ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE SUDIES

Process Evaluation on Child Survival Interventions in SNNPR: Special Focus on Community Health Promotion Initiatives.

By

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Advisor

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Summary

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Current trends in the field of health promotion emphasize community-based programs employing multiple interventions as the main strategies for achieving population-level change in risk behaviors and health. It may be difficult to find the individual who would be friendly concerned about the welfare of the other, uninterested in money, and hard working respecting and willing to visit any who ask her/him.

The purpose of this study was to evaluate child survival program interventions with special focus on community health promotion initiatives and to assess determinants of community health promoters' functionality in SNNRP, two Woredas of Gamogofa Zone and Alaba Special Woreda

A comparative cross-sectional study was used to compare functioning CHP with nonfunctional CHP in study areas. The study was a census survey, thus the study population were all the CHPs trained in the study area in 2003 (n=443). In addition, 2 focus group discussions were held in each study woreda and in-depth interviews were made with key informants in the study areas. Epi-Info and SPSS software were used for data entry and analysis to reveal the finding. The finding revealed that 88.3% of interviewed community health promoters were performing 50% or more of the activities mentioned in their job description. Eleven point seven percent of the community health promoters were found to be performing no activities at the time of interview .i.e a point prevalence attrition rate of 11.7% over 2 years in the study areas. According to the community response, community health promoters were very good health teachers," Increased ITN utilization, toilet use, hand wash practice after toilet, and improved household hygiene, were the major appreciable change observed following the introduction of CHPs".

The finding could help the health planners who are interested to improve community based health interventions as to address the primary health care services through community involvement and responsibility for health.

Introduction

Current trends in the field of health promotion emphasize community-based programs employing multiple interventions as the main strategies for achieving population-level change in risk behaviors and health. This focuses on a community and population-based approach over the past several decades, representing a shift in emphasis from individually focused explanations of health behavior to ones that also encompass social and environmental influences. The approach is based on the premise that an individual's behavior is shaped by a dynamic interaction with the social environment, which includes influences at the interpersonal, organizational, community, and policy levels (1, 2).

Health is attainable, accessible and sustainable by people for themselves and their communities if they are given the opportunities. Unless people are empowered to take charge of their own lives and health no sustainable achievement in improving health is possible. Effective community program of awareness, education and development of human and economic resource with the emphasis on valuing local cultural practices as sources of preventive and curative health is crucial (3). Eighty percent of the illnesses that affect populations in poor countries are preventable (4). Many community based health promotion initiatives were undertaken pre and post Almata Primary Health Care declaration both in developed and developing countries to fight against diseases to reduce illness, disability and untimely death (9). The last few decades have witnessed large and sustained decrease in child mortality in most low and middle income countries. However, an estimated 10.8 million children under the age of five still die every year from preventable or treatable diseases. Many of these deaths are attributable to the condition targeted by integrated management of childhood illness (IMCI), diarrhea, acute

respiratory infection, malaria, measles and malnutrition (10, 11). A large proportion of this could be prevented through early recognition for care seeking, appropriate and low cost treatment of sick children at home or in the community with antibiotic, anti malaria or oral rehydration (10, 11, 12, and 13).

Ethiopia has also trained and uses various types of community health workers such as Community Health Agents (CHA), Traditional Birth Attendants, Community Based Reproductive Health Agent (CBRHA), Bridge to Health Team (BHT), and Health Action Committee (HAC). The BHT, and HAC training were initiated and supported by save the children USA by Child Survival Project/ Wise Women Project in 2000

Currently, ESHE supported community health promoter initiatives is launched in three Regions of the countries; SNNPR, Amahara, and Oromia as a pilot in project woredas. Consequently, the need for program process evaluation is crucial to check the status of program implementation to estimate the trajectory of success or failure towards the target. Therefore, this study was designed to evaluate the community health promoters program and to assess the determinants of functionality of community health promoters launched in 2003 in SNNRP, Arbaminch Zone and Alaba Special Woreda

Process evaluation:

Process evaluation is one of the components of program evaluation which is concerned with how the particular program actually works. It serves as monitoring function in assessing whether the program has been implemented as planned and meet set indicators. It is one of the strategy needs to be developed in congruence with other program plans to check whether the whole process is on track to achieve intermediate objectives (32). It is

a verifying tool for program managers to recognize the ongoing situation of a program to appreciate success or trace constraints to take well-timed desirable action (33).

Process Evaluation for Public Health Intervention and Research

Improving and sustaining successful public health intervention relies increasingly on the ability to identify the key components of interventions that are effective, to identify for whom the intervention is effective. However, a limited number of studies disentangle the factor that ensure successful outcomes, characterize the failure to achieve success or attempt to document the steps involved in achieving success of implementation.

In the last decades, the literature on process evaluation related to public health has grown considerably. There are plausible explanations for these noticeable increases in the use of process evaluation. Social and behavioral interventions have become increasingly complex, making it important for research to know the extent to which all intervention components are actually implemented. This complexity stems from the fact that projects are often implemented at multiple locations so that process evaluation becomes essential for ensuring that planned interventions are carried out at all sites. Complexity also results when interventions are implemented at multiple levels and with multiple audience, group organization, community, and population level. Another plausible explanation for why process evaluation efforts have increased is that we are looking for ways to explain why certain results were achieved. Specifically when interventions lead to significant

Outcomes, it is important to understand which components of the intervention contributed to the success. Thus, process evaluation can reveal both positive as well as negative results.

Process evaluation also provides important link in understanding and improving theory-informed interventions since more programs are developing theory-informed interventions, there is a great need to understand which theoretical constructs make difference (35)

Understanding the mechanism for how and why this constructs produce successful change or fail to produce change is a key to refining theory and improving interventions effectiveness. Process evaluation efforts also help us understand the relationship among the selected interventions or program components. Assessing the quality and accuracy of the intervention delivered to program participants can also be achieved with process evaluation.

