	270	27	297
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Therefore, the final sample size was the largest number from the table 297 HHs for each group (297 Model and 297 non-model HH heads) with a total of 594.

#### 4.6. Sampling procedure

The study area was stratified into 15 woredas. The study participant's model and non-model female HH heads were selected by using multistage sampling techniques.

Prior research showed that 19-25% of sample sizes were taken from the total samples (34-38), based on this evidence at the initial stages, four woreda (25%) were randomly selected by lottery methods among 15 woredas.

In the second stage, since there was no kebeles structure in AA city administration, four ketena (lowest administrative units in a kebele) were selected randomly from four woredas. Then the total number and lists of model and non-model female HH heads were taken from woreda health office.

Sampling frame for each model and non-model female HH heads were prepared, the first HHs selected randomly from registration listed by the name of HH Heads in each ketena. Assuming the first HH as an index, then applied systematic random sampling technique with intervals of two HHs for each model HHs and three HHs intervals for each non-model female HH heads until the required sample size of 297 model and 297 non-model HHs were obtained.

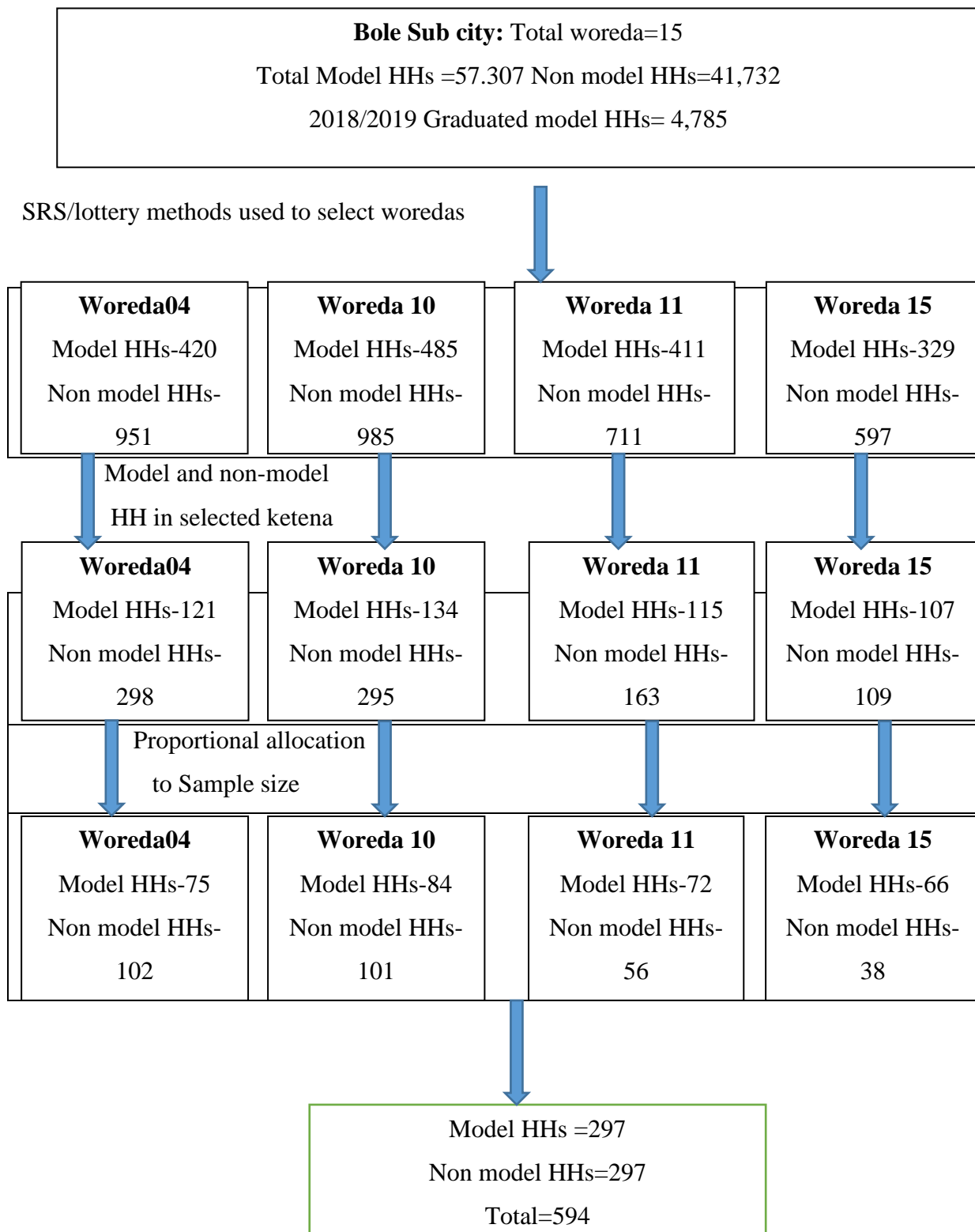


Figure 2. Schematic presentation of sampling procedure in the community of Bole sub-city, Addis Ababa, Ethiopia, 2020.

#### **4.7. Data collection**

Data was collected from June to July 2020.

##### **4.7.1 Data collection tools**

In this study to get primary data, two types of data collection tools were used; questionnaire, and observational checklist.

###### **4.7.1.1. Questionnaire**

A structured questionnaire was developed based on the MOH UHEP implementation guidelines, literature, and DHS questionnaire. A questionnaire was prepared in English then translated into Amharic and translated back into English to check for consistency. The questionnaire includes socio-demographic information, Knowledge, UHEPa utilization, and healthcare-seeking behaviors of the model and non-model HHs in the community of Bole sub-city, Addis Ababa, Ethiopia.

###### **4.7.1.2. Observational checklist**

The presence and utilization of packages at home and whether or not the study participant utilizes health service at the HF level were checked through observation. Concerning health service utilization and healthcare-seeking behavior, different cards like Immunization, family planning, appointment, disease diagnosis and treatment, ANC, delivery, and postnatal follow-up card were observed. The availability and utilization of UHEPa like the presence, absence, and use of liquid and solid waste disposal, latrine and hand washing facility, cleanliness of the house and compound (Health home environment), safe water handling, and first aid kits were also checked by watching.

##### **4.7.2. Data collection procedures**

The questionnaire for data collection was first prepared in English then translated into Amharic. Before data collection, all data collection tools were pre-tested 5% of the sample size in the model and non-model female HH heads in Yeka sub-city, Addis Ababa, and modification was done accordingly. The data collection was done on the model and non-

model female HH heads using face to face interview questionnaire and observational checklist.

Data collectors were selected from those health professionals works in Addis Ababa FMHACA staff. Six data collectors and 2 supervisors were recruiting and two days training was given on the data collection technique, how to administer the questionnaire, techniques how to observed health service and UHEPa utilization, and then the supervisors were conducted follow up visit, support and control of day to day activities and received complete fill questionnaire. Data collectors were degree holders in health and the supervisor's Bachelor of Science holders in public health Officer.

#### **4.8. Data quality assurance**

Before data collection, two days of training were given to the data collectors and supervisors. In Yeka sub-city, Pre-testing of the questionnaire with 5% of the total sample size was conducted to check for clarity, completeness, consistency, and length of the day before starting the survey. Based on the findings obtained during the pre-testing of questionnaires, data collection tools were remodified, and also immediate updates on the data collectors were done. In addition, questions that posed difficulty or lacked clarity was rephrased and corrected to minimize errors during data processing. Principal investigator and Supervisors during data collection, every day completed questionnaires were reviewed and checked for completeness and consistency. All the necessary feedback was given to the data collectors the next morning before the actual procedure. Finally, the data was cleaned thoroughly and double entered before analyses.

#### **4.9. Study variables**

##### **4.9.1. Dependent variables**

- Urban health extension program packages utilization and
- Healthcare-seeking behaviors

##### **4.9.2. Independent variables**

- Socio-demographic factors
- Distance to HF, medical cost
- Perceived severity of the disease, disease condition
- Quality health service, referral linkages, HF visit
- Understanding of UHEPa,

- Source of information, heard about UHEP
- UHE-Ps communication skills
- Training of HHs, Being model HHs
- Home visits/frequency of visit
- Self-medication, traditional healer/holy water

#### 4.10. Operational definition

**Model household:** define as those who attend /take/ at least 75% of the total 60hrs (at least 45hrs) training time on UHEPa given by UHE-Ps and implement and utilize a minimum of 75% of the 15 UHEPa (12 packages). Model HHs Verify through observing training profile/documents from UHE-Ps/woreda health office and check /observe/ utilization of different packages at home.

**Non-model household:** a woman or any HHs member attend less than 75% of UHEPa training and utilizes less than 75% of the 15 UHEPa.

**Household visits by UHE-Ps:** is the number of home visits the UHE-Ps made in the last 12 months. Categorized as more frequent visits when there is at least one visit per month, less frequent visit one visit per quarter, and no visits if there is no home visit per year.

**Urban Health Extension Packages Utilization** is the use of different components of the packages and service verified by observation through physically by footprints and fresh excreta/wet inside the pit, liquid and solid waste around the home, safe handling of water, cleanliness of home and environment and observe different medical appointment cards like vaccination, Antenatal/postnatal care, Family planning, growth monitoring. Urban health extension program packages utilization measured in two ways:

1. Health Facility level: defined as any government HF visited by any family members in the home in the last 12 months for any health services. Measured based on frequency score of HFs visit for health services:
2. Household-level: is the implementation and utilization of UHEPa at the household level. Measured based on the participant's mean scores on packages  $\geq 75\%$  high utilization (use at least 12 packages from 15 packages, 60-74% of moderate (9-11 from 15 packages) and  $\leq 60\%$  low ( $\leq 9$  from 15 packages).

**The knowledge status:** The study participant's knowledge of UHEPa. Based on Bloom's cut-off point revised in 2007 with few modifications' knowledge classified into three parts

good knowledge when the mean score (75-100%), moderate knowledge mean score (60-74%) and poor knowledge mean score less than 60%.

**Health care-seeking behaviors (HSB):** defined as the intention to seek diagnosis when ill at Government health facilities or private clinic for medical service/ checkup. Classified as appropriate and inappropriate.

**Appropriate HSB:** defined as situations when women or any family member visited health institutions (governmental or private) during illnesses or medical checkups. Conversely, **Inappropriate HSB** refers to situations when a woman or any family member did not visit any of the formal health sectors but visiting Holy water, traditional healers, pharmacy or drug shop, self-treatment (treating one's health without medical supervision or intervention), stay at home during illness.

**Distance to health facility/Accessibility/:** This was measured by the respondent's response on the walking hours to the health facilities. When the walking time to reach the health facility less than 30 minutes near and 30 minutes and above was a far distance from the health facility.

#### 4.11. Data management

During data collection, the principal investigator and supervisors were reviewed and checked the completed questionnaires in hard copy before data entry into the epidemiological information package (Epi Info) version 7.2.1.0. The coded data was cleaned before data analysis and soft copy of questionnaires were cross-checked to ensure its completeness and consistency.

#### 4.12. Data analysis

All questionnaires and data were first visually checked for completeness, missed values, and any errors and then entered into Epi info version 7.2.1.0. Finally, the data exported into SPSS version 23 computer software for analysis.

Descriptive statistics were used to calculate the frequency distribution and proportions for categorical variables. Mean and standard deviations were used for continuous variables, Socio-demographic and economic status of the study participants. Moreover, bivariate logistic regression analyses were applied to assess the factors associated with urban health extension program packages utilization and healthcare-seeking behaviors. Multivariate

logistic regression was used to control confounding factors and to obtain less biased estimates of the association between independent and outcome variables.

