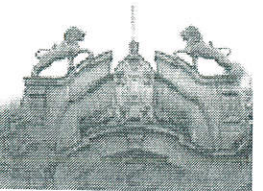
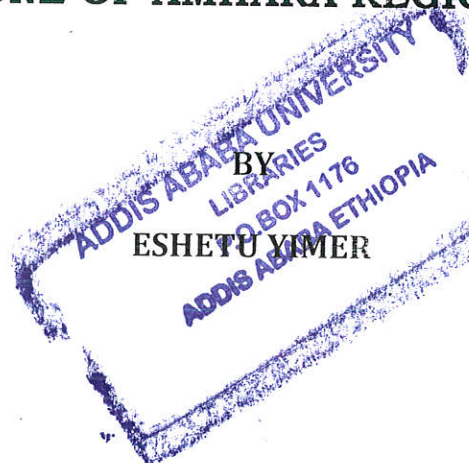


Addis Ababa
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ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES

**AN ASSESSMENT OF THE IMPLEMENTATION OF HEALTH
EXTENSION PROGRAM IN SELECTED WOREDAS OF SOUTH
WOLLO ZONE OF AMHARA REGIONAL STATE**



**THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA
UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF ARTS IN ADULT AND LIFE LONG LEARNING.**

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**DEPARTMENT OF CURRICULUM AND TEACHERS PROFESSIONAL
DEVELOPMENT STUDIES (ADULT AND LIFE LONG LEARNING)**

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STATE**

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Acronyms and Abbreviations

ADLI	Agricultural Development-lead Industrialization
CNHDE	Central for National Health Development in Ethiopia
CSA	Central Statistic Agency
ESHE	Ethiopian Essential Service for Health Project
HEP	Health Extension Program
HEW	Health Extension Workers
HSDP I	Health Sector Development Program I
HSDP II	Health Sector Development Program II
MDGs	Millennium Development Goals
MoE	Ministry of Education
PASDEP	Poverty Alleviation Sustainable Development Program
PHC	Primary Health Care
RDPS	Rural Development Policies and Strategies
TGE	Transitional Government of Ethiopia

Abstract

The purpose of the study was to assess the implementation of health extension program in the South Wollo Zone of the Amhara regional state. To accomplish this purpose, the study employed a descriptive survey method, which is supplemented by qualitative research methods to enrich the data. With this respect, household models, health extension workers, zonal and woreda health extension experts were sources of data in the study. The data gathering instruments included questionnaires interviews, focus group discussion and documental analysis. Data obtained through questionnaires were quantitatively described and interpreted in light of available literature where the information obtained through interview were qualitatively described to supplement the quantitative data. The result of the study reveal that model households participated in health-extension training through the organizers of model house holds were health extension workers and kebele administrator, model households agreed on the criterion for selecting only female health extension agents in their kebeles and neighboring kebeles, model households are giving training during coffee ceremony, in development work and in large community meetings to the other households. Further more, the study revealed that: lack of trained supervisor personnel, lack of support or incentives, lack of career growth and continuing education to health extension workers and lack of clearly defined job description to the supervisor personnel hinder proper implementation of health extension program in the study area. Finally, recommendations are made based on the results of the study. The point of recommendations include: Timely response to social and psychological need of health extension worker such as arrangement of upgrading program based on their performance and year service can decrease dropout rate. Regular supportive supervision and follow up of health extension workers will increase the motivation of health extension workers and facilitates the provision of quality services.

CHAPTER ONE

Introduction

1.1 Background of the Study

Education and training contribute to an individual's personal development, increased productivity and income, and, to facilitate every day's participation in economic and social life. According to UNESCO (2002), education and training can help individuals escape poverty by providing them with the skill and knowledge to rise their behavioral change and make the right decisions for solving their problems on their own free will and effort.

Therefore, unless the education and training needs of all young people and adults are met through equitable access to appropriate learning and life skill programs, it is apparent that the difference among individuals as well as group of people and societies will continue. But it is impossible to ensure the education and training needs of all individuals only with in the formal system. People who have not been able to benefit from formal education and training must be given opportunities to acquire skills and knowledge within non-formal adult education framework (UNESCO, 2003).

Of course, as Fordham (1993) noted, non-formal adult education and training emerged from the inability of formal education system to provide an access to a great majority of the people. It is organized as a result of the inefficiency of the formal education system in terms of its access and failures to provide the necessary skills and to enable the learners participate in socio-economic development of society.

In the past, emphasis was given to literacy as a strategy for alleviating poverty. However, in recent years it is affirmed that poverty alleviation can also be approached through the use of adult education programmes, especially those that will provide skills with which people can earn a living or improve their conditions (Akinpelu, 2002). The alternatives include continuing education and

continuing professional education such as Agricultural and Health Extension Education.

In Ethiopia, since 1991 the government is undergoing extensive changes. Based on the underlying political philosophy of federalism, the education and training policy which was launched in 1994 is being implemented.

The policy states that, non-formal forms of adult education will concentrate both on basic literacy and occupational skills which will be given parallel to the formal schooling (TGE,1994). The policy has adopted a new direction of rural centered development on the basis of decentralization. The policy's sub-article 2,3,6 states that non-formal forms of adult education deals with literacy, numeracy, environmental, agricultural, crafts, health and civic education. In accordance with the new economic policy, the focus on agricultural-led-industrializations and health extension programs reflect the need to pay equal attention to need based rural community farming and health training.

The Poverty Alleviation and Sustainable Development Program (PASDEP) on its part will serve as a means to refocus activities and resources towards reducing the level of poverty by making health services accessible to the poor and vulnerable population. The importance of particular policies and strategies to support the rural population, and the agricultural sector as an essential part of this, cannot be under estimated in a country where 85% of the population live in rural areas and 51% of GNP is derived from agricultural sector. In this respect, both the rural development policies and strategies (RDPs) issued in 2001 and the Agricultural Development-led Industrialization (ADLI) policies developed in 1994 are strategic importance for health sector development (MOFED; 2002).

According to Health Sector Development Program II (2003), RDPs outlines various policy directions related to health, emphasizing health both as a human right, and as playing a key role in building the capacity of the population to contribute all over development, and stressing primary health care.

ADLI also emphasizes primary health care and environmental health, the need for intersect oral collaboration and decentralized management as a strategy to increased agricultural production. The PASDEP, regards education as one of the key of achieving its goals. That is why, it consider non-formal adult education for out-of-school children at primary school age. Literacy program for youth and adult above 15 years of age and providing skill training for youth and adults (MOFED, 2003:1)

As adult learning in health sector, Ethiopia had adopted Primary Health Care as the national strategy to achieve equitable access to health services by all people of the country as early as 1970's. The past regime gave emphasis on primary health care, rural health services, prevention and control of common diseases, self-reliance and community participation as a policy direction in 1976. Later on, the government endorsed the Health For All (HFA) target and PHC strategy in 1978. However, this approach did not sustain mainly due to inconsistent, insufficient supervision and in-service training and the adult education program in Ethiopia was emphasizing reading and writing rather than primary health care training as well as the top-down nature of the implementation (Habtamu, 2007).

Following the health policy of 1993, the health sector undergone many reforms. In this aspect, the decentralization has particularly given the opportunity for the district level (woreda) management of health services (TGE, 1993).

Currently Ethiopia is implementing a 20 year Health Sector Development Program (HSDP) to be implemented in phase. Review of the first HSDP (1997/98-2001/2002) indicated the challenges in achieving universal coverage of PHC and revealed that the necessary basic health services did not reach the people at the grass roots level as envisaged and desired due to the nature of the services given by the health system.

In response to this government has introduced an innovative adult education program called Health Extension Program (HEP) and its started implementation

during the 2nd HSDP (2002/3-2004/05). The HEP is an innovative community based program that aim to create healthy environment and health full living by making available essential health services at the grass root levels, primarily focusing on preventive and promotive aspect. The modalities for HSEP implementation include an outreach program run by female health extension workers, two per kebele surveying 5000 people (HSDPII, 2003).

The implementation of Health Extension Program involves deployment at each village (Kebele) of two salaried female health extension workers who are trained for a year at Technical and Vocational Training and Education Centers (MOE, 2003). Besides addressing the whole public the HEW are expected to select model households and work with them. These are the families considered to be innovative and ready to change and influential community members. The HEW gives trainings on the packages for up to 60 members and let them graduate when they are convinced and well informed of the interventions. The graduates are expected to demonstrate practical changes in the use of health programs, environmental and personal hygiene and serve as models to others. This is expected to expand gradually until it covers the whole kebele.

In addition to the family packages, the HEW also run house to house visit and deal with individuals to give training, make demonstrations and educate families particularly mothers with regard to harmful traditional practices (MOH; 2003).

Based on the decentralized nature of preventive primary health care, in 2004 Amhara regional state in general, south Wollo zone in particular has implemented health extension program within 350 health posts and 300 health extension workers in the rural kebeles.

As part of adult education, it is expected that there are many factors that determine the successful implementation of the HEP. Although there are appreciations to this innovative program, there is no systematic and organized study with regard to the effectiveness of the implementation of the program.

Thus, it is relevant to undertake a study on the challenges and opportunities of the implementation of health extension program for further policy intervention.

1.2 Statement of the Problem

According to HSDP II (2003), Ethiopia is located in the Horn of Africa and has a total area of about 1.1 million square kilometers. It is one of the most populous countries in sub-Saharan Africa: More than 85% of the people live in rural areas. The average population density is 52.2 per square km with great variation among regions. The annual total population growth rate is 2.9%. While that of the urban population is 4.1%. The country is one of the least developed countries in the world with an estimated of USD 6.4 billion giving a per capital income of USD 100. Poverty is persistent with 47% of the population estimated to live below the poverty line (MOH, 2007). The country has a worrisome health situation. Most of the health problems are associated with infectious diseases and nutritional deficiencies amenable to preventive measures. Issues such as wide spread poverty, low education levels, inadequate water, poor sanitation facilities and health services contribute to the ill health situation (World Bank; 2007).

Among others, it is recommended that the provision of the various forms of adult education such as agricultural extension, health education, and etc. For such poor rural people can lead to the improvement of their livelihood and it could help them to know how to improve their environmental situation. It also contributes to the development of healthful living among the society. In this way, it can be claimed that it also plays an important role in poverty alleviation (Duke; 1988).

Since 1970's Ethiopia had adopted primarily health care program to the rural community as a national strategy to achieve equitable access to health services. But the program did not achieve its desired objectives because; this adult education program in Ethiopia has mainly emphasized reading and writing without being linked with relevant community development activities. Since

people were not able to sense its importance practically, they were not interested to fully participate in programs offered. The program also lacked coordination and feedback (MOH; 2007). To this effect, it is difficult to find full recorded reports on the number, age and sex of participants in the program and also its impact on the socio-economic development of the country. The other factor which did not allow effective implementation of the PHC was related to the structure of the minister of health itself. The structure was limited to central and regional level and maintained vertical program with no management structure at district level and below (Habtamu; 2007).

As a means of achieving the goals of the health policy, the government has formulated a twenty-year health sector development strategy, which is being implemented through a series of five year plan. In 2003, the Federal Ministry of Health launched a new health care plan, the “Accelerated Expansion of Primary Care Coverage”, through a comprehensive Health Extension Program which designed in align with the wider policy framework such as PASDEP and MDGS (HSDP; 2003).

• According to MOH (2005) the objective of health extension program is to increase awareness, knowledge, and skill among community members so that communities are empowered to take care of their own health through

- Promoting health life style
- Availing basic health care services
- Promoting equity in health care delivery
- Improving quality of health care
- Promoting gender empowerment

Health extension approach follows the basic principles of primary health care that underlines accessibility, community participation, decentralization, equity, health promotion, disease presentation and political commitment in order to bring a remarkable change in the health care delivery system. Health extension is a basic shift of methodology and adoption of attitudes towards removing the

top-down and non participatory approach to a participative and bottom-up way of planning health development schemes (MOH, 2005).

For the formulation and implementation of the appropriate health and health-related policies and strategies, political commitment is crucial and necessary at various levels. Besides the commitment of the central government, commitment of the local government is extremely important for the implementation of the health extension strategy. This local commitment will have a strong impact on health service. The presence of this commitment is a supportive environment, which is necessary for a successful implementation of health extension program. The political and financial commitment for the successful implementation of health extension package at all levels will be an induction or reflection of the accountability of the politicians and policy makers for health and welfare of the people. The implementation and realization of decentralized and democratized health care delivery system in this country is a yardstick for the success of all development endeavors in the country (HSDP II, 2003).

Through the decentralization natures of the program, Amhara Regional State has launched its implementations to the various woredas and kebeles. Over all there are appreciations to the program in the region, however there are no such organized and systematic assessments of the implementation of HEP at a local level.

Therefore, it is pertinent to undertake an assessment of the program implementation. Besides to this, identifying factors that influence the implementation of the program would help for better policy interventions; thereby the program will address its designed objectives.

This raises the following research question.

1. How is the involvement of households on extension health training and implementation?
2. Does the extension program incorporate different method of adult learning?

3. What are the major challenges and opportunities that negatively and positively influence the implementation of the health extension programs package?
4. What are the perception of the household towards the health extension workers and the service they provide?
5. What are the major administrative activities to the successful implementation of the program?
6. What does the prospect of the health extension look like?

1.3 Objectives of the Study

The general objectives of the study: is to assess the implementation of health extension program practices.

The specific objectives of the study:

1. Identifying the challenges and opportunities of the implementations of health extension program in South Wollo zone.
2. To identify the methods of health extension training program.
3. To examine the perception of households towards health extension worker and the service they provide.
4. To identify the administrative activities to the successful implementation of the program.

1.4 Significance of the Study

The health extension sector is given particular emphasis for the overall future transformation of the national health development. One of the factors for its success is the sustainable prevention of health action and increased health awareness.

Hence, the researcher believes that this study could have the following significances.

1. It may help the health extension program practitioners and policy makers to understand the status of implementation of health extension program in the region in general and in the zone in particular.
2. The woreda /kebele/ may benefit from the findings of the study for it can identify the strength and weakness of the implemented health extension program
3. The outcomes of the study may contribute some ideas to the field of health extension as a country experience.
4. It can help other researchers as stepping stone for investigating health extension program related issues

1.5 Delimitations of the Study

The study is aimed at assessing the implementation of health extension program as adult learning and its hindering factors in detail. To make the study manageable, geographically it is delimited only to six rural kebele in three woredas of south Wollo zone of the region, where the researcher has wide work experience in the zone.

1.6 Limitations of the Study

In conducting this study, the researcher has faced the following problems, which contributed to the limitation of the study.

1. Shortage of reference materials, especially on health extension program of the rural people in international context.
2. Lack of transportation to some rural health post was also another limitation that obliged the researcher to travel on foot. Thus, all these may have some effect on the result of the study.

1.7. Definition of Key Terms

Packages- A set of content and activities that the health extension implementation contains, and, to bring about health behavioral change.

Health Extension Program- A program designed to achieve significant health care coverage in Ethiopia targeting household

Health Extension Workers- Workers are teachers/facilitators trained for one year predominantly about prevention and promotive health services to be assigned in health post at kebele level.

Model Household- are representatives of the community, who get a health extension training about prevention and promotive health service and they are community health workers.

Participation is a process during which individuals, groups and organization are given the opportunity to become actively involved in the program development, implementation and evaluation (Nyerere, 1974).

CHAPTER TWO

2 Review of Related Literature

2.1 Adult Education Concept, Principle, Purpose, and Type

2.1.1 Concepts of Adult Education

The concept of adult education has been defined in different ways and according to the different perspectives of various scholars. The report of the first international congress of a university Adult Education (1969:50) defined adult education as:

“A process where by persons who no longer attend school on a regular and full-time bases. Under take sequential and organized ctivities in information, knowledge, undertaking or skills, appreciation and attitudes or for the purpose of identifying and solving personal or community problem.”

Darkenwald and Merriam (1982:9) as well define the concept of adult education as:

A process of where by persons whose major social roles are characteristics of adult status under take systematic and sustain learning activities for the purpose of bringing about change in knowledge, attitude, values or skill.

A review of these early definition, as well as more recent definitions proposed by authors such as Marsiam and Caffarella (1999), Wilson and Hayes (2000), and Caffarella (2002), suggests that the overall purpose of adult education is to help individual become knowledgeable, skilled and dedicated citizens who are willing to work individually and collectively, towards achieving and maintaining an improved quality of life.

The concept of adult learning articulated by UNESCO (2002) is a broad one embracing **formal**, **non formal** and **informal** learning processes in all areas of people’s lives.

In the developing world adult education is very clearly linked with social and economic goals, and promoting social and economic change. Therefore it has

collective and communal rather than individual implications usually linked with income generation and other profits_ food and fuel supplies, basic political rights and literacy (Nyerere, 1976).

The development process is in fact an educational process, or rather it should unfailingly be viewed as such, we cannot therefore conceive of development in the absence of education any more than in the absence of development (Fanduez, 1988).

Many case studies illustrate how crucial development goals to do with health, nutrition, or economic progresses can be achieved when people are encouraged to identify their own needs, concerns and priorities and translate them into learning objectivities.

In line with the above preamble the Ethiopian government has taken an adult education as one important way to strengthen the human resource bases by providing the people with powerful tools literacy and livelihood. Accordingly, a national adult education strategy is established to lay down strategic guidelines and implementation framework for the development of adult education to contribute more development and ending poverty in Ethiopia.

Opportunities for the learning are availed by a wider variety of providers. The state has a central responsibility to promote and facilitate adult learning. In some countries this responsibility has been diminished by the impact of structural adjustment polices. But in others, the state continuous to pay an important with a wide range of government departments that involves adult learning. These programs are multi-sect oral, including activities as varied as agricultural extension, health extension, business training, consumer education, community development and wildlife education.

2.1.2 Principles of Adult Education

There are six principles which are based on the psychological definition of what it means to be an adult. As adults, self direction and responsibility are

necessities. In contemporary African society in general and Ethiopian society in particular, the following principles of adult learning are especially meaningful.

Adults need to know why

Knowles, Holton and Swanson (1998:64-68) noted that adults need to know why they need to learn something before they will take the time to learn it. The need to know could include the benefits to be gained from knowledge acquired or from skills learnt, and any negative effects for not learning new skills or not enrolling in specific learning programs. As Knowles, Holton and Swanson (1998:64) stated that if adult learners can discover the gap between where they are now and where they want to be, they will become more conscious of their "need to know" new knowledge and skills.

Responsibility for Decisions Taken

As an adult, the individual's tendency is to always depend on his or her established identity. Adults have a need to be seen by others as being capable of directing themselves. When adults realize others are imposing ideas on them. They may withdraw by not returning to class or they may voice their concerns to the teacher. Therefore when planning for adult learning, efforts must be made to create experiences for adults where they can go from being dependent to independent or self directed learners (Knowles, Holton and Swanson, 1998:65).

Learners Experiences

Linedman (1989), emphasized, the value of the learners experience with regard to adult education, observing that the approach to teaching adults should be through situation rather than subjects. He noted that experience is the adult learners' living text book.

