



ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF BUSINESS, ECONOMICS AND INFORMATICS

DEPARTMENT OF PUBLIC ADMINISTRATION AND MANAGEMENT

**AN INVESTIGATION INTO THE CHALLENGES OF
IMPLEMENTATION OF THE HEALTH EXTENSION PROGRAM IN
BEREK WEREDA OF OROMIYA REGION**

BY: - TEWODROS MEKONNEN

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ADDIS ABABA

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Addis Ababa University

School of Graduate Studies

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Advisor Signature Date

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List of Acronyms

AIDS	Acquire Immune Deficiency Syndrome
APHSDP	Action Plan for the Health Sector Development Program
CBHC	Community Based Health Care
CHPs	Community Health Programs
CHWP	Community Health Worker Program
CHWs	Community Health Workers
CNHD	Centre for National Health Development
FGD	Focus Group Discussion
FMoH	Federal Ministry of Health
HEP	Health Extension Program
HEW	Health Extension worker
HIV	Human Immune Virus
HP	Health Post
HSDP	Health Sector Development Program
HSDS	Health Sector Development Strategy
MDGs	Millennium Development Goals
ORHB	Oromiya Regional Health Bureau
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PHC	Primary Health Care
SSA	Sub-Saharan African
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TVET	Technical and Vocational Training and Education
TVETI	Technical and Vocational Training and Education Institute
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health organization

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Abstract

The Health Extension Program which has been implemented in Ethiopia since 2005 is launched with the view of taking healthcare services closer to the local people. This program aims to improve access and equity of primary health care through provision of essential health interventions at the village and household level. It focuses on sustained preventive health actions and increased community awareness. In the implementation of the program, however, different challenges are limiting the achievement of its objectives. In light of this, this study was conducted to investigate the challenges of Health Extension Program (HEP) implementation in Berek Wereda of Oromiya Region. In doing this investigation, descriptive research design was followed. Subjects of the study were Health Extension Workers (HEWs), program beneficiaries or the community and Wereda Health Bureau Officials. In the study, two types of sampling techniques were used. Using purposive sampling method, four Kebeles of the study sites were selected. One hundred thirty- eight community participants were selected using random sampling technique. Beside these, seventeen HEWs were randomly selected and participated in the study. The data gathering instruments employed in the study were questionnaire, interview schedule, key informant interviews, focus group discussion and site observation. The study involved strict respect for informed consent, voluntary participation and confidentiality. The findings of the study indicated that there are improvements in the accessibility of primary health care services to the community. However, different challenges are limiting the proper implementation of the HEP in the study Wereda. Attrition of HEWs, low budget allocation, irregular and insufficient supply of medical logistics and drugs, weak infrastructure facilities, poor working conditions for HEWs and insufficient community participation, are the major challenges identified in the study. Based on the findings of the study, the research recommended the strengthening of infrastructure facilities, allocation of sufficient budget, sufficient and regular supply of medical logistics, office materials and drugs, creation of better working environment for HEWs and promoting community participation. It is also important to consider the development of local resource capacity and strengthening better coordination among all stakeholders of the program for better implementation of the program in the study area.

Chapter One

Introduction

1.1 Background of the Study

Ethiopia, being one of the least developed countries in Sub-Saharan African (SSA), the work done by the health sector does not meet the desire of the people and standards set by the World Health Organization (WHO) (Alemayehu, 2009, p.1). Based on the common health indicators such as infant and maternal mortality, mortality from common disease and average life expectancy, the country's health condition place it among the least privileged nations in the world (As World Bank, 2007 cited in Alemayehu, 2009, p.1). Preventable infectious diseases and nutritional deficiencies take the highest portion of the disease that cause the [death] of its nationals (Adey, 2007, p. 2). The country has also high rate of population growth of which many of the people are destitute of sufficient access to clean water and hygiene facilities, poor access to health services and low educational levels (ibid). Moreover, Action Plan for the Health Sector Development Program (APHSDP) stressed that problems are observed in the health service delivery as it suffers from the shortage, poor distribution and inadequate training of its health personnel (Federal Ministry of Health (FMOH), 2005a, p. 4). This shows that many people in the country especially in rural areas are deprived of basic health services and this situation is calling for an immediate action as the main health problems of the country are those that can be easily prevented.

The multifaceted health and health related problems in the country have necessitated the formulation and implementation of different health programs one of these being the country's national health policy adopted by the Transitional Government of Ethiopia (TGE) in 1993. In this policy, the development and provision of equitable and acceptable standards of health services to all segments of the population has been recognized as major policy objectives (FMOH, 2005b, p. 5). It is also indicated that the promotion of Primary Health Care (PHC) is taken as one of the strategies that country endorsed during this time for the realization of equitable access of health services to the community though its achievements had been limited (Habtamu, 2007, p. 6).

The health policy has also been translated into a strategic program through the launching of Health Sector Development Program (HSDP). As described in the health and health related indicators document of (2006), HSDP deals with effective planning, implementation and monitoring of health sector development activities (FMoH, 2006, p. 2).

The Health Sector Development Program covers a 20-year period divided into 3-5 years rolling plans (Habtamu, 2007, p.7). The first HSDP-I (1997-2002) and the second HSDP-II (2002-2003) implementation had been completed with certain achievements. The results and the potential experiences gained in implementation of HSDP-I and II have been used as an input for the development of HSDP-III (2005-2010) (ibid). Beside this, the stock of experiences gained from the implementation of HSDP-I and further including the delivery of cost effective preventive and curative health care services, the HSDP-II has put the initiative of Health Extension Program (HEP). Therefore, the HEP has been implemented as one component of HSDP-III since 2005 (Adey, 2007, p. 3).

The Health Extension Program (HEP) is an innovative community based initiative introduced in 2003 as a pilot program as part of HSDP-II in response to the findings of HSDP-I (Habtamu, 2007 p.7). Then, in 2005 it is fully started with a view to taking health services closer to the people. According to the Amharic version of the guideline for the implementation of HEP indicated, the objectives of this new program is to increase equitable access to essential preventive health interventions at the community level including the basic treatment of major causes of child death (FMoH, 2007b, p. 2).

Health Extension Program is designed to achieve significant basic health care coverage in the country through the provision of staffed Health Post to serve every 5,000 people in each Kebele of the country (Sefihun, 2007, p. 2). This initiative is also designed to address primary health care at community level targeting households as centre-piece. The implementation of HEP involves the deployment of two salaried female Health Extension workers (HEWs) who are trained for a year at Technical and Vocational Training and Education Institutes (TVETIs) in each Health Post found in the country (WHO, 2010, p. 14).

Despite the believes that universal health coverage could be achieved through the implementation of HEP; many challenges have occurred in the outset of its implementation (Habtamu, 2007, p. 13). Study conducted in Wolayita Zone of Southern Nation Nationalities and Peoples Region has also revealed that there have been many challenges of HEP implementation due to absence of clear guidelines on relationship of HEWs with other health workers (Sefihun, 2007, p. 57).

Low quality practical trainings, weak health information system and shortage of demonstrative materials are also indicated as the major problems of the Health Extension Program (Alemayehu, 2007, p. 4). Because of these different challenges and problems, the implementation process of the program is facing limitations. This thesis, therefore, has tried to investigate and describe the major challenges and problems in the implementation of the Health Extension Program in a specific Wereda of Oromiya Region.

1.2 Rationale of the of Study

Health Extension Program is a recently introduced community based health sector approach. The fact that it has been in place in the study area for five years would make it possible to investigate the implementation of the program and identify the challenges which limited the achievements of its objectives. To this end, as there are no researches conducted to assess the implementation of the Health Extension Program and identify its challenges in Berek Wereda, it becomes difficult to make the right interventions in order to properly implement the program. Hence, there is a need to conduct studies in order to investigate the challenges and improve the implementation process of the program in the study Wereda. This claim is, therefore, becomes the central essence of the rationale of the study.

1.3 Statement of the Problem

High rates of disease and premature mortality in Sub-Saharan Africa (SSA) are costing the continent dearly. Poor health causes pain and sufferings, reduces human energies, and makes millions of Africans less able to live (Sefihun, 2007, p. 6).

In Ethiopia, similar to other SSA, wide spread poverty along with generally low-income level, low-education level, inadequate access to clean water and sanitation facilities contribute to the burden of ill health in the country (Adey, 2007, p. 2).

Despite remarkable achievements in primary health service coverage in Ethiopia (90%) (HSDP III, Annual Performance Report, 2010 p. 37); the health challenges facing the country are substantial. According to the HSDP III, Annual Performance Report of 2010, maternal mortality in Ethiopia is 470/100,000; infant and child mortality rates are estimated at 45/1000 and 83/1000, respectively. In addition to these, the total fertility rate is approximately 5.3 children per woman, which is among the highest rate in the world. The contraceptive prevalence rate stands at 56.2%, and 12.8% of women report indicates the unmet need for family planning service (ibid).

Beyond these, a large proportion of the country's health problems are preventable which indicate the need for accelerating the expansion of Primary Health Care (PHC) facilities and training of Health Extension Workers in order to attain universal health coverage as set by Millennium Development Goals (MDGs) (FMoH, 2005b, p. 5). Moreover, the Health Extension Program is given priority in the overall health policy to increase the coverage of health services and meet the needs of millions of rural people residing in regional states (Habtamu, 2007, pp. 7-8).

It is believed that universal health coverage could be achieved through the implementation of HEP; however different challenges and problems are limiting the proper implementation of HEP (Habtamu, 2007, p. 13). There is a perceived risk that HEWs may not be equipped with the necessary skills and competence to properly implement the health extension packages with one year of training.

The multi tasking of HEWs, as well as the unbalanced allocation of time among the service packages may also lead to inefficiencies of HEP (Centre for National Health Development ((CNHD), 2007, p. xiii). Beside these, HEWs perception and satisfaction with their living and working environment, the performance management system, and support from stakeholders are also important factors that may affect the implementation of the program.

In light of this, researches that identify the challenges of HEP implementation could have a positive impact in the success of the program. However, nothing is known about HEP implementation, its achievements and challenges in Oromiya Region in general and Berek Wereda in particular. This requires an investigation which identifies the challenges of the program. This helps to place the program implementation on the right track so as to achieve its objectives. It also facilitates the achievements of health related Millennium Development Goals (MDGs).

1.4 Objectives of the Study

1.4.1 General Objective

The general objective of the study was to identify the challenges of HEP implementation in Berek Wereda. This was undertaken by assessing the program implementation and the institutional arrangements instituted in the study Wereda.

1.4.2 Specific Objectives

The following were the specific objectives of the study.

1. To identify the major achievements of the program in the study area.
2. To identify the problems and bottlenecks of the program implementation.
3. To assess the working conditions of the Health Extension Workers.
4. Finally, suggesting possible conclusions and relevant recommendations.

1.5 Research Questions

The following were the leading questions of the study.

1. What is the structure and management of Health Extension Program in Berek Wereda?
2. What are the working conditions of the Health Extension Workers in the study area?
3. What progress is achieved through implementing the program of health extension in Berek Wereda?
4. What are the challenges of the program implementation in the study area?
5. What possible recommendations will be forwarded in order to solve the challenges of the program in the study area?

1.6 Significance of the Research

In the last five years, the program of health extension is becoming a key concern for ensuring Primary Health Care (PHC) coverage in Ethiopia. It is also believed that the program, if it is strictly implemented, would help in achieving the health related Millennium Development Goals (MDGs). Moreover, in the long term, it is hoped that the program may bring a change in the sustainable development of the health service in the country. However, these are possible only in the presence of continuous follow-ups, ongoing identification of challenges and their proper remedies. In this regard, this research tried to bring relevant information in the study area on the challenges that limited the proper implementation of the program and recommended possible suggestions.

It is, therefore, important that the research findings help different stakeholders involved in the implementation of HEP at Wereda, Zonal, Regional and Federal levels to identify and grasp the challenges of the program implementation. The research findings also help the stakeholders found at Wereda, Zonal, Regional and Federal levels to determine what type of additional interventions is needed to make the implementation process of the program meet its objectives.

In addition to these, the research suggested relevant recommendations to program planners, program implementers and policy advisors that help in the formulation and implementation of different health related programs at community level. Finally, this study can serve as a springboard for future researches in this area.

1.7 Scope of the Study

Health Extension Program (HEP) is a broad initiative in the Health Sector Development Strategy (HSDS) of Ethiopia that involves multiple actors and factors at its implementation. It consists of sixteen (16) different but interrelated packages. In this view, such broadness made the simultaneous assessment of program's implementation, progresses and challenges very difficult. Hence, the study was limited to the investigation and identification of the challenges of HEP implementation at community level. This was done by studying the program implementation in the study area and analyzing the responses of study respondents.

The time framework for the Health Extension Program was five years. It is five years since HEP is launched in a full-fledged manner in the study Wereda. In terms of the area that the study covered, the scope of the research was limited to a single Wereda and the purposively selected Kebeles.

1.8 Description of the Study Area

The study was conducted in Berek Wereda, one of the Weredas found in the Special Zone of Oromiya surrounding Addis Ababa. The capital of the Wereda, Sendafa is located 38Kms to the northwest of Addis Ababa. Berek Wereda is bordered by Aleltu Wereda in the north-east, Addis Ababa City Administration in the south-east, Sululta Wereda in the north-west, Jida Wereda in the north and Gimbichu, Akaki, and Adea Wereda in the east.

1.8.1 Demography and Agro-Ecology

According to the information obtained from the Wereda's Capacity Building Desk (2010), Berek Wereda is divided into 22 rural administrative Kebeles. It has a total population of 74,587 of which 37,859 were males and 36,728 females. There were a total of 11,547 households in the Wereda. The stratification of the population in terms of religion indicated that Orthodox Christians were 88.9%, Muslims were 9.5%, Protestants were 1.5 and traditional believers accounted about 0.1% of the total population. The agro-ecology of the Wereda, as indicated in the 2009/10 annual plan of the Wereda, is 72% *Dega (Cold)* and 28% *Woyinadega (temperate)*. The Wereda has its highest peak around 3,228m and its lowest altitude is 2,280m above sea level. Similarly, the maximum annual rainfall in the Wereda is 1,250mm while the smallest is 700mm. The average mean annual temperature of the Wereda ranges between 27 and 7 degree centigrade.

1.8.2 Land and Agriculture

The information obtained from the Capacity Building Desk of the Wereda indicates that the total area of the Wereda in 2009/10 was 72,722 hectares. Of this, 55.6% was used for farming while 19.7% and 11% of the land was used for grazing and covered by forests respectively.

Agriculture, which is basically rain-fed and is dominated by small and subsistence holders, is the backbone of the inhabitants of the Wereda. The dominant crops grown by farmers in the Wereda are Wheat, Teff, and Barley.

1.8.3 Social Infrastructure

a. Education Sector

The primary educational coverage has reached 94% and there were 52 schools (35 first cycle and 17 second cycle) and one school comprising both grades 9-10 and preparatory school was located in Sendafa town.

b. Road and Water supply coverage

The road access to the rural community has reached 42.5%. The water supply access for the community in the Wereda has reached about 65%.

c. Communication and Transport

Concerning communication, there is frequently interrupted automatic digital telephone service, and in transport aspect, there is one main asphalt road connecting the Wereda to Addis Ababa in south-east and Aleltu Wereda in the north-east.

d. Health Sector

In terms of health service, there were 2 health centers, 2 clinics and 22 health posts in the study area. As to the information obtained from the Wereda Administration Office, the Health Post construction coverage in the Wereda has reached 100%. The document from the Wereda Capacity Building Desk further states that there were 32 Health Extension Workers, 23 diploma holder nurses, 2 first degree holder nurses, one health officer, 2 druggists, 2 laboratory technician and 10 other supportive staffs, in the Wereda as human resource for the health service 2010.

The Wereda Health Office statistical report of 2002 E.C indicated that the most top five diseases that affect the community in the Wereda were pneumonia, parasitizes, diarrhea, dermatitis, and gastritis.

1.9 Research Methodology

1.9.1 Research Design

The research is basically descriptive in its nature. Descriptive research helped the study to identify the challenges that limited the proper implementation of the Health Extension Program in the study area.

1.9.2 Study Population

The study population consisted of 138 randomly selected households from 1976 household beneficiaries of the program living in four Kebeles of Berek Wereda. One Health Extension Worker from each Health Post which means a total of twenty-two (22) HEWs out of 44 HEWs were also incorporated in the study. In addition to these, the respective Wereda Health Bureau officials were included under the study population.

1.9.3 Sampling Techniques and Sample Size

Two types of sampling techniques were employed in the research to identify respondents. These were purposive and random sampling techniques.

1.9.3.1 Purposive sampling at Kebele level

It was employed in order to identify representative Kebeles of Berek Wereda. Since the Wereda has relatively similar population settlement pattern, rainfall distribution, temperature condition, and economic base, the study used two criteria in order to select representative Kebeles through purposive sampling method. These criteria were the **distance of the Kebeles from the Wereda capital and the location of Kebeles with respect to the main road that comes from Addis Ababa and divide the Wereda into two parts.**

a. Distance of Kebeles from the Wereda capital, Sendafa: this is the first major criterion that was used in the study to select representative Kebeles for the study. This criterion is used to analyze the impacts of distance on the accessibility of health service delivery in rural areas. In many developing countries, facilities are not evenly distributed. They are mostly located in urban areas. In rural areas, there are fewer facilities and the service seeker has to travel long distance to reach them, as in the case of health service. The problem is compounded more by the lack of adequate transportation facilities.

Farrington (2002, p. 2) analyzed the rural-urban linkage in service delivery and described the impact of distance on health service delivery. He explained that a perceived accessibility of health services in terms of distance plays a significant role in influencing people's decision to seek care. In particular, if the distance to the nearest health facility is long, it is a disincentive to service seeker to seeking health services. Moreover, the effect of distance becomes stronger with a lack of transportation and poor roads. A study in rural Western Kenya shows, for instance, that 80 percent of women delivered outside a health facility with 22 percent of women receiving no assistance at all. A contributing factor in their decision to give birth at home is the distance to health facilities (Health and Development Information Team (HDIT), 2007 p. 4). Beside this, long distance coupled with absence of public transportation greatly affects the service delivery of health personnel in rural areas. In the absence of vehicle transportation, it becomes difficult and complicated to health personnel to carry health facilities and medical drugs manually to distant rural area to deliver health services to the community.

