

**ADDIS ABABA UNIVERSITY COLLEGE OF HEALTH SCIENCES**

**SCHOOL OF PUBLIC HEALTH**



**Assessment of the role of health extension workers in improving utilization of family planning services in Libido /Mareko Woreda, Guraga zone, Southern Nation, Nationalities and Peoples Regional state**

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## List of Acronyms

<b>AIDS</b>	Acquired Immune Deficiency syndrome
<b>ARV</b>	Antiretroviral
<b>CBRHAs</b>	Community Based Reproductive Health agents
<b>CHAs</b>	Community Health Agents
<b>CHW</b>	Community Health Worker
<b>CPR</b>	Contraceptive Prevalence Rate
<b>DHS</b>	Demographic and Health Survey
<b>EDHS</b>	Ethiopian Demographic and Health Survey
<b>FGD</b>	Focus Group Discussion
<b>FP</b>	Family Planning
<b>FWAs</b>	Family Welfare Assistants
<b>HDA</b>	Health Development Army
<b>HEP</b>	Health Extension Program
<b>HEWs</b>	Health Extension Workers
<b>HIV</b>	Human Immunodeficiency Virus
<b>HP</b>	Health Post
<b>HSDP</b>	Health Sector Development Program
<b>L10K</b>	Last 10 Kilometer
<b>MDG</b>	Millennium Development Goal
<b>MNCH</b>	Maternal, Newborn and Child health
<b>MOH</b>	Ministry Of Health
<b>NGO</b>	Non Governmental Organization

<b>PHC</b>	Primary Health Care Unit
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>RH</b>	Reproductive Health
<b>SNNPR</b>	Southern Nation, Nationalities and Peoples Region
<b>TTBAs</b>	Trained Traditional Birth Attendants
<b>USAID</b>	United States Agency for International Development
<b>VCHWs</b>	Volunteer Community Health workers
<b>WHO</b>	World Health Organization

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## **Abstract**

**Background:** Family planning service, one of the health extension package which mainly implemented at health post by health extension workers and which play major role in reducing maternal and newborn morbidity and mortality. This thesis focuses on the assessment of role of health extension workers on family planning service utilization

**Objective:** To assess the role of health extension workers in improving utilization of family planning services in Libido/Mareko Woreda, Gurage zone Southern Nation, Nationalities and Peoples regional state

**Methods:** The study used both quantitative and qualitative study methods. The quantitative method employed community based cross-sectional study design to assess role of Health extension workers in family planning services utilization in Libido/Mareko Woreda during the month of March 2013. Data for the quantitative study was collected using a structured questionnaire from a total sample size of 348 respondents. The number of women with in reproductive age group was systematically selected from 10 randomly selected kebeles and the number of households included in the study was proportionally allocated to selected kebele. For qualitative data focus group discussion was conducted in four groups with purposely selected health extension workers, health workers from health center and Woreda health office and 1to5 leaders and annual family planning service report from 1996 to 2004 Eth.c of the Woreda was also reviewed by using checklist. Data obtained was compiled, analyzed and interpreted accordingly.

**Results:** Current use of contraceptive was found to be 57.8% of which majority (77.6%) of the respondents use the injectable methods. Women who were age group 25-34(AOR= 0.334 (95 CI; 0.17-0.67)), who were married (AOR=89.22 (95 CI; 1.61-4956.04)), who were orthodox Christian (AOR=0.12 (95 CI; 0.02-0.78 )) as well as who were heard about family planning (AOR=0.14 (95 CI; 0.04-0.47)) and who were participated on family planning related activity (AOR=0. 20 (95 CI; 0.11-0.35)) were more likely to demonstrate good utilization of family Planning service. In Focus group discussion health extension workers mentioned that they have got enough support from the health center and Woreda health office. In addition, the 1to5 network leader and kebele administrators witnessed that improvements of family planning service have been observed after the arrival of the health extension workers.

**Conclusion and Recommendations:** This study demonstrated that the roles of health extension workers were crucial for the improvement of family planning service utilization in the Woreda. The significant factors influencing family planning service utilization were age, marital status, religion, information about family planning service and participation on family planning related activity. More effort is needed from different stakeholders to strengthen the role of health extension workers on the utilization of family planning services. In addition, women's participation in family planning related activity, access to family planning information and health education on FP could be targets for future interventions.