In addition to this, Knowles and Holton (1998:26), stated that adult learners bring to the classroom a diversified range of individual differences related to their experiences, interests, backgrounds, goals and learning styles. The best way to manage the differences between adult learners is by creating activities

that tap into the adult experience, such as group discussions, problem solving activities and simulations. When we apply this principle to Ethiopian situation it needs to be critically examined.

Coping with Real Life

This is applicable to many adult learning situations. The main issue in this principle is not one of age or maturity but what is conducive to effective teaching. Also, the focus on immediate application of skills learnt may not be true with regard to adult literacy classes.

Real Life Application

Knowles (1984) suggests that this means that when designing a curriculum for adult learners, courses should be organized around the acquisition of skills necessary for one to earn a living. These skills may be computer skills, farming skills, health and business skills.

Motivation to Learn

Knowles, Holton and Swanson (1998:68) have stated that even though adults can be motivated by external factors (such as higher salaries, promotion and better jobs in the future) they are more motivated to learn by internal pressure, such as the desire for increased job satisfaction, self-esteem and quality of life issues

According to Gboku and Lekoko (2007), besides the internal pressures, adults in Africa are motivated to enroll in adult education programmes in professional areas as well, including education, health, law and agriculture.

2.1.3 Purposes of Adult Education

All over the world, two general purposes of adult education, namely individual improvement and societal development, as identified by Lindeman (1989), have remained central to the field of adult education. Merriam and Brockett (1997: 17-18), while quoting Lindeman, noted that

Adult education will become an agency of progress if its short-term goal of self improvement can be made compatible with a long term, experiential but resolute policy of changing the social order. Changing individuals in continuing adjustment to social functions- this is the bilateral though unified purpose of adult education.

Knowles (1980), on the other hand, writes that the mission of adult education is one of satisfying the needs of individuals, institutions and society. Adult educators have the responsibility of helping individuals satisfy their needs and achieve their goals. Although institutions that offers adult education programs have a need to improve their ability to operate effectively and establish public understanding and involvement.

2.1.4 The Role of Adult Education to Eradicate Poverty and Accelerate Development in Ethiopia

The national adult education strategy document MOE (2008) clearly explains how adult education could contribute to the elements of Ethiopia's PASDEP. This is a summary of explanation for each element:

- **Massive push to accelerate growth** - Evaluation has shown that participants in adult education, especially FAL, develop more modern attitudes and skills in agriculture, health and other aspect of life.
- **Geographically differentiated strategy** _ adult education promotes flexibility which is important for adopting and fulfilling the differentiated strategy.
- **Addressing the population Change** _ adult education enables people to reflect critically and take informed decisions on their reproductive health, especially on when and how often to have children.
- **Unleashing the potential of Ethiopian's women**_ adult education programs usually attract more women and thus enable them to increase their responsiveness to government life _ improving intervention and make more inputs for their family's livelihoods.

- **Strengthening the infrastructure backbone** _ adult education develops understanding and skills for appreciation, proper use and maintenance of infrastructure.
- **Managing risk and volatility** _ adult education can provide flexibility and skills to facilitate diversification of agriculture and off- farm income sources to reduce the impact of draught and increase the range of crops that can be grown
- **Scaling up to reach the MDGs** _ adult education can contribute by strengthening the skills and by raising awareness on health and education.
- **Creating jobs**_ adult education, in particular FAL, emphasizes developing skills to enable people employ themselves more profitable in addition to training for employability by others.

2.1.5 Types of Adult Education Programs

From the various definitions of adult education, it is generally accepted that effective adult education programs enable people to develop new knowledge, attitude and behaviors that will help to sustain improved quality of life for individual adults, groups, communities and society at large. In this regard, a program can be viewed a variety of activities designed to bring about the desired behavior change in adult learners.

Ehiametator and Oduaran (1991:7) identifying a number of programs in adult education, each with its won curriculum and objectives. The programs include

1. Adult basic education, including basic literacy functional literacy and innumeracy;
2. Out school youth programs;
3. Income generating programs.
4. Extension programs, including agricultural extensions, community health extension,

5. Training and re-training programs, including vocational/technical training, workers education and labor relations
6. Civic education, including community development and political socialization

Therefore, health extension program is the part of this research which is going to be discussed in detailed.

The World Health Organization (1984) has defined health extension as enabling people to increase control over, and to improve, their health. The Ottawa charter for health extension called for a collective and cooperative, rather than individualistic approach to promote health (World Health Organization, 1986).

On the other hand, Labonte (1993) defines health extension as “any activity or program designed to improve social and environmental living conditions such that a person’s experience of well-being is increased.

2.2 Health Education and Behavior Models/Theories

Definition of Health Education

Simonds (1976) defined health education as aimed at bringing about behavioral changes in individuals, groups and larger populations from behaviors that are presumed to be detrimental to health, to behaviors that are conducive to present and future health. Moreover, Green (1991), defined health education as any combination of learning experiences designed to facilitate voluntary adoption of behavior conducive to health.

As a part of any planning model, it is necessary to attempt to classify and explain the multitude of factors which can, and do influence human behavior. Current models/theories that helps to explain human behavior, particularly as it relates to health education, can be classified on the basis of being directed at the level of: **individual (intrapersonal), interpersonal** and **community**, within these three categories, those models/theories that have tended to dominate in the health education field in the past 20-30 years (Glanz, Rime and et al 2002).

2.2.1 Individual (intrapersonal) health behavior models/theories

Stage of Change Model or Trans Theoretical Model

According to Prochaska and Diclemente (1982), behavioral change is viewed as a process, not an event, with individuals at various level of motivation or readiness to change or attempt to change, towards health behaviors. Since people are at different points in this process, planned interventions should match their stage. There are six stages that have been identified in the model:

- Pre contemplation : the person is unaware of the problem or has not though seriously about change
- Contemplation: the person is seriously thinking about change (in the near future)
- Preparation: the person is planning to take action and is making final adjustments before changing behavior.
- Action: the person implements some specific action plan to overtly modify behavior and surroundings
- Maintenance: the person continues with desirable action (reseating the predict recommended steps while struggling to prevent lapses and relapse.
- Termination: the person has Zero temptation and the ability to resist relapse

It is more of a spiral as the person may go through several cycles of contemplation, action, relapse (or recycle) before either reaching termination or existing the system without becoming free of the addictive behavior. Prochaska has used a “revolving-door schema” to explain the sequence that people pass through in their efforts to become free form addiction. People do not go through the states and graduate. They can enter and exit at any point and often recycle several times. Other studies indicate that individuals often go through these same changes whether they use self-help or self-management techniques, seek professional counseling organized programs.

Consumer Information Processing Model

According to Bettman and McGuire (1986), the consumer information processing (CIP) model developed out of the study of human problem solving and information processing. Information processing has been one of the dominant paradigms in social psychology for quite a while, even though CIP is still relatively new. This model was not developed specially for health related behavior, but it has many useful applications in the area of health education. Information is a necessary tool in health education. However, just as knowledge is necessary but not sufficient for behavior change, information is necessary but not sufficient for knowledge. There are limits to any person's information processing capacity. This is defined as the limitations upon individuals in the amount of information they can acquire, use and remember.

By understanding the key concepts and process of CIP, health educators can examine why people use or fail to use information, and then design information strategies that have better chances for success. The search for information is the process of acquiring and evaluating information. This process is affected the person's motivation, attention, and perception at that point in time. In general, consumers tend not to be engaging in extended information searches.

There are two central assumptions of CIP. First, individuals are limited to how much information they can process. Secondly, in order to increase the usability of information, individuals combine little pieces or bits of information into "chunks" and make decision rules to make choice faster and move easily.

This model has now been extended to consider that the information how environment affects how easily people obtain, processes and use information.

According to Bettman's (1986), there are some basic CIP concepts that can be applied to health education. Before people use health information, it must be: 1) available 2) seen as useful and new, and 3) process able or in a friendly format. It is necessary to choose the most important and useful points to communicate (either verbally or in print) and place this information first and/ or last in the

presentation in order to be remembered best. The information designed specially for the target population must be placed conveniently for their use.

Theory Reasoned Action

As suggested by Fishbein and Ajzen (1980), in this theory a person's intention to perform a specific behavior is a function of two factors:

1. Attitude (positive or negative) toward the behavior and,
2. The influence of social environment (general subjective norms) on the behavior.

The attitude toward the behavior is determined by the person's belief that a given outcome will occur if she/he performs the behavior and by an evaluation of the outcomes. The social or subjective, norm is determined by a person's normative belief about what important or "significant" others think he/she should do and by the individual motivation to comply with those other peoples' wishes or desire.

Attitudes are a function of beliefs in this theory. If a person believes that performing a given behavior will lead to on the whole positive outcomes, then he/she will hold a favorable attitude toward's performing those behavior subjective norms also a function of beliefs. However, these are beliefs of a different kind. These are the person's beliefs that certain individuals or groups think she/he should or should not perform the behavior. If the person believes that most of these significant others think she/he should perform the behavior, the social pressure to perform it will increase the more she/he is motivated to comply with these others. If she/he believes that most of this reference group is opposed to performing the behavior, her/his perception of the social pressure not to perform the behavior will increase along with her/his motivation to comply with these referents. The beliefs which underline a person's subjective norms are termed normative beliefs.

Social Learning Theory/Social Cognitive Theory

In social learning theory, human behavior is explained using a three-way reciprocal theory in which personal factors (one's cognitive process), behavior, and environmental influences continually interact in a process of reciprocal determinism or reciprocal causality. These are very dynamic relationships where the person can shape the environment as well as environment shaping the person. Change is bi-directional. According to this theory, reinforcement contributes to learning, but reinforcement along with individual's expectations of the consequence of behavior determines behavior. This type of approach has been referred to as "value-expectance theory"

As suggested by Rotters (1954), there are several constructs in social learning theory (SLT) which may be applicable learning situations in health education. Behavioral capability refers to the knowledge and skills necessary to do a behavior which influence actions. If individuals are to be able to perform specific behaviors, they must first know what the behaviors are and how to perform them. Therefore, clear instructions and/or training may be needed. Another construct is expectations, refers to the ability of human to think and, therefore, to expect certain results in certain situations. Expectations are the values that people place on an expected outcome. The more highly valued the expected outcomes, the more likely the person will perform the needed behavior to yield that outcome.

In addition to, Bandura (1997), considered self-efficiency the single most important aspect of the sense of self that determines one's effort to change behavior. A person can increase self-efficiency through: 1) personal mastery of a task: 2) observing the performance of others (vicarious experience): 3) verbal persuasion, such as receiving suggestion from others: and 4) arousal of her/his emotional state. In the construct of emotional coping responses, a person must be able to deal with any sources of anxiety surrounding that behavior in order to learn.

2.2.2 Interpersonal Health Behavior Theories

Social Networks/social support theories

Based on Israel (1982), most health educators today recognize the crucial importance of social environment and advocate changes in the social ecology which is supportive of individual change leading to better health and a higher quality of life. However, within the community, long term behavior change depends on the level of participation and ownership felt by those being served. In order to see how social networks and social support theories might impact on health needs, it is first necessary to define what is meant by certain concepts.

Social networks can be kin (extended family) or non-kin (church or work groups, friends or neighbors who regularly socialize, clubs and sporting teams), social network have certain types of characteristics:

1. Structural, such as size (number of people) and diversity (extent to which numbers really know one another)
2. Interact ional, which include mutual sharing, durability (length of time in relationship), intensity (frequency of interaction between members)
3. Functional, such as providing social support connections to social contacts and resources, and maintenance of social identity.

As suggested by House (1982), **social support** is the function content of relationships that can be categorized in the following four broad types of supportive behavior.

1. Emotional support, listening, showing trust and concern
2. Instrumental support, material aid.
3. Information support, providing advice, suggestion, directives, referrals, and
4. Appraisal support, affirming each other and giving feedback

2.2.3 Community level models/theory

Community Organization

Even though community organization does not use a single unified model, there are several key concepts that are central to its practice to bring about change on the community level. The first of these, empowerment, has been described as a process by which individuals and communities gain mastery over their lives by becoming enabled to take power and then to act effectively to transform or change their environments. Within community organization, this concept of empowerment operates on two levels at the same time. First, the individual who is involved in the community organizing effort may experience increased social support. This support may result in a more generalized sense of control. An increased sense of control (empowerment) could have positive benefits on one's health. On the second and broader level, community organization can contribute to community-level empowerment which leads to increased community competence. Community competence may be thought of as the equivalent of self-efficacy and behavioral capability on a community level; both the confidence and skills to solve problems effectively are present within the community. The health practitioner or community organizer could play a crucial role in helping communities increase their problem-solving ability.

Two principles which are important in community organization practice are the principle of participation and the principals of relevance. Dewey (1946) and Lindeman (1926) paid close attention to the principle of participation or "learn by doing" in their work within the field of adult education. Adult education was (and still is) considered a process of increasing people's understanding activating them, and helping them make decisions for themselves. This idea fits nicely with the community organization principle of gaining true involvement and participation by community members at each stage within the process. The principle of relevance was identified by Nyswander (1956) as one of "starting where the people are." The change agent who begins with the individual or

community's felt needs rather than a personal or agency plan will experience far more success than imposing an agenda from outside. It is widely acceptance that communities should identify their own needs and issues to be addressed. When an issue is chosen by the community, a sense of ownership emerges which leads to empowerment and the development of a competent community.

However, in the concept of issue selection one must differentiate between problems, which are troublesome, and issues, which are problems the community feels strongly. In addition, the selected issue should also be: 1) specific, 2) simple, and 3) winnable.

One of the most important concepts by Brazilian educator Paulo Freire (1973) was recently added to the model of community organization. In the concept of critical consciousness, Freire spoke of entering a dialogue with illiterate peasants so that they could teach themselves how to read and write as well as how to understand the root causes of their problems.

According to Friere, the educator's main role is to converse with the students about concrete situations and offer them the tools in order for the students to teach themselves to read and write. It is a collaborative effort. From this understanding, a person could rally learn to think critically about real-life problems and take action to change his/her own plan of action to deal with any problems collectively identified.

Diffusion of Innovations Theory

Diffusion of innovations Theory provides an explanation for how new ideas, products and social practice diffuse or spread within a society or from one society to another. Diffusion can be thought of as a special type of communication in which messages are concerned about a new idea, if a health education program is viewed as an innovation, this theory could describe the pattern the target population would follow in adopting the program (Rogers, 1983). Time is an important element in this diffusion process. Five adopter categories are used to classify members of a social system on the basis of their

innovation: 1) innovators (active information seekers of new ideas); 2) early adopters (very interested in the innovation but not the first to sign up); 3) early majority (need external motivation ' to get involved); 4) late majority (are skeptics and will not adopt an innovation until most people in the social system have done so); and 5) laggards (last to become involved by a mentoring program or through constant exposure and have limited communication networks).

Another aspect of time considers the rate of adoption, which is the speed in which an innovation is adopted by members of a social system. When the number of individuals adopting a new idea is plotted on cumulative number or percentage of adopters over time.

According to Fullan (1991), and Rogers (1995), there are certain characteristics which are associated with successful diffusion efforts. These attributes of innovations can help to explain the different rates of adoption of innovations by individuals. Some of these include: 1) Relative advantage. The level at which an innovation is perceived as better than the idea it attempts to replace; 2) Compatibility - the level at which an innovation is viewed as being consistent with the existing values, past experiences and needs of the potential adopters; 3) Complexity the level at which an innovation is viewed as difficult to use and understand; 4) Trial ability or Flexibility - the level at which an innovation can be experimented with on a limited or "ideal" basis; 5) Observe ability- the level at which the results of an innovation can be seen by others.

This process of diffusion of an innovation involves someone who has knowledge or experience with using the innovation, someone else who does not yet have knowledge of the innovation, and a communication channel between the two people. The communication channel is the means by which messages get from one individual another. Mass media channels are the most rapid and effective ways to create an awareness/knowledge about an innovation. These channels are mass media such as radio, television, newspapers, and magazines, where one source create-potentially reaches an, audience of many. In regards to improving health, when physicians and communities leaders act to reinforce

information that is also provided through mass media channels, there is a much better chance that consumers will decide to act. Interpersonal channels, which involve a face-to-face exchange between two or more people, are more effective in persuading an individual to adopt a new idea. The innovation decision process is a five-step procedure through which an individual passes. These steps include: 1) knowledge, 2) persuasion, 3) decision, 4) implementation, and 5) confirmation. The person has an awareness/knowledge of an innovation forms an attitude about it. Decides to accept or reject, implements the new idea, and confirms the decision.

Organizational Change Theories

Zimmerman (1994), organizations are complex and layered social systems. Change may be influenced at each of these levels. Health education strategies that are directed at several layers at once may be the most durable over time in producing the desired results. In terms of sociology, ecology refers to the study of human populations in terms of physical environment, spatial organization distribution, and cultural characteristics. Since organizations can be influenced at many levels in their ecology, no single theory can completely explain how and why organizations change. Among the many theories of organizational behavior, two have shown special promise in the area of public health: i) **Stage Theory** and ii) **Organizational Development**.

I. Stage Theory of Organizational Change

Lewin (1951), this theory helps to explain how organizations plan and implement new goals, programs, technologies and ideas. Organizations are believed to pass through a series of "stages" with each stage requiring a unique set of strategies if the innovation is to progress. A strategy that may be effective at one stage may be wrongly applied at the next. An innovation's current stage of development must be correctly assessed and the proper strategies select in order to be successful in the application stage theory.

Goodman and Smith (1991), one shortened version of Stage Theory, organizational change consists of four stages: 1) Awareness (Problems are recognized and analyzed, and solutions are suggested and evaluated); 2) Adoption (policies are formulated, and resources for beginning change(s) are allocated); 3) implementation (The innovation is implemented. Reactions take place, and changes in roles occur); 4) Institutionalization (The policy or program becomes an integral part of the organization, and new goals and values are a part of its structure). These stages are "in sequence." However, movement can be forward, backward, or abandoned at any point in the process.

It is also known that different actors may play leading roles at different stages of the organizational change. Senior-level administrators tend to be important at the awareness and early adoption stages. Mid-level administrators become important at the adoption and early implementation stages. Workers (e.g. teachers) are instrumental at the implementation stage. Finally, senior-level administrators again key role during the institutionalization stage.

II. Organizational development

Human relations and the quality of life at work are often the targets of Organizational Development Theory. According to Robertson (1987), it has been divided into two main sections 1) Change Process Theories and 2) implementation Theories. Change Process theories deal with the underlying dynamics of change. And these have not yet been integrated into an adequate explanation of the change process. On the other hand, implementation Theories are much better defined. These are the activities that health educators would use to make sure the change is successful. Under implementation, there are Procedure Theories which identify the sequence of actions needed for producing change in the organization. These four steps include: 1) Diagnosis - a specially trained person, usually an outside consultant, helps the organization identify its most striking problems which interfere with its functions; 2) Action Planning - strategies are developed for addressing these diagnosed problems; 3) Intervention - the consultant usually does not offer specific solutions but will

aid in problem solving among the organization's members in group interactions;
4) Evaluation - the effort of the planned changes is assessed, and these changes in the organization are allowed to settle.