The above discussion is similar in Ethiopia. As healthcare service delivery in rural Ethiopia is hampered by deep-rooted challenges, many of these challenges are related to the access problem emanating from the remoteness and spatial dispersion of rural communities (FMoH, 2005a, p. 3). This implies that access factor has a impact on rural communities' ability to gain access to, and hence benefit from the healthcare systems of the country. Given this, most rural communities in the country experience severe infrastructure problems like transportation and inadequate health services as they are situated far from towns where better health care services are situated.

In conclusion, when we come to the study Wereda having the above argument in mind, it becomes clear that rural Kebeles that are close to the Sendafa (Wereda Capital) are better served than those rural Kebeles that are far from the town in the provision of health care services. Therefore, the geographical idea of distance (nearness and remoteness) of Kebeles from the Wereda capital where better health care services are situated is primarily considered in the selection of representative Kebeles. The Wereda Capital which is Sendafa is taken as the center of better healthcare service provision and the distance of the 22 rural administrative Kebeles is measured from it. This is how the Kebeles are classified on the basis f distance.

b. Location of Kebeles: the second criterion was determining the location of Kebeles by taking the main road from Addis Ababa that divide Berek Wereda approximately into two equal parts. Taking this main road line, the study classified all Kebeles found in Berek Wereda into two clusters according to their locations.

i. Clustering of Kebeles

Based on the indicated criteria, two clusters of Kebeles were made. The first cluster consisted of 10 Kebeles which were located south-east of the Wereda capital and to the right of the main road from Addis Ababa. The Second cluster constituted 12 Kebeles and situated to the south-west of the Wereda capital and to the left of the main road from Addis Ababa. After determining the two clusters, the study took a sample of 18% of the total number of Kebeles which is about four (4) Kebeles out of the twenty-two (22) Kebeles found in Berek Wereda. (See Annex one)

ii. Selection of Kebeles

From the first cluster, two Kebeles were purposively selected, namely Kontoba-Wadecha was selected as the farthest Kebele about 55KM from the Wereda capital and Dabe-Muda as the nearest Kebele about 2KM to the Wereda capital. This is shown in the following table.

Table-1.1 Location and Distance of Kebeles from Wereda capital, Sendafa (To the right of the main road)

s. n	Name of Kebeles located to the right of the main road from Addis Ababa	Total number of Households in the Kebele	Location of Kebeles from the Wereda capital, Sendafa	Distance of the Kebeles from Wereda capital, Sendafa in KM
1	Dabe-Muda	446	South-east	2
2	Guta -Lamlam	957	South-East ``	10
3	Kontoba -Wadecha	532	South-east	55
4	Kura- Jida	426	South-East	19
5	Laga-Bollo	515	South-East	5
6	Lenca	610	South-East	12
7	Mugaro	540	South-East	20
8	Ripha	520	South-East	35
9	Roge	628	South-East	50
10	Sere-Goyo	703	South-East	12
	Total	5877		

Applying the above procedure to the second cluster, two Kebeles were purposively selected. Bura-Jate was selected as the farthest Kebele about 60KM from the capital of the Wereda and Girar-Berek was selected as the nearest Kebele which is 4KM to the capital of the Wereda. This is shown in the following table.

Table-1.2 Location and Distance of Kebeles from Wereda Capital, Sendafa (To the left of the main road)

S. n.	Name of Kebeles located to the left of the main road	Total number of Households in the Kebele	Location of Kebeles from the Wereda capital, Sendafa	Distance of the Kebeles from Wereda capital, Sendafa in KM
1	Achani	433	South-West	47
2	Bura-Aeltu	342	South-West	41
3	Bura-Berek	339	South-West	27
4	Bura-Dibdibe-Kike	378	South-West	32
5	<i>Bura-Jate Monyo</i>	<i>486</i>	<i>South-West</i>	<i>60</i>
6	Café-Kullo	335	South-West	53
7	Dire-Sokoru	459	South-West	17
8	<i>Girar-Berek</i>	<i>512</i>	<i>South-West</i>	<i>4</i>
9	Tulu-Korphecha	504	South-West	35
10	Walgaho	853	South-West	10
11	Warabi-Tenkole	457	South-West	30
12	Yeka-Saden	575	South-West	40
	Total	5670		

1.9.3.2 Random Sampling at the Household level

The second sampling technique of random sampling method was used to select respondents at the household level in each purposively selected Kebele. Due to the homogeneous nature of the population and the big size of the total households found in each geographically selected Kebele, 7% of sample household respondents were selected as representative of the total population in each purposively selected Kebele. Therefore, 7% or 138 household respondents in the four selected Kebeles were considered to be representative of the study population. This is shown in the following tables 3 and 4.

Table-1.3 Random sampling of household respondents in the first cluster

S.n.	Name of Kebele	Distance of Kebeles from Wereda Capital, Sendafa	Total number of Households in the Kebele	7% of household Respondents (Approximate Value)
1	Dabe-Muda	2KM	446	31 Household Respondents
3	Kontoba-Wadecha	55KM	532	37 “ ”
	Total		978 Households	68 Household Respondents

Table-1.4 Random sampling of household respondents in the second cluster

S.n.	Name of Kebele	Distance of Kebeles from Wereda Capital, Sendafa	Total number of Households in the Kebele	7% of household Respondents (Approximate Value)
1	Bura-Jate	60KM	486	34 Household Respondents
2	Girar-Berek	4Km	512	36 “ ”
	Total		998	70 Household Respondents

1.9.4 Data Sources and Types

The data sources for the research were from both primary and secondary sources. The primary data was collected from the households, HEWs and Wereda Health Bureau officials. The data was also supported by the direct observation of the researcher to the study sites.

In utilizing secondary sources, different publications, previous studies, books and internet sources were reviewed. In addition to this, both qualitative and quantitative data were collected through data collection instruments and were used for the research.

1.9.5 Data Collection Instruments

The research relayed on key informant interview, questionnaire, interview schedule, focus group discussion and direct observation to gain the relevant primary data. In addition to this, the research used secondary data by reviewing relevant literatures on the topic.

a. Interviews

The first data collection technique employed in this research was key informant interview. It was conducted with officials including the Wereda Health Bureau Head and Health Extension Program Coordinator. Two HEWs were also interviewed. This provided a chance to have face to face interaction and clarify any questions and gave chance to gather more information from the respondents. The response of the respondents was captured in local language and translated into English language after the interview.

b. Questionnaire and Interview Schedule

The second data collection technique used in the field survey was distributing questionnaire and interview schedule to study participants.

- i. Twenty-two questionnaires were planned to be distributed to 22 or 50% of HEWs out of 44 HEWs. However, since two Health Posts were not staffed by HEWs and three of HEWs were not interested to fill the questionnaire, data was obtained from seventeen (17) HEWs. The questionnaire had both open and close ended questions. It was administered when the HEWs were gathered together in the Wereda capital to participate in a meeting.
- ii. Interview schedule was administered for randomly selected 7% or 138 households out of 1976 household beneficiaries of the HEP in four Kebeles. The interview schedule had both open and close ended questions and it was collected in survey method.

c. Focus Group Discussion

A focus group discussion was carried out among community members to gather relevant information on the implementation of the HEP and its limitations. The focus group discussion consisted of male and female participants who were expected to be potential source of relevant information about the achievements, challenges and remedies of HEP. The focus group discussion was moderated by the principal investigator. In the discussion six people were participated. Among the participants, two were female beneficiaries and one participant was Kebele official and three of them were male farmers. The researcher conducted one focus group discussion due to time and budget limitations.

In addition to these, since the data was collected in the month of January when farmers were collecting their agricultural products, it was difficult to get farmer participants for conducting focus group discussion as expected.

d. Observations

In order to get primary information on the existing implementation of HEP in the study area, the researcher made direct observation to two study sites. This provided an opportunity in getting first hand information regarding the service delivery of HEWs, impacts of the HEP on the community's living conditions and the problems of HEP implementation in the study area.

1.9.6 Data Analysis and Interpretation Method

The collected data was analyzed and interpreted in accordance with statistical tools that included tables and tabular tools. Data editing, compiling and analysis of all verbal discussion were also made. In the interpretation part, descriptive type of interpretation that involved percentage, frequency, ranges, and mean were used.

1.10 Limitations of the Study

Even though efforts were made to investigate the challenges of the HEP in Berek Wereda, the study was not without limitations. Some of these include:

- i. Time and budget constraints were the major limitations of the study. The time duration given to conduct this study was not sufficient. Therefore, the researcher was in a stress to produce the final thesis in the due date of submission of the study paper.
- ii. Meeting the Wereda Health Bureau Officials for conducting key informant interview was also a problem for the researcher.
- iii. Absence of well documented data sources and adequate reports especially in the study area were also problems in making this study.
- iv. Finally, due to the absence of public transportation deep to the randomly selected rural households and Health Posts there was some delay to work as per the schedule of the study.

1.11 Organization of the Thesis

The thesis is organized into four chapters. The first chapter is the introduction which consists of the background of the study, statement of the problem, objectives of the study. The second chapter presents a review of literature on the conceptual issues that provide a brief framework for the study. The third chapter presents the analysis of the data gathered from the respondents and the discussion part. Finally, chapter four presents conclusions and recommendations. In the end, references follow chapter four.

Chapter Two

Literature Review

This chapter primarily deals with the conceptual analysis of international experiences of Community Health Programs (CHPs), the meanings of the concept of Extension and the development and meanings of Ethiopia's Health Extension Program (HEP). It also briefly reviewed the major objectives, components and approaches of HEP in Ethiopia. In addition to these, lessons learnt on the challenges of Community Health Programs at the international level are also analyzed. Conceptual issues related with the management, supervision, monitoring and evaluation of HEP are also discussed in brief.

2.1 Introduction

With an area of 1.1million Sq. Kilo Meter and an estimated total population of 79.5 million in 2009/10, Ethiopia is the third most populous country in Sub-Saharan Africa (Ethiopia Health and Nutrition Research Institute, 2010, p. 1). A very large proportion of the population (84%) lives in the rural areas. The country experiences heavy burden of health problems mainly attributed to communicable infectious diseases. In light of this, the Ethiopian Government has formulated a series of Health Sector Development Programs (HSDPI, II and III 1997-2010) in line with the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) and to achieve the health-related Millennium Development Goals (MDGs) (Alula, 2008, p. 1).

An audacious plan to achieve universal access to primary health care has been prepared and embedded in HSDP III. This plan aims to address the service coverage problem of the health system through an accelerated expansion and strengthening of primary health care services. It focuses on both physical availability and accessibility of essential health services by sufficiently reducing physical distance between primary health care facilities and health care users and by making essential health services available in the facilities (FMOH, 2005a, p. 3). The prime target is expansion of essential health system inputs towards the achievement of the Millennium Development Goals (MDGs) by 2015.

The 1993 Health Policy focuses mainly on providing quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach all segments of population, with special attention to mothers and children. The policy has a particular emphasis on establishing an effective and responsive health delivery system for those who live in rural areas (Alula, 2008, p. 2). In the past, public health financing gave priority to the curative sector. This led to a considerable increase in the number of health facilities but with limited rates of utilization, partly because of lack of physical access (ibid).

Evaluation of HSDP-II has also revealed the constraints in the availability of trained, high-level professionals and failure of essential services to reach the people at the grass root level that showed the existence of huge gap between need and health care service availability (FMoH, 2005c, p. 36).

In response to the country's health problem, in 2003 the Ethiopian Federal Ministry of Health launched a new health care plan, the "Accelerated Expansion of Primary Health Coverage" through a comprehensive Health Extension Program (HEP), which serves as effective mechanism for shifting health care resources from predominantly urban to rural areas, where majority of the country's population resides (Habtamu, 2007, p. 7). Therefore, HEP could be considered as the important institutional framework for achieving the MDGs.

In summary, the essence of Health Extension Program originated from the need for health services to be managed in a smaller community (Kebele) by developing local understanding of health problems, and acting upon them in a participatory and locally relevant manner (FMoH, 2005b p. 3). The Health Extension Program is a government priority; it was developed and is being implemented by the Federal Ministry of Health in collaboration with the Ministry of Education. Implementation began in 2005 as part of the national health plan and it is currently in progress.

In the coming two sections the knowledge and experience gained in the development, formulation and execution of community health programs in different countries at the international level will be discussed briefly.

2.2 International Experience of Community Health Programs

The global policy of providing primary level healthcare was initiated with the declaration made at Alma-Ata, the capital of the Kazakh Soviet Socialist Republic in 1978s. The conference was jointly sponsored by the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF). At the conference, the participants committed themselves to the achievement of a health status consistent with socially and economically productive life (Teweldebrhan, 2005, p. 5). It was recognized that health is not a commodity to be delivered but a quality of life to be cared for. Primary Health Care (PHC) and Community Based Health Care (CBHC) were seen as the most practical approach in achieving the goal of "Health for All by the year 2000" (ibid).

The countries signatory to Alma Ata declaration considered the establishment of Community Health Program (CHP) as synonym with Primary Health Care (PHC) approach (Prasad and Muraleedharan, 2007, p. 2). Thus in many developing countries PHC approach was seen as a mass production activity for training of Community Health Workers (CHWs) in 1980s. During these processes the CHWs were identified as the key workforce of human resource for Health (ibid).

Since the launch of the Alma-Ata conference in 1978 the goal of health service delivery programs promoting primary health care approach using CHWs have been established in many developing countries (Getachew, 2009, p. 5). These programs are expected to improve the effectiveness of health care systems by reaching large number of previously underserved people with high-impact basic services at low cost (ibid). Community Health Workers (CHWs) or Community Care Workers (CCWs) are community-selected lay persons providing a community-based health service for which they have been trained (Friedman I., et. al., 2007, p. 4). CHWs have been widely recognized as having a vital role in complementing existing primary health care services and improving their quality and outreach.

According to literatures, CHWs have certain characteristics one of which is CHWs come from the community and it even becomes the best if CHWs are chosen by the community (WHO, 2010, p. 25).

The literature also shows that merely being a person from community is not enough to ensure that they can create an impact on the health and social wellbeing of community, education has its own imperative effects. The educated person gives responsible direction to the community and at the same time has his/ her own social standing and respect in community, which makes his/her role easy in imparting knowledge and bringing up healthy modifications in attitudes and practices (Prasad and Muraleedharan, 2007 p. 4 and WHO, 2010, p. 360).

In Thailand, Haiti, Uganda and Mozambique, CHWs are selected if they are able to read and write, while the educational criteria was updated from read and write to 8 years of schooling in Brazil after 2004. CHWs in Pakistan are only given a privilege to become a worker if they have 8 years or above school education (WHO, 2007, p. 7).

Training is the most crucial element in the implementation of the program. This is the phase where the much touted transfer of knowledge from professionals to community representatives takes place (WHO, 2010, p. 361). Though universal guidelines for the extent of training are not laid down but it ought to be extensive, thorough and complete which should always be appraised by the exam or viva so that it assures their competency when they work in the community (ibid).

The basic role of CHWs in primary health care services is similar in many CHW programs but it varied a lot in more specified and focused delivery of interventions related to Malaria, TB and HIV/AIDS control and other non-communicable diseases (Prasad and Muraleedharan, 2007, p. 5). Overall, the role of CHWs in services delivery for nutrition, malaria, tuberculosis is profound and showed improved maternal and child health and reproductive health indicators in their catchment areas, but interventions initiatives for the control and treatment of HIV/ AIDS are in infancy in many of these programs particularly in Asia (WHO, 2010, p. 360).

For a competent program, investment in provision of proper supervision, equipment and supplies, and linkages with health system is also required to compliment the training of CHWs (WHO, 2007, p. 21). As Getachew (2009, p. 8) indicated; only good supervision, together with adequate material support, will enable the CHWs to adequately function. Supervision has proven to be effective in improving the impact of CHWs driven interventions.

Pakistan and Bangladesh have trained and deployed assigned supervisors for CHWs who also work and support them in community, but there are programs in Haiti and Mozambique which are utilizing the services of health care staff like doctors and nurses for supervising CHWs (WHO, 2010, p. 361). They are all fully equipped with necessary equipment and essential supplies but major shortages in the stock has been recorded and reported in almost all of these programs because of intermittent deficiency in the overall funding and lack of proper logistic management in the programs (ibid).

The services from CHWs with proper skills and handful supplies can be further enhanced if they work hand to hand with formal health. The role of CHWs in the community would be incomplete if they work in isolation, without creating a link with health care system (As Samb et al. 2002 cited in Geatachew, 2009, p. 9). Key functional areas for CHW activity include creation of effective linkages between communities and the health care system, where they can refer cases.

Finally, one of the most critical problems for CHW programs is the high rate of attrition which leads to lack of continuity in the relationship between a CHW and community, and increased costs in selecting and training of CHWs (WHO, 2010, p. 362). Indeed, the very effectiveness of CHW programs work usually depends on retention. CHWs in Pakistan, Brazil, Haiti, and Mozambique are paid workers but drop-outs among them are still their main concern (ibid). On the other hand, some countries have allowed their CHWs to earn meager amount from the sales of drugs and are given performance based incentives for referring patients for complications during pregnancy and bringing women to health care center for delivery. Apart from monetary rewards, in countries where these CHWs are volunteers, they are given non-monetary rewards in terms of career advancement, recognition and rewards for their services (As Chilowa, 2007 cited in Getachew, 2009, p. 10).

Having a brief discussion on the international practices of Community Health Programs, the following section will elaborate the major challenges and better lessons associated with these programs.