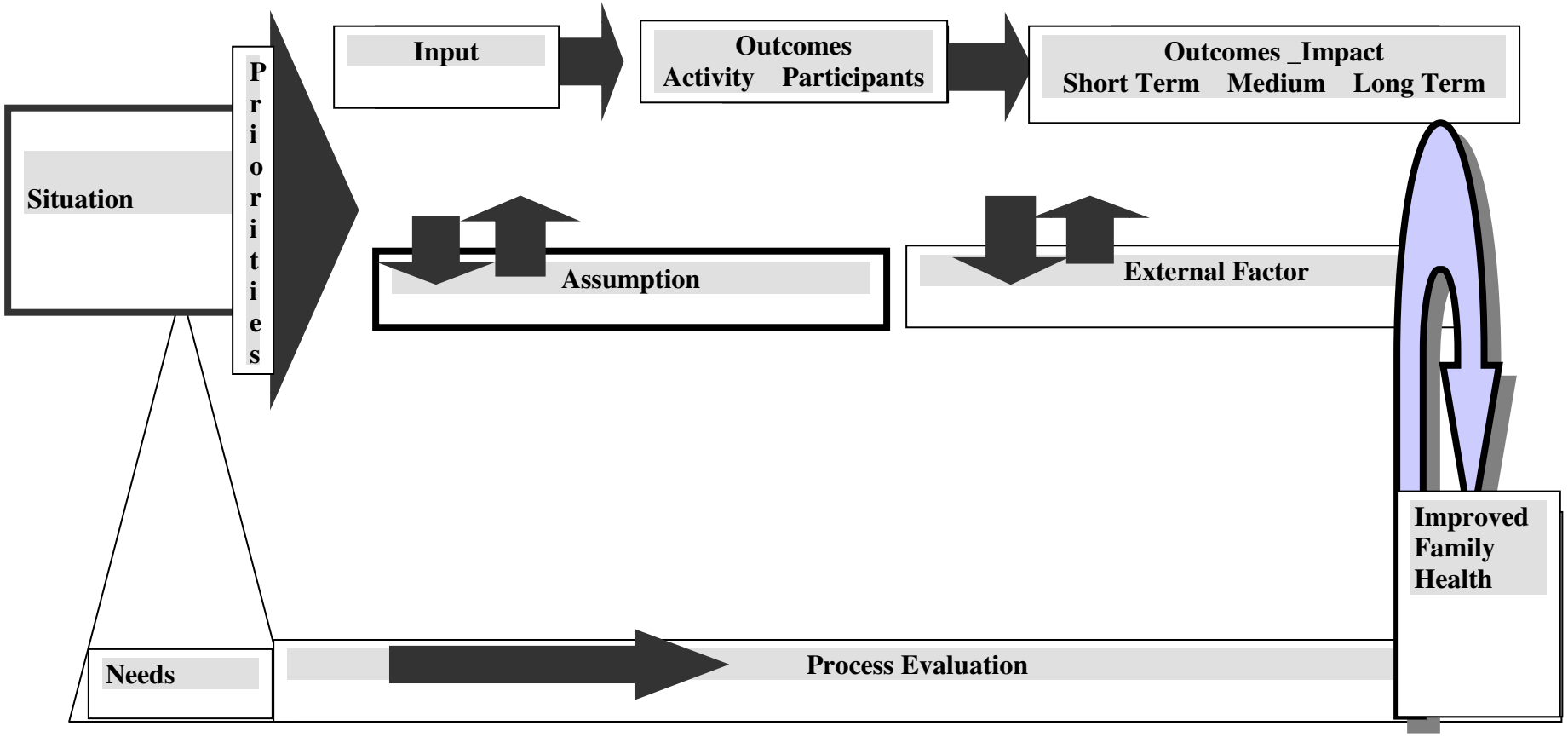
Process evaluation frequently uses both quantitative and qualitative methods, such as field site visit, structure observations of interventions, and open ended interviews are often employed in conducting process evaluations. Integrating different methods such as qualitative and quantitative methods yield rich details about study outcomes that neither method could achieve alone (36)

Taken together, the recent increase in published literature on process evaluation results reflects the growth of public health interventions today and it emulates the many ways in which thoughtful, comprehensive process evaluation efforts can shed light on questions that will inform improvement in theory interventions design, and methods in the future.

Conceptual Framework for the Study

Therefore, the present study has used process evaluation as a conceptual framework by adopting the logical model developed by the University of Missouri

Conceptual Framework for Evaluation



Literature Review

Community Health Workers in Contexts

In the 1950s and 1960s public health was developing Primary Health Care (PHC) as an approach (5, 6). PHC was defined at a joint UNICEF-WHO conference as the bridge between existing health care services and communities in need. It was said to be "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and their families in the community through their full participation and at a cost that the community and country can afford (7)." One of the approaches used to meet the goal of PHC were the Community Health Workers (5, 6, 8, and 9). The rationale for the CHWs use was that they could reach communities and lead them to become involved in their health

Definitions of terms related to CHWs

The umbrella term '*Community Health Worker'* (CHW) embraces a variety of community health aides who are selected, trained and work in the communities from which they come. A widely accepted definition was proposed by a WHO Study Group. Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers (17).

Community Health Workers include the most generic type of community based workers, including cadres, such as village health workers (VHWs), community resource persons (CORPs). In addition to these CHWs, there are also a range of more specialized cadres such

as community rehabilitation facilitators (CRFs), community-based directly observed therapy (DOTS) supporters, HIV/AIDS communicators (HACS), home-based care (HBC) workers, first aid workers, and community health promoters (CHP)

All these types of CHWs carry out one or more functions related to health care delivery, are trained in some way in the context of the intervention, but usually have no formal professional or paraprofessional certificate (17**).**

The Establishment of CHW Programs

The history of man, putting his health and life at the mercy of another, goes back to ancient times. Herodotus described the practice of' the whole people as physician'. In Babylon prior to the stage of special doctor for others as follows:

…they bring out their sick to the market place for they have no physician, then those who pass by the sick confer with him about the disease to discover whether they have themselves been afflicted with the same disease or have seen others afflicted, thus the same treatment as that by which they escaped a similar disease or they have known to cure others may help him (15). Thus, the use of health care practitioner with different degree of skill is not a new practice.

The training and use peasant doctor in china to provide basic health which was started in the 1960's was a major turning point in the history of the village health worker concept.

In United State, the formal participation of Community Health Workers (CHWs) in health and human services systems has been documented since the 1950s, and that current estimates indicate more than 12,000 CHWs serving throughout the U.S. in a diverse array of cultural settings, in programs involving both volunteer and paid CHWs (23).

In Africa, the community health programs have come about as a result of dramatic political transformation, as part of health sector reform processes, or at the initiative of NGO and faith-

based organizations. This type of prcess can be found in Zimbabwe. The earliest origin of the Zimbabwe national program stemmed from a time, when comrades (guerrillas) in the Zimbabwe African National Union who were fighting a war to liberate their country helped to establish a community-based public health program in Masvingo Province in the South of the country (17).

In Tanzania, government set out to promote rural development and mobilize the country's resources to eliminate poverty, ignorance and disease. It focused on local contribution (self-reliance) with the goal of state ownership and control of the major means of production to ensure equity. Three levels of administration were introduced: central, regional and district. The district was further divided into divisions, in turn comprising administrative wards made up of "cells" each with 10 households. Viable villages or "Ujamaa" of 100-500 households were encouraged. The Health Ministry developed a decentralized health system comprising district hospitals, health centers, dispensaries and health posts. These health posts were to provide treatment for minor ailments. In both countries, CHW programs came about as one aspect of much broader political, 'revolutionary' transformation, with a focus on liberation, democracy and self-reliance.

Ghana and Somalia are examples of countries that introduced CHWs as part of health sector reform initiatives, aiming to enhance accessibility and affordability of health services to rural and poor communities within a PHC approach. In Ghana, the Ministry of Health introduced substantial numbers of community or village health workers in the late 1970s as part of a substantial review and reorganization of MOH activities aimed at implementing PHC strategies.

Bentley reports on a fascinating initiative in the northwest of Somalia in the mid-1980s, which provided access to basic health care to large numbers of rural communities, including nomads, before it fell victim to the civil war after 1988 (17).

In Ethiopia, CHWs were first established in 1960s in the Northern Region (especially Gonder), but failed due to lack of community and health institution support (18). Later again in 1976, UNICEF supported CHWs were established as part of the Basic Health Service Program, but still encountered many problems and the program was left to be restarted in 1979. In the same way, the 1993 declared national health policy and the1995 revised health sector strategy mainly focused on the importance of community involvement on health development to enhance the preventive, promotive, and rehabilitative services through decentralization by improving community based health services at grass root level. In addition, Health extension program (HEP) is recently initiated throughout the country to implement community based primary health care predominantly focused on prevention and health promotion.

Currently, ESHE project supported community health promoter initiatives is also established in three big regions of the country: Oromia, Amahara and SNNPR.