Generally speaking, Stage Theory and Organizational Development Theories have the greatest potential for creating positive health changes in organizations when used together. One example would be using consultation (Organizational Development) as the intervention in both the adoption and institutional stages (Stage Theory) in an organizational change.

2.2.4 Review of Health Educational Communication Method in Ethiopia

Principles of Health Education in Ethiopia

MOH (2003) stated the following principles of health education

- Health education is not a one time affair. It is a continuing process based on planned and organized activities.
- It is planned to address different community members and not limited to a specific audience.
- It uses different communication methods as appropriate and not limited to a specific method only.
- Health education strategy from planning, implementation, and monitoring and evaluations stage involves active and full participation of the concerned audience; and not limited to program heads and administrative offices.
- It is given based on the objective reality of the area, culture, tradition, language and local resources.
- The program to be successful requires coordinated approach, full participation of different professionals and resources; and the community at large.

Places for Delivering Health Education

Health is the tool for enabling the community to identify the factors which have negative influence on their health; and helps them to solve these problems by their own initiatives and efforts. Today, health education can be found nearly every where. The setting are important because they provide channels for delivery programs, provide access to specific population and gate keeps usually have exiting communication system for diffusion of programs, and facility development of policies and organizational change to support positive health practices (Mullen, et al 1995)

To achieve the expected results, MOH (2003), stated that, health education delivery at different stages or places where people are in:-

Health Institution

Health institutions are ideal place for communicating health message and health program. Health institutions are convenient for giving health education to patients on person to person basis; proving counseling to their problem and having them to face their problem calmly and take action towards alleviating these problems. It is conducive place to give health education to health facility users, patients, care takers of patients, workers of health institutions and etc. it is also a place where there are different health professionals, who can assist in disseminating health message. Health posts are ideal pace for communicating health message.

Working Place

These places are large scale farming stations production and distribution, mining; service deliveries, animal breeding and fattening places etc. workers in these places due to lack of knowledge; level of health awareness, lack of appreciations for positive health behavior, or being subjected to harmful health behavior etc. are easily exposed to various health risks. Hence special attention

should be given to health risks. Hence special attention should be given to these places to deliver to continuous health education in order to reduce health risks among these productive segments of the population.

Living Areas and Villages

Different members of the household can be contacted in person, and can be given health education on critical health problems of the area. These are the places where the health extension workers are assumed to bring about health improvement and behavior change and consequently lead a healthy and productive life.

Religious Institutions and Traditional Social Meeting Place

These places, including churches, mosques, Idir are where we can contact people of different ages. They are good places for communicating health messages and therefore, health extension workers organize themselves and use opportunities.

2.4.5 Methods of Communicating Health Education

WHO (1988), Health education can be given to individuals, groups and variety of audience in different methods. Therefore, methods of communicating health education can be explaining, story telling, using posters, pictures, printed materials, electronic media (radio, TV), songs, music, drama, dialogue, films, exhibiting (during holidays) etc.

Person to Person (home-visit) communication method

This is the method of communication in which the health extension workers exchanges ideas and information with the community and individual around health development program. Person to person communication is useful in rural areas where mass media is not available.

The advantage of this method is that it enables the health extension worker visit house to house, sanitation facilities etc. This person to person communication method helps to create positive attitude for behavioral change.

Communicating health message through group discussion

According to WHO (1988), group discussion is a method in which health extension worker communicates in with two or more people. If communication is two-way it will increase participation and desire to receive the message. It will help for synthesizing knowledge, ideas and skills. It will create forum for learning and exchange experiences.

Better result is achieved in group discussion if the discussants are fewer in number. If the group is large the level of participation will be low. Therefore, the discussion should be organized in such a way as to enable full participation of all the group members. Group discussion helps for in-depth exchange of ideas and experience and enables to have better understanding of the group members. The health extension worker has the responsibility of leading, giving information, encouraging free discussion in order to achieve successful and common decision on the major topics discussed.

Method of communicating health message in a large meeting

This is a meeting in which the whole kebele, village and the area people participate. It is useful to communicate important health information message immediately.

Based on Ramach (1995), it is preferable if the meeting period lasts about 40 minutes, and if the presentation is assisted by visual aids the education topic to be communicated must take into account such things as suitability to the audience, matching to their level of education, to their experience and desire.

Traditional methods of communication message

Traditional method of communicating message such as: songs, anthems, poems, printing on cloth etc. are useful for communicating messages, exchanging experience in a motivating, recreating and informative ways, especially good for those who can not read or write to enable them to group

messages that needed to be communicated. However, this method is supported with other communication methods.

Communicating Messages through Demonstration

MOH (2003) demonstration is a teaching method in which the students are taught the basic concepts of what we want to teach in theory. After they have grasped the basic concept, then they are made to try on their own in practice. It is learning by doing. Teaching given through demonstration arouses the will and interest of the trainees; and what they learn this way is well understood and practiced later on. If the demonstration is not prepared well, the trainees will lose confidence and the expected result will not be achieved. Hence, demonstration should be based on the immediate needs of the trainees and must be carefully prepared. It can be used for teaching such things as preparing and feeding babies, building healthful housing, building sanitary latrine and usage, giving vaccination and etc....

Using role-play for message communication

In role play certain persons pay the role of another's character in a type of drama. The character or role-play is based on the objective reality which the audience known as very well. It is like real life. In role-play a script is not necessary. Through role play people can better understand the cause of certain problem in question and the solutions form the characters in the play.

Communicating message in the form of drama

Drama is a person, in which the subject matter or topic is studied either well written or in words, and then represented in educative and recreating manner. The preparation and presentation of drama should be based on objective reality and must take into consideration the culture and tradition. Drama should be prepared and presented in a recreating manner and at the same time informative and moving towards better positive behavior change.

Communicating message in the form of mass-media

This method consists of radio, television, written materials, newspapers, journals, films, pamphlets leaflets, brochures, booklets, posters, calendars, pictures and photos. They are useful for transmitting message and this can be done by health professional or other development worker during his/her oral presentation for better explanation. In order to achieve the objective of the program, the extension workers should understand the language and culture of the people.

2.2.6 Health Extension

Definitions of health extension: health extension is a term of more recent origin than health education. As defined by Green (1991), it is “any combination of health education and related organizational, economic and environmental support for behavior of individuals, groups, or communities conducive to health.

Moreover, MOH (2005) defined it as a community based essential health care delivery system to individuals and families in the community through their participation. It is also a promotive, preventive, and basic curative service targeting households particularly women and children. The service is delivered to each village by two ladies called Health Extension Workers (HEW) with support Voluntary Community Health Workers (VCHW).

Objectives of health extension package

As stated by MOH (2004), the health extension package is organized to improve access and equity to prevent diseases and promote essential intervention through community/kebele-based health services by enhancing community education/dialogue for sustainable preventive actions for active involvement/participation, empowerment, and ownership of the people to manage their own health issues. These objectives will be realized through promotion of behavior and making the environment conducive to health. Health is a basic right, which is also essential for social economic development (WHO;

1988). Therefore, the constitution of Federal Republic of Ethiopia confirms that all the citizens have the right to a clean and healthy environment [TGT, 1993].

The health extension package program needs to be carried out through participatory approach to ensure acceptance and sustainability. It is assumed that the targets of the educational activities will be the women, who shoulder the major responsibility for the health, hygiene and nutrition and care of the family (HSDP II, 2005). These essential packages are:

1. Hygiene and environmental sanitation

- Solid and liquid waste disposal, water quality control , Food hygiene and proper housing

2. Disease prevention and control

- HIV/AIDS and other STD prevention and control
- TB prevention and control
- Malaria prevention and control

3. Family health service

- Maternal and child health, family planning, immunization,
- Adolescent reproduction health
- Nutrition

Characteristics of Health Extension Workers

The targets of health education and communication and other preventive and promotive health service will be mostly mothers and children. The deployment of female health extension workers to community-based health extension has been adopted as preferable strategy. This time two female health extension workers are deployed in each rural kebele[HSDP II,2003].

A health extension workers is a health care provide, permanent government employee trained for one year in preventive and promotive health measures and who work with the community to address the health needs of the community. They should be trusted by, and identified with their community. Because, they

are chosen for this purpose to live and work in the community, they need to be accepted and accountable to the communities.

The role of health extension workers

Their basic role is to make health services more fully available to the community, achieve these objectives by performing.

- Linking communities with health resources and services
- Providing health information, mobilizing communities to determine health needs, to take greater responsibility for their health, advocating for appropriate health resources, services and actions.
- Raising awareness and increasing knowledge about disease prevention and health promotion and rendering first aid service.

Besides addressing the whole public the health extension worker are expected to select modern households and work with them.

According to MOH (2005) the selection of the native trainees is the privilege of the various organization and missions. Important criterions for choosing the trainees/community household are:

- lasting presence in the village
- Member of the community
- Recognition and acceptance by the village people
- Initiative, credible life style, able to learn and teach.
- Ability to read, write and speak the national language.
- Not resistant to change.

These are the families considered to be innovative, and are ready to change and influential committee members. The health extension worker give trainings on package for up to 60 members and graduate them when they are convinced and well informed of the interventions. The graduates are expected to demonstrate practically change in the use of health program environmental and personal hygiene and are serve as models of others.

Therefore, the key responsibilities of health extension workers include prevention and control of diseases, promotion of health, helping the community to take the necessary action for early diagnosis and treatment and where necessary referral to higher and better health care facilities.

2.2.7 Health Extension Package Implementation in Ethiopia

According to Habitu (2007), Ethiopia had endorsed primary health care strategy since 1970's, to realize equitable access health service but the achievement had been very limited. A review of the HSDP I, (2002), indicated that due mainly to inconsistent and insufficient support from health system including health supportive provision and in-service training as well as lack of remuneration and incentives. The other factors which do not allow effective implementation of the primary health care were related to the structure of the ministry of health itself. The structure was limited to central and regional level and maintain vertical programs with no management structure at district level and below. As a result of this, it has not reached the people at the grass root level as envisaged and desired. In response to this, the government has introduced an innovative program called health extension program and this started implementation during HSDP II (2003),

Policy Environments- Health and Health Related Policies

Health is a development issues that can be considered from different social, economic, political and other conditions. The formulation or development of supportive policies and strategies is a prerequisite for successful planning and implementation of health care delivery system especially community health services.

According to FMOH (2005), some of the health and health related government policy direction and priority areas including health policy, drug policy, women policy, and population policy; health sector development strategy, economic policy, rural development policy and others have been implemented. The main focus of these policies and strategies is promotion of health and welfare of the

people especially rural people who are at low access to all social and economic services. All these are in line with the rural-focused general development strategy of the country.

In the health policy of this country, equity in health care, coverage and the quality of health care, prevention disease and promotion of health, use of appropriate technology democratization and decentralization of the health service strengthening and reorganizing of health services, intersect oral collaboration and co-operation, community involvement and participation have well-underlined as priority areas.

Much of the health policy and strategy is shaped and dominated by the principles of the primary health care approach launch by the WHO at Alma Ata in the former USSR in 1978. As an enabling environment and opportunities is the government structures that have government ministers that are responsible and involved for the rural development. These are ministries of rural development and capacity building and rural infrastructure.

2.2.8 Opportunities and Challenges of Implementation of Health Extension Program in Ethiopia

MOH (2005) stated the following opportunities and challenges.

Opportunities

- Government readiness to implement the strategy,
- The policy and strategy environment health and health related policy HSDP,
- Decentralization and democratization of health delivery system,
- Economic and rural development strategy
- Experiences gained from agricultural extension,
- Rich experiences from and support from NGOs and other agencies,
- Woreda level-strengthened authority or power,
- Availability of trained and experienced community health workers.

Challenges

- Lack of time or high workload on the extension workers to cover all these activities,
- Lack of budget for the implementation of preventive and educational activities,
- Weak institutional arrangement to support the implementation, monitoring and evaluation of the extension programme,
- Poor economic situation-lack of resources may limit the implementation of the programme,
- Lack of motivated and skilled staff for implementation, monitoring and evaluation and supervision,
- Poor communication network and transportation facilities,
- Poor logistics supply and inaccessible implementation areas,
- High turnover of health extension and other community level health workers,
- lack of strong institutional support,
- high turn over of staff that may lead to discontinuity of the programs,

2.2.9 Guiding principles and strategies used in health extension package program implementation

MOH (2005), health extension strategy can be seen as a part of their wider movement or reform from the more tradition forms of top-down development practice to the participatory development and implementation direction. In line with, the health extension as a health development strategy follows the following principles in its working direction:

- The supremacy of the people's involvement- peoples priorities, interest, needs and wishes must be respected and accumulated in all aspect,
- People's knowledge and skills must be seen as a potential contribution to the health extension scheme or activities,

- Women involvement in all decision making process should be the center issue in the health extension strategy,
- Community ownership, empowerment and autonomy on the program and self-reliance need to be performed,
- Community health actions need to be promoted or taken participation of the community in the health schemes of the communities.

Enhancing Political Commitment and Support

For the formulation and implementation health and health related policies and strategies, political commitment is crucial and necessary at various level. MOH (2005) stated that besides, the commitment of the central government, commitment of the local government is extremely important for the implementation of the health extension program. This local level commitment will have a strong impact on the health service. Presence of this commitment is a supportive environment, which is necessary for a successful planning and implementation of the health extension program. The financial and political commitment for the successful implementation of health extension package at all level will be an indication or reflection of the accountability of the politicians, practitioners and policy makers for health and well-fare of the people.

This is to reorient health services to fit the health extension package by reviewing and strengthening of organizational infrastructure facilities. The attitude of staff, which were trained and coached in an old health service delivery system (medical – focused) need to be changed in line with the present innovative approach, that is preventive and promotive services.

Enhancing decentralization and strengthening of the implementing role of the regional government

Decentralization, which came after the devolution of power facilities the participation of people in the decision-making process, resource allocation and utilization, creates a supportive environment MOH (1993). The woreda level skill

should be enhanced or upgraded in order to create a supportive and facilitating environment for health extension strategy, staff development, logistic support, teaching materials design and development are necessary resources needed for the health extension program.

According to the present government decentralization policy, development planning and budgetary activities are carried out at woreda level and transferring responsibilities, which zones and regional health bureau held were transferred to woreda health departments.

To make possible the organizational and functional restructuring

- Setting up different committees whose members are drawn from different sectors, agencies, community leadership organizations, civic societies, women and youth groups,
- Designating responsible unit/body/person who make a follow up,
- Staffing the unit with the responsible and skilled person both technical and administrative staff,
- Carrying out capacity building and training, carrying out training needs assessment and priorities,
- Creating, forming and strengthening and co-coordinating the necessary infrastructures and organizations such as health committees, health councils, boards, community-based organizations, women's groups, youth groups and others.

Enhancing team development and motivation of the health and management staff-changing attitude of professionals

This will facilitate the working capacity of staff working in health extension services. This will be realized through creating and organizing discussion forums, experience and information net works, team development sessions, shared vision and mission development meetings. Introduce motivating and reward system for the staff for a better achievement. Develop better training-and education system. Implement collective and progressive leadership in the

organization. Develop mechanisms that lower or minimize the attrition rate or turn over of the staff in the organization. Introduce good health communication system in the organization.

Poor motivation of some staff hinders the success of the supervision. This needs the awareness and change of attitude of the health professionals and the health extension agents for this purpose. This activity requires the motivation of the health professionals and other staff to be fully committed to improve the health status of the rural population who are at lower level of health status.

The Need for motivation and management of health extension workers

There needs to be proper procedures in all staff management process that include employment, retention, support, on the job training, coaching, performance appraisal/reviews, recruitment, promotion, information network, transfer, designation of tasks and job descriptions, taking disciplinary measures, leave, creation of better working condition, creating reward and motivating system, using good method of resolution of possible conflict, bearing responsibility and accountability of works. The immediate responsible supervisor or head of the program needs to carry out periodic assessment of work performance and based on the assessment needs to take the necessary corrective and preventive measures. These can be simple feedback for better future performance, recommendation for promotion or reward, on-job training or disciplinary action.

Continuing education is also essential because of several factors. The main reasons may due to the fact the effectiveness of performance of the health extension workers increases with the information or knowledge. The second reason can be due to the fact that health or any other government policy or strategy can effectively performed when there is continuous flow of information to the health extension workers; the third reason is to keep their credibility as a good source of information is mandatory. All these have a high resource implication for the regional government.

Promoting community involvement

As recommended by FMOH (2005), community participation is a health development strategy. This is because health can be achieved through community involvement or participation and collaboration of wide range of stakeholders. Participation of the community in decision-making process is a reflection of the political power of the people and mobilization of resources. This promotes empowerment, self-reliance, responsibility and ownership for health actions. The type and level of community participation are expressed in terms of the needs assessment, leadership, organization, resource mobilization, and management.

Community involvement can be in different forms which includes gaining of individuals or community members greater responsibility for their health, decision-making on health issue, identifying priorities, mobilization, allocation, contributions, management and control of resources (Collins, 1994) To adopt a revolutionary and innovative approach in health development, in which the communities have a part and voice in community diagnosis and controlling the health determinants. There is high implication for community participation in community-based health service. Health development like any other type of development is a multi sectoral process; especially in this particular case of community-based health extension this is crucially important.

For participation of people in development two measures are taken, these are structural change, and capacity development of people. For empowerment peoples participation in development, as a means, is essential. It is the right of people to take part decision making and action. This builds self-esteem, enhances sense of responsibility.

Conditions that help community involvement in health care

AS identified by MOH (2005) factors influencing involvement of the community in health extension program include:

- Enhancing reform in health services that responsive to the needs of the people, decentralization that take the powers and authority down nearer to the community, reorientation of the health services that is working towards to the community involvement and empowerment.
- Respecting community values and norms (diversity)
- Wining community trust and respect,
- Making available resources, skilled health staff, logistic support, interactive teaching materials that attract and meet the needs of the people,
- Creating and understanding or agreeing on common purposes, goals, and objectives of health extension package with in the community.
- Enhancing information, education and communication about health and other development issues to create understanding with community,
- Enhancing the capacity and skills of the health staff -how to effectively work with communities,
- Training and retraining of staff to adopt/use participatory approach in health development and its implementation.
- Creating participatory community dialogue or forums to discuss issues, where success in health extension and other development issues are discussed and success will be shared and owned with the community,
- Giving top priority to women and youth involvement in health extension issues,
- Collaborating with other sectors as they share their experiences and agenda, which is essential to address the community needs,
- Promoting or creating experience sharing visits among communities (visits can be by their representative leadership organizations).

- Carry out periodic monitoring and evaluation of the level of community participation in health extension.

Through strengthening woreda level health system community participation will be enhanced and facilitated more effectively in the planning and implementation of health services and creates harmony community and woreda level condition harmony with the national health policy guidelines and resource allocation and utilization.