2.3 International Lessons on the Challenges of Community Health Programs

2.3.1 Challenges of Community Health Program

The studies conducted by World Health Organization in 2007 and 2010 on community health programs in many countries which include Thailand, Haiti, Uganda and Mozambique, Brazil, Bangladesh and Ethiopia) has identified some common challenges of the CHP across these countries. The studies have also forwarded helpful and relevant recommendations. The studies have identified a number of institutional, financial and capacity related challenges.

a. Institutional and Administrative Challenges

Among the most critical Institutional and Administrative challenges or constraints that were identified by the study the following are critical (WHO, 2010, pp. 22-41).

- i. Time use of Community Health Workers (CHWs) and working schedule are not harmonized and varied from one place to other places.
- ii. Due to absence of clear description about the working conditions of CHWs, they are leaving their job from deployed area and this resulted in attrition of the workers. In order to overcome such issues, guidelines need to be set on the outset regarding their transfers, leave of absence, and career structure.
- iii. The study also revealed that creating practical linkages with the health centers and hospital services and ensuring effective and regular support from the higher levels of the system is also a challenge.
- iv. The necessary working and living conditions for CHWs are not created in most of the cases which is compounded by poor communication and transportation system and long distances from health centers.
- v. The curriculum and the modules for CHWs training needs to be revised according to country specific Millennium Development Goal (MDGs) goals and targets. The curriculum had also more time for theory beyond the needed skill they would implement in the future, but with less time for acquiring practical skills due to little time for hands-on practice.

b. Material and Logistic supply related Challenges

As the study conducted by WHO (2010, pp. 22-42) on CHPs reported that most of the programs have shortages or lack of medical equipment for patient examination, and drugs supplies which are useful for promotive, preventive and curative health services. Irregularity in the supply of vaccines, drugs, and necessary equipment has been reported and their availability and sustainability of resources is also a major concern.

c. Absence of Continuous Training and Professional Advancement

The study conducted by WHO (2007, pp. 20-21) has also established that the following were critical challenges facing most Community Health Programs with regards to the availability of Continuous Training and Professional Advancement for the CHWs.

- i. Lack of opportunities for upgrading and training and refresher courses on relevant areas such as delivery services, counseling for HIV/AIDS and etc. In some countries assessments showed that the CHWs had lower competence in interventions related to some curative services including malaria control and acute respiratory infection.
- ii. Lack of promotion and professional advancement for CHWs is also a major challenge.

d. Supervision and Monitoring Problems

As it is recognized in the study made by WHO (2010, pp. 22-41), the major challenges related to supervision and monitoring of CHP are the following.

- i. There are no clear guidelines for working relationship between CHWs and the other community based health workers (if any) trained previously, such as the community mobilizers.
- ii. In most cases, documentation and reporting system are not instituted properly.
- iii. Referral system and linkage with the health system is weak. The CHWs do not have good relationship with health workers working in higher level health institutions. Moreover, communities' attitude towards the CHWs is not to the desired level due to their failure to assist in some curative and some preventive health services. The continued demand for curative care services with weakened referral system may compromise community's confidence in CHWs.

e. Capacity and Financial Problems

According to the WHO (2010, p. 21), the most chronic problems related with capacity and financial are;

- i. The other challenge is related with the limited capacity of health systems to support the CHW programs. Most programs lack sufficient, human, financial material and infrastructure facilities which are basic for effective implementation of the CHPs.
- ii. Countries had also reported deficiencies in the practical training of CHWs particularly on skilled delivery and key clinical skills due to limited facilities for large numbers of trainees.
- iii. The resources needed to support the training, supplies and equipment, to pay the salary and to conduct regular supportive supervision requires sufficient funds. By the time the targets are achieved they will make nearly half of the workforce and the financial implications of achieving these would be huge.

2.3.2 Lessons learnt from Community Health Programs

The lessons and recommendations learned from the studies conducted on Community Health Programs (CHPs) have a role to play in reforming the Ethiopian Health Extension Program. Therefore, the researcher has believed that the summary of studies conducted by World Health Organization on CHPs in 2007 (pp. 17-23) and 2010 (pp. 361-362) have importance for this study. Thus, the summary of the studies that provide major lessons and recommendations for better implementation of CHPs especially in developing countries are presented below.

a. Planning Activities

- i. The programs should be coherently inserted in the wider health system, and CHWs should be explicitly included within the health system strategic planning at country and local levels.
- ii. From the outset, the program should develop village health committees in the community that can also contribute in participatory selection processes of CHWs.
- iii. The outline of the country plan of action to develop and improve CHW program(s) should be finalized by a working group of relevant multiple stakeholders, including identification of resources needed, indicators and targets, and monitoring tools, and formally authorized by the Ministry of Health.

b. Training, Selection and Development Lessons

- i. Given the broad role that many CHWs play in primary care, a program must assure that a core set of skills and information related to Millennium Development Goals (MDGs) be provided to most CHWs. Therefore, the curriculum should incorporate scientific knowledge about preventive and basic medical care, yet relate these ideas to local issues and cultural traditions. They should be trained, as required, on the promotive, preventive, curative and rehabilitative aspects of care related to maternal, newborn and child health, malaria, tuberculosis, HIV/AIDs as well as other communicable and non-communicable diseases.
- ii. Other training content and training duration may be added pertinent to the specific intervention that the CHW is expected to work on.
- iii. The CHW programs should regulate a clear selection/ deployment procedure that reassure appointing those who certify the course completion and pass the writing or verbal exam at the end of training.
- iv. CHW programs should also provide opportunities for career mobility and professional development. These should include opportunities for continuing education, professional recognition, and career advancement. This can be through specific programmatic opportunities or access to educational and training scholarships.

c. Logistic and Resource Supplies

- i. The CHW programs should support provision of requisite and appropriate core supplies and equipment to enable appropriate functionality of such workers.
- ii. Sustained resources should be available to support the program and workers in the program.

d. Community Mobilization and Participation

- i. Community preparedness and engagement is a vital element in the success of CHWPs that is relatively rarely practiced.
- ii. CHW programs should be based in and respond to community needs. In practical terms, such programs should continually assess community health needs and demographics, hire staff from the community who reflects the linguistic and cultural diversity of the population served, and promote shared decision making among the program's governing body, staff, and community health workers.

e. Supervision and Monitoring Activities

- i. The programs should have regular and continuous supervision and monitoring systems in place and supervision should be taught to be undertaken in a participatory manner that ensure two-way flow of information. Moreover, both external and internal evaluations need to be carried out on regular basis to improve services and analyze the need of various logistics, supplies and training according to the requirements.
- ii. Ideally, programs should evaluate their own performance on annual basis, while a third party evaluation could be recommended in every 4-5 years, which would generate a neutral and free from bias findings.
- iii. The programs should have established referral protocols with community-based health and social service agencies.

2.4 Conceptual Definition of Terms

2.4.1 What is Extension?

The word ``extension`` is first introduced in England and the concept of Extension education was first pioneered in 1873 by Cambridge University to describe a particular education innovation (as Farquhar, 1962 cited in Adey, 2007 p. 18). The aim was to win the education benefit of the universities to the ordinary citizens. Extension originally was conceived as a service to extend research-based knowledge to the rural sector to improve the lives of farmers (ibid). It thus included components of technology transfer, broader rural development goals, management skills, and non-formal education.

2.4.1.1 Extension in Agriculture

Agriculture extension was later developed in agriculture education, advice and demonstration (as Farquhar, 1962 cited in Adey, 2007, p. 18). In this sense, the traditional view of extension was very much focused on increasing production, improving yields, training farmers, and transferring technology. Today's understanding of extension goes beyond technology transfer to facilitation; beyond training to learning, and includes assisting farmer groups to form, dealing with marketing issues, and partnering with a broad range of service providers and other agencies(ibid).

The objectives of extension are focus on finding ways of using indigenous national programs that combines international ideas tailored to meet the local conditions. Furthermore all forms of extension are related to the provision of education to the people (as Farquhar, 1962 cited in Adey, 2007, p. 18).

As per R.N Farquhar (1962) cited in Adey, (2007 p. 18) extension in its wider sense is defined as:

“The extending of a service or system which extends the educational advantages of an institution to persons unable to avail themselves in a normal manner”

As Seville cited in Adey 2007, the desire of every extension work is to educate people living in rural areas on how to increase their standards of living, by their own performances, using their own assets of human recourses and supplies, with the smallest assistance from governments. It extends to induce local leadership and stamina of self-help which then develops community satisfaction and their progressive growth.

2.4.1.2 Extension in Health

According to Adey (2007, p. 19), extension in the health sector is related to delivering health care service to rural people in order to improve their life standards. In that, it is related to the delivery of Primary Health Care (PHC). PHC has been given the highest attention as it contributes for the development of a country's health as well as for creating a social equity in terms of community health. Promotion and securing health of people is assumed to be vital for continued economic and social development. It also adds to improved features of life and helps stabilize the human life condition.

Considering this importance, governments as well as the international agencies are responsible for producing socially and economically productive nationals (as WHO, 1978 cited in Adey, 2007, p. 19). In PHC programs, a great deal of time, manpower and material resources in the training of health workers are necessary conditions. It also requires continuous trainings in order to upgrade the service delivery by advancing their knowledge and skills (Adey, 200, p. 19).

There should also be proper supervisions, support and follow-ups in addition to a continuing educational program to assure that the health workers maintain and increase their knowledge and skills and also improve the meeting of community health needs.

2.4.2 Ethiopia's Health Extension Program (HEP)

The central idea of the household health extension package is to create an opportunity to every household to access basic health services and improve their health status through their active participation. Through community's own actions and efforts to help themselves facilitate their journey towards household livelihood security (Teweldebrhan, 2005, p. 8). It addresses the health need of each member of the household as individual and as a household unit. Such initiative will never work on mobilization basis, and the HEP basically underscores full and active participation of the household rather than mobilization towards it (FMoH, 2005b, p. 4). This shall be a rule starting from need identification and planning of interventions and must be practiced in all the functions of the management (organization, implementation, monitoring and evaluation and replanting) of the initiative (Teweldebrhan, 2005, p. 8).

The Health Extension Program aims to improve and provide primary health services in rural areas through an innovative community-based approach that focuses on prevention, healthy living and basic curative care. It, therefore, introduced a new cadre of health worker, Health Extension Workers (HEWs), and defined a package of essential interventions for them to deliver from village health posts (Pathfinder International, 2008, p. 1).

The concept HEP can be defined by scholars in the following manner. As Teweldebrhan (2005, p. 8) define HEP, it is 'a pool of basic and essential preventive, promotive and minor curative health services targeting households in a community, designed based on the concepts and principles of Primary Health Care to improve their health status with their full participation and using local technologies and capacities'. It is conceptualized considering that a good deal of work on health promotion can be done at home by parents who are informed on key health issues and supported with health promotive techniques and skills, to take care of the health of their family (ibid).

According to the Ethiopian Federal Ministry of Health (FMoH) (2005b, p. 3), HEP is an innovative program which encourages community members to participate actively in planning and implementing health programs that improve the overall health status of their communities.

It works with community members to identify common health problems, discuss root causes and solutions, set priorities, develop plans of action, implement activities, and monitor and evaluate achievements. In particular, the HEP targets those most often underserved—mothers, children and rural communities—and places an emphasis on preventive health care practices. Moreover, the definition given by Ethiopian Federal Ministry of Health-Health Extension and Education Center (2008, p. 1) stresses that the Health Extension Program is made up of 16 distinct packages, which are listed later in this study, of health care that have been carefully identified and developed by the Federal Ministry of Health to provide quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children.

In general, the HEP emphasize on establishing an effective and responsive health delivery system for those who live in rural areas, focusing on households at the community level. The program is the primary vehicle for bringing key maternal, neonatal and child health interventions to the community.

2.5 Objectives of the Health Extension Program in Ethiopia

According to the Implementation Guideline of HEP Amharic Version (2007a, p. 5), the program of health extension has the following general objectives:

1. To improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas.
2. To ensure ownership and participation by increasing health awareness, knowledge, skills among community members.
3. To promote gender equality in accessing health services.
4. To improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through HEWs.
5. To reduce maternal and child mortality.
6. To promote healthy life style.

2.6 Components of the Health Extension Program in Ethiopia

The HEP is designed to give services at Kebele level covering sixteen health extension packages categorized under three major areas and one cross cutting approach (FMoH, 2005b, p.31). As a preventive program, the program promotes the following areas of care: Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation, and Health Education and Communication (FMoH, 2007a, pp. 34-36).

It has introduced 16 packages in four main areas that include:

- a. Disease Prevention and Control:** to reduce morbidity, disability and mortality
 - i. HIV/AIDS and other Sexually Transmitted Infections (STIs) and TB prevention and control
 - ii. Malaria prevention and control
 - iii. First Aid emergency measures
- b. Family Health:** - to strengthen and gradual expansion of family planning, maternal and child health, youth and nutrition services.
 - i. Maternal and child health
 - ii. Family planning
 - iii. Immunization
 - iv. Nutrition
 - v. Adolescent reproductive health
- c. Hygiene and Environmental Sanitation:**
 - i. Excreta disposal
 - ii. Solid and liquid waste disposal
 - iii. Water supply and safety measures
 - iv. Food hygiene and safety measures
 - v. Healthy home environment
 - vi. Control of insects and rodents
 - vii. Personal hygiene
- d. Health Education and Communication:-** the main objective of this component is to bring about behavioral change through intensive and continued investment of knowledge to the community.

The objectives of each component of HEP is defined, and services provided by the HEWs under the different headings are put in the guideline. The HEP is given as a package focusing on preventive health measures targeting households and particularly mothers and women through house to house visit, education and demonstration.

2.7 Health Extension Approaches in Ethiopia

HEWs are required to spend 75% of their time conducting outreach activities by going from house to house. During these visits, HEWs are expected to teach by example (e.g. by helping mothers care for newborns, cook nutritious meals, construction of latrines and disposal of pits). In doing these activities, HEWs utilize the following three approaches (FMoH, 2007b, p. 12).

2.7.1 Model Families

HEWs identify and train model families that have been involved in other development work, and /or that have acceptance and credibility by the community, as early adopters of desirable health practices to become role models in line with health extension packages. Model families help diffuse health messages leading to the adoption of the desired practices and behaviors by the community.

2.7.2 Community Based Health Packages

HEWs communicate health messages by involving the community from the planning stage all the way through evaluation of the program. HEWs utilize Women and Youth Associations, Schools and Traditional Associations such as Idir, Mehaber, and Ekub, to coordinate and organize events where the community participates by providing money, raw materials and labor.

2.7.3 Health Posts

At the Health Posts HEWs provide antenatal care, delivery, immunization, and growth monitoring, nutritional advice, and family planning and referral services to the community of the Kebele.

2.8 Functions of Health Extension Workers in Ethiopia

The implementation of Health Extension Program involves deployment at each village (Kebele) of two salaried female Health Extension Workers (HEWs) who are trained for a year at Technical and Vocational Training and Education Centers (TVETs) (FMoH, 2007b, p. 4). The HEP is managed by the HEWs whose station is in the Health Posts (HPs).

According to the Implementation Guideline of HEP (FMoH, 2007a, p. 25), at the Health Post the steps for the work of HEWs is defined and starts by collection and documentation of basic data on the Kebele. In the implementation guideline, it is also stated that the HEWs are expected to select model households and work with them. These are the families considered to be innovative, and ready to change and influence community members.

The HEWs give trainings on the packages for up to 60 members and graduate them when they are convinced and well informed of the interventions of HEP. The graduates are expected to demonstrate practical changes in the use of health programs, environmental and personal hygiene and serve as model family to others. This is expected to expand gradually until it covers the whole Kebele.

Besides the family package, the implementation guideline indicates, the HEW also run house to house visit and deal with individuals. Through this, they give trainings, make demonstrations, and educate families and particularly mothers starting from common problems and issues that would face less resistance to topics for which deep rooted cultural issues may exist such as female circumcision, and early marriage (FMoH, 2007a, p. 27) .

The other function of the HEWs is community package. This is regarding the organizing of the community for joint plans, and joint interventions related to health such as environmental and water projects, drainage of swampy areas and others. HEWs use all the available opportunity to educate and mobilize the community in this aspect. They also mobilize and use other volunteers including Treatment of Tuberculosis Agents and community Health Agents to deliver messages and to implement interventions. They are also expected to train such volunteers and use them as assistants and promoters of health issues. As FMoH, (2007b, p. 12) and FMoH, (2007a, p. 45) documents show, HEWs are required to pass 75% of their time outside the Health Post, dealing with model families, community groups or households.

At the Health Post, limited services are given which complement the rest of the packages. These include immunization, health education, antenatal care, family planning, delivery and postnatal care, growth monitoring of children, diagnosis and treatment of malaria, treatment of diarrhea with oral rehydration fluids and treatment of eye infections with eye ointment, as well as selected skin problems with ointments, vitamin A supplementation, first aid, referral of difficult cases and documentation and reporting of activities.

2.9 Health Extension Program Management

2.9.1 Planning Processes

The HEWs, in collaboration with the members of the Kebele Council, begin work by first conducting baseline surveys (FMoH, 2007a, pp. 25). Based on the survey findings, health problems are identified and prioritized, and plans of action are prepared. The draft plans of action are submitted to the Wereda Council through the Kebele Council for approval. Once approved, the plans are disseminated to the Wereda Health Office, Regional Council and Regional Health Bureau (FMoH, 2007a, pp. 26).