Community Health Promoters Initiatives (CHPI) in SNNPR:

Community health promoters' initiative was initially recommended by the ESHE/JSI project based on its successful implementation in Madagascar. The overall goal of CHP initiative is to strengthen the link between the community and health facilities in order to raise the quality of health services and improve the health of the families in SNNPR. The CHPs are volunteers whose primary motivation is to learn how to take care of their own families and share the

needed action with their neighbors. The concept of community health promotion is based on transmitting simple action based health messages using understandable behavior change and communication (BCC) materials to the community by the community health friendly volunteers. The CHPs are given short, action oriented two days training on interpersonal communication and negotiation skill as to able to transfer a doable key health messages on: child feeding/exclusive breast feeding, immunization, family planning, hygiene and sanitation and control of malaria to improve the child health in the region. The CHPI is not intended to replace the existing or the upcoming categories of community health workers or activities. They are thought to add momentum to existing health services and upcoming program such as health extension agents (HEP). CHP can amplify the voice and action of Health Extension Program (HEP) and help the community to improve health. At the same time, CHP can benefit from support, mentoring and encouragement by HEP, the new cadre of community based health workers. One community health promoter is selected and trained for every 30-50 household to promote health in his/her village.

Thus, ESHE works with partners in the regions to engage communities and families to utilize available health services and practices preventive behaviors and home based health care as a major component of its strategy to improve child health (26, 27).

Community Health Promotion Program in Madagascar

In Madagascar, the Ministry of Health (MOH) and district health teams in partnership with other donors and non-governmental organization (NGOs) supported a program that attempts to mobilize the communities and linked them with quality service for reproductive and child health.

Soon after, the country made a national political decision to decentralize, and its first national policy in 1996 emphasize the importance of community involvement and district responsibility for health. The new program was designed to focus on communities provide a package of services to addresses routine child hood immunization, essential nutrition action (ENA), Reproductive health including family planning and IMCI as a framework (31).

Then, a large number of community health promoters who are the first to carry out priority health actions were trained for their respective village. This forms a grassroots network of parents who serve as models and community resources. Training a large group of community members, developed an energetic enabling behavior change environment by using strategies such as engaging a broad cross-section of community members, communicating extensively and conducting mass public educations improved the health care in the country. Exclusive breast feeding for the first six months, appropriate complementary feeding beginning at six months with continued breast feeding to two years and beyond, feeding of the sick child and woman nutrition, home visiting and counseling at home provide the CHPs to negotiate with the mothers as well as health talks and facilitated drama to stimulate participants were the major efforts to try out the new practice to improve women and children health in Madagascar (30, 31)

Profile of community health workers

Recruitment and selection

While there has only rarely been direct community participation in the establishment of CHWs programs, its central importance in the selection and recruitment of community health workers has been widely acknowledged (17).

The qualification of community health worker is based on its profile; the individual must be from the community that he or she will serve. However, programs need to carefully consider and establish requirement methods and selection criteria because this could greatly influence CHWs' overall performance and acceptability to the community. In addition, cultural, political, and social context of the program area will influence which criteria define the best qualified CHW and those most acceptable to the community (19).

The most common approach employed by organizations to initiate CHW selection has been the setting up of Village Health Committees (VHCs*)*, which would then be tasked with the selection of CHW candidates. In some cases, like in Somalia, existing village committees were used to play the role of VHC. However, most studies only report that CHWs were chosen or selected "by the community themselves". There is more information, however, on the selection criteria for choosing health workers. Mature age (between 20 and 45 years) and often married status is a criterion in a large number of cases, such as the Church of the Brethren initiative in Nigeria, the Somalia CHW program, a Safe Motherhood initiative in Uganda, and numerous others (17). There are different practices concerning whether the CHWs have to be literate. In Somalia and Uganda, literacy was a prerequisite, while the Tanzanian CHW program and Kenyan AMREF programs required seven years of primary education as a pre-requisite (24). The Church of the Brethren project in Eastern Nigeria required the ability to read and write in Hausa, the local language, as well as good communication skills. However, in the community self-help health development program in Saridid, Kenya, literacy was not considered as a selection criterion (17).

There are different approaches to gender choice in selection processes asserted that "in Africa, village health workers are generally of two types:

- The young, male and literate CHW, trained in curative and preventive work; and
- The elderly, illiterate female traditional birth attendant (TBA), who deals with childbirth (17).

Training

There is no detailed information available on the length and depth of training given to CHWs, although the literature does provide some sense of the variety of approaches. At Maradi in Niger, for example, courses of seven to ten days were provided at the rural dispensary base to which the project was attached. They covered: "general health concepts, emergencies and referrals, epidemic diseases, health education (including nutrition), elementary health care, environmental sanitation and some record keeping. Each year the VHWs were sent to a ten-day refresher course, where they would be introduced to new items such as the treatment of malnutrition and the preparation of weaning foods. In Bangladesh, a competency-based approach to training is commonly used to train community health workers who treat sick children. The competencies that are achieved during training are also those that should be assessed during supervisory visit or follow up, frequently with the checklist used during training (24).

In Tanzania, VHWs would undergo 3 - 6 months while in Nigeria VHWs were trained for three months in groups of twenty, and sent for refresher courses twice a year subsequently.

In Somalia, VHW initiative provides more insight on the content and structure of training. Here the newly appointed CHWs were trained over a period of seven weeks, with four to six

months of practical on-site application in between and one-week refresher courses being offered subsequently every six months (17).

Retention of CHW

The retention of CHW or volunteers is one of the largest operational challenges in almost any CHP. Program managers and technical experts alike have cited retention of community health workers as an operational issue that needs much attention. Attrition rate in CHW program often are as high as 30% over 9 months (26). Loss of trained CHW can lead to poorer program coverage and the necessity for greater operational input of further recruitment and training. CHW dropout can also disrupt program continuity and relationship between individual CHW, the community, and the health system (27).

Retention of CHWs can be affected by numerous interrelated factors including:

1. operational input of the program, such as recruitment methodology, training and supervision
2. Importance of program activities to the individual CHW and the community,
3. Monetary and non-monetary incentives, and
4. Clarity of defined CHW role and responsibilities. For instance, in the CARE Siya program, some CHWs anticipated compensation and when it was clear that compensation was not forth coming they drooped out (25)

Technical Support and Supervision of CHW

The explanations as to why supervision and refresher course are so beneficial are: because people who are involved in supervision think that continuous supervision provides the CHW reliable and valuable back up in terms of referring patient and in terms of enhancing the CHW credibility with the community. Refresher course improves his or her skills status as an

effective member of the health team (30). Determining their needs, providing supportive workplace supervision, and providing refresher courses and different forms of assessment can enhance the motivation of CHWs through continuing education.

Therefore, technical management support and supervision are recognized as the key elements which make or break community health program (17). Many evaluations have documented the weakness of supervision and support in national programs, which is often irregular or non existent. Investigator from Botswana, Tanzania, China, India, Srilanka, Iran, Colombia, Peru, Ecuador and Alaska have looked into the effect of refresher course and regular supervision by the health sector. They invariably found that health activities performed by the CHWs were sustained better when she or he is regularly supervised every month and given a refresher course every 3 months (29).

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Rationale

The challenge and potential difficulties that exist in developing community participation in health program are paramount: negotiating the myriad of cultural and social issues in diverse communities is challenging. The community health worker should be friendly, concerned about the welfare of the other, uninterested in money, hard working respecting and willing to visit any who ask her/him. It may be extremely difficult to find the individual who on top of these characteristics also has the time and energy to take on the role of community health worker (14). Likewise, in Ethiopia it has been repeatedly mentioned that the community health service (CHS) program is having problems partly due to lack of remuneration of CHWs. According to a study in 1989, among the trained CHW, more than 45.8% are not functional (15).

Therefore, the need to evaluate the community health promotion program is widely acknowledged and crucial to know whether the program is promising for desired effects or not.