## **1. Introduction**

### **1.1 Background**

Improving maternal, newborn and child health (MNCH) remains an important global health objective, particularly in developing countries with high rates of maternal and neonatal mortality rate(1). Evidence for high-impact and low-cost MNCH interventions continues to accumulate but have yet to be adopted in the majority of these high risk settings. Implementing these interventions presents a challenge to the global health community primarily due to weak health systems and human resource constraints. Particularly in Africa, the health worker crisis affects coverage and quality of health services (2). Family planning service considered as an essential component of PHC and RH, plays a major role in reducing maternal and newborn morbidity and mortality(3, 4). Family planning is a means of promoting the health of women and families and part of a strategy to reduce the high maternal, infant and child mortality. Couples shall be offered the opportunity to determine the number and spacing of their own children. Information about FP should be made available, and should actively promote access to FP services for all individuals desiring them(3, 5).

The Ethiopian health service is restructured in to three tier system consisting of Primary Health Care Unit ( Health post designed for 3,000-5,000 population, health center for 15,000-25,000 people, and primary hospital for 60,000-100,000 people),Secondary Level Health Care( General Hospital serving 1-1.5 million people) and Tertiary Level Health Care(Specialized Hospital for 3.5 – 5 million people)(6).There are currently more than 17,300 health facilities in Ethiopia: 14,416 Health Posts, 2689 Health Centers and 195 hospitals. The potential health service coverage is 90% but much more remains to be accomplished to ensure universal access. In terms of human resources, there is a critical shortage of staff, as demonstrated by health staff to population ratio. For instance, the current physician to population ratio is 1:36,710 which are far below the WHO standard (4, 6, 7).

In response to inadequate numbers of health personnel, Ethiopia has been training and deploying different categories of volunteer community health workers (VCHWs) in the past four decades. These CHWs include trained traditional birth attendants (TTBAs), community based reproductive health agents (CBRHAs) and community health agents (CHAs). However, to accelerate the expansion of primary health care coverage and to ensure equitable access to health

services, the government of Ethiopia started deploying specially trained new cadres of community based health workers named Health Extension Workers (HEWs). This initiative has been called the Health Extension Program (HEP). The HEP has been introduced in recognition of the failure of essential services to reach the people at the grassroots level in particular to underserved rural population(8).

The HEP focuses on community-based interventions, including the promotion of family planning align PHCU with community-based approach to the delivery of quality reproductive health and family planning (RH/FP) services(9). HEWs spend 75 percent of their time visiting families in their homes and performing outreach activities in the community. The remaining 25 percent is spent providing services at the health posts, including family planning (condom, pills, implalon, injectable), immunization and others (4, 9).

This study focuses on the extent to which health extension worker have contributed to the improvement of utilization of family planning services by women in Woreda.

### **Statement of the problem**

Family planning service is one of the health extension packages which mainly implemented at health post by health extension workers and which play major role in reducing maternal and newborn morbidity and mortality. Ethiopia implements Health Extension Program in all regions which is mainly function community based intervention from which Provision of Family Planning services at community level is one of the activity which addressed by HEWs (10). Family Planning reduces mortality and morbidity from pregnancy and childbirth. Spacing childbirth at intervals of three to five years significantly reduces maternal, prenatal, and infant mortality rates. Using family planning prevents the depletion of maternal nutritional reserves and reduces the risk of anemia from repeated pregnancies and births(10).

Most of the existing in relation to the health extension program in Ethiopia is carried out focusing on the perspectives and views of providers, ignoring the community views. In addition to this, most of the studies employed quantitative methodologies. There are some studies that tried to use qualitative methods but still emphasized in quantifying the results. It is not reliable to quantify the impression of people to the HEP program and also numerically measuring the interaction between the various groups may produce superficial results(11)

In other words, most studies have assessed some concerns about the preparedness at the Woreda and other levels to support the training and work of HEW focusing on what is not addressed in the provision of facilities.

Having to this, this study was tried to see the overall role of the HEWs focusing on the family planning service utilization and their interaction with community, 1to5 leaders and others health workers in Libido/Mareko Woreda.