2.9.2 Roles and Responsibilities

Clear identification of roles and responsibilities is imperative for effective planning, implementation, monitoring and evaluation of the HEP. Duties and responsibilities of different government stakeholders at each level are described below (FMoH, 2007a, pp. 7-24):

a. Federal Ministry of Health

The following are the major responsibilities of the Federal Ministry of Health;

- Develop overall program concept, standards and implementation guides
- Determine career structure for HEWs
- Mobilize national and international resources
- Provide communication tools and materials
- Procure medical equipment and supplies
- Set up Health Management Information System.

b. Regional Health Bureau/Zonal Health Department

The following are the duties of regional health bureau;

- Provide technical and administrative support to Wereda Health Offices
- Adapt implementation guidelines to local conditions
- Adapt communication tools and materials into local languages and distribute to Wereda Health Offices
- Obtain reports from Wereda Health Offices and provide information to the Ministry of Health
- Mobilize regional resources
- Establish referral systems between Health Posts and Health Centers
- Strengthen Health Management Information System.

c. Wereda Administration has the following responsibilities;

- Allocate budget and other resources
- Co-ordinate activities implemented by Governmental and Non-Governmental bodies
- Monitoring and Evaluation.

d. Wereda Health Office is responsible for the following activities;

- Provide technical, administrative and financial support to HEP
- Allocate budgets and supplies to Health Centers and Health Post
- Adapt communication materials
- Provide supportive supervision of HEWs and the overall management of Health Centers and Health Posts
- Plan and provide in service training to HEWs and Wereda Health Office staff
- Obtain reports from Health Posts and Health Centers and provide information to Regional Health Bureau/Zonal Health Department.

e. Health Extension Workers are responsible for the following duties;

- Manage operations of Health Posts and provide reports to Wereda Health Office
- Conduct home visits and outreach services to promote preventive actions
- Provide referral services to Health Centers and follow up on referrals
- Identify, train and collaborate with Voluntary Community Health Workers.

2.9.3 Monitoring and Evaluation of Health Extension Program

Monitoring and evaluation are integral and important components of the HEP and contain both technical and managerial purposes (FMoH, 2007b, p. 15). Monitoring is the process of regularly reviewing achievements and progress towards the goal. In this context, monitoring is the process of measuring, analyzing, and communicating information on the implementation of the HEP for effective decision making at all levels (ibid).

Evaluation is carried out to assess whether objectives are met and to determine the effectiveness and efficiency of the program. This helps to correct and improve the future planning process. Monitoring and evaluation have to be built into the program from the outset as an integral part of the planning process. Monitoring and evaluation requires a health management information system to measure progress against objectives indicators and targets. Both qualitative and quantitative methods can be used to evaluate HEP (FMoH, 2007a, p. 55). Tools or techniques to be used in collecting qualitative data are observations, in-depth interviews, and focus group discussions. In quantitative evaluations, tools used should include surveys. Quantitative and qualitative data are used together to give a clearer picture of the situation about the performance of the program (ibid).

The HEWs collect information with standardized reporting formats. According to the HEP Implementation Guideline the HEWs must keep accurate and timely records of their activities (FMoH, 2007a, p. 50). The information captured is passed on to the Kebele Council and Wereda Health Office for review and action. At the Kebele level, the Kebele Committee, HEWs and Voluntary Community Health Workers meet weekly and provide a report to the Kebele cabinet on program implementation (FMoH, 2007a, p. 39). During town hall meetings the community identifies weaknesses and strengths and provides ideas for improvement.

2.9.4 Supportive Supervision

According to the HEP Implementation Guideline, supportive supervision enhances capacity and helps to correct any constraints encountered in the implementation of the HEP (FMoH, 2007b, p. 15). Effective supervision requires a team of experts with an appropriate mix of skills, strong management abilities and continuity among team members.

A supervisory team drawing its members from different disciplines is established at the Federal, Regional and Wereda levels to direct and support HEWs so that they effectively perform their duties (FMoH, 2007a, p. 55).

The organizational composition of supportive supervisory team with their members at each level of government is described below.

a. Federal supervisory team

- i. Disease prevention and control expert
- ii. Maternal and child health expert
- iii. Administration and finance expert
- iv. Environmental / hygiene expert
- v. Health education expert

b. Regional supervisory team

- i. Disease prevention and control expert
- ii. Maternal and child health expert
- iii. Administration and finance expert
- iv. Environmental / hygiene expert
- v. Health education expert

c. Wereda supervisory team

- i. Health officer
- ii. Public health nurse
- iii. Environmental / hygiene expert
- iv. Health education expert

The teams will be involved in all aspects of the program management including planning, implementation, monitoring and evaluation. Through these planned and coordinated supervisory activities at various levels, it will be possible to ensure that the quality and quantity of work is to the standard and in line with the general government policy.

Members of the team are trained in skills needed for supportive supervision (facilitation, interpersonal communication, problem solving and analytical skills), oriented on various tools and methods (such as peer review, performance assessment tools), and provided with opportunities to frequently upgrade their technical skills (ibid).

The supervisors are trained on a specially designed curriculum. At each level the supervisory team prepares its own annual plan, checklists and detailed schedule for each supervisory visit. Establishing this type of supportive and effective supervision, the program enhances capacity and helps to correct any limitations occurred in the implementation of the HEP.

Chapter Three

Research Findings and Discussion

This chapter deals with the analysis and discussion of the data gathered from the study respondents. It primarily discusses the major achievements and challenges of Health Extension Program (HEP) implementation in Berek Wereda of Oromiya Region. The data were gathered through questionnaire, interview schedule, key informant interview, focus group discussion and observation. The data analysis and discussion is supported by relevant literatures and researcher's own opinion. The chapter begins with the analysis of socio-demographic characteristics of respondents and forges ahead with the analysis and discussion of major issues that include selection of HEWs, community perception about HEWs, the working condition of HEWs and the review of Health Posts' working condition. In the final parts of the chapter, the management, supervision, achievements and challenges of HEP in the study area will be discussed thoroughly.

3.1 Socio-demographic Characteristics of Respondents

3.1.1 Socio-demographic Characteristics of Household Respondents

One hundred thirty eight (138) household respondents were expected to participate in the study. However, completed information was gathered from one hundred thirty two (132) household respondents. This was due to the reason that out of the total interview schedules filled, 6 (3.8 percent) of them were discarded because of inconsistency and incompleteness. Therefore, fully completed and correctly filled data was collected from 132 (96.2 percent) household respondents.

Age of Respondents

As indicated in the following table 3.1, the age of household respondents that participated in the study ranges in the age range between 22 to 68 years. In the same table it is indicated that about 30 percent of the respondents came within the age group between 20 to 30 years. Similarly, in the age group between 31 to 40 years 35 percent of the respondents were constituted while the age group between 41-68 years accounted about 35 percent of the total respondents.

Table-3.1 Socio-demographic characteristics of Household Respondents in Berek Wereda.

Description of Socio-demographic variables	Response	Frequency	Percentage
Age	20-30	39	30
	31-40	47	35
	41-50	28	21
	51-60	12	9
	≥60	6	5
	Total	132	100
Sex	Male	111	84
	Female	21	16
	Total	132	100
Religion	Christian	124	94
	Muslim	8	6
	Total	132	100
Ethnicity	Oromo	131	99.2
	Amharic	1	0.8
	Total	132	100
*Language	Afar Oromo	132	100
	Amharic	50	38
	English	3	2
Educational level	No education	75	57
	Able to read& write	17	13
	Grade 1-8	29	22
	Grade 9-12	8	6
	Above Grade 12	3	2
	Total	132	100
Marital status	Single	6	4.5
	Married	120	91
	Widowed	6	4.5
	Total	132	100
Occupation	Farmer	126	95.5
	Merchant	4	3
	Government Employee	2	1.5
	Total	132	100
Source of water for drinking	Pipe water	2	1
	Spring water	46	35
	Hand-Dug Water	59	45
	Others (river and well)	25	19
	Total	132	100

* indicates multiple responses are possible

Source: - Filed Survey, January 2011

Gender

According to the above table 3.1, the gender mix of respondents was predominantly dominated by male participants that accounted about 84 percent. The remaining 16 percent participants were female registered household participants.

Religion

The stratification of the respondents in terms of religion indicated that 94 percent of the household respondents were Christian and 6 percent of them were Muslims.

Ethnicity and language

The ethnic composition of the respondents indicated that 99.2 percent of the participants came from Oromo ethnic group while the rest 0.8 percent were from Amhara ethnic origin. All respondents speak Afar Oromo. In addition to this, 38 percent the respondents speak Amharic language as well.

Education

Out of the total respondents, 55 percent of household heads had no educational background while 13 percent of them had an informal education of reading and writing. Twenty-two percent of household head respondents had formal education that ranges between grade one to grade eight and only 11 (8 percent) respondents of the study participants has attended grade nine and above.

Marital Status

Ninety-one percent of the respondents were married while the remaining 4.5 percent were single and 4.5 percent of them were widowed.

Occupation

As indicated in the survey, nearly 96 percent of the respondents were farmers while 3 percent and 1 percent were merchants and government employee respectively. All respondents were born in Berek Wereda except one respondent.

Rural water use

About Forty-five percent of the household respondents mentioned that hand-dug water was their source of potable water while 35 percent of them were using spring water. Small number of the respondents (1 percent) indicated that they used pipe water as their sources of drinking water.

3.1.2 Socio-demographic Characteristics of Health Extension Workers in Berek Wereda

As part of this descriptive study, twenty-two Health Extension Workers (HEWs) were planned to fill the questionnaire prepared for them. However, two Health Posts (HPs) had not been staffed by HEWs during the data collection time and three of the HEWs were not interested to fill the questionnaire. Therefore, data was obtained from 17 (85 percent) of female HEWs who were working in 17 Health Posts of Berek Wereda.

Age of HEW Respondents

As it is indicated in the following table 3.2, more than three fourth (76 percent) of the HEWs were found in the age group between 21 to 25 years. In the age group between 17 to 20 years, two HEWs or 12 percent were found. Similarly, the remaining 12 percent of the respondents were found in the age group between 26 to 30 years. The mean age of the respondents was about 22.3years.

Table-3.2 Socio-demographic characteristics of Health Extension Workers in Berek Wereda

Socio-demographic Variables	Response	Frequency	Percentage
Age	17-20	2	12
	21-25	13	76
	26-30	2	12
	Total	17	100
Sex	Male	0	0
	Female	17	100
	Total	17	100
Religion	Christian	16	94
	Muslim	1	6
	Total	17	100
Ethnicity	Oromo	16	94
	Amharic	1	6
	Total	17	100
*Language	Afar Oromo	17	100
	Amharic	15	88
	English	6	35
Marital status	Single	15	88
	Married	2	12
	Total	17	100
Educational Level	TVETC 10+1 certificate	17	100
	TVETC 10+2 certificate	0	0
	TVETC 10+3 diploma	0	0
	Total	17	100
Service year as HEW	1- 2years	5	29
	2-4 years	10	59
	5 years	2	12
	Total	17	100

* indicates multiple responses are possible

Source: - Filed Survey, January 2011

Gender, Language, Religion and Ethnicity of HEWs

According to the above table all of the respondents were female and speak and write Afar Oromo. In addition to this, 88 percent of HEWs speak and write Amharic language. When the religion of the respondents was taken, nearly 94 percent of the HEWs were Christians while the rest two (6 percent) HEWs were Muslims. According to the above table, the ethnic composition of HEWs indicated that 94% of HEWs were from Oromo ethnic group while 6% of them were from Amhara ethnic origin.

Marital status

The survey result also revealed that 88 percent of the HEW respondents were single and 12 percent were married. Out of the total HEWs who filled the questionnaire, 94 percent of them had no children prior to the data collection time.

Education

During the of data collection time, all of the HEWs respondents had educational certificate of 10+1 from Technical and Vocational Training and Education Centers (TVETCs).

Service Year

In terms of service year that HEWs served, about 59 percent of the HEWs had worked for two to four years while 12 percent of them had worked for more than four years. The remaining 29% HEWs had worked for less than two years in the study area.

3.2 Selection of Health Extension Workers in Berek Wereda

Table-3.3 Selection of Health Extension Workers in Berek Wereda

Questions on Selection of HEWs	Response	Frequency	Percentage
Educational Level when recruited for the post of HEW	Grade 10 Complete	15	88
	Grade 12 Complete	2	12
	Total	17	100
Were you resident of this Kebele before the training	Yes	0	0
	No	17	100
	Total	17	100
Who Selected you for the training	Wereda Health Office	16	94
	Community	1	6
	Total	17	100

Source: - Filed Survey, January 2011

As it is indicated in the above table 3.3, 88 percent of the HEW respondents mentioned that they completed grade 10 when they were recruited for the one year training given in Technical and Vocational Education and Training Centers (TEVTCs) while 12 percent of the respondents were grade 12 complete when they were recruited. This fact is clearly illustrated in the implementation guideline of Health Extension Program adopted in 2007 that any candidate HEW must be women with at least 10th grade education.

The response of the HEWs is also supported and validated by the interview response of Berek Wereda Health Office Head that all HEWs had the required educational level when they were recruited for the post of HEW. When we see the residence Kebele of the respondents before they were recruited for the post of HEW and the Kebele of their work as HEW at the time of data collection, none of the respondents were working in the Kebele of their first recruitment. In addition to this, the report of household survey indicated that more than half (54 percent) of the respondents did not know from where the HEWs who were working in their Kebele Health Posts were selected (See table 3.4). Beside this, 94 percent of the HEWs were recruited by the Wereda Health Office while the remaining 6 percent of respondents were selected by the community participation.

This, in the researcher's opinion, opposes the procedure of recruitment and selection of HEWs described in the HEP implementation guideline of 2007. As the HEP implementation Guideline Amharic Version (2007, p. 2) stated, any HEW should work in the Kebele she was first recruited. Moreover, in the guideline it is also stressed that the involvement of the community in the recruitment and selection of HEWs is mandatory and indispensable for the success of the program. Furthermore, the document gained from the FMOH (2007b, p. 8) clearly stated that HEWs must be selected from the community in which they reside in order to ensure acceptance by community members after the training. Moreover, as it is revealed in the interview the researcher had with HEWs, the contradiction in the recruitment and selection of HEWs, has posed a challenge for the HEWs to properly handle the functions of the Health Posts in their respective Health Posts. According to the HEWs participated in the key informant interview indicated, they faced a problem when they were first assigned in the Kebele which they had no information before and they were in a trouble while they were trying to flourish a conducive working environment and deliver the health extension packages to the community.

The situations described in the above, as the researcher believes, are among the factors that negatively affected the implementation of HEP in Berek Wereda and therefore, these problems to be solved, need to have a proper application of the procedures of recruitment and selection of HEWs as described in the implementation guideline of HEP in the study area.

3.3 Perception of Household Respondents about Health Extension Program in Berek Wereda

Table-3.4 Perception of household respondents about health Extension program in Berek Wereda

Question on Community Perception about HEP	Response	Frequency	Percentage
Do you know the presence of Health Post in Your Kebele?	Yes	120	91
	No	12	9
	Total	132	100
If Yes, who is working in the Health Post? (n=120)	Health Extension Workers	117	97.5
	Nurses	0	0
	Doctors	0	0
	I do not Know	3	2.5
	Total	120	100
From which Kebele was the HEW selected	From our Kebele	0	0
	From other Kebele	61	46
	I do not know	71	54
	Total	132	100
Respondents' gender preference	Male	9	7
	Female	57	43
	Both	66	50
	Total	132	100
Where does the HEW of your Kebele reside?	In our Kebele	81	61
	In Sendafa town	32	24
	I do not know	19	15
	Total	132	100

n:- indicates the number of respondents

Source: - Filed Survey, January 2011

As illustrated in the above table 3.4, overwhelming number of household respondents (91 percent) knew the presence of Health Posts in their respective villages while the remaining 9 percent of them were not aware of its presence in their Kebele. From the total 91 percent of household respondents who knew the presence of Health Post in their Kebele, 97 % of them indicated that HEWs were working in the Health Posts while 3 percent of them have failed to identify who were working in the Health Posts.

In support of the above report, the focus group participants in the study argued that the community was able to grasp the presence and functions of Health Posts in course of time because of the unreserved efforts of HEWs. They further stated that all segments of the community knew the works of the HEWs due to the outreach and home to home services they provided to the community.

But the participants also indicated one instance and stated that since the Health Post found in their Kebele was not located in the center of the Kebele, some group of the community who were situated far from the Health Post had failed to identify what the Health Post is and who works in it. This, they believed, made some segment of the community not to know what the Health Post exactly works and not to benefit from the services given by the Health Post. In the researcher's site observations to two study Kebeles, it is also identified that the Health Posts in both Kebeles were not situated in mean places. Therefore, the researcher believed that the location of Health Posts in Kebeles has an impact in the access of HEP services to all segments of the community. In addition to this, as distance plays a critical role in the delivery of health services to the community (Health and Development Information Team, 2007 p. 4), those households living near the Health Posts are more served than those situated far from the Health Posts. This affects the implementation of the program to meet its objectives by impeding its accessibility to all segments of the community in equitable manner.

Therefore, the researcher argued that the location of sites during or before construction of Health Posts should be analyzed and constructions must be in the midpoint of Kebeles. This could make the accessibility of Health posts fair to all segments of the community and in turn significantly contributes for the efforts of raising the awareness of the community.

With regards to the gender preference of household respondents for the post of HEW, the report of the household respondents' survey revealed that half of them (50% percent) preferred to have both male and female HEWs together in the activities of the Health Posts. However, about 43 percent of the household respondents favored only female HEWs while the remaining 7 percent of respondents indicated that their preference was male HEWs. Similar to households' argument, both the HEW interviewees and the majority of the focus group participants stressed the need to have male HEWs together with female HEWs in the service delivery of the Health Posts.

The reasons given by the respondents indicated that female HEWs were not capable of reaching geographically remote areas to conduct home to home visits and they were afraid to deliver services during night times in the Health Posts. In the focus group discussion, it is also raised that female HEWs were afraid of openly discuss sex-related education with male community members. In addition to this, as literatures on Community Health Programs clearly indicated, gender issues in practices of health programs are to a very large extent influenced by wider societal practices, beliefs, and gender relations more generally. To this end, the involvement of male HEWs together with the female HEWs in the activities of the Health Posts is important and therefore, the researcher as well as the study participants suggested it strongly.