Study objectives:

General objectives

To evaluate the community health promotion program and to asses the determinants of the functionality of community health promoters in SNNPR, two woredas of Gamu Gofa Zone and Alaba Special Woreda

Specific objectives:

1) To determine the level of functionality of the CHPs .
2) To determine the demographic and social factor which may affect CHP functionality
3) To identity the support of the community and health system on CHP functionality
4) To assess community perception towards CHP jobs

Material and methods

Design

The study used both quantitative and qualitative methods analysis. The quantitative method has constituted the major design of the study. The comparative cross-sectional study was used to compare functioning CHP with non-functional CHP in study area.

Study Area

The study area was the Southern Nations, Nationalities and People's Region (SNNPR).The SNNPR is located in the Southern and South Western part of Ethiopia and Awassa is its capital. The region's people are estimated to be 14 million with considerable ethnic diversity by current estimate, more than 50 ethnics and culture group each with its own linguistic and cultural identity. It has 13 administrative Zones and 8 special Woredas. It encompasses an area of 118,881 Square Km, which is about 10 % of Ethiopian land mass. This study was conducted specifically in two Woredas of Gamugofa zone, Arbaminch Zuria, Mirab Abaya and Alaba Special Woredas where 574,251 people of the region live.

Population

The source population for the study were all members of CHPs trained in 2003 for two districts of Gamugofa zone; Arbaminch zuria, Mirab Abaya and Alaba Special Woreda. The study was a census survey, thus the study population were all the CHPs trained in the study area in 2003 (n=443), In addition, 2 focus group discussions and interview with key informants were held in each study Woreda.

Sample size estimation

The study was a census study that had included all CHPs trained in 2003 in the study areas

Measurements

Outcome measurements:

1) Functionality of CHPs

In this study, the outcome of interest was functionality of CHPs. This was measured by assessing the activities of CHP against their job description. See the functionality score on the table1:

2) CHPs related performance achievement from health institution record in the past 2 years (2003-2005)

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Table 1: Functionality score from the job description

Job description	Performance	Score

1 Home visiting	No	0
	2-3 times in a months	2
	Once in a month	1
2 environmental Health activities	No	0
	2-3 times in a months	2
	Once in a month	1
3 MCH/EPI activities	No	0
	2-3 times in a months	2
	Once in a month	1
4 Giving H/E	NO	0
	Occasionally	1
	Regularly	2
5 Referring sick patient Advising family/ neighbor to visit HI When they get sick	NO	0
	Occasionally	1
	Regularly	2

Maximum score---------- -------10

The following operating definition was set for this particular study.

Functional CHP (= those scoring 5 and above

Non-functional CHP (those scoring less than 5. Each item on functionality scale was given equal weight

Exposure measurement: The information on exposure was found from the CHPs, FGD, Community leaders and health facilities staff.

Data collection

The structured questionnaires were used to interview the study subjects for both measurements of outcome and exposure. Those who had completed 10 grades were recruited as data collectors and trained for 3 days before deployment to collect data. . Health staffs (Nurses and sanitarians) were trained to supervise the interviewers. The CHPs, interview with key informants, and FGD were conducted at respective interviewees setting.

The use of none-health professional interviewers was used to improve the honesty of the responses, and the result in less interviewers' bias

Recall bias was reduced by limiting the questions to recent activities of CHP (maximum 3-6months). Pilot test was also conducted ahead of major study in one of the three study districts for adjustment if needed.

Method of analysis

The qualitative data, the tape record interview/ FGD were transcribed and translated into English. The statement was arranged in respective of its questions and was analyzed for interpretation

The quantitative data were entered and analyzed using computer software packages of Epi-info and SPSS.

Major steps to be followed during analysis

1) **Descriptive analysis;-**

- Describing the proportion of functional and non- functional CHP
- Describing some of the socio demographic attributes of the CHP trained
- Describing CHPs job related performance achievement
- Elucidate community perception towards CHP jobs

2) Bivariate analysis:-

- To determine any association between categories of functionality and the different exposure faced by the categories with respect to attributes

3) **Multivariate analysis:-**

- To further see the relative importance of the various exposure attributable to CHP functionality

List of items from the job description of CHP were given scores of 0, 1, and 2. The maximum score was obtained 10, and the minimum was 0. Those who scored 5 or more were classified as functional (ie. They were doing 50% or more of the tasks in their job description) and those who scored below 50% were classified as non functional for this particular study

Ethical considerations

Ethical clearance was obtained from Department of Community Health, AAU. Then, letter of cooperation was received from SNNPR and submitted to the study areas.

Interview was carried out after getting the consent of the interviewees. Before each interview, the study's objective was clearly explained to the subjects. Each respondent was assured that the information provided was confidential and used only for the purpose of a research. A clear explanation of research objectives and the assurance of confidentiality helped the respondents to be honest with their responses.

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Results

General Description of quantitative results

A total of 433 community health promoters were planned for interview and 400 responses were obtained. Other community health promoters couldn't be traced due to different reasons in spite of repeated visits. Ten CHPs changed their residence, 3 died and 20 were not available during visit or survey

Socio Demographic Characteristics of Community Health Promoters

The age distribution of community health promoters ranged between 18-60 years old .Majority of the community health promoters were between the ages of 23-42 years with the mean age of 32 years. The gender mix of the community health promoters seems to be good

during recruitment. Of all community health promoters interviewed, 53% were males and 43% were females.

Married community health promoters constituted for 90% while the rest 10% were single, widowed and divorced.

The Education status of community health promoters was both literate and illiterate. The large majority (60%) of the community health promoters were illiterate while 40% were literate.

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Table 1: Comparison of selected characteristics of non-functional and functional community health promoters in SNNPR, 2006

Comparison variable Non functional Functional Adjusted

	Frequency (%)	**Frequency (%)**	**OR (95%CI)**
Age			
<30	24(51.1)	158(44.8)	1
>30	23(48.9)	195(55.2)	1.282(0.696, 2.362)
Sex			
Male	29(61.7)	183(51.8)	1
Female	18(38.3)	170(48.2)	1.423(0.740, 2.73)
Marital status			
Single (unmarried)	4(8.5)	16(4.5)	1
Married	43(91.5)	326(92.4)	0.528(0.169, 1.651)
Educational status			

Literate	22(46.5)	137(38.8)	1
Illiterate	25(53.2)	214(60.6)	1.201(0.627, 2.300)
Supervision			
No	14(29.8)	72(20.4)	1
Yes	32(66)	279(79)	0.502(0.239, 1.055)
Training adequacy			
Yes	15(31)	99(28)	1
Partially	23(48.9)	219(62)	0.491(0.191, 1.67)
Not adequate	9(19.1)	35(9.9)	0.3391(0.167, 1.98)

Note: 1 denote reference category adjusted for socio demographic variables

Functionality

According to this study result, 353(88.3) % of the community health promoters were found to be performing more than 50% of their job during interview. Only 47 community health promoters were not performing any of their jobs resulting in the attrition rate of 11.7% over 2 years. For detail, see table 2 Functionality status by address

Attributes that associated with functionality were computed using SPSS software. However, none of the studied attributes were found significantly associated with functionality.

Table 2: CHPs Functionality status by their address

Address	**Functionality Status**				
	Nonfunctional	**%**	**Functional**	**%**	**Total**

M/Abaya	16	9.4	154	90.6	170
A/Zuria	4	9.1	40	90.9	44
Alaba S. W	27	14.5	159	85.5	186
Total	47	11.7	353	82.3	400

Support of the community and the health system

In this study, 32.5% of the community health promoters responded that they have community support while 66% of the community health promoters don't have any support from the community.

Regarding health system support, 71.8% of the community health promoters have received supervision ones or more times within a year that created the opportunity for the CHPs to receive the necessary support from the health personnel.