## **2. Literature review**

### **2.1 Definition and principle of CHW**

The CHWs are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments(10, 12). According to the World Health Organization, CHWs “should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers”(12).

CHWs in different countries play many roles such as provide ambulatory care, serve as liaisons between facilities and community members and have varying levels of training and responsibility(12). They usually share ethnicity, language, socioeconomic status and life experiences with the community members they serve(13). They have been identified by many titles (nearly 36). Some of them are community health advisors, lay health advocates, promoters, outreach educators, community health representatives, peer health promoters, and peer health educators(14).

### **2.2 Ethiopian context of Community Health Workers (CHWs):**

Ethiopia has a long experience in implementing CHW programs since 1960's (14) .Ethiopia has been training and deploying different categories of volunteer community health workers (VCHWs) in the past four decades. These CHWs include trained traditional birth attendants (TTBAs), community based reproductive health agents (CBRHAs) and community health agents (CHAs)(4). Partly, in response to the critical shortage, however, maintaining the programs sustainable and obtaining their effective contribution had left an important challenge. In the past, many CHW programs had failed, mainly, due to lack of community and health institution support. Thus, Ethiopia with such challenges needs to increase rapidly the number of health workers at the (rural) community level where the need is greatest (14).

For this reason Ethiopia want to accelerate the expansion of primary health care coverage and to ensure equitable access to health services, the government of Ethiopia started deploying specially trained new cadres of community based health workers named Health Extension Workers (HEWs). This initiative has been called the Health Extension Program (HEP). The HEP has been

introduced in recognition of the failure of essential services to reach the people at the grassroots level in particular to underserved rural population. It was designed based on the concept and principles of comprehensive primary health care(4, 8).

### **2.3 The Health Extension Program Concept: Definition and principle**

The Extension Program (HEP) is defined as a package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of PHC, it is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom. HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facility-based services(8).

HEWs are responsible for explaining and promoting health extension components such as disease prevention and control, family health, hygiene and environmental sanitation and health education and communication at community level (15)

Furthermore, HEWs address the health need of each member of the household as individual and as a household unit. HEP is improving access and equity to preventive essential health interventions at the village and household levels, accessing health services by increasing health care coverage to the rural areas by ensuring ownership and participation of community by increasing health awareness, knowledge, and skills totally the HEP aim is to improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through HEWs (11).

In addition to this the government of Ethiopia implements the new initiative which is called scale up strategy the main activity of this strategy is a scale up health extension packages (HEPs) in a short period of time with high coverage. The core issue to ensure scale up strategy is building a capacity of community and participation by establishing health development army (HDA) 1to5 network. HDA is the best mechanism to build the capacity of all involved in the implementation of health more than ever, to improve capacities of families at the household level by forming 1to5 networking the household heads in the area of skill and attitude. Besides the HDA approach builds strong support and monitoring mechanism in identifying bottlenecks and gaps and seeking solutions as early as possible. health development army address the issue of community

mobilization especially in the area of family planning, skill delivery and others by the help of HEWS and kebele administrator (16).

#### **2.4 Health service accessibility and availability**

Global evidence shows that CHWs increase the accessibility of the health service. Especially to reduce the maternal mortality by increasing the availability of family planning service in grassroots level(17). Family planning is one of the four pillars of the Safe Motherhood Initiative to reduce maternal death in developing countries(18). The evidence indicates that a well-implemented community health workforce can improve health seeking behaviors and provide low-cost interventions for common maternal and child health issues, while enabling improvements in the continuum of care(19).

In planning for health care services in any society, special arrangements have to be made to ensure the availability of services to persons who reside in remote or rural areas. Today, millions of people in low- and middle-income countries do not have access to basic, good quality health services. Most policy considerations of health care for rural areas deal in some fashion with the difficult issue of defining minimally adequate levels of service and equity in access to care(20).

The government of Ethiopia is recognizing the importance of FP for health and development, a country with a population of more than 79.5 million(5) is engaged in a range of efforts to improve access and quality of FP services in accelerated manner through HEWS. HSDP-IV has put an ambitious target of increasing the CPR from 32% to 65% by 2015(21).

Beside this the government of Ethiopia implements PHCU which is one health center for five health post to facilitate support in case of plan preparation, implementation and logistic at all Woreda level with Woreda health office especially in the implementation of Health extension package(22).