3.4 Working Conditions of Health Extension Workers in Berek Wereda

Table-3.5 Working Conditions of Health Extension Workers in Berek Wereda

Working Conditions of HEWs	Response	Frequency	Percentage
Availability of transportation to go to Wereda Health Office	Yes	5	29
	No	12	71
	Total	17	100
Distance of Health Post from Wereda Health Office in Hours	≤1hr	4	24
	2hrs -3hrs	5	29
	≥ 3hrs	8	47
	Total	17	100
Housing Provision	In HP resident house	4	23
	In the HP	11	65
	In SendafaTown	2	12
	Total	17	100
Sufficiency of Salary	Sufficient	0	0
	Not sufficient	17	100
	Total	17	100
Presence of Job description	Present	16	94
	Not Present	1	6
	Total	17	100
Availability of reference Material	Available	11	65
	Not available	6	35
	Total	17	100
Asking for Transfer/ Promotion by HEWs	Yes	3	18
	No	14	82
	Total	17	100
Presence of weekend Leave	Yes	6	35
	No	11	65
	Total	17	100

Source: - Filed Survey, January 2011

When we see the working conditions of HEWs in the study area, certain key variables were observed in the study. One of these variables was the availability of transportation means for HEWs to go to the Wereda Health Office from their respective Health Posts.

According to the above table, 29 percent of HEW respondents indicated the presence of transportation means while the remaining 71 percent of the HEWs indicated the absence of it to go to the Wereda Health Office from their respective Health Posts. In relation to this, when the distance of the Health Posts from the Wereda Health Office in time duration was considered, almost half of the Health Posts (47 percent) were located at a distance that takes more than 3 hours from the Wereda Health Office. Beside these, 29 percent of the Health Posts were located at distance that travels for about 2 to 3 hours to reach at the Wereda Health Office and the remaining 24 percent of the HEWs admitted that they had to travel less than an hour to reach at the Wereda Health office from their respective Health Posts.

As the above data indicates, there is absence of transportation means for the majority of Health Posts in addition to the long distance that majority of them had from the Wereda Health Office. These conditions, as the researcher argues, hammered the efficient and effective implementation of HEP in Berek Wereda. In support of this argument, the study conducted by WHO (2007, P. 16) argues that that the successes of Community Health Programs are limited by absence of transportation system and long distance from the broader health system compounded by poor communication.

Therefore, it stressed that to make these programs more accessible and acceptable to clients in their communities and improve the overall coverage of services as well as equity, i.e. increased service use by poorer individuals and households; there should be sufficient transportation access both for the program implementer and the community members. From this, it can be possible to indicate that the HEP implementation in the study area is suffering from absence of transportation means which is more aggravated by the long distance the Health Posts had from Wereda Health Office. Hence, there should be a better establishment of transportation system that connects the Health Posts to Wereda Health Office for the improvement of the implementation of program in the study area.

On the other hand, nearly one fourth (23 percent) of HEWs reported that they were residing in Health Post compounds having their own house which was built separately from the Health Posts while the majority (65 percent) of the respondents mentioned that they resided in the Health Posts. The remaining respondents that accounted about 12 percent admitted that since there were no residential houses in the Health Posts, they were residing in Sendafa town.

With this regards, majority of the household respondents (61 percent) stated that the HEWs were resided in the Kebele of their work while 24 percent of them mentioned that HEWs live in Sendafa town. The remaining 15 percent of the household respondents did not know where HEWs were residing (See table 3.4).

The reason provided by HEWs for residing in Sendafa town is that as there were no basic facilities like residential houses and toilets in addition to the absence of guards in the Health Posts compound, they were afraid to pass the night in the Health Posts. Therefore, they continued arguing, resided in Sendafa town and they went to village every morning where they were assigned. As a result this they were not spent full time in their activities which affected the day to day activities of the Health Posts and influenced the community not get the services of HEP like delivery and first aid during night times. It might also contribute its share for the burden of problems associated with the activities of the Health Posts in the study area.

When we see the amount of salary the HEWs got in a monthly basis during the data collection time, all HEW respondents participated in the study admitted that it was not sufficient to satisfy their needs. They also stressed that their monthly salary and the load of activities they expected to perform did not match. Therefore, they suggested for the increment of their salary and provision of other financial benefit.

This dissatisfaction of HEWs with their salary, as the researcher believes, can be one of the causes for the frequent attrition of HEWs (as described by Berek Wereda Health Office Head) in the study area. Therefore, as the retention of HEWs in the Berek Wereda is affected by the concerns of financing the program, retention should be addressed as part of a broader package of management interventions in the implementation of the program.

With regards to the presence of a reporting system in Health Posts, all HEWs who participated in the survey admitted that they had reporting system in which they notify their weekly activities to the HEP Supervisors and 35 percent of the respondents indicated the presence of feedback for their weekly report. Out of the total respondents, 94 percent of them agreed that they had their detailed job description. With regards to the availability of reference materials to refer to in their operation, 65 percent of the respondents had the necessary materials for reference purpose while the remaining 35 percent had nothing to refer to.

In relation to this, out of the total respondents who possessed the necessary reference material, 64 percent of them claimed that the available reference were sufficient for their work while the remaining 36 percent of the respondents disclosed that the available reference were insufficient. As indicated by 82 percent of respondents, they did not ask for transfer from their work place to other Health Posts while 18 percent of them indicated that they have asked for transfer. About 35 percent of respondents admitted that they had a weekend leave while the majority or 65 percent of the respondents revealed the absence of weekend leave in their weekly activities (These issues will be dealt with in detail in section 3.9.1 of this chapter).

3.5 Review of Health Posts' Working Conditions in Berek Wereda

3.5.1 Infrastructural Facilities of Health Posts

As it is indicated in the following table 3.6, thirty-five percent of the Health Posts were located on road line that made them accessible to service seekers throughout a year. The remaining 65 percent of the Health Posts were not located in line with road that serves all round the year and therefore; majority of the Health Posts were in a situation which poses challenges to the community in accessing them during rainy seasons.

According to the response of HEWs, all Health Posts lack water supply in their compound and got water from nearby sources. As the response of HEWs indicated, 23 percent of the Health Posts got their water supply from pipe water. Other Health Posts that accounted about 18 percent, 18 percent, 23 percent and 18 percent got their water supply from hand-dug, borehole, spring and river water respectively.

Table-3.6 Review of Infrastructural Facilities of Health Posts in Berek Wereda

Health Posts Status Review	Response	Frequency	Percentage
Presence of Road	Yes	6	35
	No	11	65
	Total	17	100
Source of Water	Pipe water	4	23
	Hand-dug Water	3	18
	Bore hole	3	18
	Spring water	4	23
	River water	3	18
	Total	17	100
Toilet room	Yes	12	71
	No	5	29
	Total	17	100
Solid Waste disposal pit (Garbage)	Yes	10	59
	No	7	41
	Total	17	100
Hand washing Facilities	Yes	4	24
	No	13	76
	Total	17	100
Number of Staff of Health Posts	Staffed by One HEW	3	18
	Staffed by Two HEWs	14	82
	Total	17	100

Source: - Filed Survey, January 2011

In addition to these, around 71 percent of the HEWs reported that there were pit latrine in the Health Posts compound and 59 percent of them indicated that there were waste disposal pit in their Health Posts. When we take the availability of hand washing facility in the Health Posts, only 24 percent of HEWs reported its presence while the remaining 76 percent of the respondents indicated the absence of these facilities in the Health Posts.

However, as it is proved by Sefihun, (2007, p. 41) in the study of the implementation of HEP, absence of necessary working conditions like living houses, toilets, refuse pits and hand washing facilities in the Health Posts affected the proper implementation of program in his study area. Therefore, absence of toilets (29 percent), refuse pits (41 percent) and hand washing materials (76 percent) in the Health Posts not only affects the working conditions of HEWs but also contradict with the basic essence of HEP that Health Posts should have demonstrative toilets, refuse pits and hand washing facilities for the demonstrative teaching of health educations to the community.

When we see the staffing of Health Posts by HEWs, the response of HEWs indicated that three (18 percent) Health posts were staffed by one Health Extension Workers while the remaining 82 percent of the Health Posts were staffed by two HEWs. This also contradicts with the idea of the implementation guideline of the HEP as it clearly stipulated that each Health Post must be staffed by two salaried HEWs.

In general, as the study revealed, the working conditions of HEWs were constrained by interrelated challenges and problems that gravely obstructed the proper implementation of the HEP in the study area.

3.5.2 Supply of Logistics to the Health Posts in Berek Wereda

Table-3.7 Supply of Office Materials for Health Posts in Berek Wereda

Supply of Office Materials	Response	Frequency	Percentage
Office Stationery	Yes	9	53
	No	8	47
	Total	17	100
Family planning Cards	Yes	17	100
	No	0	0
	Total	17	100
Folder	Yes	0	0
	No	17	100
	Total	17	100
Service registration Book	Yes	16	94
	No	1	6
	Total	17	100
Table and Chairs	Yes	17	100
	No	0	0
	Total	17	100
Bench	Yes	15	88
	No	2	12
	Total	17	100
Store Shelf	Yes	5	29
	No	12	71
	Total	17	100
Dry Battery	Yes	14	82
	No	3	18
	Total	17	100
Megaphone	Yes	12	71
	No	5	29
	Total	17	100
Stretcher	Yes	14	82
	No	3	18
	Total	17	100

Source: - Filed Survey, January 2011

As shown in the above table 3.7, fifty-three percent of the respondents mentioned that office stationery was supplied for Health Posts activities regularly. All respondents also indicated that family planning cards reached Health Posts regularly. However, none of the HEW respondents indicated that they possessed folders. Around 94 percent of the respondents disclosed that they had registration books in the Health Posts which were used for daily registration of service seekers.

As the HEW respondents' report indicated, the supply of store shelf was limited and only 29.4 percent of them mentioned its presences in their respective Health Posts. The supply of tables and chairs, benches, dry batteries, megaphones and Stretcher was described by HEWs as it was 100 percent, 88 percent, 82 percent, 70 percent and 82 percent respectively.

Table-3.8 Supply of Medical Logistics and Medicine for Health Posts in Berek Wereda

Supply of Medial Logistics and Medicine	Response	Frequency	Percentage
Disposable Syringe	Yes	17	100
	No	0	0
	Total	17	100
Contraceptives	Yes	17	100
	No	0	0
	Total	17	100
Condoms	Yes	17	100
	No	0	0
	Total	17	100
Oral Rehydration Salt	Yes	7	41
	No	10	59
	Total	17	100
Ergometrine Tabs	Yes	0	0
	No	17	100
	Total	17	100
Blood Pressure Apparatus	Yes	15	88
	No	2	12
	Total	17	100
First Aid materials	Yes	17	100
	No	0	0
	Total	17	100
Delivery Materials	Yes	15	88
	No	2	12
	Total	17	100
Alcohol and other detergents	Yes	15	88
	No	2	12
	Total	17	100

Source: - Filed Survey, January 2011

Concerning the availability of medical logistics for Health Posts function indicated in the above table, all of the HEWs reported that there was sufficient supply of syringes, needles, the recommended type of family planning drugs, and condoms. However, less than half or 41 percent of the respondents stated that they had Oral Rehydration Salt drugs recommended for the Health Posts function. Nearly 88 percent of HEWs mentioned the presence of both blood pressure measurement apparatus and delivery materials in their respective Health Posts. About 88 percent of the respondents indicated that they had alcohol and other detergents for their first aid health activities. According to the reports of HEWs, the other frequently supplied medical logistics for Health Posts were first aid medical materials and all HEWs reported that first aid materials were supplied for their activities regularly. On the other hand, the most hardly supplied drug in the Health Posts was found to be Ergometrine; and none of the respondents had the recommended type of this medicine.

In conclusion, the study has identified that there was a shortage of some logistics such as, store shelf, folders, and medical supply that is recommended for Health Posts, more commonly shortage of Oral Rehydration Salt and Ergometrine in the study area.

3.6 Management Structure and Stakeholders of Health Extension Program in Berek Wereda

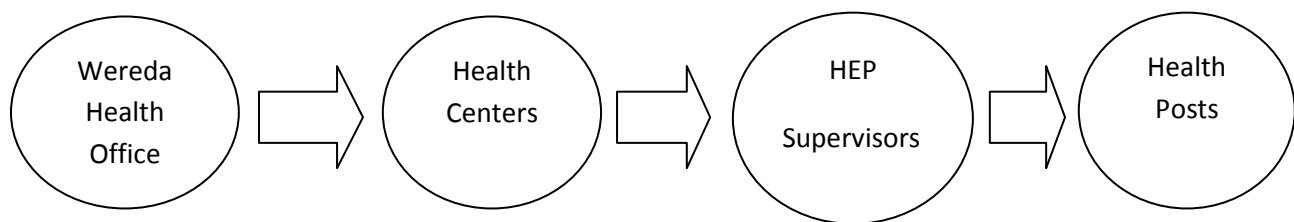
3.6.1 Management Structure of HEP in Berek Wereda

As management is one of the most crucial factors in implementation of HEP, the study has tried to analyze and describe the overall management structure of the program in Berek Wereda. In the study, the Wereda Health Office Head who served in the post for about a year described that the management of HEP in the Wereda involved two types of management systems. The first involved the relationship between the Wereda Health Office and the Health Posts. In this condition, the Wereda Health Bureau provides administrative and financial support to the Health Posts. The second type of management involved the relationship between the Health Centers and Health Posts. This management of the HEP provided a condition for Health Posts to get technical supports from Health Centers.

These management systems of HEP in the Wereda were functioning by clustering of Health Posts into five clusters based on Health Posts proximity to one another. They also indicated that this cluster- wise division of Health Posts provided a better situation to manage and control the activities of the HEWs in their respective Kebeles.

The Wereda Health Office Head further stated that the service delivery of the Health Posts in the Wereda, involved the implementation of 16 packages of the HEP categorized into four major themes: (i) hygiene and environmental sanitation services; (ii) diseases prevention and control service; (iii) family health service, and (iv) health education. In the implementation of these packages, the Wereda Health Office Head added, an institutional arrangement centered on the Health Posts was adopted in the Wereda. In this institutional arrangement, the activities of Health Posts on the implementation of the HEP were directly accountable to HEP supervisors and the HEP supervisors were directly accountable to the Health Centers. Finally, the Wereda Health Office followed the overall activities.

Figure -1 Institutional Structure of Health Extension Program in Berek Wereda



Source: - Key informant interview with Wereda Health Bureau Officials

In addition to this, the HEP Coordinators' report revealed that the institutional arrangement of the HEP in Berek Wereda involved the Zonal Health Office supports as the Zonal office provide technical, material and financial assistance to the Health Posts for proper implementation of the HEP. In addition to this, the coordinator has also indicated that within this institutional arrangement, the Wereda Health Office was providing on-job training and regular supportive supervision to enhance the implementation capacity of the HEWs.

Similar to this, the responses of HEWs involved in the key informant interview indicate that there were two types of HEP management used in Berek Wereda. However, they continued arguing, the management system was weak enough to properly lead and control the activities of the Health Posts.

The HEW interviewees further indicated that the administrative links between the Wereda Health Office and Health Posts and technical link between the Health Centers and Health Posts was not strong. These made the reporting and referral system between the Wereda Health Office and Health Centers in one hand and Health Posts in other hand weak.

When they concluded their argument the HEWs stressed that the established administrative and technical support management system must be strengthened in order to properly implement the HEP in Berek Wereda. Finally, the researcher also indicates his intension that as management is one of the crucial elements in the success of any health programs, due attentions must be paid for the activities of management conducted by both Wereda Health Office and Health Centers in the implementation of the HEP in Berek Wereda.

3.6.2 Stakeholders of Health Extension Program in Berek Wereda

The stakeholders in the implementation of Health Extension Program as explained by Teweldebrhan (2005, p. 22) are the target households, the community and the health system. These are the major stakeholders involved in the implementation of HEP.

Similarly, in the Berek Wereda, the Wereda Health Office Head and the HEP Coordinator indicated that the primary stakeholders involved in the implementation of the program were the community or beneficiaries of the program, Health Extension Workers, Wereda Health Office, Health Centers and each Kebele officials found in the Wereda. In addition to this, Wereda administration offices, schools, agriculture sector, Non-Governmental Organizations like Agri-service Ethiopia were playing significant role in the implementation of the HEP in the Wereda.

These stakeholders, as the researcher believes need to know the spirit of partnership in the implementation of the HEP in the study area. It is also critical to understand the benefit of partnership, collaboration, integration, coordination, and synergy with all other potential stakeholders, and the stakeholders have to further promote transparency, accountability, and integrity in the implementation of HEP in Berek Wereda. Furthermore, there must be a capacity as well as a system for efficient utilization of resources mobilized by different stakeholders like the community, Non-Governmental Organizations like Agri-service Ethiopia and donor agencies like UNICEF.

3.7 Supervision and Monitoring on Health Extension Workers in Berek Wereda

As it is widely acknowledged and emphasized in the WHO studies (2007 and 2010) that the success of CHW programs hinges on regular and reliable support and supervision. It is equally acknowledged, however, that supervision is often among the weakest links in most of Community Health Programs. In light of this, the study has analyzed the supervision and monitoring activities of HEP in Berek Wereda.

The Wereda Health Bureau Health Extension Program Coordinator has indicated that during supervision activity, the supervisors assist the HEWs on the planning of physical activities of the Health Posts. In addition to this, it was reported in the study that the supervision included technical support on implementation of HEP and also involves the monitoring and evaluation of tasks performed by the HEWs both in the Health Posts and in the field work on weekly basis.