Independent variables having a p-value  $<0.25$  in the bivariate logistic regression analysis were entered into a multivariable logistic regression analysis to control the confounding effect. P values of 0.05 and 95% confidence interval for adjusted odds ratio (AOR) were used as a cutoff point for statistical significance in the final model. The degree of association between dependent and independent variables was assessed using the odds ratio and 95% CI.

#### **4.13. Ethical consideration /approval**

The study was approved by the Ethical Clearance Committee of Addis Ababa University School of public health (Ref.No prev/075/12). A letter of support was obtained from Bole sub-city health office (Ref.No B/S/C/H/O/1.5w2032/12) and submits it to the woreda health office. The study participants participated voluntarily. The purpose of the study was explained for the participants and obtained verbal consent. Confidentiality was assured by omitting personal identifiers instead of using codes during data collection, data analysis, and reporting. Privacy during the interview was maintained by conducting interviews at sites free from any form of disturbance.

#### **4.14. Dissemination of the results**

The Findings of this study were submitted to Addis Ababa University, College of health science, and the department of public health as partial fulfillment of a master's in public health. Besides, the copies of this study documents were given to Bole sub-city health office, AAHB, and Addis Ababa city food, medicine, and health care administration and control authority. Eventually, the findings were tried to disseminate via publication in the scientific journal.

## 5. RESULTS

### 5.1. Socio-demographic and economic characteristics of the respondents

A total of 594 HHs, 297 (50%) model and 297(50%) non-model female HHs head was selected for the study, of which 587 female HHs head 294(50%) model and 293(50%) non-model HHs were successfully interviewed with a response rate of 99%,out of this rate 99 % model and 99% non-model HHs head. The remaining 7 participants were partially refused to provide some information; therefore, 7 copies of questionnaire (3 models and 4 non models female HHs) were excluded, during data cleaning process because of incompleteness and inconsistent values. All the study participants were female household heads in both groups.

The mean age of model HHs study participants was 36.46, standard deviation (SD) of 8with a range of 20-62 years, and the mean age for non-model HHs participants was 35, standard deviation (SD) of 7 with a range of 19-61 years.

During the study, most of the participants' 208 (71%) model and 196 (67%) non-model HHs heads were married. Among participants, the majority of the model and non-model female HH heads were Orthodox Christians, which accounts for 31(79%) and 233(80%) respectively.

Regarding the educational status, most of the study participants 76 (26%) model and 70(24%) non-model HHs were attended secondary school.

Out of the study participants, the average family size of model female HH heads was 3, standard deviation (SD) of 1whereas non-model female HH heads were3.31 with a standard deviation (SD) of 1.

The average monthly income of participants model female HH heads was 3671,standard deviation(SD) of 1184 while non-model female HH heads were 3524.91 with a standard deviation(SD) of 1107 Ethiopia Birr. (Table 2)

Table 2. Socio Demographic Characteristics of the study participants in the community of Bole sub-city, Addis Ababa, Ethiopia, 2020.

Variables	Model HHs		Non-model HHs		Total	
	No.	(%)	No.	(% )	No.	(% )
<b>Age</b>						
19-29	68	23	68	23	136	23
30-40	129	44	132	45	261	45
41-51	63	21	61	21	124	21
51-62	34	12	32	11	66	11
<b>Marital status</b>						
Single	37	13	41	14	78	13
Married	208	71	196	67	404	69
Divorced	29	10	33	11	62	11
Widowed	20	6	23	8	43	7
<b>Educational status</b>						
Illiterate	57	19	65	22	122	21
Read and write	41	14	44	15	85	15
primary school	64	22	69	24	133	23
secondary	76	26	70	24	146	25
Certificate& above	56	19	45	15	101	17
<b>Occupation</b>						
Housewife	183	62	173	59	356	61
Government employ and others	111	38	120	41	231	39
<b>Family size</b>						

	0-3	183	62	173	59	356	61
	4-6	111	38	120	41	231	39
	Monthly Income						
	1550-1900	43	15	47	16	90	15
	1901-5200	251	85	246	84	497	85

### 5.2. Knowledge status of households towards UHEP and Packages

The majority of the study participant, Two hundred sixty-four (90%) model and 213 (73 %) non-model HHs were heard about urban health extension program, and UHE-Ps were the source of information for two hundred twenty-seven (77%) model and 82 (28%) non-model HHs heads.(Figure 3)

Among the study participants, 247(84%) model and 159(54%) non-model female HH heads knew the urban health extension package components. Out of the participates, the highest number of packages known and reported by model HH respondents were 257(87%) Immunization, 247(84%) latrine and excreta disposal, and 239(81%) Solid and liquid waste disposal whereas non-model HHs were 221(75%) Immunization, 217(74%) Solid and liquid waste disposal and 216(74%) Family planning.

On the other hand, the least number of packages known and reported by model female HH head participants were 83(28%) first aid and emergency measures, 90(31%) mental health, and 109(37%) rodent and insect control and non-model HHs participants were 62(21%)first aid and emergency measures, 66(24%) malaria prevention and 74 (25%) mental health.

In general, the knowledge status of participants towards UHEPa was measured based on the respondents' mean score of 75-100% classified as good knowledge, 60-75% moderate, and less than 60% poor knowledge. According to this, the knowledge status of model female HH heads was good knowledge with the respondents' mean score 221(75%) whereas non-model female HH heads were moderate knowledge with a mean score of 181(64%).

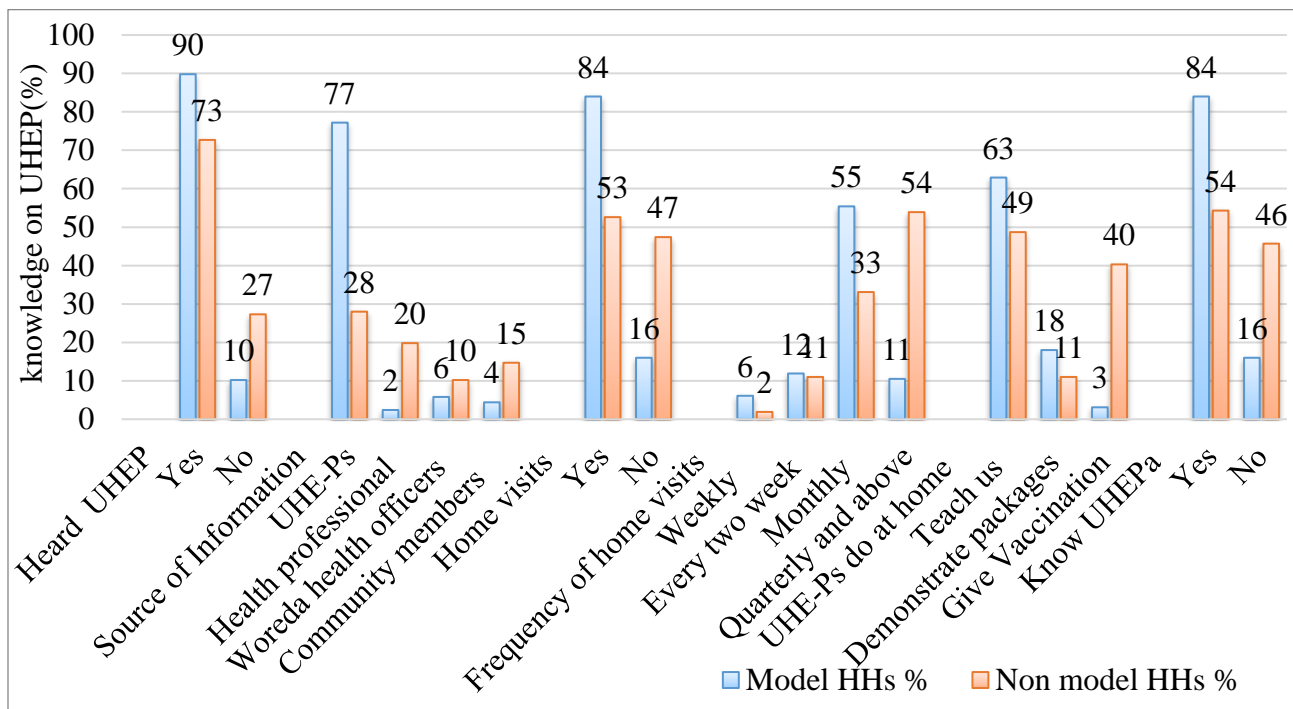


Figure 3. Knowledge status of model and non-model HHs towards UHEP in Bole sub-city, Addis Ababa, Ethiopia, 2020.

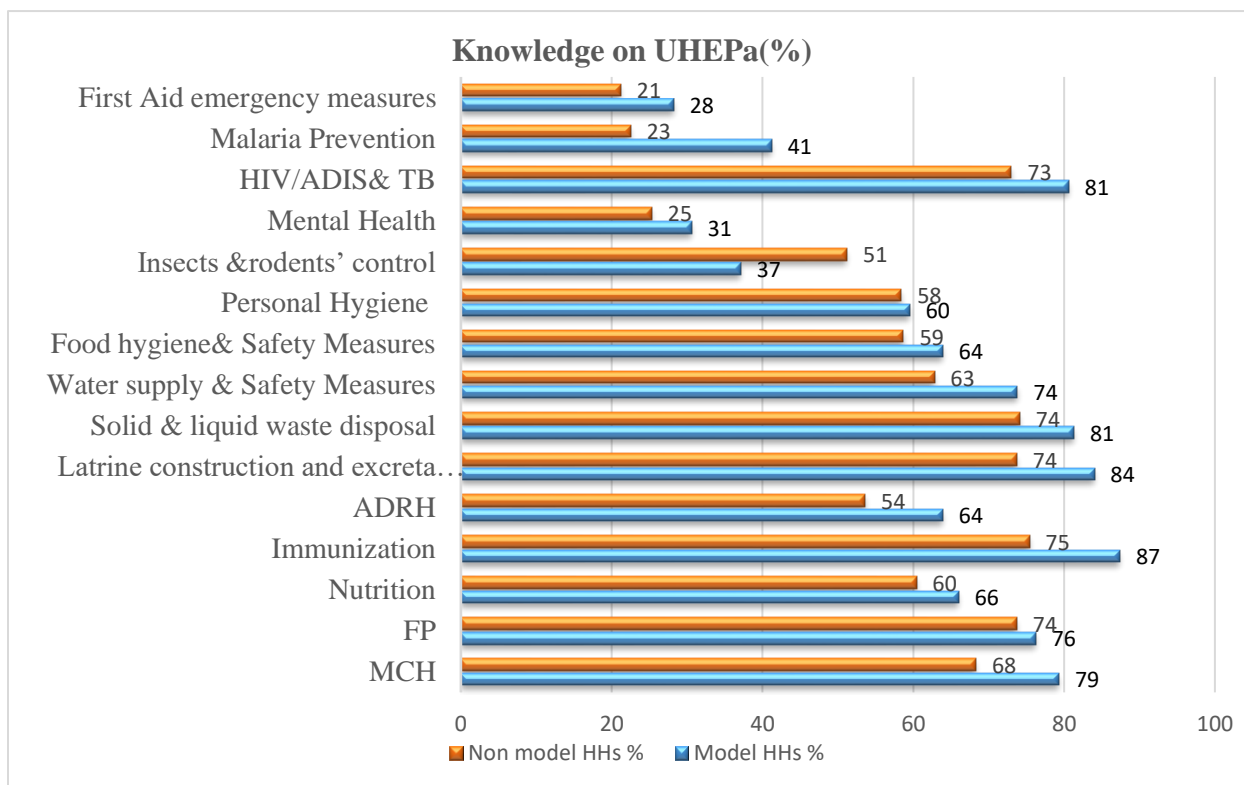


Figure 4. knowledge status of model and non-model HHs on urban health extension program packages in Bole sub-city, Addis Ababa, Ethiopia 2020.