#### **2.5 Family planning and Health Extension Worker**

In most of the developing country, there is a shortage of trained health professionals; especially all of sub-Saharan Africa critical shortage health professionals. Furthermore, the poorest of the poor and the least educated are also the least likely to utilize health services, even when they are available. Consequently, 200 million women worldwide who want access to safe and effective

modern contraceptives do not have it. This leads to higher rates of unintended pregnancies, unsafe abortions, and pregnancy and childbirth complications(17).

The review of CHWs across the globe provided us an interesting and diverse picture of the current scenario in outreach services of health care workers. There is a wide range of services offered by the CHWs to the community, ranging from provision of safe delivery, contraceptives, counseling on breast-feeding. The services offered by CHWs have helped in the decline of maternal death(23).

Community Health Workers (CHWs) can considerably increase coverage where access to health facilities is difficult and service utilization is already low. They can play a vital role in increasing access to family planning and working within a community-based team to educate women on the importance of attending antenatal, delivery, and postnatal care with a skilled professional(17). WHO report show the effectiveness of community-based interventions with CHWs is important to increase coverage particularly HIV care, PMTCT, ARV therapy and give information to the patients(19)(24).

Family planning was once a sensitive issue in Indonesia, but today it is considered essential. This paper reports on the role of village family planning volunteers and the cadres. The volunteers and cadres have made a significant contribution to the implementation of the family planning programme in Indonesia. They promote family planning, organize meetings, provide information, organize income-generation activities, give savings and credit assistance, collect and report data and deliver other family welfare services. As their activities are directed towards women, especially in women's traditional roles, the programme tends to entrench the existing gender gap in responsibility for family planning and family welfare(25).

A study done in Bangladesh showed the increasing contraceptive prevalence rate since 1978 due to the efforts of the female grassroots family planning workers known as family welfare assistants (FWAs). Which show the increasing the acceptors of permanent methods and modern methods, also it show significant increase of sterilization. These findings explain the huge increase in use of modern reversible methods in Bangladesh since 1975(26).

Community-based projects are currently operating in 40 countries, including the program in Oyo State in southwest Nigeria. The report shows the utilization of volunteer community workers to expand the availability and accessibility of primary health care services, family planning

information, and nonprescription contraceptives in rural areas. These workers play a vital role in linking the village with government health facilities. The responsibilities of community health workers are promotion contraceptive and other services. After 2 years of program services in Oyo State, approval of family planning increased from 20% to 50% and the desire to postpone the next pregnancy beyond the period of postpartum abstinence increased from 15% to 34%. Knowledge of a modern family planning method rose from 24% to 45%. Current use of contraception rose from 1.5% to 4.5%(27).

A study done in Uganda showed the importance of community health workers reduce morbidity and mortality in children under five and neonates; and trained traditional birth attendants may improve prenatal outcomes and appropriate referrals(28).

Assessment conducted by USAID/African bureau, USAID/Population and RH with ministry of Ethiopia, Malawi, Rwanda showed health extension worker are credited with the achievement of doubling contraceptive prevalence from 2005-2011(29).

A study done by L10K in 2009 showed HEWs can effectively provide Family planning with a broad method mix and improvements in the contraceptive prevalence rate (CPR) exceeded rates of maternal care use with the exception of antenatal care: Amongst married women of reproductive age, there was a 32% rate in 2008/9, 29% reported in 2008 and a 16% CPR in L10K areas in 2005(30).