Community involvement and collaboration in health extension program includes: -

- Diagnostic study of the community, identification of needs,
- Selection of health Priorities, planning, implementation,
- Monitoring, supervision, evaluation of activities
- Allocation and management of resources

Benefits of community involvement includes for the sustainability of development and maximum utilization of health services, local knowledge, skills and resources.

In line with Goldman(1991) and MOH(2005), especially creation of the awareness of the need of the project and winning the trust of the community and working through the community organizations are important approach to enhance community involvement'

Enhancing supportive supervision

This will try to find out and correct any constraints encountered in the implementation of the health extension program. Effective supervision requires team of experts with an appropriate skill mix, continuity among team members, strong management skills, and client orientation. Supervision is a well-planned activity undertaken at scheduled time that is undertaken by highly skilled health professionals and health mangers aimed at providing information, feedback on the performance of health extension activities.

The supervision activities are carried to promote staff support, motivation, communication, skill or capacity building, better coverage, better performance, high health impact, cost-effectiveness, provide information on staff performance and useful information for staff promotion or development and to promote team spirit.

Necessary conditions for effective supervision

- Effective decentralization process- delegation of authorities, resources, decision-making power,
- Effective strategic management of the federal government ministry of health,
- Effective multi-sectored collaboration and coordination at different levels,
- Creation of effective supervisory system,
- Development of supervision schedule that indicates frequency of supervision visits and duration of supervision,
- Sustainable and effective supervision programs,
- Selection and designation of proper or qualified staff with technical managerial skills,
- Proper training of staff,
- Availability of qualified staff of higher skills, education, experience, training and positive attitude towards health extension program or community health services,
- Good communication and understanding, and participatory discussions among the staff for maximum gain from the supervision,
- Development and creation team-working and team spirit among the staff involved in the supervision activities,
- Availability of checklists to be used to measure performance,
- Giving rewards or incentives to staff with better performance

Stakeholders & their Roles in the Health Extension package

Planning and implementation of the health extension programme involves a wide range of sector stakeholders, government departments, public and private agencies, donor agencies, civic societies, professional associations, community leadership organizations, women and youth groups, community members, media groups, parliamentarians, and political and government units. However, the major or key leading role players will be the health sector at different levels to ensure sustainability and effectiveness of the health extension package.

Developing and strengthening referral arrangement

To fit into the health care delivery system and infrastructures and create harmonization with other health care facilities there is a need to devise a smooth and effective referral system that meets the health needs of the people in the areas of family planning, maternal and child services, adolescent health services, prevention and control diseases, first aid management, immunization services, and other services which are beyond the capacity of health extension workers MOH (2004). This may again help to form linkages with the next health care facility staff that may serve as information and educational support.

In a referral system the necessary points are:

- Building public confidence
- Provides accurate and helpful information and advice
- Support families to facilitate referral
- Incorporating the relevant and necessary information
- Developing good relation and communication with health care facilities that receive referred cases

CHAPTER THREE

3. Research Design and Methodology

This deals with research method, source of data, sampling technique or procedure, instrument of data collection, pilot study and methods of data analysis.

3.1 Research Design

The main purpose of this study was to assess the implementation of health extension program in the South Wollo zone of the Amhara Regional State. Furthermore, the study was intended to forward possible solution for the problems identified while implementing the program.

To serve this purpose, descriptive survey was employed as an appropriate methodology to reflect the intended program of the study. This is due to the fact that descriptive survey is the most important research design to collect descriptions of existing phenomena with the intent of employing data to justify current conditions and practices or to make more intelligent plan for improving program implementation (Lokoul, 1984).

3.2 Sources of Data

The sources of data for the study were classified into two (primary and secondary)

Primary data sources: Model households who have gained training and implemented health extension program, kebeles health extension workers, and woreda and zonal health extension experts were used as sources of primary data. All these were the most important agents who are thought to have better information about the implementation of health extension program in the selected woredas/kebeles.

Secondary data sources: the secondary data sources were obtained from documents, work plans, reports and works in the study area that were from

regional, zonal and woreda health office, minister of health, CSA, and internet and so on. Moreover, the relevant review of literature (books, journals, published and unpublished materials) was examined as secondary sources.

3.3 The population, sample and Sampling Procedure

On the basis of their accessibility and familiarity to the researcher three woredas were selected randomly out of the 17 woredas. Then with the close collaboration of the health extension experts of the woreda, two kebeles from each woreda were selected randomly. And a total of 180, household models in six rural kebeles were randomly selected proportional from the total 1865 household model that have gained and implemented health extension training in the respective kebele.

Health extension workers were also selected purposively from the selected sample kebele. This is due to the fact that purposive sampling methods are very convenient in the situation where the sampled to be selected is very small and to get some idea of the population characteristics in a short time (Kidder, 1981).

Besides, from selected woreda health office department, head of woreda health extension experts were selected by using purposive/availability sampling technique. From the zonal health office department, the head of health extension program experts were selected by using purposive/available sampling technique.

Table 1: Sample size (in subject and woreda/kebele) and sampling technique

	Woreda	Kebele	Total model household	Total Sample household	Sampling techniques
1	Tehuladary woreda	Bededo	300	30	Simple random
		Korka	250	25	Simple random
2	Dessie zuria woreda	Abasso	400	40	Simple random
		Kelina	515	50	Simple random
3	Dessie ketema woreda	Teta	175	15	Simple random
		Gerado	225	20	Simple random
	Total		1865	180	

3.4 Instrument of Data Collection

Both the quantitative and qualitative data gathering instrument were employed. The instruments were designed to fit and address the types of information required for the study. The main instruments of the data collection in the study were questionnaires, interviews, document analysis and focus group discussion.

Questionnaire

As defined by Good and Hatt (1952:33), the word questionnaire refers to a device for securing answers to a series of questions by using a form which respondents fill in him/herself. In addition to this, Barr (1953:65) also defines questionnaire as a systematic compilation of questions that are administered to a sample of population from which information is desired.

With regard to this, two types of questionnaires were prepared to collect data from two groups of respondents (households and health extension workers). To gain all the possible information from the respondents, the questionnaire included both open-ended and close-ended.

The questionnaires include key contents such as personal information, participation of household in the program, methods of health extension package training, the perception of households towards health extension service and health extension workers, challenges, opportunities and prospects of implementation of health extension program.

Interview

Koul (1984) defines interview as a process of communication or interaction in which the subject or interviewee gives the needed information verbally in face to face situation. And, Wiersam (1995) defines semi-structured interview as one in which the procedure to be followed is standardized and is determined in advance of the interview. It imposes a degree of formality which does not permit the interviewer to establish the kind of relationship him/herself and the interviewee which is necessary if the interview is to be conducted at some depth

and the interviewer has no freedom to rephrase questions, add extra ones or change the order in which the questions have to be presented. Thus, semi-structured interview questions were prepared to gather factual and detailed information from health extension experts at zonal and woreda level. Those respondents were selected purposively, which in turn, is the major way in which the qualitative evaluation seeks to understand the participation of the household in the program, methods of the program training, administration of the program, challenges, opportunities and prospects of the program through in depth, intensive interviewing to find out what is in interviewees mind.

Focus group discussion

This method of data collection was arranged with the purpose of supporting the data obtained by the questionnaire and interview. As indicated by McNeill and Chapman (2002), focus group discussion produces a good deal of qualitative data expressed in the word of participants. Therefore, this technique was employed to acquire the necessary data from health extension workers and model household about the perception of the community towards health extension workers, problems encountered while working in the community, health extension workers view about the problem they faced for being female and the relationship between health extension workers and other workers in the kebele and suggestion to improve health extension program implementation in their respective district.

Document Analysis

Besides, various documents related to administration, opportunities and challenges of health extension implementation program were used to obtain relevant information.

Table 2: Sources of Data Collection and corresponding Data collection Instruments

Respondents	Instruments
Model household	Questionnaires and focus group discussion
Health extension workers/trainers	Questionnaires and focus group discussion
Zonal and woreda health extension experts/officers	Semi-structured interview
	Document assessment

3.5 Piloting the Instrument

“A pilot study can be done to determine whether the procedure has merit and to correct obvious flaws (Gall, Burg, and Gall, 1996: 65)” Therefore following the design and preparation of each of the instruments particularly the questionnaire was submitted to the clients for a comment. In addition, the zone and weoreda health extension experts were invited for additional comments/correction. Then the questionnaire which was prepared in English was translated in to Amharic. The respondents in the pilot study are not included in the actual data collection process.

With regard to questionnaire, in the mid February, 2010, a pilot test was administered among 15 respondents in Tehuladary woreda within two kebele (Bededo and Korka) in the study area.

The purpose of this test was to check the appropriateness of the items in the instrument and to make necessary amendments based on the obtained feedback from respondents.

However, the pilot test result did not show major defect on the developed questionnaire. Hence, only few amendments were made on questionnaire before the final version was prepared. All the results from these tests were not included in the main study.

Finally, the response obtained from questionnaire interview, focus group discussion and the document analysis were analyzed and interpreted.

3.6 Methods of Data Analysis

To analyze the data gathered, both the quantitative and qualitative methods were employed, with a special focus on qualitative analysis. This is because qualitative research is highly useful in policy and evaluation research and yield useful insights about program implementation such as HEP (Seyler, 1993). Moreover, the analysis were supported with some descriptive statistics. The data collected by various tools were analyzed and interpreted.

All the closed-ended questions of the questionnaires were quantitatively described by using frequency distribution and percentage. Whereas data collected through open-ended questions of the questionnaires, interview, focus group discussion and document analysis were analyzed qualitatively. In other words, analysis of data was done with a help of descriptive statement and simple statistical method based on frequency and percentages, calculated on the basis of response of the respondents.

CHAPTER FOUR

Presentation and Analysis of Data

The purpose of this study was to assess the implementation of health extension program in South Wollo zone. For this study six rural kebeles were selected from three woredas. Data were gathered from model households, health extension workers, using closed-ended and open ended questionnaire, interview question was conducted with zonal and woreda health extension experts and focus group discussion was also conducted with model household and health extension workers.

4.1 Study Area

The study area was three woredas of south Wollo zone which is one of the eleven zones that are found in Amhara region, is located in the Northern Eastern part of Ethiopia. The capital zone is Dessie which is 401 kms North of Addis Ababa and 475 kms east of the regional capital Bahir Dar based on 2007 census estimated population of the zone in 2010 is 2,500,000 residing in the 17 woredas and 75% of the populations are residing in 350 rural areas (Zonal Document/2008). Based on the decentralized nature of preventive primary health care, in 2004 Amhara Regional State in general South Wollo Zone in particular has been implemented health extension program packages within 364 health posts and 374 health extension workers in the rural kebele. As report zonal health department tuberculosis, unspecified diarrhea, skin disease, stomach parasite, gastric disease and HIV/AIDS are the main health problem of the zone currently.

4.2 Model Households Involvement/Participation in Health Extension Training.

Community involvement/participation is a health development and implementation strategy. This is because health extension can be achieved through community involvement or participation and collaboration of wide

range of stakeholders. Different settings or places are important to deliver health extension training to the community.

In relation to this, informants were asked some questions to investigate household participation and their responses are summarized and analyzed as follows.

Table 3: Percentage Distribution of Model Households' Involvement/ Participation in Health Extension training

No	Items	Model household			
		Yes		No	
		No	%	No	%
1	Have you participated on health extension/packages program training in your kebele?	176	97.8	2	11
2	Did health extension workers organize you to participate on health extension program?	153	85	25	13.9
3	Did the kebele administrator organize/recruite you to participate on health extension program?	137	76.1	41	22.8
4	Did health extension training take place in your kebele compound?	121	67.2	57	31.7
5	Did health extension training take place in religious compound?	62	34.4	112	62.2
6	Did health extension training take place in your village?	127	70.6	55	30.6
7	Did health extension training take place in your working places?	145	80.6	31	17.2
8	Did health extension training take place in your kebele health post?	151	83.9	25	13.9
9	Do you think that health extension training appropriate to your language and culture?	174	96.7	-	-
10	Did the health extension training applicable to your real life situation?	170	94.4	6	3.3

The issues related to participation/involvement on health extension program (item-one), 97.8 percent of model households responded that, they participated on health extension training. This process done in a context of true health message communication: one in which the learners/household and health extension workers/ facilitators trusted and respected one another.

Interview responses from zonal and woreda health extension experts showed that, the level of community participation on health extension programme reached to 68% and 75.8% respectively. This shows that health extension program is a community-based, and the households were agreeing on common purpose and objectives of health extension program. This is similar to Lindeman (1926), Adult Education was (and still is) considered a process of increasing peoples understanding and helping them to make decision for themselves when there is true involvement and participation by community members at each stage with in the processes. Moreover, Frerie (1990), for education to be humanizing, it must involve the learners in problem identification in which learners and facilitators trust and respect each others and Israel (1982) also stated that behavioral change depends on the level of participation and ownership by those being served.

Regarding the organizers of households, 153(85%) of respondents were organized by the local health extension workers where as 137(76.1%) of respondents were organized by their local kebele administrators.

Moreover, interview responses from zonal and woreda health extension experts explained, that the organizers of the community on health extension training was the jointly task of both the health extension workers and kebele administrators.

This reveals that the organizers of model households to health extension training are a collaborative task of both the local health extension workers and kebele administrators. This is inline with what the MOH (2003), has stated in the implementation guideline that model households have to recruit by kebele

administrators and health extension workers and community organizer could play a crucial role in helping communities to increase their problem solving abilities.

As presented in table 3 (item 4), 121(67.2) percent of household respondents responded that health extension training takes places in their kebele compounds. This is because the kebele compound is one of the training places of health extension program.

Regarding villages, 70.6 percent of household responded that health extension training was takes place in their villages. This shows that villages are also place of health extension training delivery. Whereas 145(80.6%), and 151(83.9%) of respondents said that health extension training takes place in their working place and health post respectively. As a result health extension training mostly takes places in health post, working place and village of the study area. From this we can observe that there are different places of adult education programme delivery in general and health extension programme training in particular. This is similar to MOH (2003) states that there are different places of health message communication delivery; these are kebele compounds, villages, working places, religious compounds and health posts. Because, the existences of different places of health extension training delivery are important to increase the community participation on the training packages and have positive impact on the implementation of health extension program. Since, these places are found around the community's residential place.

As it can be seen from table 3, (item 9), almost 97 percent of respondents responded that, the health extension training is appropriate to the communities language and culture. This could increase the communities trust and involvement/participation to the effective implementation of health extension program and its sustainability. Likely to this, (Knowles, and et al, 1998 and MOH, 2003) stated that when adults learn by their own language, norms and values increase their decision-making abilities. So that, they would become owner of their health issue.

Regarding real life situation, almost 94.4% of respondents responded that, health extension training program has a real life application. It could be shown during the demonstration of the packages around their village and house's. This shows that the content of health extension is concrete, real life related, constantly changed to meet new needs, to deal with real issues of current concept. This is in line with the view of Freire (1973) a person can learn to think critically about real life problems and take action to change his or her own plan of action to deal with any problems collectively identified. In addition to Knowles (1984): one of the principles of adult education is that, it should be applicable to real life situation, when designing a curriculum for adult learner; courses should be organized around the acquisition of skills necessary for one to earn a living. These skills may be computer, farming, health and businesses.

Generally, community involvement/ participation can have positive influence on effective implementation of the health extension program as intended by MOH (2005) and Goldman (1991). Community participation on training enables to develop self-reliance, self confidence, beliefs in one's capacity and in general, develop strong will power and initiative to participate in development undertaking of the community, and to investigate one's own health problem, their causes, and once known to take alternatives for solution.

4.3 Methods of Health Extension Education/Training

Health extension training method comprises that the techniques of communication between health extension agents/workers and communities. There are several health extension training methods. This include person to person/home-visit, group discussion, demonstration, lecture and print material (pictures).

None of the method can be singled out as being the best one. A combination of method is more effective than just one method. These methods are also differ on the number of addressed, the problem to be solved; efforts and resource required. Use of wide range of health extension method will help the extension

system and improve the communication process that leads for better adoption of health extension program (Bedar, 2001 and MOH, 2003). Accordingly, to identify the different health extension training methods used by health extension workers, some questions were raised, and their responses are summarized in the following table.

Table 4: Percentage Distribution of Methods of Health Extension Education/Training

No	Methods of Training	No of Health extension workers in percent & degree of comparison			
		Frequently	sometimes	Rarely	Never
1	Lecture	10(76.9%)	3(23.1%)	0(0%)	0(0%)
2	Group discussion	2(15.4%)	11(84.6%)	0(0%)	0(0%)
3	Demonstration/learning by doing	0(0%)	4(30.8%)	8(61.5%)	1(7.7%)
4	Drama (in an entertaining way)	0(0%)	0(0%)	1(7.7%)	12(92.3%)
5	Person to person discussion (house to house visit)	5(38.5%)	7(53.8%)	1(7.7%)	0(0%)
6	Pictures or photographs	1(7.7%)	8(61.5%)	4(30.8%)	0(0%)

As illustrated in table 4 (item one), 76.9% of health extension workers responded that they are frequently using lecture method in health extension training. This indicates that, lecture method is one of the communication messages of health extension activities, because, the health extension works always present orally new information to the trainees/household.

As shown in table 4 (item two), 84.6% of health extension worker responded that, they are sometimes using group discussion in health extension packages training activities. This is unlike the view of Lekoko (2002), who consider group discussion as one of adult education method which provides an opportunity for learners to think together constructively for purpose of learning, solving problems, making decisions, and/or improve human relationship.

As presented in table 4 (item three), 61.5% of health extension workers responded that they are rarely using demonstration or learning by doing on health extension training. This is strengthened by health extension workers during focus group discussion explained that, they rarely used demonstration method for teaching on some health extension packages such as preparing and feeding babies, building healthful housing, building sanitary latrine and usages.

As pointed in table 4 (item four), 92.3% of health extension workers responded that, they are never using drama (in an entertaining way) on health extension training. As a result, drama (in an entertaining way) is not one of the communication or training methods of health extension training in the study area. However, MOH (2003) recommended that, drama is one of health message communication. It should be prepared and presented in a recreating manner and at the same time informative and moving towards better positive behavioral change.

As indicated in table 4 (item five), 53.8% of health extension worker responded that, they are sometimes using person to person discussion (house to house visit) as a teaching method. This method of health extension training enables the household more secure in his/her surrounding and willing to discuss health problem openly, such as personal hygiene, environmental hygiene, infant mortality, HIV/AIDS, TB and etc... on the spot.

Similarly, focus group discussion from health extension workers explained that through house to house visit, they are in a position to check the validity of any claims of the household with the results of their own observations and on the basis of any additional information, they found it much easier to work with the households to arrive at possible solution. The implementation guideline states that person to person communication is useful in rural area where mass media is not available; it enables the health extension workers visit house to house sanitation facilities and helps to create positive attitude for behavioral changes MOH (2003).