### 5.3. Health care seeking behaviors (HSB) of the households

In this study, the overall healthcare-seeking behaviors of the study participants were 339(78), out of this 184(79%) model, and 155(77%) non-model HHs. Out of those HHs who seek health care, only 139(76%) model and 131(65%) non-model HH had appropriate healthcare-seeking behaviors.

Concerning the health care consultation place, the health center was the most common place where one hundred nineteen (65%) model and 94(47%) non-model households sought health care. Pharmacy or drug store (10%), private clinic (11%) and homemade treatment (15%) for model HHs and pharmacy (23%), private clinic (18%), homemade treatment (9%) and traditional healers (holy water) (4%) for non-model HHs were other health care consultation place. (Table 3)

Among the participants, 48 (21%) model and 46(23%) non-model HHs were not sought health care anywhere during sick (illness). Distance to the health facility was the main reason for not seeking health care for both model and non-model HHs, 72(37%) and 68(32%), respectively. Quality of service (33%), lack of money (19%) for model and lack of money (30%), and symptoms were not severe (28%) for non-model HHs were the other reasons for not seeking health care. (Table 3)

The time of health care seeking in response to symptom was 124(53%) immediately after the illness starts, 86(37%) no improvements in the illness, and 22(10%) unable to eat or drink for model HHs and non-model HHs were 90(45%) no improvements in the illness, 83 (41%) immediately after the illness starts and 28(14%) unable to eat or drink.

The study participants 254 (86%) model and 189(65%) non-model HHs reported that UHEP was important to increase healthcare-seeking behaviors.

In general, 161(88%) model and 151(75%) non-model HHs had appropriate health care seeking behavior practice the remaining 23(13%) model and 50(25%), non-model, HHs had inappropriate healthcare-seeking behavior practice. (Table 3)

Table 3. The Healthcare-seeking behaviors of HHs in Bole sub-city, AA, Ethiopia, 2020.

No	Variables	Model HHs		Non-model HHs		Total	
		No.	%	No.	%	No	%
1	Disease Status						
	Yes	232	79	201	69	433	74
	No	62	21	92	31	154	26
2	Seek healthcare consultation						
	Yes	184	79	155	77	339	78
	No	48	21	46	23	94	22
3	Consultation Place						
	Health center	121	66	101	65	222	66
	Private clinic	40	22	24	16	64	19
	Self-treatment	18	10	19	12	37	11
	Homemade treatment	5	3	7	5	12	4
	Traditional healers/Holy water	0		4	3	4	1
4	Healthcare-seeking practices						
	appropriate HSB	161	88	125	75	286	81
	Inappropriate HSB	23	13	30	22	53	19
5	Estimated walking time to HF (Distance to HF)						
	<30 minutes	49	21	42	15	91	32
	≥30 minutes	112	49	83	29	195	68
6	Time for health care seeking during illness						
	Immediately	124	53	83	41	207	48
	No improvements	86	37	90	45	176	41
	Unable to eat or drink	22	10	28	14	50	11
7	Reason for not seeking health care						
	Symptoms not severe	23	12	59	2	82	20
	Lack of money	36	19	65	30	101	25
	Distance to HF	72	37	68	32	140	34
	Quality of service	64	33	22	10	86	21
8	Referral linkage						
	Yes	156	67	72	36	228	53
	No	76	33	129	64	205	47
9	UHEP increase HSB						
	Yes	254	86	189	65	443	76
	No	40	14	104	35	144	25

#### **5.4. Urban health extension program packages utilization among households**

##### **5.4.1 Health services (packages) utilization of HHs at health facilities level**

Two hundred eight (71%) model and 183 (63%) non-model HHs study participants have visited health institutions. The most common reasons for model HHs study participants visiting health institution were 83 (40%) for disease diagnosis and treatment, 50(24%) for Immunization, and 45(22%) for Family planning service and non-model HHs were 93(51%) disease diagnosis and treatment, 45(25%) Immunization, and 36(20%) for Family planning service. On the contrary, the major reasons for not visiting health institutions was 43(50%) long distance to HF for model HHs and 66(60%) lack of knowledge, and 19(17%) long distance to HF for non-model HHs.(Table 4)

Regarding family health packages utilization, one hundred forty-two (48%) model and 136(46%) non-model HHs were used different types of family planning methods, of which Injectable (Depo) and pills which accounts 72(51%), 41(29%) and 67(51%), 40(30%) were the most common contraceptive methods utilized by model and non-model HHs, respectively. The overall delivery attended was 156(88%), out of this 74(91%) model and 82(85%) non-model HHs study participants were delivery attended at the health facility level.

Among a total of 141 model and 163 non-model HHs study participants who had a child less than one year, 120(85%) infants lived in the model HHs and 126 (77 %) non-model HHs were vaccinated.

Based on community perception the quality of health services rated by the majority of model HHs study participants as very good quality (49.3%) and non-model HHs as good quality (49.5%). (Table 4)

Table 4. Health packages utilization of model and non-model HHs at health facilities level, Bole sub-city, AA, 2020.

No	Variables	Model HHs		Non-model		Total	
		No.	%	No.	%	No.	%
1	Visit health Institution						
	Yes	208	71	183	63	391	67
	No	86	29	110		196	33
2	Reason for visiting Health institution						
	Immunization	50	24	45	25	95	24
	Family Planning	45	22	36	20	81	21
	ANC & delivery	30	14	9	5	39	10
	Diagnosis and treatment	83	40	93	51	176	45
3	Reason for not visiting the Health Institution						
	Transportation	26	30.2	7	6.4	33	17
	Lack of knowledge	6	7	66	60	72	37
	Distance to HF	43	50	19	17.3	62	32
	poor quality service	11	12.8	18	16.4	29	15
4	Community perception of quality health service						
	V.good	145	49.3	102	34.8	247	42
	Good	141	48	145	49.5	286	49
	Poor/Bad	8	2.7	46	15.7	54	9
5	FP method user						
	Yes	142	48	136	46	278	4
	No	152	52	157	54	309	53
6	Type of contraceptive method used						
	Pills	41	29	40	30	81	30
	Injection Depo)	72	51	67	51	139	51
	Implants	29	20	25	19	54	19
7	child less than 1 year in your home						
	Yes	141	48	163	56	304	52
	No	153	52	130	44	283	48
8	Infant Vaccinated						
	Yes	120	85	126	77	246	81
	No	21	21	37	23	58	19
9	Delivery attended at health Institution						
	Yes	74	91.4	82	85	156	88
	No	7	8.6	14	15	21	12

#### 5.4.2. Environment health packages utilization at households level

Two hundred fifteen (73%) model and 154 (53%) non-model HHs participants had home visited by UHE-Ps. Out of this visit the frequency of households which was conducted by UHE-Ps for model HHs 196 (67%) had at least one visit per month and 83(54%) at least one visit per quarter for non-model HHs.(Figure 3)

Concerning environmental health and sanitation packages utilization, more than three-fourths of the study participants, 254(86%) model and two-third 218(74%) non-model HHs had different types of latrine facility in their home. Out of this 162(64%) traditional pit latrine, 68 (26.8%) ventilated improved pit latrine, 24 (9%) flush latrine was used by model HHs and 133(61%) traditional pit latrine, 69(32%) ventilated improved pit latrine,16(7%) flush latrine used by non-model HHs study participants. Only 75(30%) model and 53(24%) non-model HHs had a hand washing facility near to latrine. (Table 5)

Regarding hand washing practice of model HHs participants, 183(62%) wash before and after eating, 111(38%) wash before &after eating and cleaning compounds and 210(72%) wash before and after eating, 37(13%) wash before & after eating and cleaning compounds and 46(16%) before eating for non-model HHs.(Table 5)

More than two-thirds of the participants, two hundred forty-seven (84%) model, and 212(72%) non-model HH had a solid waste disposal site, of which the majority of 166(67%) model and 132(62%) non-model HHs disposed solid waste into covered containers. (Table 5) A total of two hundred twenty-seven (77%) model and 188(64%) non-model HHs participants use liquid waste disposal drainage systems in their home. (Table 5.4)

Table 5. Utilization of environmental health packages at HH level in Bole sub-city, AA, 2020.

n o	Variables	model HH		non-model HH		total	
		No.	%	No.	%	No.	%
1	Availability of latrine facility						
	Yes	254	86	218	74	472	80
	No	40	14	75	26	115	20
2	Type of latrine facility						
	Flush latrine	24	9	16	7	40	9
	Ventilated improved Pit Latrine	68	27	69	32	137	29
	Traditional pit latrine	162	64	133	61	295	63
3	Share a latrine facility with other households						
	Yes	46	18	73	34	119	25
	No	208	82	145	67	353	75
4	How often use the latrine						
	Always	248	98	213	98	461	98
	Sometimes	6	2	5	2	11	2
5	Hand-washing facilities near to latrine						
	Yes	75	30	53	24	128	27
	No	179	70	165	76	344	73
6	Time for washing hands						
	Before eating	0		46	16	46	8
	Both before and after eating	183	62	210	72	393	67
	Before & after eating and after cleaning compounds	111	38	37	13	148	25
7	The solid waste disposal system						
	Yes	247	84	212	72	459	78
	No	47	16	81	2	128	22
8	Types of solid waste disposal system						
	Disposed to covered container	166	67	132	62	298	65
	Disposed to open container	81	33	57	27	138	30
	Burning	0		8	4	8	2
	Thrown anywhere	0		15	7	15	3
9	Liquid waste disposal drainage system						
	Yes	227	77	188	64	415	71
	No	67	23	105	36	172	29

### 5.4.3. Disease prevention and control packages utilization of households

The role of UHE-Ps on this package was providing house to house health education and make referral linkages of clients. Based on this, two hundred twenty-nine (78%) model HHs and 161(55%) non-model HHs participants had been received health education on tuberculosis from UHE-Ps. During coughing for more than two weeks, the majority of model HHs participants 217(74%) and 132(45%) non-model HHs visited a health facility for diagnosis and treatment.(Table 6)

Concerning malaria prevention, 194(66%) model and 157(54%) non-model HH participants reported that malaria could be prevented by using insecticide-treated bed net.

Among the model HH participants 254(86%) and 197 (67%) non-model HHs received health information about HIV/AIDS, of which 155 (53%) model and 85(29%) non-model HHs were received HIV test.(Table 6)

Concerning first aid kits, out of total participants only 56(19%) model and 45(15%) non-model HHs had kits in their home. According to the study, participants reported 199(68%) model, and 164(56 %) non-model HHs was knew how to use first aid kits.

In general, the overall urban health extension packages (services) utilization was 416 (71%) of which 228(78%) model and 105(64%) non-model HH female HH heads. On the contrary, based on the study participants response the main reasons for not implementing and utilize UHEPa for the model HHs participants were 33(50%) some components are not important, 29(43.9%) I do not know how to use and 4(6%) some are cost/need money and non-model HHs 45(43%) I do not know how to use and 33(31%) Some are cost/need money and 28(26%) some components are not important. (Table 6)

Table 6. Disease prevention and control package Bole sub-city, Addis Ababa, Ethiopia, 2020.