Community Health Promoters job related activities achievement from 2003-2005

The existing data was attempted to be examined from health center that supervise the community health promoters. But the document that can shows the contributions of community health promoters on primary health care activities couldn't be found, even though the CHPs are performing various health activities as proved by focus group discussion and in-

depth interview. There was no HIMS at place that regularly captured the contributions of CHPs to see their efforts on the current health service achievement obtained by the health facilities in each study area.

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Result on Qualitative Study

The qualitative studies carried out in this study were focus group discussion (FGD) and in-depth interview with key informants as an alternative source of information to back up the quantitative study. Six focus groups (FGD) and 10 in-depth interviews were conducted in selected study areas. Both male and female of different age categories of community members were involved in FGD.

In-depth interview was conducted with heads of 2 Health centers, Mirab Abaya and Lante and heads of 3 health stations /health posts, Wajifo, Omolante and Sinbita and with respective leaders of these communities. The discussion was held in such a way that the participants were expressing their ideas freely without reservation.

The Focus Group Discussion: The focus group discussions were held at 6 places of the study area: Wajifo, Lante, Omolante, Sinbita communities. Each group was made of males and females. One FGD consists of 8-10 people during discussion. All members of the FGD

were selected from the community where the CHPs have started health work since 2003. Most participants if not all, are Gamo, Wolayita, and Alaba by ethnicity and live in their respective kebeles in the study area. None of FGD members were CHPs. The focus group discussions were initially situated in quiet places by moderators.

Sites were arranged in circulating fashion. Then, the modulator introduced himself with group members and described the objectives of the study to participants. Discussion was recorded by tape recorder.

"CHPs are the community health teachers". According to one speaker, previously, there were community health agents (CHAs) who were teaching the community on health issues. But currently, there are volunteer community health promoters who are teaching health at different places including at the household level. According to the participants, the health theme that CHPs are teaching/promoting are: Immunization and community mobilization to service utilization, environmental health and personal hygiene including latrine construction and waste disposal, importance of hand washing after using latrines.

Another participant said, "Health issue is the concern of the community not of anyone else". Moreover, he described that formerly health workers were giving health education for the community but that was not enough because the population of the kebele is more than 2000, so that the health worker cannot visit each and every household that the CHPs do currently. Other participants have mentioned family planning as being promoted by CHPs. According to participants, CHPs also participated in malaria control and distribute impregnated treated net (ITN) for household and teach how to treat the net with chemicals. The major problem being faced by the community health promoters were "the community failed to demonstrate what

has been taught by the CHPs into practice" The speakers said that the community say 'Eshi' but there is no practice. Because there is no regulation set for sanction so that some of them do not demonstrate what they have been taught. In spite of these difficulties, almost all households do have latrine even if some of them do not qualify the standard being taught by the CHP. Some do not have cover, other do not have diverting ditch. "So, CHPs basically teach the community members but they do not have any legal authority to take an action". There is no rule that supports their effort to let the community practice what they are taught by the CHPs.

"There is a change on health service utilization and practice after CHPs were trained in our community", one focus group participant mentioned. According to the speaker, toilet construction, hand washing practice after toilet use, household and personal hygiene, and ITN utilization to protect malaria are the major changes seen following the introduction of CHPs and their effort. On the contrary, the speaker said, "I assume that the educated portion of the community undermine what is being taught by the illiterate CHPs and lost the benefit" others gained from CHPs services. Therefore, I wonder if high school attended CHPs can be trained and recruited to serve the educated portion of the community in the kebele. He also said, CHPs should have better knowledge than existing to react to different question raised from community. The other speaker said, I believe that community health promoters are good health teachers, but I am not convinced with the rule of voluntarism. They are human beings that are devoted to improve family health in general. So, they have to be paid or compensated for what they are doing. Other wise," CHPs are capable to promote health message to bring a change".

Regarding community views about CHPs, very few said that CHPs are committed to work because they are paid. The other speaker said that few community members feel that CHPs are always committed because of incentives they got but this is due to lack of knowledge about CHPs' role and their unpaid assistant. According to the speaker, majority of the community members appreciate the CHPs' effort and accept their services.

Malaria is the top cause of sickness in the area. According to the participants, the CHPs roles were large in creating awareness about care taking for children. "Children cannot speak their diseases but parents should know sings of disease to take the children to health facilities for help" Diarrhea is the next cause to morbidity.

In-depth Interview:

In-depth interview was conducted with the heads of health facilities that supervise the community health promoters. Heads of health centers and health stations were interviewed. The heads of the facilities have both managerial and technical role in the facilities.

All health facilities work on curative and preventive health. Curative service is the major activities that involve community health promoters. Immunization for children and women of child bearing age, family planning, environmental health, are some of the outreach preventive activities.

Malaria, diarrhea, and respiratory tract infections are the top health problems in all visited health facilities.

All health facilities heads know the community health promoters. According to them, the CHPs were deployed to promote immunization, family planning, environmental health, and control of diarrhea diseases as a part of community participation to improve their health. The community health promoters are working on health promotion since they were trained.

One of the health workers said," There are appreciable changes particularly in three major themes: like family planning service, environmental health, toilet construction for each household and, hand washing practice after toilet use since we had CHPs" …, this was the responsibility of health workers, but it is difficult for them to reach each household. "Community health promoters have really taken a wonderful share and responsibility to promote health in their respective communities".

The health facility provides desired support for community health promoters. One health person mentioned that community health promoters are volunteers who promote health in the community. In fact they are working for the people in the community, we see their work. "Their work is visible". We appreciate their work, we thank for their effort, and we provide technical support and react to their questions. The community health promoters are solving the previous health problems. "This fact shouldn't be denied but it should be recognized".

Regarding their function, some of the promoters had started working expecting benefit under voluntarism, but on the half way they stopped due to lack of benefit for their services. On the other hand, most of the community health promoters have continued their work.

One health worker said, Community health promoters' effort is indispensable to promote primary health care. "My fear is, if CHPs' work cannot be sustained it may be a loss".

Therefore, organizations that are committed to strengthen the health service system should support this strategy and build better way on this experience. For instance, if certain organizations have interest to establish other health promoters who are paid, it will be disappointing for motivation of the existing volunteer CHPs. According to the health worker, paying salary for promoters does not improve CHPs' work but recognition of their work, appreciation and rewarding competent promoters will create more work interest and improve their performance.

Program Management

The Essential Services for Health in Ethiopia (ESHE) project was launched in SNNPR in 2004. ESHE project is an integrated program of child survival interventions and health sector

reform designed to improve the family health in the region. It is funded by the United States Agency for International Development (USAID).

John Snow Incorporation (JSI) as a sub contractor for USAID was implementing the ESHE Project activities since 2001 in SNNPR. At that time, the project used to work on institutional capacity building. System strengthening such as capacity building on health information management system (HIMS) was the center of attention at all health sectors levels in the region during JSI implementation of the ESHE project. In addition, the project assisted the Regional Health Bureau in financing to construct the health posts. According to project final evaluation, JSI project was phased out with significant outcomes in improving the health management system in the region. These positive outcomes had paved the way to design an integrated child survival program to improve the family health in the region.

The Community Health promotion Initiative (CHI) was also initiated as a pilot project in SNNPR in February 2003 by JSI. This pilot project is currently scaled up by ESHE to the major regions of the country (Oromiya, and Amahara regions)

The overall implementations of child survival interventions were designed based on the Regional Health Bureau interest and request to improve the quality and utilization of high impact child survival interventions in the form of Expanded Program on Immunizations (EPI), Essential Nutrition Action (ENA), Community Health promotion Initiatives(CHPI), and Integrated Management of Childhood Illness (IMCI) with key approaches such as: capacity building, community mobilization and behavioral change communication. ESHE works also on health sector reform with the Regional Health Bureau and District Health Offices to institute policy changes aimed at increasing resources available for and improving

service utilization in the health sectors. ESHE has also initiated the implementation of the health care finance strategy in terms of privating and cost sharing in health services.