Table-3.9 Supervision and Monitoring on Health Extension Workers (HEWs) in Berek Wereda

Supervision and Monitoring on HEWs	Response	Frequency	Percentage
Supervision of HEWs in the last two months	Yes	14	82
	No	3	18
	Total	17	100
Is the supervision supportive?	Yes	7	41
	No	10	59
	Total	17	100
Availability of Refresher course	Yes	12	71
	No	5	29
	Total	17	100
Availability of monthly Work Plan	Yes	17	100
	No	0	0
	Total	17	100
Documentation of Achievement	Yes	13	76
	No	4	24
	Total	17	100
Reporting System	Yes	17	100
	No	0	0
	Total	17	100
Referral System	Yes	5	29
	No	12	71
	Total	17	100
Sufficiency of one year training at TEVT	Sufficient	4	24
	Not Sufficient	13	76
	Total	17	100

Source: - Filed Survey, January 2011

However, in the study it is revealed that 82 percent of HEW respondents were supervised by HEP Supervisors within the last two months before the time of the data collection. The remaining 18 percent of the HEWs indicated that they were not supervised in the indicated time interval. Beside this, the interview report of the Wereda HEP Coordinator showed that the supervision activities of the Health Posts took place every week dividing the Wereda into five site clusters. Beyond this, in the eyes of HEW respondents that accounted about 41 percent, the nature of supervision conducted on the activities of Health Posts was not supportive while the majority or 59 percent of the HEWs declared that the supervision had a supportive nature. About 71 percent of HEWs' response indicated the presence of refresher course given to HEWs on implementation of HEP while the remaining 29 percent indicated that they did not get any refresher course before the time of data collection. From the total HEWs who got the refresher course, more than half or 53 percent of them indicated that the refresher course they got was sufficient for scaling up their knowledge of HEP and provide proper services for the community. However, in the eyes of 41 percent of the HEW respondents the refresher course given to them was not sufficient. The rest HEW respondents that accounted about 6 percent indicated that they had no idea to judge whether the refresher course was sufficient or not.

All HEWs who filled the questionnaire disclosed that they had both monthly work plan and reporting system in which they perform and report their activities to the Wereda Health Office. Thirty-five percent of the respondents agreed that there was feedback for their reports from Wereda Health Office while the remaining 65 percent of the respondent described that there was no feedback given to their reports. With regards to the documenting the activities and achievements of the Health Posts, more than three fourth (76 percent) of the respondents indicated that they safely documented the achievements of the Health Posts while the remaining 24 percent indicated that they failed to document the achievements of the Health Posts clearly and safely.

Nearly three-fourth (71 percent) of HEWs disclosed that they did not have any referral system in which they refer patients to higher health institutions while the remaining 29 percent of the respondents indicated the availability of referral system.

About one-fourth (24 percent) of HEWs indicated that the training they got in TVET Centers for a time of one year was sufficient enough to deliver the Health Extension Packages effectively while in contrast more than three fourth (76 percent) of the respondents agreed that the training was insufficient. In relation to this, the majority of the HEWs recommended that there should be short and medium term refresher trainings on HEP for the better performance of the HEWs.

In general, the study findings illustrated that the supervision and monitoring activities performed in the implementation of HEP in Berek Wereda were significant although they were limited by different problems. According to the data analyzed above, in sufficient supportive supervision, refresher course, feedback and referral system were identified as limiting factors. In addition to these, the inadequateness of the training which HEWs got for one year in TVET Centers could be one major factor that affected the proper service delivery of HEWs in Berek Wereda.

3.8 Achievements of Health Extension Program in Berek Wereda

This study has revealed that the service delivery of HEP to the community is showing encouraging results in Berek Wereda. This is in terms of the delivery of health extension packages like environmental and personal hygiene, family planning services, provision of immunization at outreach level, first aid emergency activities, and education on reproductive health related harmful traditional practices.

The HEP service provision also embraces activities like health education and communication about pit latrine construction, solid waste disposal pit (Garbage) construction, prevention and control of HIV/AIDS, and TB. Beyond these, the HEWs and the household respondent reports indicated that there is a significant improvement in the access of primary health care services for the community. Furthermore, the study participants both in the household survey and focus group discussion argued that it is HEWs that taught them about the benefit of family planning services, environmental health, vaccination of children and personal hygiene.

In support of the above description the following table 3.10 indicates, health services for mother and child and immunization service were given to 80 percent and 86 percent of the household respondents respectively. The household participants' responses also indicated that 91 percent and 81 percent of the respondents got HIV/AIDS and TB prevention and control services, and excrete services from the HEWs respectively.

Table-3.10 Provision of Health Extension Services to Household Respondents in Berek Wereda

Provision of Health Extension Services	Response	Frequency	Percentage
Excrete disposal	Yes	107	81
	No	25	19
	Total	132	100
Solid & liquid waste disposal	Yes	103	78
	No	29	22
	Total	132	100
Water supply and safety measures	Yes	101	77
	No	31	23
	Total	132	100
Food hygiene and safety measures	Yes	98	74
	No	34	26
	Total	132	100
Healthy home environment	Yes	104	79
	No	28	21
	Total	132	100
Control of insects and rodents	Yes	13	10
	No	119	90
	Total	132	100
Personal hygiene	Yes	108	82
	No	24	18
	Total	132	100
Maternal and child health	Yes	105	80
	No	27	21
	Total	132	100
Immunization	Yes	113	86
	No	19	14
	Total	132	100
Antenatal Services	Yes	68	52
	No	64	48
	Total	132	100
Delivery Service	Yes	58	44
	No	74	56
	Total	132	100
Postnatal Services	Yes	48	36
	No	84	64
	Total	132	100
Nutrition	Yes	117	89
	No	15	11
	Total	132	100
Reproductive health related harmful traditional practices	Yes	109	83
	No	23	17
	Total	132	100
HIV/AIDS & TB prevention & control	Yes	120	91
	No	12	9
	Total	132	100
Malaria prevention and control	Yes	44	33
	No	88	67
	Total	132	100
Health Education and Communication	Yes	115	87
	No	17	13
	Total	132	100

Source: - Filed Survey, January 2011

Beside these, the above table indicated that antenatal care, delivery service, and postnatal care were given to 52 percent, 44 percent, and 36 percent of the respondents respectively. According to the response of the household respondents, 89 percent of them got essential nutrition service while 83 percent of them got sufficient education on reproductive health related harmful traditional practices.

As it is further illustrated in the same table-3.10, thirty-three percent of household respondents got the service of Malaria prevention and control. The percentage of this service is relatively small compared with other services. This is due to the absence of malaria problem in the study area. According to 87 percent the respondents and the focus group participants, health education services were also one of the usual activities of Health Extension Workers and they indicated that they got the services regularly.

In addition to these, health education for promotion of pit latrine construction was given to 81 percent, promotion of construction of solid and liquid waste disposal facilities was given to 78 percent, and promotion of personal hygiene was given to 82 percent of the household respondents respectively. The household respondents' survey and community focus group discussion result further indicated that different kinds of home sanitation services were given to the community through Health Extension Workers. Among these services, the survey report indicated that water supply and safety measures and food hygiene and safety measures were given to 77 percent and to 74 percent of the household respondents respectively.

As it is indicated in the following table 3.11 that many households constructed pit latrine and solid waste disposal pit. They also got good taught how to use and maintain the cleanness of the pit latrine. From the total of household respondents, 37 percent of them had pit Latrine. Among the household respondents who possessed pit latrine, 92 percent indicated that they were advised by HEWs to construct pit latrine. Forty-five percent of the respondents indicated the presence of waste disposal Pit (Garbage) used for disposal of solid and liquid wastes in their home compound and from respondents who possessed the waste disposal pit, 93 percent of the respondents indicated that they were advised by HEWs to construct it. This indicated that the implementation of HEP in the study area is showing a better step forward in promotion of preventive health care services by educating the community the benefits of personal, home and environmental hygiene.

Table-3.11 Home and Environmental Hygiene of Household Respondents in Berek Wereda

Home and Environmental Hygiene of Households	Response	Frequency	Percentage
Presence of Pit Latrine in home compound	Yes	49	37
	No	83	63
	Total	132	100
If Yes Who advised you to construct Pit Latrine(n=49)	Health Extension Workers	45	92
	Friends	0	0
	I know myself	4	8
	Other way I know	0	0
	Total	49	100
Presence of Waste disposal Pit (Garbage) in home compound	Yes	59	45
	No	73	55
	Total	132	100
If Yes Who advised you to construct Refute Pit (n=59)	Health Extension Workers	55	93
	Friends	0	0
	I know myself	4	7
	Other way I know	0	0
	Total	59	100

n:- indicates the number of respondents.

Source: - Filed Survey, January 2011

It also pointed out that the HEWs started visiting community's home and provided advice to the community. This effort made the community to get a good knowledge on how to prevent many communicable diseases. Moreover, as it is reported in the following table 3.12, more than half of household respondents (52 percent) confirmed that they were visited at least once by the HEW in the last two months prior to the time of data collection. The household respondents reported that during the visit they discussed with HEWs on issues like environmental sanitation, family planning services and about the advantage of vaccination.

It is also revealed in the study that 28 percent of the household respondents visited HEWs when any member of their family gets sick. But most of the household respondents (72 percent) did not go to Health Posts to get help in the last two months prior to the data collection time. The reason given by household participants in the focus group discussion for not visiting HEWs can be generally explained by strong affinity of the rural community to medical treatment, low medical availability in the Health Posts and the assumption that HEWs may be not present in the Health Posts.

Table -3.12 Household Respondents Response on Health Extension Workers' activities in Berek Wereda

Questions for Households on HEWs' activities	Response	Frequency	Percentage
Did HWEs visit your family in the last two months?	Yes	69	52
	No	63	48
	Total	132	100
Did you get help from Health Post family in the last two months?	Yes	37	28
	No	95	72
	Total	132	100
Was there a child born in your family or neighborhood?	Yes	39	30
	No	93	70
	Total	132	100
If Yes, where the child was born(n=39)	At home with no medical personnel	25	64
	At home assisted by health extension worker	9	23
	At health post	0	0
	At health center	5	13
	Total	39	100

n:- indicates the number of respondents.

Source-Filled survey, January 2011

In this study, however, it was also showed that out of the total number of mothers who gave birth within the last 6 months prior to investigation only 23 percent of them were assisted by HEWs at the house of the mother and no delivery service was given in the Health Posts. This could be attributed to many factors, like absence of residential house for HEWs, water supply within the Health Posts compound, in adequate exposure of HEWs to the management of labor during the field practice and absence of delivery logistics in the Health Posts.

In addition to these, the community participants in the study indicated that it was the HEWs that taught them to separate human and animal resident places in order to avoid infection of diseases that can be transmitted from animal to human being. In the focus group discussion it was also reported that the HEWs advised them to conduct voluntary testing for HIV/AIDS before marriage and not to make extra-marital sex. With this regards, a 25 years old participant in the focus group discussion indicated that the HEWs usually communicate with him and advised him to have a voluntary testing for HIV/AIDS before marriage and not to make extra-marital sex after he get marriage.

However, the community focus group participant further said that when he asked them to have the test for HIV/AIDS, they told him that the service is not started to be given in the Health Posts and advised him to go either to Health Centers or to other higher Clinics to get the service.

In summary the following achievements are worth mentioning.

1. Mothers and children are getting vaccine and health service regularly
2. The majority of mothers who were in need of family planning service are getting the service regularly
3. Even if delivery service was not started to be given in the Health Posts due to absence of delivery facilities, drugs and water supply to Health Posts, antenatal and postnatal services are given to mothers.
4. Since the benefit of having pit latrine and refuse pit is becoming clear among the community, many households have constructed pit latrine and refuse pit and the rest are on the construction process.
5. The community is in a passion to access to the Health Posts when there are any emergency cases that need first aid services.
6. The promotion of health education through door to door visit increased the awareness of the community on how to keep their personal, home and environmental hygiene. In addition to this, the knowledge that that community got with regards to the cleanness of drinking water and food has remarkably increased
7. Finally, the community has got the knowledge of how to prevent many communicable and contagious diseases.

3.9 Challenges of implementation of the Health Extension Program in Berek

Wereda

This study has identified a number of challenges of Health Extension Program implementation in Berek Wereda. These challenges and problems are related to administrative issues, infrastructure facilities, office materials and medical logistic supplies, supervision and monitoring activities. Therefore, in the coming sections the major administrative, infrastructural, and logistical challenges and problems are discussed.

3.9.1 Administrative and Institutional Challenges

As the findings of this study revealed, 76 percent of Health Extension Workers (HEWs) were found in the age of 21-25 years with mean age of 22.3 years and more than 88 percent of them were single and 94 percent of HEWs had no children prior to the data collection time. This factor coupled with absence of educational scholarship programs for HEWs in the study area (as stated by HEW interviewees) might urge HEWs to look for better alternatives like to search for better jobs in towns and continuing higher education in private educational institutions. These conditions might also agitate them to look forward to find new doorways open to them if better work environment and educational opportunities were not sufficiently provided. Hence, this can be a major factor that increased the attrition rate of HEWs in the study area. This argument is supported by HEW interviewees. They argued that absence of educational scholarship and other career development opportunities for HEWs in Berek Wereda is forcing HEWs to leave their job and either to get their higher education in private educational institutions or get better jobs in towns.

This argument is supported by the study conducted on community health workers by WHO (2007, pp. 14) that turn-over of Community Health Workers in many countries is high for a number of reasons, the most important being finding better educational opportunities and/or jobs in towns. Furthermore, as the study conducted by World Health Organization (2010, pp. 35) on Community Health Program (CHP) indicated, absence of professional advancement is one of the way out for attrition among Community Health Program Workers (CHPWs) and absence of continuing education can limit the ranges and quality of CHPWs and increase the attrition rate of the workers. Therefore, absence of educational opportunities coupled with other factors like the age of HEWs, poor working conditions led them to leave their jobs. This in turn increased the attrition rate of the workers in the study area.

As it is indicated earlier, all HEWs who worked in Berek Wereda were females. This, as the HEW interviewees, 50 percent of household respondents and focus group participants, imposed a problem in the service delivery of the HEWs and the Health Posts (HPs).

According to the HEW interviewees, since they are females they faced different challenges from boys while they crossed forest areas in villages. They also stated that the Health Posts they were working did not have guards and they became afraid of opening the Health Posts at night to provide services to service seekers. In addition to this, the participants of household respondents and focus group discussion stated that female HEWs were afraid to go and give services for pregnant women at night, in rainy season, in forest areas and distance places from the Health Posts. Secondly, female HEWs were afraid not to deal with male beneficiary of the HEP on sex-related health education. To tackle this problem, household respondents and focus group participants underlined the need to recruit and include male HEWs in the activities of the Health Posts.

As all HEWs involved in the study indicated, they were assigned to work in the Kebele in which they were not residents before the training. Beside this, more than 94% of HEWs were selected by the Wereda Health Office and only one HEW was selected by the community. However, the Ethiopian Federal Ministry of Health (FMoH) implementation guideline of Health Extension Program (HEP) (FMoH, 2007b p. 2) emphasizes the centrality of community involvement in the Health Extension Program and it further stated that the recruitment of HEWs should involve the community participation.

In addition to this, the World Health Organization(WHO) case study report on Ethiopia (2009, p. 15) indicated that the selection of candidate for the post of HEW should be by a selection committee comprising one member nominated by the local people and a representative from the Wereda Offices of Health, Capacity Building and Education. Moreover, the study conducted in East Gojjam Zone Amhara Regional state of Ethiopia (2009, p. 57) showed that Community Health Worker Programs (CHWP) are vulnerable unless they are driven, owned by and firmly embedded in communities themselves. The experience from Philippines also revealed that any program directed toward the community will not work without the essential element of community awareness and community involvement in its planning and implementation activities.

From this, it is possible to infer that failure to include the direct participation of the local community in selection and management of Health Extension Program could negatively influence the proper implementation of the program in the study area.

On the other hand, only 23 percent of the HEWs mentioned that the training which they got in TVET Centers for one year training is adequate to acquire the necessary knowledge and skills to deliver the packages of health extension properly. Beside this, absence of continuous trainings, workshops and scholarship programs in the Wereda has affected the implementation of the program in the study area. Therefore, they indicated their need to upgrade their knowledge and skills. All HEWs were dissatisfied with their salary and indicated as it was not sufficient to fulfill their needs. In relation to this, the HEWs who participated in the interview have also raised the inadequacy of their monthly salary. They also indicated that they got other financial incentives related to their work rarely. However, in the FMOH the Health Extension Department Expert stated in the interview he had with the researcher that the HEWs were getting the salary which fit with their educational level.

Nevertheless, as the WHO stated in the Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals (2010, p. 25), low status and remuneration of Community Health Workers is one major factor that limits the ranges and quality of their impacts on the community. Similarly, the study conducted by WHO (2007, p. 15) indicated that low remuneration is one of the major reason for high attrition of CHWs in many developing countries. Therefore, the problem raised by HEWs on the inadequacy of their salary could be one major challenge for the proper implementation of the HEP in the study area.

In addition to the above challenges and bottlenecks identified in the study area, absence of reference materials for HEWs was indicated as a problem by 35 percent and absence of transfer was indicated by 18 percent of the HEWs. Majority (64 percent) of HEWs who participated in the study revealed that they had no weekend leave. Beside the absence of weekend leave, additional works which the HEWs perform as extra office works like mobilizing the community for different meetings and disseminating government information to farmer households in their respective Kebele might influence the proper activities of the workers.

In support of the above idea, the focus group discussion participants indicated that one problem which is associated with the performance of Health Posts is related with the issue of work load of HEWs. They further stated that the HEWs participate in the activities mentioned above and conduct Kebele administration tasks in addition to their usual duties.

These activities performed outside the regular duties of HEWs, as described in the job description of HEWs might have negatively affected the day to day activities of the Health Posts and the function of HEWs. This in turn, made things difficult for HEWs to carry out a community house to house visit as expected from them.

In addition to these, the participants of the FGD indicated that there were times that the service seeker could not find the HEWs in the Health Posts due to the additional tasks described earlier which the HEWs perform in the Kebele. During such condition, anyone who seeks help from the HEWs did not get the service. In relation to this argument, one community focus group participant stated that mothers who were using family planning service and children who started vaccine faced difficulties when they did not get the services in their appointment day from HEWs.

To sum-up, absence of educational scholarship and career development for Health Extension Workers (HEWs), low community participation in the recruitment and selection of candidates for the post of HEW, low remuneration and rare financial benefit for HEWs, insufficient reference material and absence of weekend leave and work load of HEWs were the major administrative and institutional challenges of HEP which limited the proper implementation of the program in Berek Wereda. In addition to these, absence of guard in the Health Posts and gender-based attacks on HEWs are also significantly affecting the day to day activities of the Health Posts and HEWs.