	Variables	Model HHs		Non-model		Total	
		No.	%	No.	%	No.	%
1	Health education on tuberculosis						
	Yes	229	7	161	55	390	66
	No	65	22	132	45	197	34
2	What to do during cough for more than two weeks						
	visit HF for diagnosis	217	74	132	45	349	60
	Visit Pharmacy	77	26	114	39	191	33
	take Home treatment	0		38	13	38	6
	Nothing	0		9	3	9	2
3	Preventing malaria using insecticide a bed net						
	Yes	194	66	157	54	351	60
	No	100	34	136	46	236	40
4	Learn about HIV/ AIDS						
	Yes	254	86	197	67	451	77
	No	40	14	96	67	136	23
5	HIV/ADIS Test						
	Yes	155	53	85	29	240	41
	No	139	47	208	71	347	59
6	know how to use first aid kits						
	Yes	199	68	164	56	363	62
	No	95	32	129	44	224	38
7	First Aid kits in your home						
	Yes	56	19	45	15	101	17
	No	238	81	248	85	486	83
8	Utilization of UHEPa at home						
	Yes	228	78	188	64	416	71
	No	66	22	105	36	171	29
9	Reasons for not implement and use the UHEPa						
	some packages not important	33	50	28	26	61	36
	some packages do not know how to use	29	44	45	43	74	43
	cost/need money	4	6	33	31	37	21
10	Community perception on the relationship with UHE-Ps						
	Very good	99	34	80	27	179	31
	Good	160	54	145	50	305	52
	poor/bad	35	12	68	23	103	17

### 5.5. Factors associated with UHEPa utilization and HSB

The bivariate logistic regression showed that urban health extension program packages utilization had a significant association with hearing (having information) about UHEP, income, occupation, understanding of UHEPa, perception on the quality of service, being model HHs, home visits, and frequency of home visits by UHE-Ps. However, age, educational status, marital status, religion, and family size had no significant association with UHEPa utilization. In the multilevel logistic regression home visit by UHE-Ps, occupation, perception on the quality of service, and hearing about the UHEP was not found a significant association. On the other hand, income, frequency of home visit, understanding the UHEPa, and being model graduated HHs was the predictors of UHEPa utilization by model HHs, and for non-model HHs understanding the packages and income were the predictors of UHEPa utilization. On the other hand, distance to the health facility, family income, and disease condition had a significant association with appropriate health care seeking behaviors for both model and non-model HHs in addition to being model HHs only associated with model HHs.

Model female HH heads frequently HHs visited by UHE-Ps were 2.114 more likely to utilize the UHEPa (AOR = 2.114, 95% CI = 1.002 to 3.125) as compared to HHs who did not have frequent HHs visits. But the frequency of HHs visits by UHE-Ps was not statistically associated with the utilization of UHEPa for non-model HHs. Model female HH heads with a monthly income greater than 1901 Ethiopia birr 1.958 more likely to utilize the UHEPa (AOR = 1.958, 95% CI = 0.0182 to 2.582) than those model HH less than 1900 Ethiopia birr. On the other hand, non-model female HH heads income greater than 1901 Ethiopia birr 1.514 more likely to utilize the UHEPa (AOR = 1.514, 95% CI = 0.289, 7.102) as compared to income less than 1900 Ethiopia birr. (Table 7)

Understanding the urban health extension program packages by model female HH heads had 3.135 more likely to utilize the UHEPa (AOR = 3.135, 95% CI = 2.429 to 4.470) than those female HH heads who did not understand the packages. On the contrary, for non-model female HHs heads understanding the UHEPa was not significantly associated with UHEPa utilization.

In model female HHs heads, being model HH graduation was 3.052 times more likely to utilize the UHEPa than non-model HHs (AOR = 3.052, 95% CI = 2.024 to 5.113). (Table 7).

Family income was a determinant factor for both model and non-model female HH heads on the healthcare-seeking behaviors. Model female HH heads with monthly family income greater than 1901 Ethiopia birr, 1.958 more likely to seek health care (AOR = 1.958, 95% CI = 0.0182 to 2.582) than income less than 1900 Ethiopia birr.(Table 8)

Whereas non-model female HH heads with monthly family income greater than 1901 Ethiopia birr 1.514 more likely to seek health care (AOR = 1.514, 95% CI = 0.289, 7.102) than the comparatives.

In the model and non -model, female HH heads, having the disease were 1.009 and 1.401 times more likely to seek health care (AOR = 1.009, 95% CI =0.489 to 2.081) and (AOR = 1.401, 95% CI = 0.713,2.751), respectively as compared to their counterparts.(Table 8)

Household's graduation status in the model female HH heads 1.629 times to seek health care higher than non-model HHs (AOR=1.629, 95% CI: 0.596, 4.453).Moreover, household graduation was not statistically associated with healthcare-seeking behaviors in the non-model HH heads.(Table 8)

Walking time greater than 30 minutes from health facility 1.138 and 1.025 times less likely to seek health care (AOR = 1.138, 95% CI =0.493 to 2.626) and (AOR = 1.025, 95% CI = 0.429, 2.452) in the model and non-model female HH heads, respectively than the walking time less than 30 minutes from the health facility.(Table 8 )

Table7. Factors associated with the utilization of urban health extension program packages in Bole sub-city, Addis Ababa, Ethiopia, 2020 (n =587).

Variables	Model HHs				Non-model HHs			
	UHEPa Utilization		COR (95% CI)	AOR (95% CI)	UHEPa Utilization		COR (95% CI)	AOR (95% CI)
	Yes	No			Yes	No		
<b>Heard about UHEP</b>								
No	7	23	1	1	34	46	1	
Yes	218	46	2.66(1.262, 3.964)	<b>2.35(1.075, 3.415) **</b>	155	58	0.934(0.516 ,1.691)	<b>1.1(0.591,1.938) **</b>
<b>Home visits by UHE-Ps</b>								
No	52	27	1		62	77	1	1
Yes	205	10	3.125(1.018 ,4.231)	<b>1.35(0.063, 2.751) **</b>	127	27	1.288(0.759 ,2.186)	0.776(0.457, 1.318)
<b>Frequency of home visits by UHE-Ps</b>								

Once per Quarter	29	2	1		66	17	1	1
At least once per month	163	53	3.321(1.723, 4.168)	<b>2.114(1.002, 3.125) *</b>	57	14	0.344(0.030, 3.989)	0.624(0.200, 1.944)
<b>Understanding UHEPa Components</b>								
No	32	15	1		73	61	1	1
Yes	222	25	2.075(1.039, 3.145)	<b>3.135(2.429, 4.470) **</b>	129	30	0.107(0.091, 0.281)	<b>1.088(0.533, 2.224) **</b>
<b>Mothers' occupation</b>								
Government employees and others	97	24	1		75	41	1	1
House wife	128	45	2.84(0.39, 2.0.8)	0.349(0.037, 3.249)	114	63	3.62(0.342, 40.712)	0.428(0.019, 9.081)
<b>Family (HHs)Income</b>								
≤1900	25	15	1		29	10		
≥1901	226	28	2.343(1.015, 3.033)	<b>1.958(0.018, 2.582) *</b>	217	37	0.692(0.310, 1.546)	<b>1.514(0.289, 7.102) *</b>
<b>Household Graduation status</b>								
No	41	28	1		0	104	1	
Yes	209	16	4.11(2.106, 6.203)	<b>3.052(2.024, 5.113) *</b>	0	189	1.82(0.0-0.0)	0
<b>Community perception on quality of health service</b>								
Poor (Bad)	25	8	1		26	20		
Good	200	61	1.003(0.42, 2.43)	1.351(0.462, 3.949)	163	84	0.172(0.832, 3.415)	1.22(0.53, 2.8)

**Note: Reference Category \* P-value <0.001, \*\*P-value ≤0.05 cut off points for AOR**

Table 8. Factors Associated with Healthcare-seeking behaviors by model and non-model HHs in the community, Bole sub-city Addis Ababa, Ethiopia,2020 (n =587).

Variables	Model HHs				Non-model HHs			
	HSB		COR(95% CI)	AOR (95% CI)	HSB		COR(95% CI)	AOR (95% CI)
	Yes	No			Yes	No		
<b>HHs Income</b>								
1550-1900	25	15	1	1	29	10	1	1
1901-5200	226	28	0.708(0.242,2.074)	<b>1.412(0.482, 4.135) **</b>	217	37	0.25(0.04, 1.8)	<b>1.721(0.72 2,4.101) **</b>
<b>Community perception on quality of health service</b>								
Poor	25	8	1	1	26	20	1	1
Good	200	61	0.387(0.182,0.822)	2.585(1.217, 5.490)	163	84	0.682(0.23 7,1.959)	1.467(0.51 1,4.213)
<b>Disease Condition</b>								
No	24	38	1	1	48	44	1	1
Yes	213	19	0.061(0.028, 0.187)	<b>1.009(0.489, 2.081) **</b>	141	60	0.714(0.36 3,1.402)	<b>1.401(0.71 3,2.751) **</b>
<b>Estimated walking time to HF (Distance )</b>								
<30min	45	4			31	11	1	
≥ 30 minute	104	8	0.879(0.381,2.028)	<b>1.138(0.493, 2.626) **</b>	68	15	0.976(0.40 8,2.333)	<b>1.025(0.42 9,2.452) **</b>
<b>Frequency of home visits by UHE-Ps</b>								
every 2week	17	5	2.438(0.534,11.133)	1.491(0.110, 3.189)	6	4	0.319(0.07 6,1.344)	3.133(0.74 4,13.192)
monthly	106	24	1.608(0.454,5.691)	1.193(0.232, 2.712)	27	9	0.638(0.23 1,1.765)	1.567(0.56 6,4.333)
quarter	36	6	1	1	47	10	1	1
<b>Household graduation status</b>								
No	28	6	1		46	0		
Yes	159	40	2.491(0.556,11.169)	<b>1.629(0.596, 4.453) *</b>	155	0	0	0

Note: Reference Category \* P-value <0.001, \*\*P-value ≤0.05 cut off points for AOR

## 6. DISCUSSION

This study has tried to assess and compare the urban health extension program packages utilization and healthcare-seeking behaviors of the model and non-model female HHs heads. Among participants, the overall knowledge status on UHEPa was moderate, of which model female HH heads had good knowledge and non-model HH moderate knowledge. The knowledge status of the model female HH heads higher than non-model female HH heads. This discrepancy might be due to the presence of frequent home visits, and health education was given by UHE-Ps during home visits.

In the current study, the most recalled UHEPa components mention by both model and non-model female HH heads were Immunization, latrine and excreta disposal, and solid and liquid waste disposal, on the contrary, the least recalled packages were first aid and emergency measures, mental health, malaria prevention and control were mentioned by model and non-model female HH heads. The findings similar to a study done in Addis Ababa, Ethiopia(22, 24), where solid waste, Immunization, and latrine and excreta disposal were the three most mentioned packages whereas first aid, malaria prevention, and control and mental health were the least packages mentioned by HH participants. Moreover, this consistency might be as a result of similarity in the study setting, and socio-demographic characteristics, and lack of attention given in some components of packages.

The finding also consistent with a systematic review done in Ethiopia from 2003-2018 on the success and challenges of HEP shoed that, family planning, Immunization, solid and liquid waste disposal and latrine utilization were highly mentioned packages (7).

The current knowledge status of HHs on urban health extension packages higher than the study carried out in Gondar, Amhara region and Hosanna town Hadiya zone, South Ethiopia 65.3% and 42% of the participant had good knowledge of UHEPa (8, 11). This inconsistency might be a result of the difference in the study setting and socio-demographic characteristics. The results of the study also consistent with the study conducted in Hadiya zone, South Ethiopia, 68.3% of the participant had good knowledge of UHEPa (39) but lower than the study conducted in AA (24). The possible reasons for this difference might be because of the absence of mode HH training, a low commitment , and the current Covid 19 in AA restrict UHE-Ps frequency home visit to gave health education activity.