From table 4, (item-six), 61.5% of health extension workers responded that they are sometimes using pictures/photos. Because, they are using pictures/ photos during their oral presentation for better explanation. This is in line with MOH (2003), suggests that pictures/photos are useful for communicating messages to adults those who cannot read and write and these materials are very useful to health extension workers during their oral presentation for better explanation.

Therefore, as indicated in table 4, among the different teaching methods listed above, lecture method is the most widely used method followed by group discussion, person to person discussion and using picture/photos. This implies that most of the health extension workers of selected Kebele were still using the lecture method dominantly. However, as most of the trainees in such packages are adults, the implementation of various methods is vital, because as Lekoko (2002) noted, methods to train adults should be as varied as possible so as to cater for various learning to break the monotony of using a single method.

4.4 Model Households Perception towards Health Extension Workers and Their Service Provision

Community perception is important for the smooth running of health extension program. In the absence of the necessary understanding the beneficiaries, it is hardly possible to realize the objective of the program. Accordingly, to examine the perception of the community households to wards health workers and the services they offer, some questions were raised and their responses are summarized in the following table.

Table 5: Percentage Distribution of Model Households' Perception towards Health Extension Workers and their Service Provision

No	Items	Model household	
		Frequency	Percentage
1	Did you agree that the criterion for selecting health extension workers from neighboring kebeles including you is satisfactory A. Agree B. Disagree	163	90.6
		15	8.3
2	The selection of only female health extension workers is acceptable A. Agree B. Disagree	149	82
		29	16.1
3	Where does a health extension worker live? A. In the kebele B. In the town C. I don't know	161	89.4
		17	9.4
		-	-
4	Have you satisfied with health extension workers services? a. High b. Medium c. Low	113	62.8
		65	36.1
		-	-

The majority of the model households' 163(90.6%) mentioned that it was good that the health extension workers selected from their own kebeles. This implied that, the communities are nearer to the program/the program is found at the grass root level.

Regarding health extension worker being female, majority 82.6% of the respondents were agree about health extension workers being female and 12.9% of the study participants were against female preponderance in health extension program.

As reported by model household during focus group discussion, majority of the participants speculate that health extensions workers very much close to women and as a result many of the service utilizes were mothers and children's,

but some men discussants recommended that, to strengthen very good service provided by health extension workers, it also good to involve male health extension workers to deal with health related problems of male community members. The discussant ascertained that after they informed by health extension workers the women the village started to clean and maintain the cleanness of their house and also they taker of their children in better way than before. The discussant also added that by observing the activities of health extension workers women in the village some village mothers started to advice their daughter not to think of marriage before they become like health extension workers, therefore, it shows that health extension workers are females they were very much close to them and take time to teach them about their health and other health related problems of the family. Therefore, it was showed that the communities highly agreed health extension workers being female.

As shown in table,5 over whelming number, 89.4% of the model household respondents knew the presence of health extension workers in their own kebele whereas 9.4% of the study subjects mentioned that health extension workers live in the woreda town. This shows that the residential places of the majority of health extension workers are living in their working kebeles whereas some health extension workers are living in the woreda town. Health extension program implementation guideline did not state about the residential condition of health extension workers probably the assumption is majority of health extension workers were recruited from their own kebele or neighboring kebele therefore need for residential place is not the priority in this case.

But the actual situation is different that the majority of household reflected that health extension workers were living in their working kebeles. Therefore, this is also increased the communities perception about the health extension program/health services and its sustain ability.

As it clear from table 5, 62.8 percents household respondents were highly satisfied with the service provision of health extension workers. While, 36.1 percents of respondents moderately satisfied with the service provision of health

extension workers. This indicates that household satisfaction with the service provision of health extension workers varies from woreda to woreda/kebele to kebele. However, the majority of households was satisfied with the service delivery of health extension workers.

As reported by model household during focus group discussion strengths the above result majority of the households were benefited and satisfied much from the presence of health extension workers in their kebele. The discussants also elaborated that it is after the assignments of health extension workers that all household in the kebele started to construct and utilize the pit latrine, previously; pit latrine was only found in the town. Currently everyone in the village had a pit latrine, they also added that the health extension workers not only taught to construct pit latrine but also how to use and maintain the clearness of the pit latrine, using soap or ash to wash their hands after defecation is a common practice among villagers as they speak out during discussion. The discussant also reported that it is health extension workers that taught them to conduct voluntary testing for HIV/AIDS before marriage and not to make sex outside. The household also added that it is she (HEW) that taught them to isolate human and animal residence in order to be infected by the disease that can transmit from animal to human being. From this finding we can concluded that the majority of household have more positive attitude for health extension workers service provision as a result they satisfied by the service they are provided and it increases the communities participation and being ownership of their health. In line with this MOH (2005), states that the selection of extension workers from their kebele and including neighboring kebeles and their service provision will increase the communities perception towards the programme implementation and to be the owner of their health issues.

4.5 Implementation/demonstration of health extension packages

In the context of adult education programs, implementation refers to putting the program goals and design to work by conducting teaching learning activities and assessment exercises aimed at fulfilling the desired expectations. And the implementation of health extension package is increased the observe ability and sustainability of the program by others. With regard to the implementation of health extension packages the collected data are presented in the following table and the analysis present below:

Table 6: Percentage Distribution of Implementation/Demonstration of Health Extension Packages

No	Item	Model household			
		Yes		No	
		No	%	No	%
1	Have implemented/demonstrated health extension packages in house?	169	93.9	9	5
2	Did you get available material to the demonstration of health extension packages from health post?	15	8.3	163	90.6
3	Did you use locally available materials to the demonstration of health extension packages?	155	86.1	23	12.8
4	Was the demonstration/implementation of health extension packages cost effective?	178	98.9	-	-
5	Did you transfer the knowledge and skill that obtained from the training and demonstration to others?	172	95.6	6	3.3
6	Did you get reward/motivation when you demonstrated the packages in their house?	165	91.7	-	-

As shown in table 6 (item one), almost 94% of model household responded that they demonstrated health extension packages in their house. The demonstrated packages are family planning, environmental sanitation by constructing pit latrine, personal hygiene, and housekeeping by construction shelf and food nutrition.

This shows that individuals are able to perform or demonstrated specific health extension packages/behaviors, they knew what the health extension packages are and how to perform them through a clear instructions and/or training and the demonstrated packages are problem based/need based of adults and as a result of this households are mastery of a task. This is in line with the view that of Rogers (1983) diffusion can be thought of a special type of communication in which messages are concerned about new idea, if a health extension program is view as an innovation and the target population would follow in adopting the program. Moreover Rotter (1954), also behavioral capability refers to the knowledge and skills necessary to do a behavior which influence actions if individual are to be able to perform specific behaviors; they must first know what the behaviors are and how to perform them. Therefore, clear instructions and training may be needed.

Regarding sources of available materials to the demonstrated health extension package, 86.1 percents of household model were responded that they get/use locally available materials. This indicates that health extension program/preventive health care services is mostly used locally available materials to the demonstrated packages and it makes the program is friendly to the community and increased community empowerment because it reduces demonstration material costs.

As shown in table 6 (item-four), almost all model house responded that, health extension program is more of cost-effective. This is because of the program used different health extension training methods, the training takes place in different places which are nearer to the surrounding of the communities and the preventive nature of the program. As a result of this, it reduces the transport cost of the trainees to get training from their kebeles to woreda towns, and it is more of privative than curative. Thus, it reduces to buy curative/medicated materials and the people easily construct pit latrine.

Similarly, interview responses from zonal and woreda health extension experts described that in previous time the communities were come to woreda health

center to get health service, but now a days the health extension workers and health post are found in the community villages and kebeles. They also responded that in the old health service delivery system (medical-focused), needs to be changed in line with the present innovative approach, which is a preventive and promotive service. This also reduces the costs to buy medicine.

Regarding knowledge transformation from the model household to the other community, 95.6 percents of model household responded that, they transferred the knowledge and the skill that they obtained from the training and the demonstrated packages to the other community, who were not getting the knowledge and the skill from the training. The model households are giving the training during coffee ceremony, developmental work, in large community meetings and at any suitable situation to 4-6 households on the average. This indicates that, health extension implementation program is transferred from the model household to the other communities and also indicates the extent to which number of people really knows one another. This is similar with that of Bandura (1997) a person can increase self-efficiency through observing the performance of other. And Fishbein and Ajzen (1980) if a person believes that performing a given behavior will lead to on the whole positive outcomes, then he/she will hold a favorable attitude towards performing those behaviors and HSDP II (2003), besides addressing the whole public the health extension works are expected to select model households and work with them. These are the families considered to be innovative and ready to change and influential community member. The health extension worker gives training on the packages to the members and let them graduate when they convinced and well informed by the intervention and serve as a model to others.

Therefore, there is a positive attitude of the model households on health extension packages to transfer and share the knowledge and skills to the other communities.

Regarding reward/motivation system, 91.7% of model households responded that, they get reward to the demonstrated packages.

This indicates that there is strong follow-up mechanisms of health extension workers to identified who is demonstrated all the packages and/or not. As reported by health extension workers during focus group discussion, all health extension workers described that there is provision of reward/certificate to those who are demonstrated all the packages following through house to house visit and checklist. Most of the time health extension workers provide certificate as reward/motivation and finally, they graduated as models to others. This similar to HSDP II (2003) claimed that health extension workers should give certificate to model household when they are expected to demonstrate practical changes in the use of health program. Therefore, reward/motivation system has a positive impact to increases community participation on health extension program and for its sustainability.

4.6 Administrative Activities

Administration is an integral element of implementing adult education programs. Administrative functions are those activities that the administrators do in order to make the program successfully (Boyle, 1980). These activities may include handling participant registration and attendance records, distributing program materials (for example, course outlines, program packages), handling financial issues (payment for expenses associated to the program), issuing or awarding professional licensure or certification, carrying out supervision activities and providing refreshment courses/additional information, motivation and collaboration of various government and non government sectors. In relation to this, informants were asked some questions to investigate the administration activities and their responses are summarized and analyzed as follows.

Table 7: Percentage distribution of Administrative Activities

No	Item	Health extension workers			
		Yes		No	
		No	%	No	%
1	Did you get refresher courses about health extension packages?	10	79.9	3	23.1
2	Did you have detailed job description of duties and responsibilities on health extension program?	12	92.3	1	7.7
3	Have you supervised by woreda health extension supervisor?	9	69.2	4	30.8
4	Did the woreda health office department provide any motivation for you?	2	15.4	11	84.6
5	Did you get feedback from the supervision?	8	53.8	5	46.2
6	Did the school principals and teachers the major actors in your kebele to the implementation of health extension package?	5	38.5	8	61.5
7	Did religious leaders the major actors in your kebeles to the implementation of health extension program in your kebele?	2	15.4	11	84.6
8	Did NGOs the major actors in your kebele to the implementation of health extension program?	8	61.5	5	38.5
9	Did agricultural workers/DAs the major actors in your kebele to the implementation of health extension program?	10	76.9	3	23.1
10	Did kebele administrators the major actors in your kebele to the implementation of health extension program?	11	84.6	2	15.4

As indicated in table 7 (item one), 79.9% of health extension workers get/participate in one or two refresher training prior to investigation which is provided by woreda health office and NGOs. Twenty three percent of them were

not participate in none of refresher courses. Both of the refresh and non-refresh one reported that they want to be refreshed on how to manage normal labor, how to give vaccination (especially, on how to plan the targets and about the monitoring charts), on HIV/AIDS and other STDs control and prevention. They also need to be refreshed on how to care about child feeding, pregnancy control, and maternal and child health. It is clear that from what has been stated above there is attractive commitments of woreda health office and NGOs in the provision of refresher courses for health extension workers.

The implementation guide line states that, the existence of refresher training in health program will help in overcoming health problems facing at the implementation stage of the community, and ensure the sustainability of health development (MOH 2005).

Regarding job duties and responsibilities on the same table (item two), almost 92.3 percents of health extension worker have detailed description of their job duties and responsibilities that guide them what to do with in given framework. As a result, the health extension workers avoided anything which harms people's interest, honor or contrary to their well being, did everything which is good to the peoples, treated all members of the community equally and give to people trust, credit, good will and respect.

Both interview responses of zonal as well as woreda health extension experts and the document sourced from zonal health office shows that the duties and responsibilities of health extension workers distributed to all kebeles health post. Therefore, distribution of job description duties and responsibilities of health extension workers to all rural kebele health post is the task of the zonal and the woreda health office to the successful implementation of the program.

As shown in table 7, 69.2 percent of health extension workers responded that they are supervised by woreda health supervisors and 30.8 percent of them are not supervised by woreda health supervisors.

Similarly, supportive supervision, interview response from zonal and woreda health extension experts explained that, the reasons for not supervising the health extension workers were lack of transportation to reach in accessible areas, absence of fixed budget to the program and high turnover of skilled staff in the zone and woreda health office. As a result, areas or kebeles that near to woreda towns are regularly supervised by woreda health office supervisors. It is stated in health extension program guideline that supervision is the basic tool to correct any constraints encountered in implementation of health extension program.

The available zonal document also revealed that management support and supervision are the key element which “make or brake” of any community health program.

Interview response from woreda health extension expert the reasons not giving feedback to health extension workers were absence of team of experts with an appropriate skill mix and lack of strong management skills. But the health extension program guide line stated that giving feed-back requires team of experts with an appropriate skill mix and strong management to promote motivation and communication skills of the activities of health extension workers MOH (2005).

As presented in the table 7 (item 6), 61.5% of health extension workers responded that there was no involvement and collaboration of school principals and teachers to the implementation of health extension packages while 38.5% of them responded that there was the involvement of school principals and teachers to the implementation of health extension packages. It shows that the co-operation among the school principals as well as teachers and health extension workers in their own kebele's is weak.

This is because of low relationship between the school community and health extension workers, and the school principals and teachers have lack awareness about the program objectives.

But, it is stated in the health education guideline that, health extension works should select model teachers and give training on health extension package to be implemented in the school because the school teachers generally belong to a learned community segment with their knowledge and skills, they can easily communicate health messages to community and in the school the students are believed to be agent of change. Once they understand the objective of the programme, they can easily transmit to their parents and would influence them to implement the programme. Thus, schools are important place to deliver organized continued health education as well as to introduce other health program such as immunization, HIV/AIDS control and prevention. And Goodman and Smith (1991) also state that the involvements of teachers are instrumental to the implementation of health extension program.

Regarding religious leaders to be the major actors for the implementation of health extension packages, almost 84.5 percent of health extension workers responded that there is no the involvement of religious leaders to cooperatively work with health agents to teach the community. This is due to the fact that health extension workers did not organize themselves with the religious leaders to the successful implementation of the program. Whereas the program guideline stated that health extension workers should cooperate with the religious leaders for communicate health extension message in religious institution, because religious institution are good places for communicating health message and health extension workers should organize themselves and use the opportunity.

As presented in the same table (item 8), 61.9% of respondents responded that there is the collaboration of NGOs to the successful implementation of the program and 38.5% of respondents responded that there is no collaboration of NGOs to the implementation of health extension program.

Moreover, interview responses from zonal and woreda health extension experts explained that, the existence of NGOs varies from woreda to woreda, even kebele to kebele and their cooperation also varies from kebele to kebele, NGOs like

World Bank, family planning association, ESHE and USAID are found in different woreda and kebeles of the zone and they said that woredas /kebeles which have NGOs cooperatively work with health extension workers and they are providing health materials/resources and training to the community and health extension workers.

This shows that woredas/kebeles and NGOs are working cooperatively with health extension workers to the successful implementation of health extension program.

Regarding the cooperation of agricultural workers (DA's), almost 75% of health extension workers responded that there was a significant cooperation among health extension workers and agricultural workers (DA's).

Responses of health extension workers from focus group discussion strengthened the above results. Majority of health extension workers said that there was strong collaboration between agricultural workers and them. The reason given by discussant was because of strong management of the kebele leaders to make strong relation between health extension workers and agricultural extension workers, as a result of this, the agricultural workers in their field work they taught the community about importance of environmental sanitation, to develop healthful living and to increase their productive capacities.

Eighty five percent of health extension workers responded that there is highly cooperation and relationship between them and the kebele administrators to the implementation of health extension program. This is because of that the kebele administrators are aware about the significances of the program objectives.

As reported by health extension workers during focus group discussions strengthen the above result. The majority of health extension workers were described that the majority of kebele administrators have good aware about the preventive health care and, they are cooperation with health extension workers. For example if health extension workers want to give health education at

meeting place they give their time to health extension workers at the beginning of the meeting. This is similar to the implementation guideline, it states that the kebele administrators should have a commitment or responsibilities to work with health extension workers because health extension program is a collaborative activities of various government and non government sectors to bring about health development.

4.7. Opportunities of the Implementation of Health Extension Program

Opportunities are an important input which increases the effective utilization of the program by health agents and the community to bring about a behavioral change within the life of the community. As MOH (2005) recommended that government readiness to implement the strategy, health and health related policy, decentralization and democratization health delivery system are the corner stone to the effective implementation of health extension packages. In relation to this, informants were asked some questions to investigate the opportunities and their responses are summarized and analyzed as follows.

Table 8: Percentage Distribution of Opportunities of Implementation of Health Extension Program

No	Item	Health extension worker				
		Rte of frequency				
		V.H	H	M	L	VL
1	Health extension is ensure equitable access to service	10(76.9%)	3(23.1%)	-	-	-
2	Existence of community involvement to the implementation of health extension packages	-	4(30.8%)	9(69.2%)	-	-
3	The decentralization nature of health delivery system	2(15.45%)	10(76.9%)	1(7.7%)	-	-
4	The bottom-up approaches of health extension implementation strategies	10(76.9%)	2(15.4%)	1(7.7%)	-	-
5	Low cost intervention to address the major cause of health problem	11(84.6%)	2(15.4%)	-	-	-
6	Health extension implementation involves individual particularly women and children	11(84.6%)	2(15.4%)	-	-	-

As indicated in table 8 (item-one), all of health extension workers responded that, health extension program was highly ensure equitable access to services.

This indicated that there is health extension program service in all study kebeles. The zonal and woreda health extension document also strengthen the above result, it showed that all 350 rural kebele in the zone get health extension services. The presence of health extension service in all kebeles is likely to encourage the participation of the community, because they see the establishment of health post as opportunities for their health problems and increases the sense of ownership/decision makers about their health issues. MOH (2005) states equitable access to health services helps to promote the perception and participation of the community about their health.

Regarding existence of community involvement, 69.2% of the health extension workers responded that, the involvement of the communities to the implementation of health extension program is medium. This is because in the previous time/before the origin of the program in Ethiopia in general and in the zone/woreda of the study areas in particular there was no such kinds of a community health services at the same time there was no involvement/participation of the community as a whole to prevent their health problems.

Interview respondents from zonal health experts, strengthened the above findings, they described that the involvement of the community increases from time to time. For example in 2008, it was 51% whereas in 2010, it is almost 65% (at medium level). Therefore, the involvement of the community on health extension packages clearly shows that their awareness about their health issues/problems increased from time to time and it is also an opportunity to the successful implementations of the program.