The community health promoter initiatives work plan was designed to achieve child survival program through community health promoters' involvement by strengthening the link between the community and health facilities in order to raise the quality of health services and improve the family health in the region. . Health talks, and health education on nutrition, EPI, household and environmental sanitation, family planning, controls of malaria and community mobilization to improve health services utilizations were the major components of health plan implemented by CHPs since their introduction.

To achieve the project objectives, the office was devoted to making administrative, personnel, financial and institutional arrangements to set strong foundation for project implementation. Material and Finance resources were allocated to implement the child survival activities in a comprehensive manner.

Staffs with diverse caliber, professions and experience were invested. A Project Manager, Child Survival Specialist, Community/BCC Specialist, Community Program Officer, Performance Improvement Specialist, Health Care Financing Specialist, Woreda Cluster Coordinators, Program Assistants and supportive staffs were deployed in the project areas for overall program management and implementation. Community /BCC specialist and community health officer are the key staffs working 100% on community health initiatives. Designing curriculum for training, establishing selection criteria for recruitment of CHPs, developing BCC materials, and testing materials, preparing community training guideline, annual festival, and staff training are the major tasks of the community BCC specialist.

In addition to ESHE, the Regional Health Bureau has community health arrangements, CHPI and BCC sections under Family Health Department who are jointly working with ESHE project on community health promoters' initiatives. The role of Regional Health Bureau is paramount in the community health promoter initiative activities. The joint planning and implementation of both parties and recent linkage of health extension program with community health promoters have huge potentials to improve harmonious working relationship between primary health workers and the community. Community health promoters' initiative is the major strategic approach to implement child survival intervention at community level. All staffs working for child survival program under ESHE project have their own share to contribute to community health promoters initiative as the program calls for assistance.

Regarding financial plan, each of the child survival project intervention gets the proportionate share of the overall allocated budget. However, sufficient information was not available to see the specific budget items allocated for each of the interventions. Indeed, the community health initiative and behavioral change communication program shared the activities running cost as a part of child survival intervention components. The budget expenditure for planned activities is proved and discharged according to the proposal and request of CHP and BCC sections. Two staff, community/BCC specialist and community health program officer are paid 100% from the CHPI/BCC budget title. While others staff share the salary based on the extent of their participation. In addition, the Regional Health Bureau has invested certain proportion of the budget interns of money, staff, and time to implement community health

promoters' initiative jointly with ESHE staff in the region. Table 4 shows one year financial statement obtained from the ESHE head office to illustrate the effectiveness of the program.

Table 3: BCC Community Mobilization Activity plan, SNPRR in 2003-2004

Activity	**Accomplishment**	**Plan Vs Accomplishment**	**Remark**
Preparing CHPI Training Guide	Completed and working document is in use	100%	
Conduct 4 TOTs on CHPI(one per cluster	7 TOTs conducted in 4 cluster, which included 208 trainees	175%	
Preparing CHP implementation Guide(ID)	Prepared, commented, reviewed and in use as working document	100%	
Train 4,320 new Community Health	3897 CHPs were trained by ESHE and 1739 Through	90%	

Promoters	partners NGO, and GOAL		
Conduct 96 CHPI follow up/ Review meeting	4 review meetings conducted at cluster level 20 review meeting at woreda level 144 review meeting at kebele level = 168	175%	
Help woredas and health facilities conduct 9 community festival	8 Community festival conducted	89%	
Working on selected child health promotion message	The selected message was developed		The message were in us after field test and centra ESHE approval
Developing BCC materials ie, Family Health Card	Developed		All developed materia are in use

Table 4: Financial Expenditure for the pilot CHPIs (SNNPRS) in 2003-2004

No	Expense description	Amount	# participants	Remark
1	Purchase of megaphones	92,000		For HF and CHPIs
2	Development of BCC materials, & T-shirts	73,135		Others contribution is not included, excess copy made.
3	TOT for zonal task force	9,600	20	Per diem and travel
4	Community orientation	31,734.30	405	Lunch allowance and stationeries

5	Community promoters training	69,304.64	722	Lunch allowance and stationeries
6	Follow up training	31,724.10	526	Lunch allowance and stationeries
7	CHPI evaluation	10,232		Per diem for data collectors
8	For annual festival	8,657.85		Per diem for facilitator, Materials for award and stationeries
	Total	326,387.89		
	Cost per CHP	452 Birr/CHP		

This is estimate dose not include the staff salaries and regional health bureau input who are directly or proportionally working on the community health program.

Discussion

This study has revealed a remarkable proportion of functional community health promoters who are performing their job in their respective community.

Only 47(11.7%) of the community health promoters were not performing their job over 2 years in the study area. The major portions of community health promoters 88.3% were found to be performing their job during interview. Majority of the community health promoters had received supervision once or more times within a year. This might be a good opportunity to see what is going on by community health promoters in their respective vicinity and to provide them the necessary support in the field.

The community health promoters related job achievement from 2003- 2005 could not be checked due to lack of reporting system between community health promoters and health institution. However, as other primary health care achievements seen in some of health institutions that supervise the community health promoters seems to have improved. Of all activities the environmental health activities particularly toilet constructions have remarkably increased since community health workers have commenced their job. Indeed, this achievement was confirmed by community and health personnel during focus group discussion in the study areas.

The community perception was very positive towards the community health promoters' job as described on qualitative part of the study result.

Indeed, the problem of maintaining the activities of the community health promoters is encountered in many countries and projects which have trained them even though the attrition rate was scanty in this study. Attrition rate for community health workers of 3.2%-77%were reported in the literature with higher rate generally associated with volunteers (34) there was a reports citing a 20% attrition rate in rural health assistant in Costa Rica, 25% attrition rate in the simplified medicine program in Venezuela (15). The retention of trained volunteers is on of the largest operational challenges in almost any CHW program which should be cited as operational issue needing much attention. Attrition rates in CHW program often 30% over 9 months in Senegal and 50% over two years in Nigeria (25). Community health workers who depend on community financing have twice the attrition rate as those who receive a government salary. In Solomon Islands attrition was attributed to multiple causes in addition to inadequate pay, including family reasons, lack of community support, and upgrade of

health posts. Loss of trained CHW can lead to poorer program coverage and necessity for greater operational input for further recruitment and training. When CHW leave their post, the opportunity is lost to build on their experience and further develop their skill over time through refresher training. CHW dropout can also disrupt program continuity in relationship between individual community health worker, the community and the health system. Furthermore, a study for Chilalo Awuraja in 1989 has revealed only a quarter of community health workers were performing 50% or more of the activities in the job description as this study functionality definition is almost closes to each other though the community health workers profile such as duration of training, level of CHW education and selection procedure might be different.

Community health promoters occupy a unique position in the health system. They are not usually fulltime paid or not completely paid health workers, yet they are the pivotal bridge between the community and the health system. Compared with other health workers they tend to have the lowest status because of their low level of educational status and poor economic status. This computing and contradictory tension created a host of problem related to a CHW's sense of inclusion in support from the health system. Therefore the MOH can help the community health workers feel supported and appreciated in many ways. In Zambia where the community health promoters had no contact with the health system frequent visit by outsider (NGO) helped them maintain their commitment and motivation. Sometimes the MOH sends letter of appreciation to the CHW and their families. After the initial training a community health work relationship is limited to what is usually called supervision. Supervision can give the community health workers opportunities to discuss problems, exchange information and take advantage of continuing education. In Guatemala supervised

community health workers had attrition rate 2-3 times lower than those of unsupervised community health workers.