The overall urban health extension program packages utilization of model female HH heads higher than non-model female HH heads. This finding was consistent with the systematic review done in Ethiopia from 2003-2018, the health extension packages utilized by model HH higher than non-model HH(40). The reasons for this discrepancy might be due to the presence of frequent home visits, health education and demonstration of different packages at household level during home visits.

The findings of the current study higher than the study conducted in AA, Gondar Amhara region, and Hossana town Hadiya zone, south Ethiopia 29.6%,59.5%, and 42% of participants utilize UHEPa(8, 11, 22). The result of the current study almost consistent with the study carried out in Bishoftu, Oromia region, showed that 72.8% of participants were utilized UHEPa (9) but lower than a study carried out two years ago in AA,86% of participants use UHEPa (24). The possible reason for this inconsistency might be as a result of the absence of model HH training, Covid 19 restrict UHE-Ps home visit, the low commitment and lack of supportive supervision and feedback, evidences also indicated that one of the challenges to implement and use HEP was due to the presence of limited supportive supervision(40, 41).

Moreover, the findings of the current study indicated that understanding different components of packages , frequency of home visits, family income, and HH model graduated status were predictors of UHEPa utilization for the model female HH heads, while only family income and understanding the packages had significantly associated with non-model female HH heads. On the contrary, home visits, occupation, perception on the quality of service, and hearing about the UHEP were not statistically associated with UHEPa utilization for the model female HH heads where as frequency of home visits, HH model graduated status, home visits, occupation, perception on the quality of service, and hearing about the UHEP were not statistically associated with UHEPa utilization for non- model female HH heads.

The current result supported by the study conducted in AA (22, 24), west Gojjam zone, Amhara region(26), Ambo town Oromia region(32),and the systematic review done in Ethiopia (7) in which understanding of the packages, frequency of home visit, being model graduated HHs and monthly income significantly associated with UHEPa utilization. The finding also consistent with the other study carried out in the Gondar, Amhara region, and

Sebeta Hawas district, Oromia region indicated that understanding packages were significantly associated with urban health extension services and maternal and child health packages utilization(8, 34).

The study done in the rural community of Gamo Goffa Zone, South Ethiopia showed that HH income and model graduated status significantly associated with health extension services utilization which was consistent with the current study(42).The other study, Hawassa South Ethiopia the prevalence of diarrheal disease under-five children model HHs (8.1%) lower than non-model HHs (20.2%) this was due to frequent home visits, model training, and being model graduation of HHs(43).

In this study, the frequency of home visits in the model female HH heads higher than non-model female HHs heads. The finding in the model female HH heads consistent with the MOH UHEP implementation guideline (3, 4) but lower than the study done in Addis Ababa (24) and Hosanna town Hadiya zone, south Ethiopia(39).This discrepancy might be due to Covid 19 restrict UHE-Ps home visits and the presence of high gap in the proportion of UHE-Ps to HHs; One UHE-Ps is expected to cover 500 HHs (3) but in the study area proportion of one UHE-Ps cover 812 HHs.

According to the study participant's response, the main reasons for not utilizing the UHEPa were lack of knowledge on some of the components of packages, some of the packages not important, and some are cost/need money. This was consistent with the study carried out in AA and Akaki district Oromia region, the main reasons for not using packages were some components not important, not prepared well, and needs money(25, 44).

The overall healthcare-seeking behaviors of the participants were 78%, of which 79.3% model, and 77.1% non-model female HH heads. Out of those participants who sought health care, 75.5% model and only 65.2% non-model female HH head had appropriate HSB.

The findings of this study higher than the study conducted in AA 18.2% and 70.8% of participants sought health care during illness (22, 23). The results of the study higher than the study carried out in the rural area in Esera district Dawuro zone, south Ethiopia 48.1% of participants had healthcare-seeking behaviors (15). This inconsistency might be as a result of the time gap, and study setting differences in the rural community may not have access and availability of health institutions this might be reduced participants to seek health care.

The finding of the study also higher than the study conducted in Nigeria and Sub-Saharan Africa, 63% Nigeria (45) and 45.9% western Africa, 34.8% Central Africa, 41.6% Eastern Africa, and 44.1% Sub-Saharan Africa (14) sought health care during sick. This discrepancy might be due to the time gap, and study setting.

In this study, the finding was almost consistent with the other study done in the urban community of Esera district Dawuro zone, South Ethiopia, 80.7% of participants had healthcare-seeking behaviors but lower than the study carried out in AA which indicates 97.6% of participants sought healthcare during sick (24). The reasons for this might be because of the current Covid 19 situation in Addis Ababa, participants may be staying at home instead of seeking care in the health facility (HF).

In general the results of this study showed that distance to HF, family income, disease condition, and HH model graduated status had significant association with the appropriate healthcare-seeking behaviors for model female HH heads while only distance to HF, family income, and disease condition were associated with appropriate HSB for non-model female HH heads. However, occupation, perception on the quality of service, home visits, and frequency of home visits were not predictors of health care seeking behaviors for both model and non -model HHs.

The finding of this study consistent with the study conducted in AA (22), and a systematic review done in Ethiopia (7) indicated that being model graduated HHs associated with healthcare-seeking behaviors. The results also consistent with the study done in AA(22, 23), Esera district Dawuro zone and Kindo Didaye district Wolaita Zone South Ethiopia(15, 46), Tigray region, Northern Ethiopia (28),Aneded district North west Ethiopia(38)and rural community in Ethiopia (47)showed that distance to the health facility, disease status, and monthly income significantly associated with healthcare-seeking behaviors.

The other study was carried out in Sub-Saharan Africa, indicated that the HH wealth (being rich) in western Africa, Central Africa, and Sub-Saharan Africa had a significant association with mothers sought health care(14).The result also consistent with another study conducted in South Africa and Turkey in which economic status of HHs were the determinant factors for healthcare-seeking behaviors of the community(48, 49).

In the study, still self-medication and seeking traditional healers were practiced in the study area. This finding lower than the study carried out in AA and Esera district Dawuro Zone,

South Ethiopia 26.1% of HHs visit pharmacy/drug stores and 5.1% traditional healers(23), 35.5% self-medication (15).The results of the current study also lower than the study carried out in South Africa ,5.6% of participants visit traditional healer and 25% self-medication (48). This inconsistency might be related to the availability and accessibility of HF, and licensing of pharmacy/drug shops, and the presence of supportive supervision and follow-up by AAFMHACA.

Both model and non-model female HH heads were not seeking care because of symptoms were not severe. The findings of the study lower than the study conducted in the Esera district Dawuro Zone, South Ethiopia,26.5% was not seeking health care because of symptoms were not severe (15). This might be due to lack of awareness on one of the urban health extension packages components that is communicable and non-communicable disease prevention and control packages.

## 7. STRENGTH AND LIMITATION OF THE STUDY

### 7.1. Strength of the study

1. Being using comparative study design was the first time to assess and compare UHEPa utilization and healthcare-seeking behaviors of model and non-model female HH heads.
2. The data collected was from primary sources focused on community-based which give a real assessment of availability, accessibility, and utilization of different services.

### 7.2. Limitation of the study

1. Because of the current national and Addis Ababa Covid 19 situation: The healthcare- seeking behaviors and health service utilization at the health facility level could be affected by seasonal (temporal) variation the HH heads might be stay at home instead of visiting health facility
2. This cross-sectional study provided only one point in time (snapshot) of observation and interview on UHEPa utilization and health care seeking behaviors of the community, so recall bias was expected as a result of the study participants might be forgetting all the UHEPa components.
3. Limitation of the studies in the same program area to compare UHEPa utilization and healthcare-seeking behaviors of model and non-model HHs

## 8. CONCLUSION

Based on the finding of this study, it can be concluded that HH status being model and non-model HHs had its effect on the urban health extension program packages utilization and healthcare-seeking behaviors.

- ❖ The findings of the current study showed that, model female HHs heads was 3.052 times more likely to utilize the urban health extension program packages than non-model female HH heads. Understanding packages, frequent home visits, income, and being model HH graduated were significantly associated with UHEPa utilization. Therefore, providing model HH training, and giving more attention to disease prevention and control packages for both model and non-model female HH and frequent home visit, being graduated as model HHs and awareness creation on different components of packages for non-model female HH heads were essential to increase UHEPa utilization.
- ❖ Model female HH heads 1.629 times more likely to seek health care than non-model female HH heads. The results of this study indicated that, distance to HF, income, being model HH graduation and disease condition significant association with appropriate health care seeking behaviors. In addition, inappropriate HSB such as self-medication, homemade treatment, and visiting traditional healers (holy water) were practiced in the study area. Thus, accessibility and availability of government HC in some woreda, emphasizing and increasing awareness on the disease prevention and control packages, providing model HH training, and continuous follow-up visits of private health institutions like Pharmacy, and drug vendors (shop) were important to avoid inappropriate health care seeking practices of both model and non-model female HH heads.

## 9. RECOMMENDATION

Based on study findings, the following essential measures are recommended to increase urban health extension program packages utilization and healthcare seeking behaviors of the model and non-model female HH heads.

### **Urban health Extension Professional**

- UHE-Ps should be providing home visits for non-model female HH heads based on the MOH UHEP implementation guideline.
- Develop and had proper documentation for those graduated HHs and model HH training participants at office level

### **Woreda and Sub-city Health Office and AAHB**

- Based on the MOH UHEP implementation guideline, provide training for model female HH heads ,Also for non model female HH heads
- Fulfilled different supplies and office for UHE-Ps to provide and implement some urban health extension packages like injury prevention and control and first aid and emergency measures packages.

### **AAFMHACA**

- Strong supportive supervision (follow up) private health institution like pharmacy, drug shops (vendors) to avoid inappropriate healthcare-seeking practices

### **Researchers**

- Eventually, further studies would be done to assess seasonal variation and compare urban health extension program packages utilization and healthcare-seeking behaviors of model and non-model HHs.

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## ANNEXES

**Annex 1: Information sheet**

My name is -----, from Addis Ababa University College of Health Science School of Public Health Department of General Master of Public Health I am submitting my topics for partial fulfillment of the Requirement for the Degree of Masters. I am working Bole sub-city FMHACA. I am conducting a survey and collecting data for research projects to assess the urban health extension program packages utilization and Healthcare-seeking behaviors in the community of model and non-model HHs, Bole sub-city, Addis Ababa. Your house was selected for the survey. Now, I want to ask you, your willingness to participate in this research by your full interest. I would like to ask you some questions about your household. The questions usually take about 20-30 minutes.

**Title of the study:** Urban health extension program packages utilization, and healthcare seeking behaviors in the model and non-model HHs in Bole Sub-city, Addis Ababa, Ethiopia.

**The benefit of the study:** There is no direct benefit for participants for participating in responding to this questionnaire. This research is indirectly important for you and the community to increase UHEPa utilization and healthcare-seeking behavior and also give clues for the government and policymaker to take action.

**Risk of the study:** participating in the survey has no risk and interviews will also be conducted privately to have free feelings in households.

**Rights of the participant:** Full rights to Participating or not participating in the survey and you have the freedom to withdraw at any time even during being interviewed. And also, the participant can skip questions that you do not want to respond, and ask any questions which are not clear for understanding.