Regarding the decentralization of health extension delivery system, 92.3% of health extension workers responded that the decentralized nature of health extension delivery system is high. This finding is supported by interview respondents of zonal and woreda health extension experts. They described the

reason that the existence of a highly decentralization of health extension delivery system is because of the transfer of the major part of decision-making, health care organization, capacity building, planning, implementation and monitoring from the federal, regional, zonal, woreda and to the kebele with clear definition of rules. As a result the decentralized nature of health extension delivery system there is an opportunity to the successful implementation of health extension program in the study area. It is similar to the implementation guideline, it stated that for the formulation and implementation of health and health related policies and strategies. Political commitment is crucial and necessary at various levels. Besides, the commitment of central government, commitment of local government is extremely important for the implementation of the program at all level will be an indicator or reflection of the accountability of the politicians, practitioners and policy makers for health and well fare of the people (MOH, 2005).

As shown in table 8 (item four), 92.3% of health extension workers responded that health extension program was highly a bottom up approaches/ characteristics. This is due to the establishment of health council with strong community representation at all levels and health communities at grass-root level to participate in identifying major health problems, budgeting, (to the construction of health post), planning, implementation, monitoring and evaluating health activities. Therefore, a bottom-up natures/approaches of health extension program was a good opportunities to the identification their health problem and at the same time to address their major cause of health problem.

Regarding the cost-effectiveness of the program, all of respondents responded that health extension implementation is highly cost-effective. This is due to the fact that, it reduces the transport cost of the community to get health services from woreda town, and its preventive nature reduced the cost to buy medicine and most of the time the communities used locally available material to prevent their health problems. As a result of this, the cost effective nature of the

program is a good opportunity to the effective implementation of the packages, and its sustainability and the involvement of the communities on the packages.

One of the opportunities of implementation of health extension program identified in focus group discussion and interview was that health extension workers being females, they could make a good role model for female children living in rural communities. They were also found to have been trying their best to attain promotive health at household level.

The competence of health extension workers in communication skill, and intervention related to family planning, prevention and control of HIV/AIDS and intervention related to immunization were found to be strong.

- The establishment of health post in all the 350 kebeles of the zone
- The majority of health extension workers were recruited from the community makes the community to trust the program.

On the other hand, from the zonal health extension document the opportunities of health extension program are:

- The zonal health service coverage is reached to 93.3%.
- The rural kebeles health extension packages coverage is increased from time to time and it reached to 97.2% and, the total urban and rural kebeles of health extension packages coverage was reached to 88.5%.
- Traditional harmful practices, like female genital mutilation and early marriage totally reduced as a result, the females' educational enrollment rate is increased.
- A vaccination system was mostly carried out around the living villages of the community.

4.8. Challenges of implementation of Health Extension Program

Factors and conditions that constraints the implementations of health extension program are lack of time or high work load on health extension workers to cover all these activities, weak institutional arrangement to support the implementation monitoring and evaluation of health extension program, Lack of motivated and skilled staff for implementation and evaluation and

supervision, poor communication network and transport facilities, lack of strong institutional support and poor logistic support and in accessible areas. In relation to this, informants were asked some questions to investigate the challenges and their responses are summarized and analyzed as follows.

Table 9: Percentage Distribution of Challenges of Implementation of Health Extension Program

No	Challenges	Health extension workers f				
		Rte of frequency				
		V.H	H	M	L	VL
1	Lack of time on health extension workers to cover all health extension package	10(76.9%)	-	3(23.1%)	-	-
2	Lack of textbook/reference as well as demonstration materials	2(15.4%)	7(53.8%)	4(30.8%)	-	-
3	Lack of regular supportive supervision from health center and woreda health office	8(61.5%)	1(7.7%)	3(23.1%)	-	-
4	In adequate number of health extension workers to the target group ratio	10(76.9%)	3(23.1%)	-	-	-
5	Lack of continuing education to health extension workers	13(100%)	-	-	-	-
6	Weak relationship between health extension workers and other sector workers	-	-	4(30.8%)	8(61.5%)	1(7.7%)

As indicated in table 9 (item one), 77% of health extension worker responded that lack of time is highly affected to the implementation of health extension packages. This is because of the broadness of the health extension packages.

Similarly, concerning time, focus group discussion from health extension workers and interview responses from the zonal and woreda health extension experts explained that the given time to the implementation of the program did not enough to effectively address the general objectives of health extension packages towards the community. They also discussed that, 96 hours did not enough to carry out house to house visit to communicate a health message across a community. This is because, some villages are far remote from the health post and they are difficult for transportation. Whereas the implementation guideline stated that, 96 hours is enough to effectively address the whole packages for the community (MOH, 2005).

Therefore, time is one of the constraints for implementation of health extension packages in those rural communities.

Regarding textbook/reference as well as demonstration materials, 69% of health extension workers responded that, there is highly shortage of textbook as well as demonstration materials. However, the zonal document analysis claimed that textbook/reference as well as demonstration materials were distributed to all woredas health offices and to all rural kebele health posts.

Generally, when health extension workers prepare programs, they usually consult books for more information on the relevant packages matter. Regarding books broadness and deepness health extension workers understanding of here area of interests, which can intern be incorporated in to the development and implementation of the program for the ultimate benefit of the adult learners. And the health extension workers will also question, refine and modify their perspectives on packages.

As shown in the table 9 (item three), 69.2% of respondents respond that there is highly lack of regular supportive supervision from the woreda health office and the clustered health centers where as 30.8% of health extension worker were more or less regularly supervised. This is due to the fact that lack of transportation to reach inaccessible area, lack of motivated staff and, mostly

regular supportive supervision is carried out kebeles, where nearer to woreda town and health center.

This result is strengthened by interview respondents from the zonal and woreda health extension experts. They explained that there was no regular supportive supervision across in each rural health post in the zone. This is because of lack of skilled or experienced senior staff, lack of resource to carryout, feedback is not given most of the time, high turn over of skilled staff (this is because of absence of career growth or promotion) and most of the time very distance area is not covered by supervision.

As a result of the above factors, lack of regular supportive supervision is one of the constraints of the successful implementation of health extension program in the study area.

As presented in table 9 (item four), all of the respondents responded that, inadequate number of health extension workers to the target population ratio highly affects the implementation of the packages. This is difficult to managed and supervised the activities of 5000 people by one health extension workers. In some kebele the target populations are beyond the standard of the implementation guideline or more than 5000 peoples managed and supervised by one health extension workers. This is also take time to supervision activities. As a result of this, some people returned back to their first phase.

Therefore, in adequate number of health extension workers to the target community were also the major challenges to the implementation of the program.

As shown in table 9 (item five), all of health extension workers responded that they did not get upgrading their educational level. However, MOH (2005) recommended that continuing education or upgrading the educational level of health extension workers is essential because of several factors. The main reasons may due to the fact that the effectiveness of performance of the health extension workers increases with the information or knowledge and to keep

their credibility as a good source of information is mandatory. These positively influence the motivation of health extension workers in general and to the successful implementation of health extension packages in particular.

Report from woreda health office revealed that, due to lack of continuing education, in some kebeles there is high turn over of health extension workers and it also described that the regional health bureau department was not develop policy guideline and standards for continuing education and career structure to health extension workers.

Therefore, lack of continuing education is the major factors which affected the implementation of health extension program in the study area.

As pointed in table 9 (item six), 70% of health extension worker responded that there is good relationship between them and other sectors workers in their surrounding kebele. This particular true with in agricultural workers, kebele administrators, in some school teachers and, health extension workers this is due to the fact that, strong managements of the kebele administrators and awareness about the programs objectives: that is health is a collaborative activities to bring about healthy full generation in all aspects of development activities. This is not the major challenge for the successful implementation of the program.

Based on interview responses from zonal, woreda health extension experts and focus group discussion from health extension workers there were also other challenges. The challenges and gaps were:

- The recruitment were planned to be from the same kebeles to allow better integration. But in a few kebeles young ladies from urban and pri-urban center were recruited this may have effect on permanent availability of health extension workers in the kebeles.
- Documentation and reporting was not instituted properly.

- Referral system and linkage with health center is weak. The health extension workers do not have good relationship with health worker working in higher level health institutions.
- Health extension workers did not get career growth and did not get transfer mechanism to the nearest kebele based on their services.
- Most of the health post has deficiency of medical equipment for patient examination, and drugs/supplies useful for promotive, preventive and curative health services. One of the constraints discussed at field study where health extension workers were represented was that the availability and sustainability of resources is a major concern.

The other challenge is limited human resource capacity of district health systems to support the program. Also integration of health extension program to the whole health system, creating practical linkage with health center and hospital services, and ensuring effective and regular support from the higher level of the system is also a challenge.

On the other hand, from the zonal health extension document the challenges of health extension program are:

- There was no annual review/experience meeting in the zone and region.
- There was absence of regular supportive supervision in between the zone and regional health office department.
- There was no research and studies on health extension activities among zonal and regional health offices department.
- Some woreda health office were not selected/recruited health extension workers based the stated criterion.
- Most woreda administrators are not given feedback on the implemented packages by observing the rural kebeles.
- High turnover of health extension workers.
- Some kebele administrators were not regularly follow up and give feedback for some health extension workers.

4.9: Prospects of Implementation of Health Extension Program

Responses of health extension workers, households, zonal and woreda experts from focus group discussion and interview discussed that due to the establishment of health post in each rural kebele of the zone, the existence of health extension workers, acceptance and awareness of the community on the program, the involvement of some stakeholders such as agricultural workers, kebele administrators and NGOs, the presence of different places of health extension delivery and varieties of different health extension training methods in the study areas were a good prospect for the implementation of health extension program. The prospects of the implementation of health extension program in the study area.

- It will under take measures to reduce morbidity, disability and mortality for the major communicable disease in the zone.
- It will strengthen and expand family planning health and nutritional service for mothers, children and youth at all levels of health system, including community level in the zone.
- It will provide and increase the coverage of hygiene and environmental health service to the community.
- It will promote political and community support for preventive and promotive health service by educating and influencing planners, policy makers, women groups and potential collaborators.
- It will review and strengthen the existing health management information system at all levels (including community level) to produce timely information for planning, management and efficient decision making in the zone.
- People will construct and use a healthful home and as a result avoid illness which might arise from unhealthy house.
- People will develop skill of building a healthful house.
- People to people experience sharing will be developed and their contribution will be increased.

Generally, these would enable to bring about behavioral changes to ensure that communities perceive and manage their own health related activities to create healthy environment as well as healthful living and it brings healthful and productive generation.

CHAPTER FIVE

5. Summary, Conclusions and Recommendation

This part deals with the summary, conclusion and recommendation. In this section, first brief summary on the study and major findings were presented second, conclusions of the fundamental findings were made. Finally some possible recommendations were given on the basis of major findings of the study.

5.1 Summary

The main purpose of the study was to assess the implementation of health extension program in South Wollo Zone of the Amhara Regional State. Six rural kebeles from three woredas were selected on the basis of accessibility for transportation. In order to come up with certain understanding about the implementation of health extension program, the following basic questions were used.

1. How is the involvement of household models on health extension training?
2. Does the extension program incorporate different method of adult learning?
3. What are the perception of the households towards the health extension workers and the service they provide?
4. What are the major administrative activities to the successful implementation of the program?
5. What are the major opportunities and challenges that positively and negatively influence the implement program?
6. What does the prospects of health extension program look like?

In dealing with the research problems, descriptive survey method was employed and relevant literature was reviewed. A total of 197 persons: that is 180 model

households, 13 health extension workers, 1 zonal and 3 woreda health extension experts have participated in the study area.

The data for the study were collected by means of questionnaire, interview, focus group discussion and document analysis. The data collected were critically analyzed and interpreted.

Based on the analysis and interpretation of data, the researcher has listed the summary of the finding here under

- ❖ Majority of model households participated in health extension training.
- ❖ The organizers of model households were health extension workers and kebele administrators.
- ❖ Health extension training mostly takes place in health post, working places and villages of the study areas.
- ❖ Overwhelming majority of the model households responded that health extension training is appropriate to their language and culture and has real life application the program.
- ❖ The study indicated that, health extension program used different teaching or communication methods, but the lecture method is the most frequently used method.
- ❖ Majority (90.6%) model households agreed with recruitment of only female health extension agents/workers from neighboring kebeles including their kebeles and they have satisfied on the service provision of health extension workers.
- ❖ The model households implemented health extension packages. They also transferred the knowledge and the skill that they obtained from the training and implementation to others. The model households are giving the training during coffee ceremony, developmental work, in large community meetings and at any suitable situation to 4-6 households on the average.
- ❖ Model households get reward certificate to the demonstrated/implemented packages in their house/environment.

- ❖ The study indicated that, there is lack of regular supportive supervision and feedback to health extension workers. This due to lack of transportation to reach in accessible areas, absence of fixed budget, high turn over of skilled staff absence of team of experts with an appropriate skill mix and strong management skills in the zone and woreda health office.
- ❖ There were collaborations with various stakeholders in the study areas to the implementation of health extensions program such as agricultural workers (DAs) kebele administrator and NGOs such as ESHE, USAID(pathfinder) and world bank, but collaborations of teachers and religious leaders was weak. This is because the relationship between teachers and health extension worker is low, teachers have lack of awareness about the program objective and health extension workers did not organize themselves with the religious leaders.
- ❖ Health extension program ensured equitable access to service because it reached in all rural kebeles of the study area.
- ❖ The study also revealed that the decentralization of health extension delivery system is high. Because there is the transfer of decision-making, health care organization, capacity building, planning, implementation and monitoring of health extension activities from federal, regional, zonal, woreda and to kebele with clear definition of rules. As a result the decentralized nature of health extension delivery system is an opportunity to the successful implement health extension program in the study area.
- ❖ The study also identified that health extension program is highly cost-effective. This is due to the fact that it reduced transport cost of the communities to get health service from the woreda town and its privative nature also reduced the cost to by medicine and the communities also used locally available materials to construct pitlaterin, house shelf and isolate their residence from animal to prevent their health problem like personal hygiene and environmental sanitation, as a result of this low

cost intervention is one of the opportunity of the implementation of health extension program in the study area.

- ❖ The study also showed that lack of time on health extension workers to cover all health extension packages is one the major challenge to the implementation of health extension program in the area.
- ❖ Shortage of textbook as well as demonstration materials also a major constraint to the successful implementation of the program in the area.
- ❖ Areas/kebeles far away from the woreda town did not regularly supervised by woreda supervisors. This is because absence of transportation, lack of resource to carryout, feedback is not give on time, and high turnover of skilled staff.

5.2 Conclusion

Based on the summary of the finding the following conclusions were drawn.

1. Involvement of household models

- ❖ Even though the health extension program is new initiative and it is in its infancy stage, there was encouraging effort done in the study areas to help households participate in health extension training. This is because the program is based on their need, the training is also appropriated to their language and cultures and the existence of different places of health extension delivery, such as health post, working places, villages and kebele compound. Thus this might have its own positive impact on the implementation of health extension program.
- ❖ Moreover, in this study it was found that with the help of extension workers, model households have implemented/demonstrated all health extension packages and were able to transfer their experiences to the other people widely.

2. Method of adult learning

- ❖ Even if health extension workers used different health communication/teaching methods, lecture method is the most frequently used method than demonstration, drama and field visit. But this method was not that much convenient to adults since it affects their free participation.

3. Perception of the households

- ❖ In the study area, the communities have apposite perception towards the selection of only female health extension workers from their kebeles and neighboring kebeles and there is strong support and satisfaction from community member for the preventive and promotive service provided by health extension workers. As a result, health extension workers are providing preventive services as intended by health sector development program and services such as family planning and vaccination at out reach level, pit latrine construction and anti natal care,

home visit and post natal care are some of the best performed activities in respective kebeles.

4. Major administrative activities

- ❖ The establishment of health posts in each rural kebeles of the study area ensured equitable access to health service and, the decentralization of health service delivery and integration between sectors as reported by health extension workers and the presence of community health workers in the kebele found to be opportunity to implement health extension program.

5. Major opportunities and challenges

- ❖ Health extension program was highly ensured access to services, the presence of health extension service in all kebeles is likely to encourage the participation of the community and the decentralized nature of health extension delivery systems are found to be opportunities to implement health extension program in the study areas.
- ❖ Lack of time on health extension workers to cover all packages, shortage of reference material and lack of regular supportive supervision, absence of career growth and continuing education to health extension workers found to be challenge to implement health extension program. This is because of it affect the motivation and the work behavior of health extension workers.

6. Future prospect of the program

- ❖ On the top of very much support to health extension workers, community suggested the involvement of male health extension worker to support each other and fulfill some needs of the community.

5.3 Recommendation

In light of the findings of the study, the following recommendations were forwarded.

- ❖ Health extension program can not be independently implemented by health extension workers and it needs the collaborations of various stakeholders. In the study area, the collaborations of teachers and religious leaders to the implementation of the program are low. Thus, health extension workers should develop intensive awareness creation to teachers and religious leaders with common understanding in order to facilitate program implementation.
- ❖ Extension agents must have adequate knowledge of the characteristics of each extension teaching/communication method as well as know the characteristics of respondents. This will enable health extension workers to use appropriate methods with appropriate time and place. In the study area extension workers frequently used lecture method without encourage communities' participation. Thus, health extension workers should give emphasis to demonstration, drama and field visit method.
- ❖ Reference materials are important and effort so far is commendable but more adapted versions might be required. More importantly, upgrading, new and improved approaches and technologies should be introduced through more flexible forms such as newsletters and leaflets.
- ❖ Supportive supervision requires team of experts with an appropriate skill mix and strong management skill which aimed at producing information, feed back on the performance of health extension activities. This will enable health extension workers to correct any constraints encountered in the implementation of health extension program. In the study area, kebeles far from the woreda town did not get supportive supervision. Thus efforts should made by woreda, Zonal and Regional Health Office to develop committed team of experts and strong management skills.

- ❖ Providing continuing education and career development that positively influences the motivation and work behavior health extension workers to successfully implement the program. In the study area health extension workers did not get career development and continuing education. Thus, Regional and Zonal health offices should develop policy guidelines and standards for continuing education and career structure to health extension workers.
- ❖ Regional health bureau and zonal health offices should conduct research and studies on health extension activities.
- ❖ Further study should consider whether to include male health extension workers in order to fulfill male needs and support each other with female health extension workers in program implementation.

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Annex

Appendix A

Addis Ababa University

School of Graduate Studies

Department of Curriculum and Teachers Professionals Development Studies

Program: Adult and Lifelong Learning

Questionnaire for model households

The main purpose of this questionnaire is to collect relevant and appropriate data from model households concerning the implementation of health extension program. It also aims at providing some possible recommendations for the encountered problems, if there are any. Because your genuine, frank and timely response for each question is quite vital to determine the success and completeness of the study, I cordially request your high collaboration in filling the questionnaire honestly and responsibly.

Thank you in advance for your heart felt collaboration.