Health promotion activities are well received by the community and both the communities and the health facilities staff gave their witness that they have seen changes since the start of the activities. A community health promoter plays an important role as a source of health information in the community to improve primary health care practice in their respective community. Increased health communication among the community, increased number of constructed toilet and use, hand wash practice after toilet are remarkable desired practice should be diffused to neighbor regions who do not have community health promoters. Community health promoters are the model that they have built their latrine and are getting their children vaccinated to let others do.

Conclusion and recommendation

Conclusion

Improved use of services and key household behavior is promising. Community health promoters' strategy may really quickly change community norms convincing subjective evidence for improved use of services and improved behavioral change. eg toilet use and hand wash practice after toilet, family planning and ITN use were improved practices:

This is good start and move but still needs improved regular supervision for technical back up, refresher training to improve quality of services in order to meet the ultimate goal of the project. The records and documents that can show the contributions of CHPs were not adequate in each health center to see their efforts.

Recommendation

Designing the tools to monitor community health promoters' efforts in the health system needs due attention and action. (eg. illiterate reporting format)

Improve quality of services (refresher training)

Strength and maintain quality of supervision

Link the CHPs and health extension agents work managerially for joint work to improve quality of services

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Annexs

Part I: Questionnaires for Focus Group Discussion

1) What is your community's name? How many house hold families are there?
2) Can you tell us about community health promoters? What do they do?
3) Do you think that CHP can be health teacher in the community? What do other people in your community think about the idea? Mothers? Fathers? Elders…?
4) How effective do you think CHPs can be to improve your community's health? Are there ways that health has improved in your community because of CHPs activities?
5) What kinds of new things have you learnt due to CHP program
6) What things were most exciting /enjoyable since the CHPs have started work in the community? Are there any new things that you might try to do differently due to the program? Are there any new things that you have all ready done differently due to this program?
7) What are the three main diseases that affect children in this community?
8) Have you heard about child vaccination?
9) Why it is important for a child to be vaccinated? What are some of the reasons why some children in your community are not vaccinated? What can be done to ensure that children in this community are fully vaccinated? Where do people in this community get information about child vaccination?
10) If a woman wants to delay or avoid having children, what can she do to prevent getting pregnant? What are some of the advantages of child spacing? What are some reasons why women don't use child spacing? Where do people in this community get information about child spacing?

Part II: Questionnaires for Health Institution Staff

1) Can you tell us about your duties here at the health facility? How long have you been here? What are the main health problems that you see?

2) What are the communities served by your facility? What is estimated population? What are the communities and estimated population that have CHPs under your facility since 2003?
3) Community health promoters' initiatives have been in place since 2003, have you noticed a change in use of health for family planning, for Diarrhea control? For EPI? And for Environmental sanitation?
4) What support do CHPs get from the health institution? Do you supervise CHP? How often you do supervision in a year? What things were most exciting /enjoyable you observed since the CHPs have started work in the community? What were the major problems you identified and solved during supervision?
5) When was the last time you receive refresher training from MOH? What was the topic?
6) When was the last time you received a supervision visit from your supervisor/MOH? Did you receive any feed back on your performance during visit? How often do you receive a supervision visit from MOH in a year?
7) What potential problems that can hinder community health promoters' work you knew in the last two fiscal years?
8) What do you suggest to improve the community health promotion program in the community?

Part III : Questionnaires for community health promoters (CHPs)

Q1.	Questionnaire number	| |
Q2.	Site in which interview is being conducted	a) Zone_____

		b) Woreda _____ c) Kebele_____
Q3.	Estimated population in your	a) Kebele _____ b) Ketena _____
Q4.	Personnel	a) Interviewer _____ b)Field Supervisor _____ c) Data Entery_____
Q5.	Date of visit	|_____|_____|_____| **DD MM YYYY**

Introduction and Consent

Helo! My name is _____ I am working with_____ _____ we are conducting a health survey in your community and would very much appreciate your participation in this survey. I would like to ask you some question about some important issues regarding community health promotion program. This information will help us to plan service that addresses the special needs of your community and yours. What ever information you provide will be kept strictly confidential and will not be shown to other individuals. Participation in this survey is voluntary, and you can choose not to answer any individual question or all the questions. However, we hope that you will actively participate in this survey since your views are important.

Do you have any question about the survey?

CHP gives verbal consent to interview, check box ☐

Coding Category

Q6	Age of the CHP	_____	_____
Q7	Sex	Male ……1	

		Female …….2	
Q8	Occupation of the CHP in addition to health activities	Farmer……..1 Teacher…….2 Other…specify……..	
Q9	Role of CHP in community leadership	Yes ……..1 No ……2 Specify…….	
Q10	Marital status	Single……1 Married ……2 Divorce…….3 Widowed……..4	
Q11	Any current disability	Yes ……..1 No……2	
Q12	Did you ever attend formal school	Yes……...1 No……2	If 2 skip to Q14
Q13	What is the highest grade you completed	Grade……..	
Q14	Number of house hold	#.....	
Q15	Who did select you for CHP employment	Community……1 Leader only ……2 Clinic staff……..3 Don't know……4 Other ...Specify……..	
Q16	When did you train on CHP	……	
Q17	Who trained you	SNNRP/RHB……1 ESHE……..2 Jointly ESHE &RHB…….3 Other ….Specify ……	
Q18	What health topic you covered during training	Breast feeding/nutrition……1 Immunization ……...2 Family planning ……3	

		Hygiene and control of diarrhea ……4 Sick child……..5 Malaria……..6 HIV/AIDS…….7	
Q19	Was the training adequate for your described job	Yes ……1 Partially……..2 No …….3	
Q20	When did you start work after training	Never……..1 Immediately……2 After sometime……..3 Specify…….	
Q21	How long have you been working	Month…….	
Q22	Were you ever supervised	Yes…….1 No……..2	If 2skip to Q24
Q23	When was your last visit	…….	
Q24	Who supervised you	MOH……..1 Jointly ESHE & MOH…….2 Community leader ……3 Other... Specify. ……	
Q25	Do you give the following services		
Q26.1	Home visiting	Yes……1 No…….2	If 2 skip to Q26.2
Q26.1.1	If yes, how often in the past months	Once in a months…….1 Once in 2-3 month ……2	
Q26.2	Environmental health activities	Yes …….1 No ……..2	If 2 skip to Q27.2
Q27.2.1	If yes, how often in the past months	Once in a months……..1 Once in 2-3 month ……2	
Q27.3	MCH & EPI activities	Yes ……1	If 2 skip

		No …….2	to Q27.4
Q27.3 .1	If yes, how often in the past months	Once in a months……..1 Once in 2-3 month ……2	
Q27.4	Giving health education	Yes ……1 No …….2	If 2 skip to Q27.5
Q27.4 .1	If yes, how often in the past months	Once in a months……..1 Once in 2-3 month ……2	
Q27.5	Referring sick pt/advising family, neighbor to visit HI when they get sick	Regularly…….……..1 Occasionally …….2 No …….3	If 2 skip to Q28
Q27.5 .1	When was your last day to refer/advice a sick child to visit HI	…….	
Q27.5 .2	What was the case	…….	
Q28	Do you report your activities to HI	Yes …….1 No ……..2	
Q29	If not, how do you communicate with HI about your activities performed in your community?	…… ……	
Q30	If you are not working at present when did you stop work?	Month……..	
Q31	What stopped you from working	Luck of supervision ……1 Luck own interest……2 Luck of community support….3 Other…specify…….	
Q32	If you are in work, what potential problems you experienced that hinder your work	Luck of supervision ……1 Luck own interest……2 Luck of community support…3 Other…specify…….	
Q33	Do you have health post for your	Yes ……..1	