**Confidentiality:** assured by omitting personal identifiers instead of used codes during data collection, data analysis, and reporting. All of the answers you give will be confidential and will not be shared with anyone other than members of our survey team.

Dear participant, thank you for your cooperation in advance; and now I will read to you or you can read this written consent form, and you will sign for me as you agreed to participate in this study after you understand the objective of the study. In case you need more information about the survey, you may contact the person listed on this card.

Signature of Interviewer: ----- Date: -----

**Annex 2: Informed consent**

I have read this form or it has been read to me in the language I understood all the conditions stated above. I also understand the research focus on urban health extension program packages utilization and healthcare-seeking behaviors in the community of model and non-model HHs, therefore, I am willing to participate in this study. Respondent agrees to be interviewed to continue with the survey. It also explained to me that I have the right to stop participation at any time. In addition, I understood that participating in this study services as a baseline for further study. Therefore, I have now consented to participate in this study by signing this form. For any additional information related to the questionnaire please contact the principal investigator.

Name of data collectors .....

Signature.....

Date.....

**Annex 3: Observational checklist****Observational checklist for urban health extension packages utilization**

No	Urban health extension program packages	Response		Comments
		Y	N	
1	Is there latrine construction and utilization?			If yes verified through physically by footprints and fresh excreta /wet urine inside the pit,cleanliness environment and home, first aid kits
2	Is there solid waste disposal site/containers and used?			
3	Is there a liquid waste disposal drainage system and used?			
4	Are you observed a healthy home environment?			
5	Is there a clean container and cover to keep food and water safe handling?			
6	Is anyone used maternal and child health services in the health facility?			
7	If question 6 yes, Is there card like follow up card ANC/Delivery/PNC, vaccination card, Family planning card, growth monitoring card			
8	Are there any activities in the home related to disease prevention and control related to malaria, TB, HIV, and AIDS? Is anyone visit a health facility to get service?			

Annex 4: Information sheet (Amharic version)

የስምምነት ማሳወቂያ ቅጽ ስሜ.....ይባላል።እዚህ የተገኘሁት የአዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና ሳይንስ ትምህርት ቤት የድህረ ምረቃ ተማሪ የሆኑት ሸታሁን የኔት ወክሮ ነው።እሳቸውም በአዲስ አበባ ከተማ አስተዳደር ቦሌ ክ/ከተማ በጤና ኤክስፐርት ፕሮግራም በጤና አገልግሎትና ፓኬጅ አጠቃቀም ዙሪያ በሞዴልና ሞዴል ባልሆኑ የቤተሰብ አባላት ዙሪያ ጥናት በመስራት ላይ ይገኛሉ።ይህንን ጥናት ለማካሄድ ተሳታፊ የሚሆኑትን በሎቶሪ የናሙና አወጣጥ ምልመላ ሲካሄድ እርሶ በዚህ ጥናት እንዲ ሳተፉ የተመረጡ ሲሆን ጥናቱ በሚካሄድበት ወቅት በጤና ኤክስፐርት አገልግሎት አጠቃቀም ዙሪያ ዳሰሳ ለማድረግ

1.ለጥናቱ የተዘጋጀ መጠይቅ እጠቀማለሁ 2.በጤና ኤክስፐርት ፓኬጅ አተገባብርና አጠቃቀም ዙሪያ የቤት ለቤት ምልክታ እና ካሄዳለን ይህም የእርሶን ሙሉ ትብብር የሚጠይቅ ይሆናል።ስለሂደቱም አጭር ገለጻ ይደረጋል።መጠይቁና ምልክታው የሚወስደው ጊዜ ከ20 እስከ 30 ደቂቃ ነው።የምትሰጡን መረጃ ሁሉም ሚስጢራዊነቱ የተጠበቀና ቅፅ ላይ ስም አይሰፍርም።ከጥናቱ በቀጥታ የሚያገኙት ጥቅም የለም።ነገር ግን በተዘዋዋሪም ጥናቱ በአዲስ አበባ ከተማ አስተዳደር ቦሌ ክ/ከተማ በጤና ኤክስፐርት ፓኬጅ የጤና አገልግሎት አጠቃቀም ዙሪያ ላይ የሚታዩ ችግሮች ለመከላከልና ለመቆጣጠር ትልቅ አስተዋፅኦ ይኖረዋል።በተጨማሪም ለቀጣይ ምርምር መሰረት በመሆን ያገለግላል።እንዲሁም ይህንን ጥናት መሰረት በማድረግ መንግስትና የተለያዩ ባለድርሻ አካላት ትኩረት በመስጠት ችግር ላይ የራሳቸው አስተዋፅኦ እንዲያደርጉ ይረዳል ብዬ አስባለሁ።ስለዚህ የእርሶ ተሳትፎ ለዚህ ምርምር ጠቃሚ ነው።በዚህ ምርምር መሳተፍ ምንም አይነት ጎንዮሽ ጉዳት አይኖረውም።ስለዚህ በጥናቱ መሳተፍም ሆነ አለመሳተፍ የእርሶ መብት ነው።ከጥናት ጋር ተያያዥ ጥያቄ ካለዎት ወይም ተጨማሪ መረጃ ከፈለጉ ከአዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና ሳይንስ ትምህርት ክፍልን ወይም ጥናት አድራጊውን በሚከተለው አድራሻ ማግኘት ይችላሉ።

የተሳታፊው ስም.....  
ፊርማ.....

**Annex 5: Informed consent (Amharic Version)**

የስምምነት መዋወያ ቅጽ ጥናቱን በሚካሄደው አካል ስለጥናት በቂ መረጃ ተሰጥቶኛል። የዚህ ጥናት ዓላማም በጤና ኤክቴንሽን ፕሮግራም በጤና አገልግሎትና ፓኬጅ አጠቃቀም ዙሪያ በሞዴልና ሞዴል ባልሆኑ ቤተሰብ ጥናቱ እንደሚሰራ ተረድቻለሁ። ከኔ የሚወሰደው መረጃ በእኔ ላይ ምንም ዓይነት ጉዳት የማያስከትልና መረጃውን ለጥናት ዓላማ ብቻ እንደሚውል ተረድቻለሁ። ማንኛውም እኔን የተመለከተ መረጃ ሚስጥራዊነቱ የተጠበቀ ነው። እንደዚሁም በጥናቱ ለመሳተፍ ፍቃደኛ ካልሆንኩ በጥናቱም ለመሳተፍ እንደማልገደድ ነገርግን በዚህ ጥናት መሳተፊ ለሳይንሳዊ ዕውቀት ጠቃሚ መረጃ የማበርከትና ወደፊት በዚህ ዙሪያ ለሚሰሩ ስራዎች መሰረት የሚሆኑ ግብዓት መስጠት እንደምችል ተረድቻለሁ። በመሆኑም በዚህ ጥናት ላይ ለመሳተፍ የተስማማሁ መሆኔን በፊርማዬ አረጋግጣለሁ።

የተሳታፊው ስም .....

ፊርማ.....

ቀን.....

**Annex 6: English Version Questionnaire**

**Addis Ababa University, College of Health Science, School of Public Health**

A questionnaire designed to assess the urban health extension program packages utilization and Healthcare-seeking behavior among model and non-model households in the community of Bole sub-city, Addis Ababa, Ethiopia, 2020.

### Household survey identification

Complete the information below for all households interviewed

Address of Household:

Woreda No.....Ketena (Gotti).....House number.....

Date /month/year..... /...../..... Interviewer's Name.....

Household: Model HH.....Non-model HH.....

### Part I. Socio-demographic characteristics of the respondents

Instruction: Circle the answer that is chosen parallel to each question and for Questions that the respondent gives a direct answer, write the answer in the space provided.

1. Sex(observe) A. Female            B. Male
2. Age            .....years
3. Family size? (in number) ..... Number
4. Religion A. Orthodox   B. Muslim   C. Catholic   D. Protestant E. Others specify .....
5. What is the current marital status? A. Single B. Married C. Divorced   D. Widowed E. Separated
6. Educational status? A. Unable to read and write   B. Read and write   C. Primary school (1-8) D. Secondary school (9-12)   E. Diploma/ Certificate   F. Degree and above
7. Occupation?   A. Housewife B. Private employed   C. Government employed  
D. NGO employed   E. Other specify-----
8. Estimated Monthly Income? ..... Ethiopia birr

### Part II. Knowledge status towards Urban Health Extension Program

9. Have you heard about the urban health extension program? A. Yes    B. No

10. If question 9 yes, where did you hear from? (Source of information) (Multiple Responses Are Possible) A. Mass media (TV/Radio/) B. Urban Health extension professional C. Health professional D. Woreda health office E. Private health professional F. Community members G. Other
11. Do urban health extension professionals visit your home? (If the answer is No skip to Q14) A. Yes B. No
12. If question 11 yes, how often do urban health extension professionals visits/ support you? (frequency of visits) A. Weekly B. Every two-week C. Monthly D. Quarterly
13. What urban health extension Professionals do when they visit the home? A. Teach us B. Demonstrate different packages to us C. Give Vaccination D. Other
14. Is UHE-Ps able to transfer health messages in an understandable way/good communication skill? A. Yes B. No
15. Do you understand the urban health extension program packages components? (If the answer is No skip to Q17) A. Yes B. No
16. If question 15 yes, which packages do you know? (Multiple Responses are Possible)  
A. Maternal and child health B. Family Planning C. Nutrition D. Immunization E. Adolescent reproductive Health F. Latrine and excreta disposal G. Solid and liquid waste disposal H. Water supply and safety measures I. Food hygiene and safety measures J. Healthy Housing K. Control of insects and rodents L. Personal hygiene M. HIV/AIDS and TB prevention and control N. Malaria prevention and control O. First Aid and emergency measures
17. Do you get/addressed health information need from the urban health extension program?  
A. All my health information needs addressed B. Most of my health information needs  
C. some of my health information needs D. None of my health information needs
18. Can people reduce their chance of getting the communicable diseases by using urban health extension packages? A. Yes B. No

### Part III: Healthcare-seeking behaviors

19. Is there anyone who had disease during the last 12 months in your home? (**If the answer is No skip to Q27**)      A. Yes      B. No
20. If the answer to 19 questions yes, would you seek healthcare consultation? (**If the answer is No skip to Q23**)      A. Yes      B. No
21. If the answer to 20 questions yes, where did you take him/her to consult for the health problem? A. Health Center B. Private clinic      C. Pharmacy/drug store  
D. Homemade treatment E. Traditional healers/holy water      F. Other
22. If the Answer to question 21 A or B, estimated walking time to reach health facilities (distance to health center or private clinic)? A. less than 30 minutes      B.  $\geq$  30 minutes
23. If question 20 yes, does the UHE-Ps make referral linkage with the health center? A. Yes  
B. No
24. If question 20 yes, when do you visit the health facility or private clinic?  
A. Immediately after the illness starts      B. No improvements in the illness  
C. Unable to eat or drink      D. Others specify....
25. Is there a reason not to seek health care visit government health centers or private clinics for consultation during illness?      A. Yes      B. No
26. If questions 25 yes, what is the reason? A. symptoms were not severe. Lack of money (Household income) C. Distance to clinic/Health Facilities D. Quality of service E. Other
27. Did the urban Health extension program increase your healthcare- seeking behaviors after its implementation?      A. Yes      B. No

#### **Part IV: urban health extension program package utilization**

##### **4.1: Utilization of Family health Service**

28. Is there anyone who had visit government or private clinic for health service during the last 12 months? (**If the answer is No skip to Q30**)      A. Yes      B. No
29. If the answer to questions 28 yes, for what health service (Reason)? (observe appointment card) A. Immunization      B. Family Planning      C. ANC, delivery and postnatal care  
D. Disease diagnosis and treatment      E. Other Specify -----
30. If the answer to questions 28 No, what is the reason? A. Transportation      B. Lack of knowledge      C. Distance to clinic/Health Facilities      D. Poor quality of service E. Other