3.9.2 Infrastructural Challenges

As the study conducted by WHO (2010 p. 38) indicated, the major challenges for weak achievement of Community Health Program (CHP) are absence of necessary working and living conditions for CHWs compounded by poor communication and transportation system and long distances from Health Centers.

This is also seen in the study report that absence of basic infrastructure like transportation, electricity, water and resident houses for HEWs in the Health Posts were the major constraints which HEWs are facing in the implementation of Health Extension Program. Related to this, 71 percent of HEWs respondents indicated the absence of transportation road that connect the Health Posts to Wereda Health Office.

Similarly, the HEW interviewees reported that the absence of road transport exposed them for different attacks while they were crossing forest areas carrying Health Posts facilities from Wereda Health Office. This problem coupled with the long distance between most Health Posts and Wereda Health Office posed a challenge for the HEWs functions. They indicated that they suffered from boys attack. In addition to this, it becomes difficult to carry Health Posts facilities from Wereda Health Office to the Health Posts without transportation. Some medicines like vaccine might also get expire due to the long journey the HEWs expected to travel.

The HEWs also reported that absence of road transportation access in rural villages during summer times complicated the home to home service delivery of the HEWs. In addition to this, the community focus group participants have also raised the absence of road that function throughout the year in the villages which hampered the community not to use the services given by the Health Posts regularly. This argument is further stressed by the Wereda Health Office Head that absence of road and bridges in villages that connects the Health Posts to Wereda Health Office and with the community in summer times made things difficult both for the works of HEWs and the community.

With regards to the residential places of the HEWs, 88 percent were residing in the Kebele of their work. But the data gathered from household respondents in one Kebele revealed that HEWs of that Kebele were residing in the nearby town. This could be because of absence of residential houses in the village or in the Health Post compound for HEWs. This was also aggravated by absence of guard, electricity light, water supply, kitchen, pit latrine, and compound fence for the Health Posts. As a result of this, the female HEWs were afraid to stay on duty during the night in the Health Post and the community did not get the health service from the Health Post.

Absence of pure water supply in many of the Health Posts compound (77 percent) is also another bottleneck identified in the implementation of HEP in the study Wereda. As the HEW interviewees reported, absence of water supply in the Health Posts compound had hindered the delivery service given in the Health Posts.

The community focus group participants has also argued similarly and said that the community expected HEWs to help mothers in times of delivery but absence of water in the Health Posts compound create implementation gap between the community's expectation and the service delivery of the HEWs. It is also the opinion of the researcher that this is one basic problem that limited the proper implementation of HEP in Berek Wereda.

To sum-up the basic infrastructure problems that adversely affected the Health Extension Program implementation in the study area, the following are worth mentioning.

1. Absence of road transport(65 percent of Health Posts had no road) that connect them to the Wereda Health Office and this exposed HEWs to different problems
2. Absence of roads and (bridges where necessary) that serve all round the year in the rural villages of the Wereda which prohibit the home to home health service delivery of HEWs during summer time
3. Absence of electricity supply to the function of Health Posts
4. Absence of water supply (only 23 percent of the Health Posts under study got pipe water) for the Health Posts activities and for the personal usage of HEWs
5. Absence of residential houses, kitchens (12 percent), pit latrines (29 percent) and refuse pits for solid and liquid waste disposal in the functioning of the Health Posts are also problems of the program in Berek Wereda

3.9.3 Challenges related to Supervision and Monitoring of HEP

This study revealed that 82 percent of HEWs were supervised within the last two months before the data collection time and only 18 percent of them were not supervised either by Health Center or by Wereda Health Office. Absence of sufficient vehicles and shortage of budget for supervisors in the Wereda Health Office were given as a reason by the Wereda Health office Head for not supervising the Health Extension Workers during this time.

Beside this, out of the total HEW respondents who were supervised, only 41 percent of them agreed that the supervision was supportive while the remaining failed to agree with this idea. In contrast to this, the HEP coordinator in Berek Wereda indicated that the supervision activities were supportive and during supervision, the supervisors assist the HEWs on the planning of physical activities of the Health Posts.

In addition to this, it was reported that the supervision included technical support on implementation of HEP and also involves the monitoring and evaluation of tasks performed by the HEWs both in the Health Posts and in the field work on weekly basis. However, it is widely acknowledged and emphasized in the literature that the success of Community Health Programs centers on regular and reliable supervision.

It is also clearly stated in HEP guideline that supervision is a basic tool to correct any technical and management problems occurred in implementation of the program (FMoH, 2007b, p. 15). It also stated that the guideline for supervision should include a list of supportive supervisory activities. Moreover, the study conducted by WHO (2007, p. 20) indicated that CHPs are often successful where they managed to establish effective support and supervisory mechanisms for CHWs, often including a significant amount of supervision and oversight by the community itself. Therefore, as supervision is often identified as the vehicle through which the quality of health care services can be assured, better emphasis should be taken by the Wereda Health Office and Health Centers to secure supportive supervision in Berek Wereda.

Beside this, 70 percent and 29 percent of HEWs complained for absence of referral system and refresher course respectively. Furthermore, most of the respondents who had reporting system and referral system argued that they got feedback rarely. This fact is supported by the response of HEWs interviewees that there is a rare feedback for weekly report and referral activities of the HEWs from Wereda Health Office and Health Centers. However, the implementation guideline of HEP explicitly stated that there should be structured referral and reporting system between Health Posts and Health Centers which facilitate the proper activities of the Health Posts. Therefore, to correctly implement the packages of the health extension, there should be a better link between Health Centers and Health Posts found in the study Wereda.

Sixty-four percent of HEWs had no Health Extension Package books or pamphlets to refer. This is also confirmed by Wereda Health Office Head that there is a rare provision of reference book and other related materials for HEWs activities. In addition to this, 9 percent of HEWs had no job description that guide them what to do with in given framework while 23 percent had failed to document the achievements of the Health Posts properly.

However, as the study conducted by WHO (2010, p. 31) indicated, there should be sufficient supply of reference materials for CHWs and they should be properly linked into the Health Centers on how the job description of the workers is noted and documentation of the activities would take place to prevent duplication in case of report. Therefore, this could also be considered as bottlenecks in the implementation of the program in the study area and hence, necessary arrangements should be taken regarding the supply of sufficient reference materials, documentation of achievements in the Health Posts and development of job description based on the implementation guideline of HEP for HEWs.

In conclusion, absence of sufficient budget and vehicle in the Wereda Health office are indicated as a problem for the absence of strong supervision and monitoring activities of the Health posts. In addition to these, absence of sufficient refresher course, reference materials, weak referral system and reporting system has jeopardized the activities of the Health posts in the study area.

3.9.4 Challenges related to the supply of Logistics and Medicines to Health Posts

The implementation guideline of HEP stated that Health Posts must be adequately provided with equipment materials and office supplies required to deliver the different packages of essential services to the community. However, in most of the programs which the WHO studied (2010), there is shortages or lack of medical equipment for patient examination, and drugs/ supplies useful for promotive, preventive and curative health services. Irregularity in the supply of vaccines, drugs, and necessary equipment has been reported and their availability and sustainability of resources is a major challenge to programs success.

As the FMOH (2007a, p. 10) stated medicines and supplies are procured and distributed to the Health Posts by the Federal Ministry of Health, Regional Health Bureaus and Wereda Health Offices. When medical supplies reach Health Centers or Wereda Health Offices then they will be distributed to the Health Posts.

In light of this, the study has examined the situation of the supply of office materials, logistic and medicines to the Health Posts found in Berek Wereda. In the study 53 percent of the HEW respondents reported that office stationeries were supplied for Health Posts activities. Nonetheless, as the remaining 47 percent of the HEW respondents lack sufficient supply of office stationeries, it becomes a problem for them to conduct their tasks both in the Health Posts and field works properly.

As the study findings have also revealed, family planning cards reached HEWs frequently. However, none of HEWs reported that they possessed folder for the documentation of the activities of the Health Posts. This could be one reason for the failure of some of the HEWs to properly document the achievements of the Health Posts.

As the respondents' report, the supply of store shelf was also limited and only 29 percent of them indicated its presences in their Health Posts. This could also be a problem for HEWs to store their facilities and documents in secured manner in the Health Posts. Beyond this, absence of this facility in the Health Posts exposes the materials and documents of the HEWs for thefts and damages. As indicated in the study, the supply of tables and chairs, benches, dry battery megaphones and Stretcher is relatively sufficient for the activities of the Health Posts found in Berek Wereda. However, it is indicated in HEWs interview and focus group discussion that irregular and insufficient supply of office materials, medical logistics and drugs for the Health Posts has brought problems in the function of Health Posts. Such problems made the HEWs effort weak in the eyes of the community who were coming to the Health Posts in order to get help. Then, the community began to consider the Health Posts' activities as weakly instituted.

Beside this, all Health Posts had both syringe and needle, the recommended type of family planning drugs, and condoms. But irregularity in the supply of these drugs harmed the implementation of the program in the study Wereda. In addition to these, as indicated by 41 percent of HEWs, they possessed Oral Rehydration Salt drug recommended for Health Posts use. However, the researcher believes that shortage of this recommended drug for Health Posts could also affect the proper delivery of health service to the community.

Nearly 88 percent of HEWs mentioned the presence of blood pressure measurement apparatus in their respective Health Posts. Similarly, 88 percent of the Health Posts had delivery materials. Nevertheless, the guideline for the implementation of HEP stated that all Health Posts should have the recommended medical logistics for proper service delivery. Hence, absence of this material in the two Health Posts of Berek Wereda can affect the service delivery of these Health posts.

In relation to the availability of delivery materials for the Health Posts, 88 percent of them had the necessary delivery materials. However, since most of the Health Posts did not have sufficient water supply in Health Posts' compounds; delivery service is being given to 43 percent of the household respondents. This implies that absence of sufficient water supply poses a problem on the HEWs in order to provide delivery service for pregnant mothers in the Health Posts. As the findings of the study further indicated, the supply of Ergometrine drug was found to be 0 percent and none of the respondents had the recommended type of this medicine. The absence of this drug might have also affected the delivery and postnatal service provision of HEWs in the Health Posts.

In summary, absence of sufficient and regular supply of the recommended medical logistic, office materials, and medicines could have harmed the implementation of the HEP in the study Wereda. Therefore, as literatures on CHPs indicated, a well functioning pharmaceutical service is the corner stone for any worthwhile health service. Thus, there should be interventions in the implementation of HEP in Oromiya in general and in Berek Wereda in particular in the provision of sufficient and essential drugs, medical supplies and equipment for the Health Posts and ensuring their rational use in the Health Posts.

Chapter Four

Conclusions and Recommendations

4.1 Conclusions

This descriptive study has given due attention to investigation of the basic challenges and problems of implementation of the Health Extension Program in Berek Wereda of Oromiya Region. In doing this, it focused on the investigation of Health Extension Workers (HEWs) working conditions, health extension packages service delivery to the community (achievements), the management of HEP and the problems of the Health Posts in the study area. Based on the findings of the study, it also provided relevant suggestions for the improvements of the program.

In the study, it is identified that the HEP has achieved promising achievements in Berek Wereda. The implementation of the program is helping the community to prevent communicable diseases and enabling them to participate in the implementation of health care education. As the findings of the study revealed, households are taught by the HEWs and have received health education on various topics like education on personal and environment hygiene, construction of pit latrine and waste disposal pit and education on HIV/AIDS and TB. Beside these, the community is also getting access to healthcare services like immunization, family planning, antenatal and postnatal services in the Health Posts.

The findings of the study have also showed that the implementation of the program is limited because of different challenges in the study area. Frequent attrition of Health Extension Workers, low budget allocation, insufficient training, and scholarship programs for HEWs, absence of infrastructure facilities, and insufficient supply of logistics for the Health Posts function were identified as the major challenges of the program.

In addition to these, absence of residence for HEWs, toilets and piped water in the Health Posts, weak administrative structure at the level of Health Centers to follow-up the activities of the Health Posts and absence of sufficient vehicles for supervision and monitoring activities have severely jeopardized the activities of the Health Posts in Berek Wereda.

4.2 Recommendations

The achievements of the Health Extension Program implementation in Berek Wereda as explained in the study and in the conclusion are encouraging. However, it is important to carefully examine the challenges of the program and identify possible remedies in timely manner for the time to come. The recommendations addressed here, therefore, present options for policy implications and practical interventions by the stakeholders of the HEP to improve the implementation of HEP, and thereby increase communities health needs satisfaction. Hence, based on the study findings, the following major recommendations are forwarded.

1. The experience of other countries in the literature showed that it is important to control the attrition of Community Health Workers for the success of the Community Health Programs. It is important to control the attrition of HEWs in the study area for a successful implementation of HEP. Filling vacant Health Posts by additional recruitment of new workers is also mandatory to strengthen the implementation of the program in Berek Wereda.
2. Health programs must be adequately funded to achieve their objectives. Hence, allocation of sufficient and regular budget should be provided by the Regional and Zonal Health Bureaus to support the HEP implementation in Berek Wereda.
3. The Wereda Health Office and Health Centers should provide sufficient technical, logistical and financial support to the Health Posts. There should also be a way for creating and strengthen mutual relationship between Health Posts and Health Centers in the Wereda. The relationship and coordination among the members of Kebele administration and the HEWs should also be strengthened. The infrastructure facilities including water supply, road transport, and bridges (where necessary) should be fulfilled for the proper functioning of Health Posts in the study Wereda. Residential houses, pit latrines, refuse pit and fence around the Health Posts should also be constructed in Kebeles where these facilities are not available by the joint efforts of Wereda Health Office, Health Extension Workers and the community. In addition to these, the recruitment of guards to the Health Posts should be facilitated by the community's direct effort in order to solve the problems of HEWs during the night duty.
4. The Wereda Health Office should provide sufficient and regular short and medium range on job training and workshops to Health Extension Workers to strengthen their implementation capacity.

- 5.** Health Extension Workers should implement the HEP with a sense of ownership. They must respect the value of the community and conduct the program implementation processes in a professional and ethical manner. There should also be a better community mobilization and participation activities to promote effective implementation of HEP in the Wereda.
- 6.** The mechanism of supervision and monitoring should be regular and supportive for the activities of HEWs and there should be proper referral, reporting and feedback systems for the activities of Health Posts. Adequate allocation of vehicles to the Wereda Health Office and Health Centers should be promoted by the Regional and Zonal Health Bureaus to make the supervision activities effective. In addition to these, the Regional, Zonal and Wereda Health Bureaus should work jointly to strengthen the existing administrative and institutional structure of HEP both at the Health Center and Health Posts.
- 7.** The right to transfer of Health Extension Workers from one area to another similar to other civil servants should be in place so that they can be more motivated to implement the program more effectively.
- 8.** It is the observation of the researcher that there is a mismatch between HEWs number, population size and Kebele size. Therefore, these issues must be considered in Berek Wereda because they have negative effects on the accessibility of the services of HEP to all members of the community.
- 9.** The study respondents in the study area indicated that it is important to consider the involvement of male Health Extension Workers in the implementation of HEP. Therefore, the researcher believes that program planners at the federal and regional levels consider the involvement of male Health Extension Workers in the implementation of the program. However, the researcher would also like to note that it should not to substitute the female Health Extension Workers but to support each other in the performance of the Health Posts.
- 10.** Creating a mechanism for sharing better experiences between and among the Health Extension Workers within the Wereda and with other Weredas should be encouraged.
- 11.** Finally, in a wider sense, the Health Extension Program should be revised and evaluated by the Federal, Regional, Zonal and Wereda Health Offices in a regular and timely manner so as to fill the gaps and alleviate the challenges that affect the implementation of the program which is serving communities at the grassroots level.