Part 1: General Information and Personal data: Circle the letter of your choice

1. Woreda _____ Kebele _____
2. Sex A. Male B. Female
3. Age A. 18-25 years C. 36-45 years
 B. 26-35 years D. 46 years and above
4. What is your marital status?
A. Married C. Divorced
B. Single D. Widowed F. Others, specify _____
5. What is your current education level?
A. Illiterate B. Read and write but not formal schooling
C. 1-8 grade D. Grade 9th and above
6. What is your job (work) currently?
A. Farmer C. Student D. Trader
B. House wife E. other, specify _____

Part 2: Issues related to model households involvement/participation in health extension package training

1. Are you trained on health extension package program? A. Yes B. No
2. If Yes, when did you get the training first _____
3. If Yes, what was the criterion to participate in health extension training?
4. If No, why not? _____

5. Who organized you to participate in the training?
A. Health extension worker C. Others, specify _____
B. Community leaders (kebele)
6. Where does the health extension program training take place? (multiple responses are possible)
A. In the kebele compound D. In the work place
B. Religious (church/mosque) compound E. In the health post
C. In the village F. Others, specify _____

7. Do you think that the health extension package training are relevant and appropriate to your culture and language?

A. Yes B. No

8. If Yes, how _____

9. If No, why _____

10. Did the health extension package training applicable to your real life situation?

A. Yes B. No

11. If Yes, how? _____

12. If No, why? _____

13. Rate the amount of your participation in each of the following health extension package.

Using the "x" mark on the space provided in the table.

VH (very high), H- high, M-medium-low VL-Very low

No	Packages	Rate of frequency				
		VH	H	M	L	VL
A	Hygiene and environmental sanitation					
1	Solid and liquid waste disposal					
2	Material quality control					
3	Food hygiene					
4	Proper housing					
B	Disease prevention and control					
1	HIV/AIDS and other STD prevention and control					
2	TB presentation and control					
3	Malaria prevention control					
C	Family health service					
1	Maternal and child health					
2	Family planning					
3	Adolescent reproductive health					
4	Nutrition					

Part 3: Methods of Health Extension Training

Rate in which of the following methods of health extension package training you are trained, by marking "x" on the table in the space provided please indicate the extent of health extension training method.

No	Methods of health extension training	Levels of methods of training			
		Frequently	Sometimes	Rarely	Never
1	Lecturing				
2	Group discussion				
3	Demonstration/learning by doing				
4	Drama/in an entertaining way				
5	Picture				
6	Home visit				
7	Others (specify)				

Part 4: Implementation/demonstration of the Health Extension Package

1. Have you demonstrated health extension package in your house?
A. Yes B. No
2. If Yes, which package did you implement in your house?

3. If No, why? _____

4. Where did you get material resource for the demonstration of health package in your house?
A. In the health post
B. From the locally available materials/ the community
C. NGOs
D. If any others, (specify) _____

5. Which health extension package was highly implemented in your area? (Rank them from the highest to the lowest)

No	Implemented Health extension Package	Rank
A	Family planning	
B	HIV//AIDS prevention	
C	Malaria prevention	
D	Food hygiene	
E	Environmental hygiene	
F	Personal hygiene	
G	Nutrition	

6. Was the health extension package implementation program cost-effective?

A. Yes B. No

7. If Yes, how? _____

8. If No, why? _____

9. Have you transferred the knowledge that you obtained from the training to others? A. Yes B. No

10. If Yes, for how many personnel did you give training _____

11. If Yes, where did you give the training _____

12. If Yes, what type of health extension package training you provided to others

13. If Yes when did you give training _____

14. Did you get reward/incentives when you demonstrate the package in your house? A. Yes B. No

15. If Yes, what kind of reward did you get _____

Who provided the reward _____

Part 5: Issues Related to Community household perception about health extension workers and service provision.

1. Do you agree that the criterion for selecting health extension workers from all kebeles including yours is satisfactory?
A. Strongly agree B. Agree C. Disagree
2. The selection of only female health extension worker's is reasonable.
A. Strongly agree B. Agree C. Disagree
3. If your response to question number 2 is "disagree" could you state the reason?

4. Where does health extension worker live?
A. In the kebele where she works
B. In the woredas town
C. I do not know where she resides D. Others (Specify)
5. How much did you get feedback from health extension workers?
A. Weekly B. Once in two weak C. Monthly D. I do not get
6. Are you satisfied with health extension workers service? A. Yes B. No
7. If your response to question number 6, is No, what is your main reason?

Part 6: General opinions of respondents

1. What are the major health problems in your kebele?

2. What are the opportunities and challenges of the implementation of the health extension program?
Opportunities

Challenges _____

3. What are the major prospects of the implementation of health extension package in your kebele?

Appendix B

Addis Ababa University

School of Graduate Studies

Department of Curriculum and Teachers Professionals Development Studies

Program: Adult and Lifelong Learning

Questionnaire for health extension workers

The main purpose of this questionnaire is to collect relevant and appropriate data from health extension workers concerning the implementation of health extension program. It also aims at providing some possible recommendations for the encountered problems, if there are any. Because your genuine, frank and timely response for each question is quite vital to determine the success and completeness of the study, I cordially request your high collaboration in filling the questionnaire honestly and responsibly.

Thank you in advance for your heart felt collaboration.

Part 1. General Information and Personal Data (circle the letter for your choice)

1. Woreda _____ Kebele _____
2. Age
 - A. 18-25 years and below
 - B. 26-35 years
 - C. 36-45 years
 - D. 46 years and above
3. Sex A. Male B. Female
4. What is your current marital status?
 - A. Married
 - B. Single
 - C. Divorced
 - D. Widowed
 - E. If nay others, specify _____
5. What is your current education level?
 - A. Grade 5-10
 - B. Grade 10/12 complete
 - C. TVET Graduate
 - D. Others _____
6. Experience
 - A. 1-3 years
 - B. 4-6 years
 - C. 7-10 years
 - D. More than 10 years
7. Where do you reside?
 - A. Rented
 - B. With my family
 - C. In the health post
 - D. In woreda town

Part 2: Methods of Health Extension Package Training

Rate the level of health extension package methods that practiced during training, by using 'x' mark in the table in the space provided.

No	Methods of health extension training	Levels of methods of training			
		Frequently	Sometimes	Rarely	Never
1	Lecturing				
2	Group discussion				
3	Demonstration/learning by doing				
4	Drama/in an entertaining way				
5	Picture				
6	Home visit				
7	Others (specify)				

8. What are the major challenges you faced to apply the methods of health extension package training in your practice? (multiple answers are possible)
- A. Lack of teaching materials
 - B. Inconvenience of the teaching classroom
 - C. Shortage of local design teaching aids
 - D. Shortage of time
 - E. Broadness of the package
 - F. Large size of the trainees
 - G. Lack of trainees participation
 - H. Others _____

Part 3 Implementation/demonstration of the Health Extension Package

1. Did the model household implemented/demonstrated the health extension package in their locality? A. Yes B. No
2. If your response to question number 1 is “Yes” Which package did you implemented?

3. If your response to question number 1 is “No” Why? _____
4. Where did the household get available material resource to the implemented package?
 - A. In the health post B. From the community
 - C. NGOs D. From kebele council
5. Which health extension package was highly implemented by the community? (Rank them from highest to the lowest)

No	Package	Rank
A	Family planning	
B	HIV//AIDS prvention	
C	Malaria prevention	
D	Food hygiene	
E	Environmental hygiene	
F	Personal hygiene	
G	Nutrition	

6. Was the implementation of health extension package cost-effective?

A. Yes B. No

7. If your response to question number 6 is "Yes" how? _____

8. If your response to question number 6 is "No" why? _____

Part 4: Issues Related to Administration Activities

1. Did you receive refresher courses about the health package? A. Yes B. No

2. Who provided refresher courses?

3. Where did you get the refresher courses?

4. On which package did you get refresher course?

5. In which health package do you feel need additional refresher course?

6. Why you need refresher course?

7. Have you supervised by woreda health supervisors?

A. Yes B. No

8. If your response to question number 7 is "Yes", how many times did they visit you?

A. Weekly B. Monthly C. Two times in a year

D. Once in a year E. If any other, specify _____

9. Did you get a feedback from the supervision? A. Yes B. No

10. If your response to question number 9 is "Yes", what kind of feedback did you
obtained? _____

11. Did the woreda health office department provide any motivation for you?
 A. Yes B. No
12. If your response to question number 11 is “Yes”, list any of the motivation you gained?

13. What are the major actors which are linked with the health extension package program in your health post? (multiple answers is possible)
 A. Schools B. Religious leaders C. Kebele admistrators
 D. NGOs E. Agricultural extension workers
 F. If any other specify _____

Part 5: Opportunities of the Implementation of Health Extension Package

The contribution of the opportunities to the successes of implementation of health extension package program is listed. Please indicate the degree by using “X” mark on the space provided in the table where

VH -Very highly , H- high , M-Moderate , L-low VL – Very low

No	Opportunities	Rate of frequency				
		VH	H	M	L	VL
1	Health extension program would ensure equitable access to service					
2	Existence of community involvement/participation and acceptable					
3	Decentralization and democratization of health delivery system					
4	The existence of bottom up approaches of health extension package implementation					
5	Low cost intervention to address the major cause of health problem					
6	The existence of female health extension workers					
7	Health extension implementation involves individuals particularly women and children					
8	If any other specify _____					

Part 6: Challenges of the Implementation of Health Package

Challenges that affect the implementation of health extension package program are listed below. Please indicate the degree of the program for each option by using “X” mark on the space provided in the table.

VH -Very highly, H- high, M-Moderate, L-low, VL – Very low

No	Challenges/Problems	Rate of frequency				
		VH	H	M	L	VL
1	Lack of time on health extension workers to cover all health extension package					
2	Lack of text books and reference materials as well as demonstration					
3	Limited facilities for large number of trainees.					
4	Lack of regular supportive supervision from the health center and woreda health office.					
5	In adequacy number of health extension worker to target group ratio.					
6	Poor communication and transportation system and the distances from woreda centers.					
7	Lack of motivation to health extension workers at all levels					
8	Lack of continuous education for health extensions workers					
9	Weak relationship between health extension worker and other sector workers					
10	If any others, specify _____ _____ _____					

Part 7: General opinions of the respondent

1. What are the major health problems in your kebele?

2. What are the opportunities and challenges of the implementation of health extension program?

Opportunities _____

Challenges _____

3. What are the major prospects of the implementation of health extension package in your kebele? _____

Appendix C

Interview questions for zonal and woredas health extension experts

Part I. General Information and Personal Data

1. Address:
Region _____ Zone _____ woreda _____
2. Sex A. Male _____ B. Female _____
3. Age range:
A. 18-24 E. 41-50
B. 25-30 F. Above 50
C. 36-40
4. Qualification
A. 12+ complete C. Diploma E. Above first degree
B. 10 or 12+ certificate D. First degree F. If any others _____
5. Total years of working experience
A. 1-3 years C. 6-9 years E. Above 15 years
B. 3-5 years D. 10-15 years

Part II. About health extension program

1. What is the level of community participation in your woreda?
A. Very high B. High C. Moderate D. Low E. Very low
2. Who organized the community participation in the package training?
3. Where the health extension program training does takes place?
4. Which method of health extension communication highly practiced in your district?
5. What is the level of the demonstration of health extension package by the community in your district?
6. Which type of package highly demonstrated by the community and what factors that encourage the community to demonstrate the package?
7. What problem that negatively influenced the demonstration of health extension package in your district?
8. Is the demonstrated health package relevant to the community need-based?
9. What are the results which obtained after the demonstration of the package?

10. How health extension worker recruited as health extension workers?
11. Did the health extension workers have detailed description of duties and responsibilities on health extension package
12. What are their responsibilities?
13. Did the health extension workers get refresher course about the health package? And who provided refresher course training to the health extension workers?
14. How supervision is conducted to the health extension worker in your woreda?
15. How many times the supervisor visit health extension workers ?
16. Did the supervisor give feedback to health extension workers?
17. In which health extension package the supervisors provided feedback and what kind of feedback they provided?
18. What are the major problems that influence the provision of supervision in your woreda?
19. Was there permanent annual budget to health extension package?
 - A. Yes
 - B. No
20. Who are the sources of for the provision of budget?
21. How much the amount of budget allocated to each kebele

Part III. General Question

1. What are the major health problems in your woreda?

2. What are the opportunities and challenges of the implementation of health extension program?

Opportunities _____

Challenges _____

3. What are the major prospects of the implementation of health extension package in your woreda?

Appendix D

Addis Ababa University

School of Graduate

Department of Curriculum and Teachers Professionals

Development Studies

Program: Adult and Life long Learning

Focus group discussion Leading Questions for model households

Part I Leading Questions

1. What are the major health problems in your locality?
2. Is there a health post in your locality?
3. How do you come and registered in health extension program?
4. In which health extension package you got training?
5. Did the health package training relevant to your need?
6. How about the schedule of the program? Is it convenient for your job?
7. What methods did health extension workers used in teaching-learning process of health extension package? Do they use teaching aid?
8. What is your perception about health extension workers and their service delivery?
9. What is your role for the implementations of the health package?
10. What are your opinion towards all health extension workers being female?
11. What are your suggestion towards the implementation of health extension program?

Part II. General Questions

1. What are the opportunities and challenges of the implementation of health extension program?

Opportunities _____

Challenges _____

2. What are the major prospects of the implementation of health extension package in your woreda? _____

Appendix E

Addis Ababa University

School of Graduate

Department of Curriculum and Teachers Professionals

Development Studies

Program: Adult and Life long Learning

Focus group discussion Leading Questions for health extension workers

1. What are the problem you faced being females?
2. What are your suggestions to improve health extension program in your districts?
3. What is the relationship between you and other sector workers in your kebele?
4. What are the problems that encountered while working in the community?

አዲስ አበባ ዩኒቨርሲቲ
የድህረ ምረቃ ትምህርት ክፍል
በሥርዓተ-ትምህርት እና የመምህራን ሞያዊ ዕድገት
የጎልማሶች ትምህርት ክፍል

የጤና ኤክስቴንሽን ሥልጠና በወሰዱ እማውራ/አባወራና በጤና ኤክስቴንሽን ሰራተኞች የሚሞላ መጠይቅ።

የዚህ መጠይቅ ዋና ዓላማ ስለጤና ኤክስቴንሽን አተገባበር መረጃ ለማሰባሰብና ችግሮች ካሉ ችግሮቹን ለሚመለከተው አካል አሳውቆ መፍትሄ እንዲያገኙ ማድረግ ነው።

ስለዚህ ለእያንዳንዱ ጥያቄዎች ግልጽና ትክክለኛ መልስ መስጠት ለጥናቱ ውጤታማነት አስፈላጊ ነው።

አጠቃላይ መግለጫ

1. ስምዎትን መጻፍ አስፈላጊ አይደለም
2. እያንዳንዱን ጥያቄ ተራ በተራ በማንበብ፡
 - ሀ. መልስ የያዘውን ፊደል ማክበብ እና
 - ለ. በሰንጠረዥ ውስጥ ላሉ ጥያቄዎች የ“x” ምልክት በሰንጠረዥ ባለው ክፍት ቦታ ያስቀምጡ
 - ሐ. አጫጭር መልስ በሚያስፈልግበት ጥያቄ አስተያየትዎትን ያስቀምጡ

ስለትብብርዎ አመሰግናለሁ።

በጤና ኤክስቴንሽን ሰራተኞች የሚሞላ መጠይቅ

ክፍል አንድ: የተጠያቂዎች ግልመረጃ

1. ወረዳ _____ ቀበሌ _____
2. ዕድሜ ሀ. ከ18-25 ዓመት ሐ. 36-45 ዓመት
 ለ. 26-35 ዓመት መ. 46 ዓመት እና ከዛ በላይ
3. ጾታ ሀ. ወንድ ለ. ሴት
4. የጋብቻ ሁኔታ ሀ. ያገባች ሐ. የፈታች
 ለ. ያላገባች መ. ሌላ ካለ ይጥቀሱ _____
5. የትምህርት ሁኔታ
 ሀ. ከ9ኛ -10ኛ ክፍል ሐ. የቴክኒክና ሙያ ምሩቅ
 ለ. ከ11ኛ -12ኛ ክፍል መ. ሌላ ካለ መልስ ይስጡ
6. በጤና ኤክስቴንሽን ሰራተኝነት ምን ያህል አገልግለዋል?
 ሀ. ከ1 እስከ 3 ዓመት ሐ. 7 እስከ 10 ዓመት
 ለ. ከ4 እስከ 6 ዓመት መ. ከ10 ዓመት በላይ
7. የሚኖሩበት የቤት ሁኔታ
 ሀ. ተከራይቼ ለ. ከቤተሰቦቼ ጋር ሐ. በጤና ኬላ ውስጥ/health post

ክፍል ሁለት: የጤና ኤክስቴንሽን ፓኬጅ የሥልጠና አሰጣጥ ዘዴዎች/ስልቶች በተመለከተ በየትኞቹ የጤና ኤክስቴንሽን የአሰላጣጠን ዘዴዎች/ስልቶች ነው እርስዎ ስልጠናውን የሰጡት? የ “x” ምልክት በመጠቀም መልስዎትን በሰንጠረዥ ባለው ክፍት ቦታ በማስቀመጥ የአሰላጣጠን ዘዴዎችን/ስልቶችን መጠን ያሳዩ።

ተቁ.	የጤና ኤክስቴንሽን ፓኬጅ ሥልጠና አሰጣጥ ዘዴዎች/ስልቶች	የሥልጠና አሰጣጥ ዘዴዎች/ስልቶች መጠን			
		በተደጋጋሚ	አልፎ አልፎ	እምብዛም	በፍጹም
1	በገለፃ				
2	በቡድን ውይይት				
3	በሰርቶ ማሳያ የተደገፈ ሥልጠና				
4	በጭውውት/ድራማ መልክ				
5	ቤት ለቤት የሚሰጥ ስልጠና				
6	በምስል/ስዕል የተደገፈ ሥልጠና				
7	ሌላ ካለ ይግለጹ _____				

6. እየተተገበረ ያለው የጤና ኤክስቴንሽን ፓኬጅ ፕሮግራም ወጭ ቆጣቢ ነውን?

ሀ. አዎ

ለ. አይደለም

7. ለተራቁጥር ስድስት መልስዎ “አዎ” ከሆነ ወጭ ቆጣቢ አለመሆኑ ምክንያቱ ምንድን ነው? _____

8. ለተራ ቁጥር 6 መልስዎ አይደለም ከሆነ ወጪ ቆጣቢ አለመሆኑ ምክንያቱ ምንድን ነው? _____

ክፍል አራት: አስተዳደርን በተመለከተ

1. ስለጤና ኤክስቴንሽን ፓኬጅ የማነቃቂያ ሥልጠና አግኝተዋል?