31. How do you rate the quality of health service which is provided by urban health extension professionals? (Community perception) A. V. good B. Good C. Poor
32. Do you get health benefits from using urban health extension service/package?  
A. Yes B. No
33. Have you got Health information dissemination about family planning method? (**If the answer is No skip to Q36**) A. Yes B. No
34. Do any family members use any family planning methods? A. Yes B. No
35. If question 34 yes, which type of contraceptive method have you ever used? (Observe card) A. Pills B. Injection (Depo) C. Implants (Norplant, Implanon) D. Condo E. Other
36. Do Urban Health Extension professionals give health education about Nutrition?  
A. Yes B. No
37. Have you visited by UHE-Ps to teach about Reproductive Health? A. Yes B. No
38. Child less than 1 year in your Household? A. Yes B. No
39. If question 38 yes, have you visited a health facility /private clinic to get Infants/child vaccination service? (Observe card) A. Yes B. No
40. Pregnant woman in your Household? A. Yes B. No
41. If question 40 yes, have you visited a health facility /private clinic to get ANC? (Observe card) A. Yes B. No
42. If question 41 yes, have you visited a health facility /private clinic to get delivery service? (Observe card) A. Yes B. No
- 4.2: Availability and utilization of environmental health and sanitation packages**
43. Is there any latrine facility available in your home? (**If the answer is No skip to Q48**)  
A. Yes B. No
44. If question 43 yes, what kinds of latrine facility do members of your household use? (Observe) A. Flush Latrine B. Ventilated Improved Pit Latrine C. Traditional Pit Latrine D. Other
45. Do you share this latrine facility with other households? A. Yes B. No
46. How often do all members of the family use the latrine?  
A. Always B. Sometimes C. Never use
47. Are there hand-washing facilities attached to latrine? A. Yes B. No

48. When do you wash your hands? (Observe) A. Before eating B. After eating  
C. Both before and after eating. D. After cleaning compound E. Others specify ----
49. Is there a solid waste disposal system in your home? (Observe) A. Yes B. No
50. How do you manage solid waste disposal system? (observe) A. Disposed into covered container/pit B. Disposed into open container/pit C. Burning D. Thrown anywhere  
E. other
51. Is there any liquid waste disposal /drainage/ system? (Observe) A. Yes B. No

#### 4.3: Prevention and control of communicable diseases status

52. In the last 12 months, have you been educated about Tuberculosis by UHE-Ps? A. Yes  
B. No
53. What do you do when there is cough for more than two weeks within the family?  
A. Visit health center for diagnosis and treatment B. Pharmacy/drug store  
C. Take homemade Treatment D. Take traditional medicine E. Noting.
54. Can you be preventing malaria by sleep under the bed net? A. Yes B. No
55. Have you learned about HIV/ AIDS from UHE-Ps? A. Yes B. No
56. Have you been tested for HIV/ AIDS? A. Yes B. No
57. Do you know how to use First Aid kits? A. Yes B. No
58. Is there First Aid kits in your home? (check the kits through observation) A. Yes B. No

#### 4.4: Household status-related question

59. Is your Family Model Household? A. Yes B. No
60. Is your Family/HH has been selected to take model household training? (If the answer is  
No skip to Q62) A. Yes B. No
61. If Question 59 yes, for how long? Hours-----
62. Do you implement and use the urban health extension service/packages at home? (check  
by observation) A. Yes B. No
63. If Question 62 No, Reason for not implement and use?  
A. It is not important B. Some components are not important  
C. I do not know how to use D. Some are cost/need money to use E. Others
64. How do you grade the relationship of urban health extension professionals with your family?  
A. V. good B. Good C. Bad

Annex 7: Questionnaire (Amharic Version)

የአማርኛ መጠይቅ

በአዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የሕብረተሰብ ጤና ትምህርት ቤት

በአዲስ አበባ ከተማ አስተዳደር በቦሌ ክ/ከተማ በከተማ ጤና ኤክስቴንሽን ፓኬጅ በጤና አገልግሎት አጠቃቀም ዙሪያ በሚደረግ ምርመራና ምዕራፍ ባልሆኑ የቤተሰብ አባላት ላይ የሚደረግ ቃለ-መጠይቅ

ወረዳ-----የቀጠና ስም-----የቤት ቁጥር-----

ቃለ-መጠይቅ ያካሄደው ስም-----የተደረገበት ቀን ---/-----/2012ዓ.ም

ምዕራፍ ቤተሰብ ..... ምዕራፍ ቤተሰብ ያልሆነ.....

ክፍል 1: የሕብረተሰብ ጠቅላላ መረጃ/ሁኔታ

1. ፆታ?      U. ሴት/ሊ. ወንድ
2. ዕድሜ?      -----ዓመት
3. የቤተሰብብዛት (በቁጥር)      ------(በቁጥር)
4. ሀይማኖት? U. ኦርቶዶክስ ለ. ሙስሊም ሐ. የካቶሊክ ሙ. ፕሮተስታንት ሠ. ሌላ
5. የጋብቻ ሁኔታ? U. ያላገባ/ችሉ. ያገባ/ችሉ.የተፋታ/ችሙ. የሞተበት/ባትሠ. የተለያየ/ች
6. የትምህርት ደረጃ?U. መጻፍና ማንበብ የማይችል/የማትችል ለ. መጻፍና ማንበብ የሚችል/የምትችል ሐ. የመጀመሪያ ደረጃ (1-8) ሙ.ሁለተኛ ደረጃ (9-12) ሠ.ዲፕሎማ /ሰርቲፊኬት ረ. ዲግሪና በላይ
7. የሰራ ሁኔታ? U.የቤት እመቤት ለ.የግል ስራ ሐ.የመንግስት ሰራ ሙ. መንግስታዊ ያልሆነ ድርጅት ሠ. ሌላ
8. የቤተሰብ የወር ግምታዊ ገቢ ምን ያህል ነው?      -----ብር

ክፍል 2: በጤና ኤክስቴንሽን ፕሮግራም ዙሪያ የሕብረተሰብ ግንዛቤ

9. ስለጤና ኤክስቴንሽን ፕሮግራም ሰምተው ያዉቃሉ? U. አዎ ለ. አልሰማሁም
10. ለጥያቄ 9 መልስ አዎ ከሆነ ከየት ነው የሰሙት? (የመረጃ ምንጭ ከአንድ በላይ መልስ መምረጥ ይቻላል) U. ከማህበራዊ መገናኛ (ከቴሌቪዥን ራዲዮ፣ጋዜጣ )ሐ. ከጤና ባለሙያዎች ሠ. ከግል ጤና ተቋማት ለ. ከጤና ኤክስቴንሽን ባለሙያዎች ሙ.ከወረዳ ጤና ኤጀንሲ ረ. ከማህበረሰብ አባላት ሰ.ከሌሎች
11. የጤና ኤክስቴንሽን ባለሙያዎች የቤት ለቤት ጉብኝት ያደረጋሉ?(መልስዎ ለከሆነ ወደ ጥያቄ 14 ይለፉ)      U. አዎ ለ. አያደረጉም

12. ለጥያቄ 11 መልስ አዎ ከሆነ የጤና ኤክስቴንሽን ባለሙያዎች በምን ያህል ጊዜ ድጋፍ ያደረጋሉ?

ሀ. በየሳምንቱ ለ. በየሁለት ሳምንቱ ሐ. በየወሩ ሙ. በየሩብዓመቱ

13. የጤና ኤክስቴንሽን ባለሙያዎች የቤት ለቤት ጉብኝት ሲያካሄዱ ምን ያደረጋሉ? ሀ. ያስተምራሉ

ለ. የተለያዩ የጤና ፓኬጆችን አሰራር ታሳየናለች ሐ. የክትባት አገልግሎት ይሰጣሉ ሙ. ሌላ

14. የጤና ኤክስቴንሽን ባለሙያዎች የጤና መልዕክቶችን ግልጽ በሆነ ዘዴ ያስተላልፋሉ? ሀ. አዎ

ለ. አያስተላልፋም

15. ስለከተማ ጤና ኤክስቴንሽን ፓኬጅ ያውቃሉ?(መልስዎ ለ ከሆነ ወደ ጥያቄ 17 ይለፉ) ሀ. አዎ

ለ. አላውቅም

16. ለጥያቄ 15 መልስ አዎ ከሆነ የትኞቹ ፓኬጆች? (ከአንድ በላይ መልስ መምረጥ ይቻላል) ሀ. የእናቶችና

ህጻናት ጤና ለ. የቤተሰብ ምጣኔ ሐ. ስነ-ምግብ ሙ. ክትባት ሠ. የወጣቶች ስነ-ተዋሌዶ ጤና ረ. የመፀዳጃ ቤት ንፅህና አያያዝና አጠቃቀም ሰ. የደረቅና ፍሳሽ ቆሻሻ አወጋገድ ሸ. የወኃ ንፅህናና አያያዝና አጠቃቀም ቀ. የምግብ ንፅህናና አያያዝ በ. የቤት ንፅህናና አያያዝ ተ. የግሌ ንፅህና ቸ. የHIV/AIDS እና የሳንባ ነቀርሳ በሽታዎችን መከላከልና መቆጣጠር ኘ. የወባ በሽታዎችን መከላከልና መቆጣጠር ኙ. ስለመጀመሪያ ህክምና እርዳታ

17. የጤና ኤክስቴንሽን ፕሮግራም የጤና ፍላጎትን ከመዳሰስ አኳያ እንዴት ያያሉ?

ሀ. ሁሉም የጤና ጉዳዮችን ለ. በብዛት ፍላጎቶቹን ዳሷል ሐ. በጣም የተወሰኑትን ዳሷል ሙ. ምንም የጤና ጉዳዮችን ለመዳሰስ አልሞከሩም

18. የጤና ኤክስቴንሽን ፕሮግራም በመጠቀም ተላላፊ በሽታዎችን መቀነስ ይቻላል ብለው ያስባሉ? ሀ. አዎ

ለ. አላስብም

**ክፍል 3: የህክምና ጤና አገልግሎት አጠቃቀም**

19. ባለፉት 12 ወራት የቤተሰብ አባላት የታመመው ነበር?(መልስዎ ለ ከሆነ ወደ ጥያቄ 27 ይለፉ) ሀ.