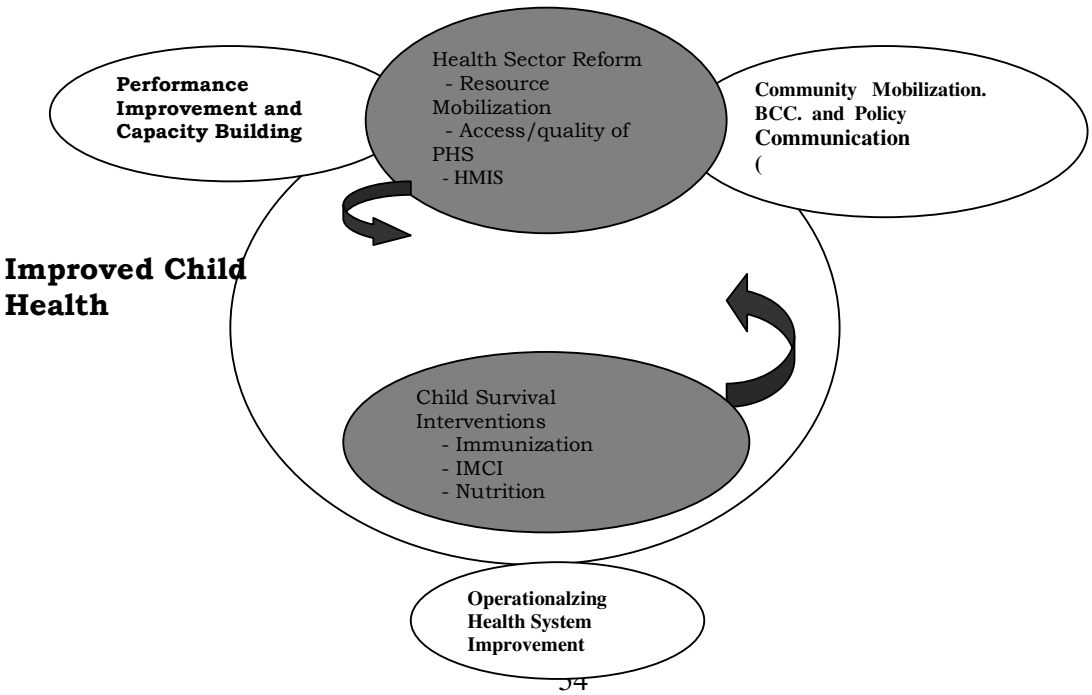
	community services	No……2 Under construction……..3	
Q34	Is there any another community health workers in your community	Yes and functional ……1 Yes but few are functional …2 Yes, but none functional……3 No……..4	
Q35	Which categories of CHWs are Mainly functional	CHA……1 TBA…….2 CBRHA……3 Other …specify……	
Q36	Do you work with other functional CHWs	Yes ……1 No ……..2	If 1 skip to Q37
Q37	If not, why you don't work with other CHW	The CHWs are not interested..1 The community leader doesn't facilitate the situation. 2 The CHP are not interested to work with other CH……3 Other……Specify ……..	
Q38	Is there any health committee in your Kebele?	Yes and functional ……1 No but none functional……2 No……3	
Q39	What is your position in health committee?	None……1 Only a member……2 An executive ……..3	
Q40	Do you have any support from the community?	Yes…….1 specify ……. No……2	
Q41	Do you get supervision from health institution?	Yes……..1 No……2	
Q42	If yes how often in a year	……..	
Q43	Do you get refresher course after your basic training?	Yes ……1 No ……..2	
Q44	How often?	……	

Q45	When was the last training	…….	
Q46	what was the topics you received during training	…… ……	

Part IV: Questionnaires for Community leaders

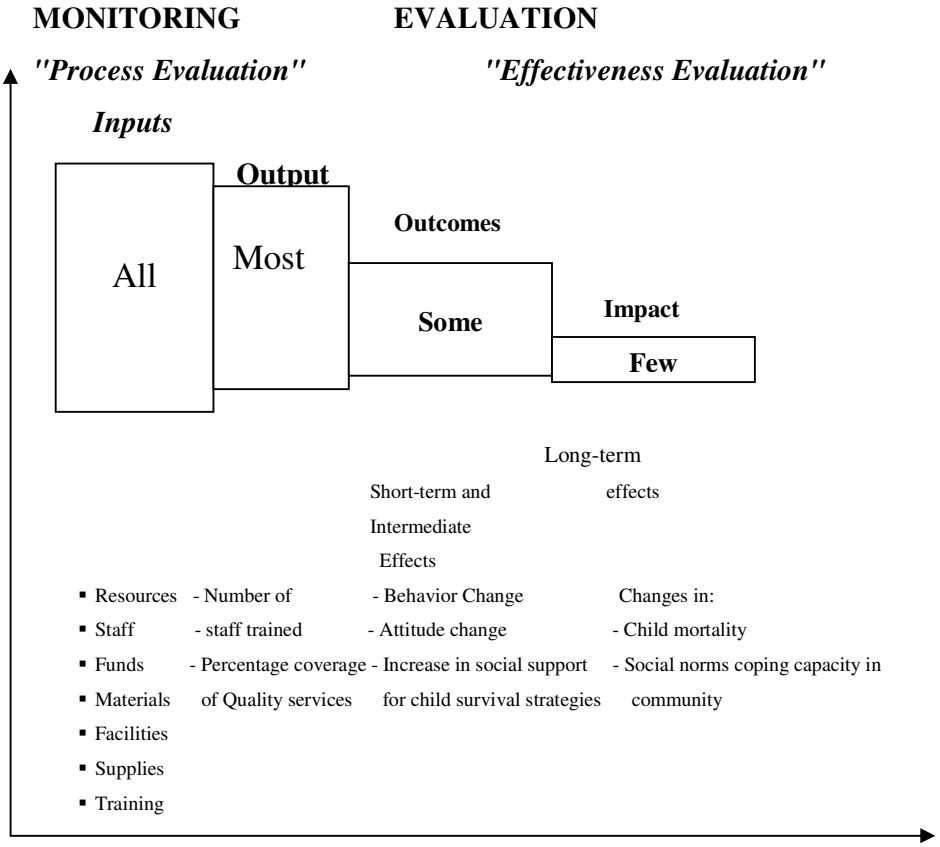
Q1	Your Position	……	
Q2	Do you think CHPs improve the health of the community	Yes……..1 No……2 Indifferent……3	
Q3	What did you except him to do	……..	
Q4	Were your expectation fulfilled	Yes ……1 Partially ……..2 No ……..3	If 3 skip to Q6
Q5	What things were most exciting /enjoyable you observed since the CHPs have started work in the community?	…… …….. …….	
Q6	Does the CHPs function their work	Yes ……..1 No…….2	
Q7	If yes, what helped them function	……	
Q8	If no, why?		
Q9	Do the CHPs get support from the community	Yes ……..1 No…….2	
Q10	If yes, what? How?	……..	
Q11	If no, why?		
Q12	Who so you think should support the CHPs		
Q13	What are the current problems that can hinder community health promoters' work	……	
Q14	What do you suggest to solve these problems		

Conceptual Frame Work of ESHE Program



Monitoring and evaluation pipeline (Logic Model)

Monitoring & Evaluation Pipeline



ASSURANCE OF PRINCIPAL INVESTIGATOR

The undersigned agrees to accept responsibility for the scientific ethical and technical Conduct of the research project and for provision of required progress reports as Per terms and conditions of the Research Publications Office in effect at the time of Grant is forwarded as the result of this application.

Name of the student: _____

Date._____ Signature _____

Approval of the primary Advisor

Name of the primary advisor:_____

Date._____ Signature _____