ሀ. አዎ

ለ. አላገኘሁም

2. ለተራ ቁጥር 1 መልስዎ አዎ ከሆነ በሚከተሉት ጥያቄዎች ላይ መልስዎትን ይስጡ

ሀ. ማነው የማነቃቂያ ሥልጠናዎችን ያዘጋጀው? _____

ለ. የትነው የማነቃቂያ ሥልጠናዎችን ያገኙት? _____

ሐ. በየትኛው የጤና ፓኬጅ ነው የማነቃቂያ ስልጠና ያገኙት? _____

መ. በየትኛው የጤና ፓኬጅ ነው ተጨማሪ የማነቃቂያ ስልጠና የሚፈልጉት? _____

ሠ. ለምንድን ነው ተጨማሪ የማነቃቂያ ሥልጠና የፈለጉት? _____

3. በወረዳው የጤና ኤክስቴንሽን ባለሙያ ቁጥጥርና ክትትል ተደርጎልዎታልን?

ሀ. አዎ

ለ. አልተደረገልኝም

4. ለተራ ቁጥ ሶስት መልስዎ “አዎ” ከሆነ በምን ያህል ጊዜ ነው ክትትል የሚያገኙት?

ሀ. በየሳምንቱ

ለ. በየወሩ

ሐ. በየስድስተ ወሩ

መ. በዓመት አንድ ጊዜ

5. ክትትልና ቁጥጥር ከሚያደርገው የወረዳው የጤና ኤክስቴንሽን ባለሙያ መጋቢ ምላሽ (feedback) አግኝተዋል? ሀ. አዎ ለ. የለም

6. ለተራቁጥር አምስት መልስዎ “አዎ” ከሆነ ያገኙት መጋቢ ምላሽ (feedback) ምንድን ነው? _____

7. ከወረዳው የጤና ኤክስቴንሽን የማበረታቻ ድጋፍ ይደረግልዎታልን?

ሀ. አዎ

ለ. የለም

8. በተራ ቁጥር ሰባት አንድ መልስዎ “አዎ” ከሆነ ምን አይነት የማበረታቻ ድጋፍ የተደረገለዎት ይዘርዘሩ _____

9. የጤና ኤክስቴንሽን ፓኬጅ ለመተግበር ማጣቀሻ መጻሕፍትና በራሪ ወረቀት አለዎት?

ሀ. አዎ ለ. የለም

10. እርስዎ ካሉበት ቀበሌ ለጤና ኤክስቴንሽን ፓኬጅ ተግባራዊነት በዋናነት የሚቀሰቅሱት አካላት እነማን ናቸው? (ከአንድ በላይ መልስ መስጠት ይቻላል)

ሀ. ት/ቤቶች ለ. የሀይማኖት ተቋማት ሐ. የወረዳው ቴና ጽ/ቤት
 መ. መንግስታዊ ያልሆኑ ተቋማት ሠ. የግብርና ኤክስቴንሽን ሰራተኞች
 ረ. ሌላ ካለ ይጥቀሱ _____

11. ከወረዳው የጤና ጽ/ቤት ያለዎት ግንኙነት ምን ያህል ነው?

ሀ. ዝቅተኛ ለ. መካከለኛ ሐ. ጠንካራ መ. በጣም ጠንካራ

ክፍል አምስት: የጤና ኤክስቴንሽን ፓኬጅ ለመተግበር የተፈጠሩ ምቹ ሁኔታዎች

የጤና ኤክስቴንሽን ትግበራ ውጤታማ ለማድረግ የተፈጠሩ ጥሩ አጋጣሚዎች በሰንጠረዥ ተዘርዝረዋል። የ“x” ምልክት በመጠቀም መልስዎን በሰንጠረዥ ባለው ክፍት ቦታ ያስቀምጡ

ተቁ.	ጥሩ አጋጣሚ	ምቹ ሁኔታዎች				
		በጣም ክፍተኛ	ክፍተኛ	መካከለኛ	ዝቅተኛ	በጣም ዝቅተኛ
1	የጤና ኤክስቴንሽን ፕሮግራም ለሁሉም ሰው እኩል አገልግሎት መስጠቱ					
2	የህብረተሰቡ ተሳታፊነትና ተቀባይነት መኖሩ					
3	ዴሞክራሲያዊ የሆነ የተማክለ የጤና አገልግሎት መኖሩ					
4	የጤና ኤክስቴንሽን ፕሮግራም ወጪ ቆጣቢ በመሆኑ					
5	የጤና ኤክስቴንሽን ሰራተኛ ሴቶች መሆናቸው					
6	የጤና ኤክስቴንሽን አተገባበሩ እናቶችና ልጆችን ያማክሉ መሆኑ					
7	ሌላ ካለ ይግለጹ _____					

ክፍል ስድስት፡ የጤና ኤክስቴንሽን ፓኬጅ ለመተግበር የሚያጋጥሙ ችግሮች በተመለከተ የጤና ኤክስቴንሽን ፓኬጅ ለመተግበር የሚያጋጥሙ ችግሮች በሰንጠረዥ ውስጥ በተራቁጥር ተዘርዝረዋል፡ የ“x” ምልክት በመጠቀም መልስዎን በሰንጠረዥ ባለው ክፍት ቦታ ያስቀምጡ።

ተቁ.	ችግሮች	የችግሮች ደረጃ				
		በጣም ከፍተኛ	ከፍተኛ	መካከለኛ	ዝቅተኛ	በጣም ዝቅተኛ
1	ሁሉንም የጤና ፓኬጅ ለመሸፈን የጊዜ እጥረት መኖሩ					
2	የሰርቶ ማሳያም ቁሳቁስ ሆነ ማጣቀሻ መጽሀፍ እጥረት					
3	የበጀት እና በቂ የተማሪ ሃይል ያለመኖሩ					
4	መደበኛ የሆነ ክትትልና ቁጥጥር እጥረት ከጤና ጣቢያውም ሆነ ከወረዳው የጤና አስተዳደር ጽ/ቤት መኖሩ					
5	ከህብረተሰቡ ቁጥር ብዛት አንጻር ተመጣጣኝ ያልሆነ የጤና ኤክስቴንሽን ሰራተኛ መኖሩ					
6	ለጤና ኤክስቴንሽን ሰራተኞች የማበረታቻ እጥረት መኖሩ					
7	የጤና ኤክስቴንሽን ሰራተኞች ተከታታይ ትምህርት አለማግኘታቸው					
8	በጤና ኤክስቴንሽን ሰራተኞችና በሌላ መስራቤት ሰራተኞች መካከል ያለው ግንኙነት ደካማ መሆኑ					
9	ሌላ ካለዎ ይግለጹ _____					

ክፍል ሰባት፡ አጠቃላይ ያለዎት አስተያየት

1. በጤና ኤክስቴንሽን ትግበራ የታዩ ጥሩ አጋጣሚዎችና ችግሮች ምንድን ናቸው?
 ጥሩ አጋጣሚ _____

ችግሮች _____

2. እርስዎ በሚሰሩበት ቀበሌ የጤና ኤክስቴንሽን ፓኬጅ ፕሮግራም በመተግበሩ ለወደፊቱ ምን አይነት ለውጥ ያመጣል ብለው ያስባሉ?

ክፍል አንድ፡ የተጠያቂዎች ግለመረጃ

1. ወረዳ _____ ቀበሌ _____
2. ያታ _____ ሀ. ወንድ ለ. ሴት
3. እድሜ ሀ. ከ18 እስከ 25 ዓመት ሐ. ከ36 እስከ 45 ዓመት
 ለ. ከ26 እስከ 35 ዓመት መ. 46 ዓመት በላይ
4. የጋብቻ ሁኔታ ሀ. ያገባ/ች ሐ. ሌላ ካለ ይጥቀሱ _____
 ለ. ያላገባ/ች
5. የትምህርት ሁኔታ ሀ. ያልተማረ ማንበብና መጻፍ የማይችል ሐ. ከ1-8ኛ ክፍል
 ለ. ያልተማረ መጻፍና ማንበብ ብቻ የሚችል መ. ከ9ኛ ክፍል በላይ
6. የሥራ ሁኔታ ሀ. ገበሬ ለ. የቤት እመቤት
 ሐ. ተማሪ መ. ነጋዴ ሠ. ሌላ ካለ ይጥቀሱ _____

ክፍል ሁለት፡ በጤና ኤክስቴንሽን ፓኬጅ ሥልጠና የእማውራን/አባውራ ተሳትፎ በተመለከተ

1. እርስዎ የጤና ኤክስቴንሽን ፓኬጅ ሥልጠና አግኝተዋል? ሀ. አዎ ለ. አላገኘሁም
2. ለተራቁጥር “1” መልስዎ “አዎ” ከሆነ ሥልጠናውን ያገኙት መቼ ነው?

3. ለተራቁጥር “1” መልስዎ “አልወሰድኩም” ከሆነ ሥልጠና ያልወሰዱበት ምክንያት ምንድን ነው?

4. ለስልጠናው ተሳታፊ እንዲሆኑ ያደረገዎ ማነው?
 ሀ. የጤና ኤክስቴንሽን ሰራተኛዎ ለ. የቀበሌ አስተዳዳሪዎች ሐ. ሌላ ካለ ይጥቀሱ
5. የትነው የጤና ኤክስቴንሽን ሥልጠና የሚሰጠው (ከአንድ በላይ መልስ መስጠት ይቻላል) ሀ. በቀበሌ ጽ/ቤት ሐ. በመኖሪ ቤቶች አካባቢ
 ለ. በሐይማኖት ተቋማት መ. በሥራ ቦታ ሠ. ሌላ ካለ ይጥቀሱ _____
6. የጤና ኤክስቴንሽን ሥልጠና ከእራስዎ ባህልና ቋንቋ ጋር ተያያዥነትና ተዛማጅነት አለው ብለው ያስባሉ? ሀ. አዎ ለ. አይደለም
7. ለተራቁጥር 6 መልስዎ “አይደለም” ከሆነ ተያያዥነት ያልሆነበት ምክንያት ምንድን ነው?

8. ለተራቁጥር 6 መልስዎ “አዎ” ከሆ ተዛማጅነቱና ተያያዥነቱን እንዴት ይገልጡታል?

9. የጤና ኤክስቴንሽን ፓኬጅ ሥልጠና እርስዎ የሚኖሩበትን አካባቢ ተጨባጭ እውነታ ያገናዘበ ነው ብለው ያምናሉ ወይን? ሀ. አዎ ለ. አይደለም
10. በተራ ቁጥር 9 መልስዎ “አዎ” ከሆነ የሥልጠናውን ተጨባጭ እውነታ እንዴት ይገልጹታል?

11. ለተራ ቁጥር 9 መልስወዎ “አይደለም” ከሆነ ምክንያቱ ምንድን ነው? _____

12. በእያንዳንዱ የጤና ኤክስፔንሽን ፓኬጅ የእርስዎን የተሳትፎ መጠን/ደረጃ የ”X” መልክት በመጠቀም በሰንጠረዥ ባለው ክፍት ቦታ መልስዎን ያስቀምጡ

ተቁ.	የፓኬጅ አይነት	የተሰጠው ዋጋ				
		በጣም ከፍተኛ	ከፍተኛ	መካከለኛ	ዝቅተኛ	በጣም ዝቅተኛ
ሀ	የግልና የአካባቢ ንጽህና አጠባበቅ በተመለከተ					
1	የደረቅና ፈሳሽ አያያዝና አወጋገድ ፓኬጅ					
2	የቤት መገልገያ እቃዎች አያያዥና አጠባበቅ በተመለከተ					
3	የምግብ ንጽህና አጠባበቅ ፓኬጅ					
ለ	በሽታዎችን መከላከልና መቆጣጠር በተመለከተ					
1	ኤች አይቪ ኤድስንና ሌሎች የአባላዘር በሽታዎችን መከላከልና መቆጣጠር					
2	የሳንባ ነቀርሳ/ቲቢ በሽታ መከላከልና መቆጣጠር					
3	ወባን መከላከልና መቆጣጠር					
ሐ	የቤተሰብ ጤና እንክብካቤ ፓኬጅ					
1	የእናቶችና ህጻናት ጤና አጠባበቅ					
2	የቤተሰብ እቅድ ፓኬጅ					
3	የወጣቶች ሥነ-ተዋልዶ ጤና ፓኬጅ					
4	የሥነ ምግብ ፓኬጅ					

5. የትኛው የጤና ኤክስፔንሽን ፓኬጅ ነው እርስዎ በሚኖሩበት አካባቢ በዋናነት የሚተገበረው? ተራቁጥር በመጠቀም መልስዎን በሰንጠረዥ ባለው ክፍት ቦታ ከከፍተኛ ወደ ዝቅተኛ ያስቀምጡ?

ተ.ቁ	የተተገበረው የጤና ኤክስፔንሽን ፓኬጅ	ደረጃ
ሀ	የቤተሰብ እቅድ ፓኬጅ	
ለ	ኤች. አይቪ. ቫይስን መከላከልና መቆጣጠር	
ሐ	ወባን መከላከልና መቆጣጠር	
መ	የምግብ ንጽህና አጠባበቅ	
ሠ	የአካባቢ ንጽህና እንክብካቤ	
ረ	የግል ንጽህና	
ሠ	የሥነ-ምግብ ፓኬጅ	
ሸ	ሌላ ካለ ይጥቀሱ? _____	

6. የጤና ኤክስፔንሽን ፓኬጅ ፕሮግራም አተገባበር በራስዎ ሁኔታ ሲታይ ወጭ ቆጣቢ ነውን ብለው ያስባሉ? ሀ. አዎ ለ. አይደለም
7. ለተራቁጥር 6 መልስዎ “አዎ” ከሆነ ወጭ ቆጣቢነቱን እንዴት ይገልጡታል?
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8. ለተራቁጥር 6 መልስዎ “አይደለም” ከሆነ ወጭ ቆጣቢ አለመሆኑ ምክንያቱ ምንድን ነው? _____
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9. በጤና ኤክስፔንሽን ሥልጠና ያገኙት እውቀት ለሌላ ሰው አካፍለው ያውቃሉ ወይ? ሀ. አዎ ለ. አላካፈልኩም
10. ለተራቁጥር “9” መልስዎ “አዎ” ከሆነ ለሚከተሉት ጥያቄዎች መልስዎትን ይስጡ ሀ. ለምን ያህል ሰው ስልጠና ሰጥተዋል _____ ለ. የት ቦታ ነው ሥልጠናውን የሰጡት _____ ሐ. በየትኛው የጤና ኤክስፔንሽን ፓኬጅ ላይ ነው ያገኙትን ስልጠና ለሌላ ሰው ያካፈሉት _____ መ. መቼ ነው ሥልጠናውን ለሌላ ሰው የሰጡት _____
11. ለተራቁጥር “9” መልስዎ “አላካፈልኩም” ከሆነ ምክንያቱን ይዘርዝሩ? _____
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12. የጤና ኤክስፔንሽን ፓኬጅ በመተግበርዎ የማበረታቻ ሽልማት አግኝተዋል? ሀ. አዎ ለ. አላገኘሁም
13. ለተራ ቁጥር “12” መልስዎ “አዎ” ከሆነ ለሚከተሉት ጥያቄዎች መልስዎትን ይስጡ ሀ. ምን አይነት የማበረታቻ ሽልማት ነው ያገኙት? _____ ለ. ሽልማቱን የሰጠዎት አካል ማን ነው? _____

ክፍል አምስት: ስለጤና ሰራተኞችና የጤና አገልግሎት አሰጣጣቸው የእማወራ/የአባወራ የህብረተሰብ አካላት እይታን በተመለከተ።

1. የጤና ኤክስቴንሽን ሰራተኞች የአመላመል መስፈርት እርስዎ በሚኖሩበት ቀበሌም ሆነ በሌሎች ቀበሌ ነዋሪዎች መሆን አጥጋቢ ነው ብለው ይስማማሉ?

ሀ. በጣም እስማማለሁ

ሐ. ሙሉ በሙሉ አልስማማም

ለ. በመጠኑ እስማማለሁ

መ. ሌላ ካለ ይግለጹ _____

2. ለተራቁጥር “1” መልስዎ “አልስማማም” ከሆነ ምክንያቱ ምን እንደሆነ ይዘርዝሩ

3. የጤና ኤክስቴንሽን ሰራተኞች ሴቶች ብቻ በመሆናቸው ትክክል ነው ብለው ይስማማሉ? ሀ. በጣም እስማማሁ ለ. በመጠኑ እስማማለሁ

ሐ. ሙሉ በሙሉ አልስማማም

4. የጤና ኤክስቴንሽን ሰራተኞች የሚኖሩት የት ነው?

ሀ. በሚሰሩበት ቀበሌ

ሐ. የት እንደሚኖሩ አላውቅም

ለ. በወረዳው ከተማ

መ. ሌላ ካለ ይጥቀሱ _____

5. በጤና ኤክስቴንሽን ሰራተኞች የሚሰጡት የጤና አገልግሎቶች አጥጋቢ ናቸው ብለው ያምናሉ? ሀ. አዎ ለ. አይደለም

6. ለተራ ቁጥር 5 መልስዎ “አይደለም” ከሆነ አጥጋቢ ያልሆነበት ምክንያት ምንድን ው?

ክፍል ስድስት: አጠቃላይ ያለዎት አስተያየት

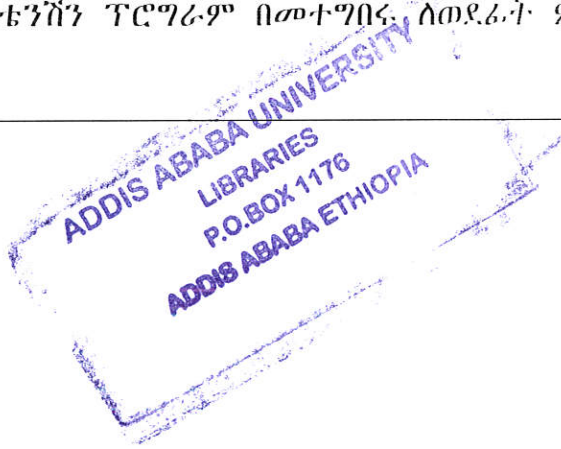
1. በእርስዎ አካባቢ ዋና ዋና የጤና ችግሮች የሚባሉት ምን ምን ናቸው ይዘርዝሩ

2. በጤና ኤክስቴንሽን ትግበራ የታዩ ጥሩ አጋጣሚዎች ችግሮች ምንምን ናቸው?

ጥሩ አጋጣሚ _____

ችግሮች _____


3. እርስዎ በሚኖሩበት አካባቢ የጤና ኤክስቴንሽን ፕሮግራም በመተግበሩ ለወደፊት ምን ዓይነት ለውጥ ያመጣል ብለው ያስባሉ?



DECLARATION

I, the under signed, declared that this thesis my original work and has not been presented for a degree in any other university, and that all source of materials used for the thesis have been duly acknowledged.

Name: Eshetu Yimer

Signature: 

Date: 15-6-2010

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

Name: Enguday Ademe (PHD)

Signature: 

Date: 16 June 2010