አዎ ለ. የለም

20. ለጥያቄ 19 መልስ አዎ ከሆነ የህክምና አገልግሎት ማግኘት ይፈልጋሉ?(መልስዎ ለ ከሆነ ወደ ጥያቄ

27 ይለፉ) ሀ. አዎ ለ. አልፈልግም

21. ለጥያቄ 20 መልስ አዎ ከሆነ የታመመውን ስው ይዘው ወዴት ይሄዳሉ? ሀ. ወደ ጤና ጣቢያ ለ. ወደ ግል ክሊኒክ ሐ. ወደ ፋርማሲ/መድሀኒት መደብር መ. ቤት ውስጥ በሚዘጋጅ ህክምና መስጠት ሠ. ወደ ባህል መድሀኒት /ጠበል ረ. ሌላ

22. ለጥያቄ 21 መልስዎ ሀ ወይም ለ ከሆነ ከጤና ተቋማት ያለው ርቀት ምን ያህል ነው ሀ. 30 ደቂቃ በታች ለ. 30 እና 30 ደቂቃ በላይ

23. ለጥያቄ 20 መልስ አዎ ከሆነ የጤና ኤክስቴንሽን ባለሙያዎች ወደ ጤና ጣቢያ ሪፈረ ያደረጋሉ? ሀ. አዎ ለ. አያደረጉም

24. ለጥያቄ 20 መልስ አዎ ከሆነ መቼ ወደ ጤና ጣቢያ ወይም የግል ክሊኒክ ይሄዳሉ? ሀ. ህመም ሲጀምረኝ በፍጥነት እሄዳለሁ ለ. ህመሙ ለውጥ ከሌለ/ካልተሻለኝ ሐ. መብላት ወይም መጠጣት ስቸገር መ. ሌላ

25. በህመም ወቅት ወደ ጤና ጣቢያ ወይም የግል ክሊኒክ ለህክምና የማይሄዱበት አጋጣሚ አለ? ሀ. አዎ ለ. የለም

26. ለጥያቄ 25 መልስ አዎ ከሆነ በምን ምክንያት? ሀ. በህክምና ዋጋ ለ. የቤተሰብ የገቢ ምንጭ ሐ. የጤና ተቋማት የቦታ ርቀት መ. ከአገልግሎት ጥራት አኳያ ሠ. ሌላ

27. የጤና ኤክስቴንሽን ፓኬጅ በመተግበር ጤናማነት ህይወት ወይም ባህሪ እንዲኖርዎት አድርጎታል? ሀ. አዎ ለ. አላደረገም

**ክፍል 4: የከተማ ጤና ኤክስቴንሽን ፓኬጅ አጠቃቀም**

**ንዑስ ክፍል 4.1: የቤተሰብ ጤና ፓኬጅ አጠቃቀም**

28. ባለፉት 12 ወራት የቤተሰብ አባላት የጤና አገልግሎት ለማግኘት ወደ ጤና ጣቢያ ወይም የግል ክሊኒክ ሄደዋል? (መልስዎ ለ ከሆነ ወደ ጥያቄ 30 ይለፉ) ሀ. አዎ ለ. አልሄድሁም

29. ለጥያቄ 28 መልስ አዎ ከሆነ፣ ለምን አገልግሎት? (መመልከት የቀጠሮ ካርድ ካለ) ሀ. ለክትባት ለ. ለቤተሰብ ምጣኔ ሐ. ቅድመ፣ ወሊድና ድህረ ወሊድ መ. ለህምና ሠ. ሌላ

30. ለጥያቄ 28 መልስ አልሄድሁም ከሆነ በምን ምክንያት? ሀ. በትራንስፖርት ምክንያት ለ. በግንዛቤ እጥረት ሐ. የጤና ተቋማት የቦታ ርቀት መ. ከአገልግሎት ጥራት አኳያ ሠ. ሌላ

31. የጤና ኤክስቴንሽን ባለሙያዎች የሚሰጡትን አገልግሎት የጥራት ደረጃ እንዴት ይፈርጃታል? ሀ. በጣም ጥሩ ለ. ጥሩ ሐ. መጥፎ/ዝቅተኛ

32. የጤና ኤክስቴንሽን ፓኬጅ በመጠቀም በጤና ዙሪያ ተጠቃሚ ነኝ ብለው ያሰባሉ?

ሀ. አዎ ለ. አላስብም

33. የጤና ኤክስቴንሽን ባለሙያዎች ስለቤተሰብ ምጣኔ አገልግሎት የጤና ትምህርት ያስተምራሉ?**(መልስዎ ለ ከሆነ ወደ ጥያቄ 36 ይለፉ)** ሀ. አዎ ለ. አያስተምሩም

34. ከቤተሰብ አባላት የቤተሰብ ምጣኔ ተጠቃሚ አለ?**(መመልከት)** ሀ. አዎ ለ. የለም

35. ለጥያቄ 34 መልስ አዎ ከሆነ ምን ዓይነት ዘዴ ? **(መመልከት የቀጠሮ ካርድ ካለ)ሀ. በእንብል የሚሰጥ(Pills) ለ. በመርፌ የሚሰጥ(Depo) ሐ. በክንደ የሚሰጥ(Implants) መ. ኮንዶም ረ. ሌላ**

36. የጤና ኤክስቴንሽን ባለሙያዎች ስለስርዓተ ምግብ የጤና ትምህርት ያስተምራሉ?

ሀ.አዎ ለ. አላስተማሩም

37. የጤና ኤክስቴንሽን ባለሙያዎች ስለሰነ-ተዋልዶ የጤና ትምህርት ያስተምራሉ

ሀ.አዎ ለ. አላስተማሩም

38. በቤት ውስጥ ከ1 ዓመት በታች ህጻናት አሉ? ሀ. አዎ ለ. የለም

39. ለጥያቄ 38 መልስ አዎ ህጻናት ለክትባት አገልግሎት ለመጠቀም ወደ ጤና ጣቢያ ጉብኝት አካሂደዋል? **(የቀጠሮ ካርድ ካለ መመልከት)** ሀ. አዎ ለ. የለም

40. በቤት ውስጥ ነፍሰ ጡር እናቶች አሉ? ሀ. አዎ ለ. የለም

41. ለጥያቄ 40 መልስ አዎ ከሆነ ለቅድ መወሊድ አገልግሎት ለመጠቀም የመንግስት ጤና ጣቢያ ወይም ግል ክሊኒክ ጉብኝት አካሂደዋል? **(የቀጠሮ ካርድ ካለ መመልከት)**

ሀ. አዎ ለ. የለም

42. ለጥያቄ 41 መልስ አዎ ከሆነ ለቅድመ ወሊድ አገልግሎት ለመጠቀም የመንግስት ጤና ጣቢያ ወይም ግል ክሊኒክ ጉብኝት አካሂደዋል? **(የቀጠሮ ካርድ ካለ መመልከት)**

ሀ. አዎ ለ. የለም

**ንዑስ ክፍል4.1:የአካባቢ ጤና ፖኤጅ አጠቃቀም**

43. መጻዳጃ ቤት አለ?**(መልስዎ ለ ከሆነ ወደ ጥያቄ 48 ይለፉ)** ሀ. አዎ ለ. የለም

44. ለጥያቄ 43 መልስ አዎ ከሆነ የመጻዳጃ ቤቱ ዓይነት?**(መመልከት)** ሀ. በውሀ ብቻ የሚሰራሊ. የተሻሻለ መጻዳጃቤት(VIP) ሐ. ባህላዊ መጻዳጃ ቤት መ. ሌላ

45. መጻዳጃ ቤት በጋራ ከሌሎች አባዎራዎች ጋር ትጠቀማላችሁ?ሀ. አዎ ለ. አልጠቀምም

46. በምን ያህል ጊዜ የቤተሰብ አባላት መጻዳጃ ቤትይጠቀማሉ? ሀ. ሁልጊዜ ለ. አልፎ አልፎ ሐ. አልጠቀምም

47. የእጅ መታጠቢያ ከመጻዳጃ ቤቱ አጠገብ አለ?**(መመልከት)**ሀ. አዎ ለ. የለም

48. እጅዎን መቼ መቼ ይታጠባሉ? ሀ. ከመመገባችን በፊት ለ. ከተመገብን በኋላ ሐ. ከመመገባችን በፊትና በኋላ መ. ግቢ ከጻዳዳን በኋላ ረ. ሌላ

49. የደረቅ ቆሻሻ ማሰወገጃ አለ ?**(መመልከት)** ሀ. አዎ ለ. የለም

50. ደረቅ ቆሻሻ እንዴት ያስወግዳሉ?(መመልከት)U.ክዳን ባለው ማጠራቀሚያ ለ. ክዳን በሌለው ማጠራቀሚያ ሐ. በማቃጠል መ. በየቦታው በመወረወር

51. የፍሳሽ ቆሻሻ ማስወገጃ ቱቦ አለ?(መመልከት)U. አዎ ለ. የለም

**ንዑስ ክፍል4.3:የበሽታን መከላከልና መቆጣጠር ፓኬጅ አጠቃቀም**

52. ባለፉት 12 ወራት የጤና ኤክስቴንሽን ባለሙያዎች ስለሰጠው ነቀርሳ የጤና ትምህርት አስተምረዋል? U. አዎ ለ. የለም

53. ከቤተሰብ አባላት ሁለት ሳምንትና ከዚያ በላይ ሳል ቢኖርብዎት ምን ያደርጋሉ? U. ለምርመራ ወደ ጤና ጣቢያ እሄዳለሁ ለ. ፋርማሲ/ መድሀኒት መደብ ሐ. ቤት ውስጥ በሚዘጋጅ ህክምና መስጠት መ.የባህል መድሀኒት እወስዳለሁ ሠ. ምንም አላደረግም

54. አጎበር በትክክል አልጋ ላይ ወጥሮ በመጠቀም የወባ በሽታ መከላከል ይቻላልን? U.አዎ ለ. አይቻልም

55. ስለኤች.አይ.ቪ/ኤድስ በሽታ የጤና ትምህርት ባለፈው 12 ወራት ተምረው ያውቃሉ? U. አዎ ለ. አላውቅ

56. ኤች.አይ.ቪ/ ኤድስ ምርመራ አድረገው ያውቃሉ? U. አዎ ለ. አላውቅ

57. የመጀመሪያ ህክምና እርዳታ እንዴት እንደ ሚሰጥ ያውቃሉ? U. አዎ ለ. አላውቅ

58. የመጀመሪያ ህክምና እርዳታ መስጫ ግብዓት በሰጥን ውስጥ አለ?(በማየት ማረጋገጥ ከ≥50%) U.አዎ ለ. የለም

**ንዑስክፍል4.4:ስለሞዴል ቤተሰብ**

59. ሞዴል ቤተሰብነዎት? U. አዎ ለ.አይደለሁም

60. ለሞዴል ቤተሰብ ስልጠና ተመረጠው ስልጠና ሰልጥነው ነበር?(መልስዎ ለ ከሆነ ወደ ጥያቄ 62 ይለፉ) U. አዎ ለ. አልተመረጥሁም

61. ለጥያቄ 60 መልስ አዎ ከሆነ ለምን ያህል ስዓት ሰለጠኑ? .....ስዓት

62. የጤና ኤክስቴንሽን ፓኬጅ በቤት ደረጃ ተግባራዊ ይጠቀማሉ?U. አዎ ለ. አልጠቀምም

63. ለጥያቄ 62 መልስ አልጠቀምም ከሆነ ምክንያቱ ምንድን ነው? U.ጠቃሚ ነው ብዬ ስለማላስብ ለ.የተወሰኑ ፓኬጆች ስለማይጠቅሙም ሐ. አጠቃቅሙን አላውቅም መ. ለመስራት ገንዘብስለ ሌለኝ ሠ. ሌላ

64. የጤና ኤክስቴንሽን ባለሙያዎች ከቤተሰብ/ማህበረሰቡ ጋር ያላቸውን የስራ ግንኙነት እንዴት ይፈረጃታል? ሀ. በጣም ጥሩ ለ. ጥሩ ሐ. ዝቅተኛ/መጥፎ

### Annex 9: Declaration/Assurance of Principal Investigator

The undersigned declare that this thesis is my original work and also not presented for a degree in any other university and place, besides all source materials used for this thesis have been acknowledged.

Name of the student: Shitahun Yenet

Signature \_\_\_\_\_

Date \_\_\_\_\_

This thesis work has been submitted to the university primary advisors for examination and approval.

Name of the primary advisor: Dr. Mesfin Addisie

Signature \_\_\_\_\_

Date \_\_\_\_\_