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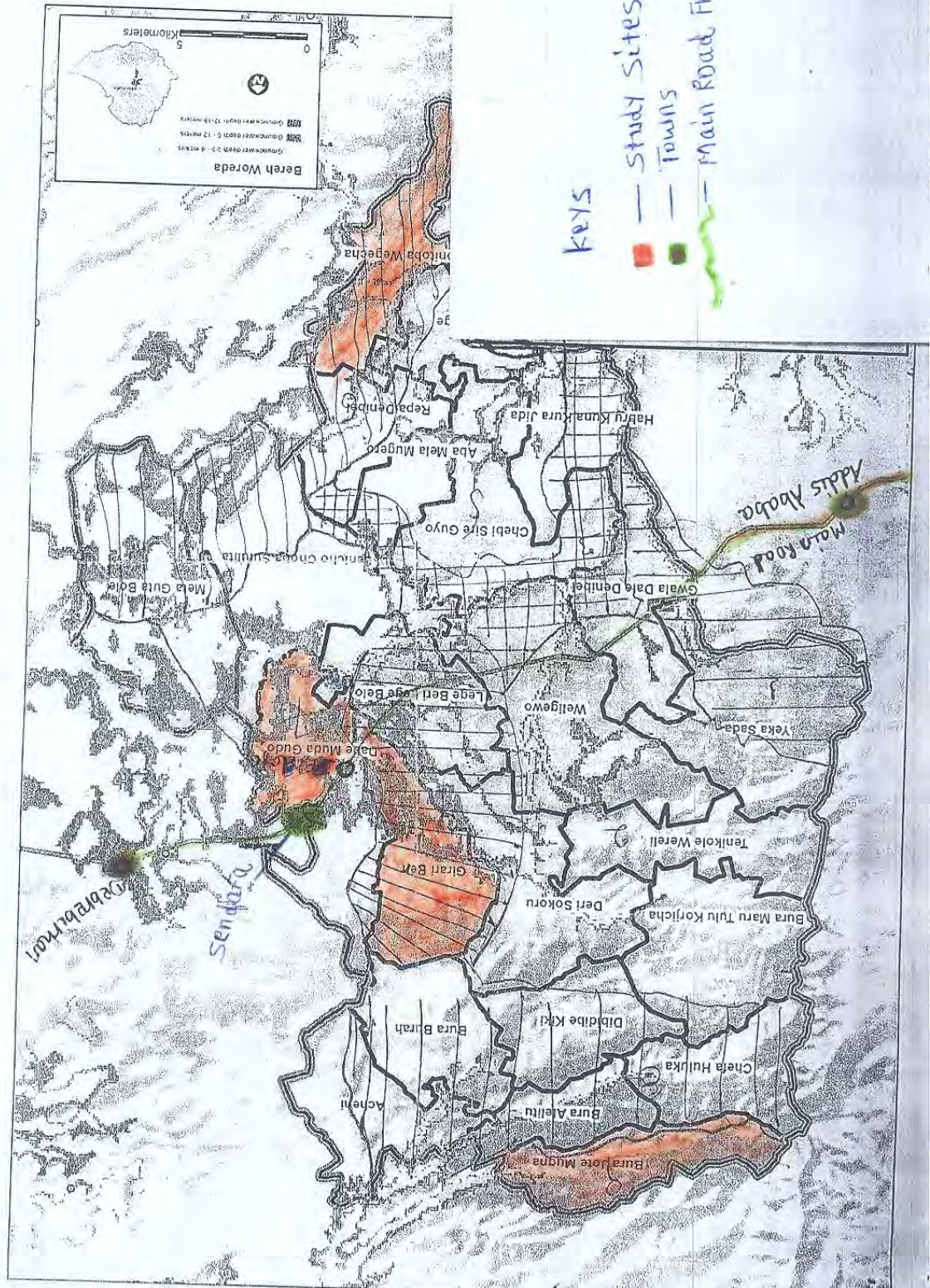
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Annex One

Berek Wereda Map

Map of Woreda



Annex Two

**Questionnaire prepared to investigate the
Challenges of Health Extension Program
Implementation in Berek Woreda of Oromiya
Region**

To be filled by Health Extension Workers

Prepared by Tewodros Mekonnen

Informed Consent

The questionnaire is prepared in order to gather information from responsible sources like you and the people that you serve, regarding the services that your health post (HP) is providing. It also deals with the strengths that you have exhibited; the challenges that you faced and how you overcome them while you perform your day to day activities. Such information is very crucial in that it enables the creation of a common understanding among all stakeholders regarding the real issues on the ground. It will help to strengthen the strong aspects, deal with weaknesses in a timely manner, understand the nature of the challenges, and suggest possible solutions which make the health services provision endeavor in your Kebele effective.

Even though this data collection is being done with the knowledge and permission of the Woreda Health Offices, I would also like to get your prior consent as to whether or not you are willing to participate. I hope that you are willing to share with us your experiences by participating in filling this questionnaire. I would like to assure you at this point that the information you give is confidential and it will only be compiled and organized along with that of your fellow HEWs for academic purposes. No personal details will ever be released. Thus, if you are willing to participate in the survey, please continue to the next page. If you are not interested you can stop here and return the questionnaire to the data collector.

Note: - Please circle a letter of your choice if the question has choices. When you complete filling out the questionnaire, please return it to the data collector (Applicable only for willing respondents).

To be filled by Health Extension Workers (HEWs)

Part One: Socio-demographic characteristics of the respondent

Region _____ Zone _____ Woreda _____ Kebele _____

1. Age (in years) _____
2. Sex Male _____ Female _____
3. To which ethnic group do you belong? _____
4. The type of language you can speak, (more than one answer is possible)
_____ , _____ , _____
5. What is your religion? A/ Christian _____ B/ Muslim _____ C/Other _____
6. What is your current marital status? A/Single _____ B/ Married _____
7. If you are married, how many children do you have? _____ Male _____ Female _____

Part Two: Health Extension Workers working conditions

8. Were you the resident of this Kebele before you became HEW?
- A/ Yes B/ No
9. Who selected you for training? A/ Woreda Health Office
- B/ Kebele council
- C/ Community through Direct Participation
- D/ If other, Specify_____
10. What was your educational level when you were recruited for the post? _____.
- A/ Below Grade 10 B/ Grade 10 complete
- C/ Grade 12 complete D/ Grade 10+ 1 Certificate E/ Other_____
11. What is your current educational level?
- A/ Grade 10+1 B/ Grade 10+2
- C/ Grade 10+3 D/ Other_____
12. Do you have means of transport to go to the health center or Woreda Health Office?
- A/ Yes B/ No
13. On average how long does it take from your HP to the Woreda Health Office?
- _____ Hours

14. Do you get your salary on time? A/ Yes B/ No

14.1 Is your salary sufficient? A/ Yes B/ No

14.2. If you say No for Q15.1, what do you suggest?

15. What other benefit you get other than your salary?

16. Do you have detailed description of your duties and responsibilities or job description?

A/ Yes _____ B/ No _____

16.1. If you say No for Q17, how you do you perform your job?

17. Have you received refresher course about health extension packages?

A/ Yes _____ B/ No _____

17.1 If you say Yes for Q17, do you think the refresher courses are sufficient?

A/ Yes _____ B/ No _____

17.2. If you say No for Q17.1, why do you think there are no refreshment courses?

18. Do you have any reference materials to refer to?

A/ Yes _____ B/ No _____

18.1 If you say Yes for Q19, do you think the references are sufficient and relevant?

A/ Yes _____ B/ No _____

18.2 If you say No for Q20, what do you do for issues that require referring?

19. Do you have reporting systems?

A/ Yes _____ B/ No _____

19.1 If your answer is Yes, do you get feedback timely for your report?

A/ Yes _____ B/ No _____

19.2 If you say No how your work is evaluated?

20. Do you have referral system? If your answer is yes, continue to Q 23 or skip to Q 24

A/ Yes _____ B/ No _____

21. Do you get feedback for your referral?

A/ Yes _____ B/ No _____

22. Have you ever requested for transfer and/or promotion?

A/ Yes _____ B/ No _____

22.1 If you say Yes, what responses you get from Wereda Health Office?

22.2 If you say No why you did not ask?

23. Do you have a weekend leave in Saturday and Sunday?

A/ Yes _____ B/ No _____

24. Have you been supervised for the last 3 months?

A/ Yes _____ B/ No _____

24.1 If you say Yes, what is the frequency that you meet with your Supervisors?

A/ More than enough

B/ Quite enough

C/ Not enough

D/ I don't know

24.2 Do you think that the supervision is supportive?

26.2.1 Yes

26.2.2 No

24.3 If you say No in Q25.2, how you can explain the type of supervision?

Part Three: Health Post Status Review

25. Does the Health Post (HP) have a road?

A/ Yes

B/ No

26. What is the HP's source of water?

A/ Pipe water_____

B/ Spring water_____

C/ River _____

D/ Hand dug_____

E/ Bore hole

If other, specify_____

27. Is there a toilet room in your health post compound?

A/ Yes

B/ No

27.1 If you say No what do you think are the reasons?

28. Is there solid waste disposal pit in your HP compound?

A/ Yes

B/ No

28.1 If you say No what do you think are the reasons?

29. Are there hand-washing facilities after using toilet in your Health Post?

A/ Yes

B/ No

29.1) If you say No what do you think are the reasons?

30. Do you get office materials on time for the Health Post? (Tick your choice)

Item	Yes	No
Office Stationery		
Family planning Cards		
Folder		
Table and Chairs		
Bench		
Store Shelf		
Dry Battery		
Megaphone		
Stretcher		

30.1. If you say No what do you think are the reasons?

31. Have you got the following needed logistic supplies for your Health Post?

Item	Yes	No
Disposable syringe		
Contraceptives		
Condoms		
ORS		
Ergometrine Taps		
Blood Measurement Apparatus		
First Aid Materials		
Delivery Materials		
Alcohol and detergents		

31.1 If you say No what do you think are the reasons?

32. Does the HP have clear weekly and monthly activity plans?

A/ Yes

B/ No

33. Where do you reside?

A/ In the health post with my own house

B/ In the health Post

C/ In rent house

D/ In Sendafa town

E/ if other specify_____

Part Four: Health Extension Program Implementation

34. Were the achievements of the HP clearly and comparably documented against plans?

A/ Yes

B/ No

35. Are you started providing the Health Extension Packages in your Health Post?

35.1 If you say yes how effective you are in providing the packages?

35.2 If your answer is No, explain your reason why you failed to implement the packages of HEP?

36. Do you think that the knowledge and skills you get in one year training in TVET Centers is sufficient to provide health extension services effectively?

A/ Yes

B/ No

36.1) If your answer is No, what should be done to fill the gap?

37) How do you explain the achievements of HEP in your Kebele?

38) What are challenges did you face while implementing the health extension packages?

39) What can you recommend as the solutions to overcome the challenges of the program in your Kebele?

40) Are there any other issues that you need to raise about the program progress, achievements, challenges in your Kebele?

I really appreciate your very interactive participation in filling this questionnaire on behalf of the community and myself.

Annex Three

**Interview Schedule prepared to investigate the
Challenges of Health Extension Program
Implementation in Berek Woreda of Oromiya
Region**

To be filled by Household Beneficiaries

Prepared by: Tewodros Mekonnen

Informed Consent

The interview schedule is prepared in order to gather information from responsible sources like you and the Health Extension Workers that serve you. It deals with the services that you get from the Health Post (HP). It also deals with the strengths that you have exhibited; the challenges that you identify and how you think the problems can be overcome. Such information is very crucial in that it enables the creation of a common understanding among all stakeholders regarding the real issues on the ground. It will help to strengthen the strong aspects, deal with weaknesses in a timely manner, understand the nature of the challenges, and suggest possible solutions which make the health services provision endeavor in your Kebele effective.

Even though this data collection is being done with the knowledge and permission of the Wereda Health Offices, I would also like to get your prior consent as to whether or not you are willing to participate. I hope that you are willing to share with us your experiences by participating in filling this interview schedule. I would like to assure you at this point that the information you give is confidential and it will only be compiled and organized along with that of your fellow household participants for academic purposes. No personal details will ever be released. Thus if you are willing to participate in the survey, please give your willingness. If you are not interested you can stop here.

Part One: Socio- demographic characteristics of respondents (applicable for Household beneficiaries)

Region _____ Zone _____ Wereda _____ Kebele _____

1. Age in year's _____ yrs

2. Sex A) Male _____ B) Female _____

3. What is your educational level?

A) Illiterate _____ B) Read and write _____

C) 1- 8 Grade _____ D) Grade 9-12 _____

E) 12+1 and above _____

If other, Specify _____

4. What is your religion? A) Christian _____ B) Muslim _____

If other, Specify _____

5. To which ethnic group do you belong?

A) Oromo B) Amhara C) Tigre

If other, specify _____

6. The language you can speak?

A) Afan Oromo B) Amharic

C) Tigrigna D) English

If other, specify _____

7. What is your current marital status?

A) Single B) Married
C) Separated D) Divorced E) Widowed

8. Your Household/family size. _____ Male _____ Female _____

9. Family members you support Male _____ Female _____

10. What is your job (work) currently?

A) Farmer B) House wife C) Local alcohol seller
D) Trader E) Student F) Government employee

If other, specify _____

Part Two: Living Condition of the Respondent

11. Are you born in Berek Woreda? A) Yes _____ B) No _____

12. For how long have you lived in this Kebele? _____ (in years)

13. What is your usual source of drinking water?

A) Pipe water _____ B) Spring water _____

C) River _____ D) Hand dug _____ E) Bore hole

If other, specify _____

- 14 Do you have pit latrine in your home? (Check if available)
 A) Yes_____ B) No_____
15. If Yes for Q14, who advise you to construct pit latrine?
 A) Health extension worker B) My friends
 C) No one because I know the advantage D) If other, specify_____
16. Is there solid waste disposal pit in your compound? (Check if available)
 A) Yes B) No
17. If yes, who advise you to construct pit latrine?
 A) Health extension worker B) My friends
 C) No one because I know the advantage D) If other, specify_____

Part Three: Community perception about Health Extension Workers in service provision

18. Is there a Health Post in your Kebele?
 A) Yes _____ B) No_____
19. If Yes for Q18, who is working in the Health Post?
 A) Health extension worker B) Nurse
 C) Doctors D) Others
20. Do you know from where the Health Extension Worker in your Kebele is selected?
 A) From the same Kebele
 B) From other Kebele
 C) I don't know
21. Which sex do you prefer to have as a Health Extension Worker?
 A) Male B) Female C) Both
- 22 Where do Health Extension Worker reside?
 A) In the same Kebele B) In Sendafa
 C) I do not know
23. Did the Health Extension Worker visit your family members for the last 2 month?
 A) Yes_____ B) No_____
- 23.1) If you say Yes for Q23, what type of health issue do you discuss with Health Extension Worker?

23.2) If you say No for Q23, do you know the reason why she didn't visit you?

24. Have you received any health service from Health Extension Worker in the last two month?

A) Yes _____

B) No _____

24.1 If you say Yes for Q24, how much you have satisfied in the service provision?

24.2 If you say No for Q24, do you have any reason why you were not visited?

25. Is there any family member or neighbor who gave birth during the past 6 month?

A) Yes _____

B) No _____

26. If you say Yes for Q25, where did she deliver the child?

A) At home with no medical personnel B) At home assisted by health extension worker

C) At health post

D) At health center

If other place specify _____

Part Four: Review of Health Extension Program Implementation

27. What are the health services that the health post in your Kebele is giving? (Tick your choice)

Type of health Services	A	B
1. Hygiene & Environmental Health		
1.1 Excreta disposal	Yes	No
1.2 Solid & liquid waste disposal	Yes	No
1.3 Water supply and safety measures	Yes	No
1.4 Food hygiene and safety measures	Yes	No
1.5 Healthy home environment	Yes	No
1.6 Control of insects and rodents	Yes	No
1.7 Personal hygiene	Yes	No
2 Family Health		
2.1 Maternal and child health	Yes	No
2.2 Family planning	Yes	No
2.3 Immunization	Yes	No
2.4 Nutrition	Yes	No
2.5 Adolescent reproductive health	Yes	No
2.6 Health related harmful traditional practices	Yes	No
3 Disease Prevention and Control		
3.1 HIV/AIDS & TB prevention & control	Yes	No
3.2 Malaria prevention and control	Yes	No
3.3 First aid emergency measures	Yes	No
4. Health Education and Communication	Yes	No

28. How did you come to know about the aforementioned health services?

A) By the Health Extension Worker during a visit

B) I heard about it when we went to the HPs seeking for services

C) Friends who heard about it

D) Community members who heard about it

E) Health Extension Worker in a meeting we held

If some other ways you heard, specify _____

29. Are you satisfied with the service of the health extension worker?

A) Yes _____

B) No _____

C) Medium

30. What challenges you face when you need to get services at the health post?

31. What has been done by the Health Extension Workers to keep the water that you use clean?

32. What were you trying to do when getting sick before the Health Post in your locality started working?

33. Which of the health problems that were prevailing most in the days before the Health Post started service?

34. From what you recall, which of the health problems do you think have improved since the Health Post started giving services in your locality?

33.1 If no improvement is observed tick in the space provided _____

35. What were the similarities and differences between your expectations before the Health Post started providing services and after you observed the types of services?

36. In your opinion, how helpful is the service at the Health Post in reducing the burden of health problems in the community?

37. What do you think are the challenges of health extension program in your Kebele?

38. What would you suggest to improve the current health service of the Health Post?

39. What do you think the community should do in order to improve the services delivered by the health post in your Kebele?

40. What advice you provide for the health extension workers in order to promote a better relationship with the community?

Are there any other issues that you need to raise about the Health Extension Service in your Kebele?

I really appreciate your very interactive participation in filling this questionnaire on behalf of the community and myself.

Annex Four

Interview Guiding Questions for Berek Wereda Health Office Head

1. How long have you served in your current assignment?
2. How many Health Extension Workers are there and what is their distribution in your Wereda?
3. How do you explain the management and Stakeholders of the Health Extension program in your Wereda?
4. How do you explain the institutional and administrative arrangement of Health Extension Program in your Wereda?
5. What supports does the Wereda Health Office gets in the management and governance of the program from Zonal and Regional Health Offices?
6. What does the Wereda Health Office contribute to the achievements of the Health Posts in Berek Wereda?
7. What are the factors that may affect the achievements of the Health Posts?
8. What does the Wereda Health Office has planned to do for the improve the performances of Health Posts?
9. What do you think are the challenges of Health Extension Program implementation in your Woreda?
 - 9.1 Institutional Challenges
 - 9.2 Administrative Challenges
 - 9.3 Financial Challenges
 - 9.4 Physical Challenges
 - 9.5 Material and Logistic Challenges
 - 9.6 Other related Challenges
10. What would you suggest to improve the current Health Extension Services in Berek Wereda?
11. What do you think the community should do in order to improve the Health Extension Services in your Wereda?
12. What advice you provide for the Health Extension Workers in order to promote a better relationship with the community and make the services at health post better?

I really appreciate your very interactive participation in filling this questionnaire on behalf of the community and myself.

Interview Guiding Questions for Berek Wereda Health Extension Program (HEP) Coordinator

1. How long have you served in your current assignment?
2. How many Health Extension Program HEP supervisors are there in your Woreda Health Office?
3. How frequently do you visit each Health Post?
4. What do you use as the basis for your plan before going to the Health Posts to undertake n supervision?
5. What are the major activities that you do during supervision visits?
6. What Health Extension Packages are being performed in the Health Posts found in your Wereda?
7. How do you explain the management of the Health Extension program in your Woreda?
8. What did the Wereda Health Office contribute to the achievements of the Health Posts?
9. What are the factors that may affect the achievements of the Health Posts in berek Woreda?
10. What does the Woreda Health Office do to improve the performances of Health Posts in the Woreda?
11. How improved is the health of the community currently as compared with the time when the HPs did not provide services?
12. What training did you have that enabled you undertake supervisory responsibilities?
13. What do you think are the challenges of Health Extension Program implementation in your Woreda?
14. What would you suggest to improve the current Health Extension Services in your Woreda?

I really appreciate your very interactive participation in filling this questionnaire on behalf of the community and myself.