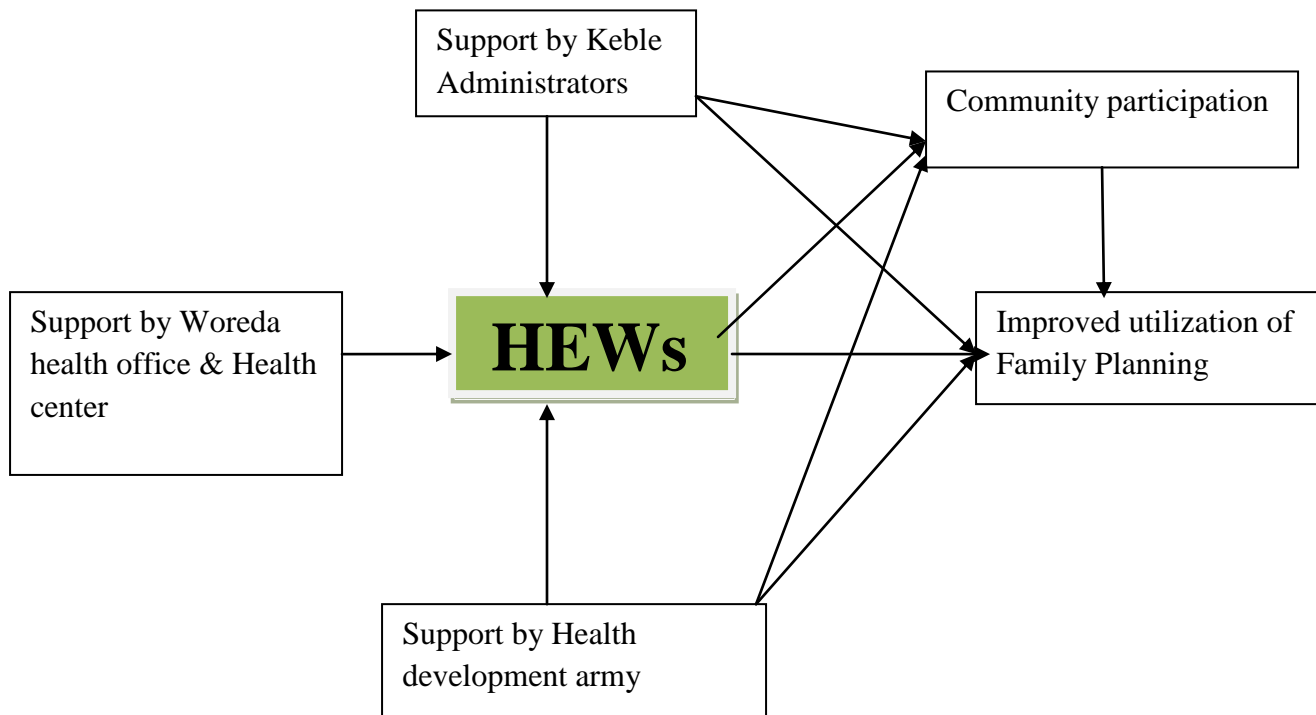
A study done in Jima zone showed HEWs have contributed substantially to the improvement in women's utilization of family planning, antenatal care and HIV testing. However, their contribution to the improvement in health facility delivery, postnatal check up and use of iodized salt seems insignificant(20).

Family planning, considered an essential component of PHC and RH, plays a major role in reducing maternal and newborn morbidity and mortality. It contributes to the achievement of the MDGs(4). One of targets of the Ministry of Health, with respect to improving maternal and child health, is to increase the contraceptive prevalence rate (CPR) to 66 percent by 2015. In order to achieve this target, the Ministry has given priority to the provision of safe motherhood services such as family planning in the community (31) mainly by using the HEWs .

The major leap forward over the past 6 years is provision of FP services at community level through the Health Services Extension Program. The Program has deployed more than 31,000, government employed, Health Extension Workers (HEWs) in all rural kebeles (villages) of the country with the aim to cover 500 households (or about 2500 population) by each HEW with a package of primary health services. For FP, the HEWs are engaged in distributing condoms and pills and are providing injectables, Implanon at community and health post level(4).

Libido /Mareko Woreda is one of the Woreda from 811 Woreda in the country; Health Services Extension Program was implemented since 2003 starting from that time there was no study which showed the role of the program on family planning service utilization improvement. This study is important for the Woreda decision maker and it is also important for other researchers to give information.

The purpose of this study was to explore the influence of the introduction of health extension workers in Libido/ Mareko Woreda improving utilization of family planning service



**Figure 1: Conceptual framework showing the role of Health Extension workers to enhance coverage of family planning service**

### **3. Objectives**

**3.1. General Objective:** To assess the role of health extension workers in improving utilization of family planning services in Libido/Mareko Woreda, Guraga zone, SNNPR

#### **3.2 Specific objectives**

- To assess utilization of family planning service and method mix that are available at community level in the Woreda
- To identify factors affecting the provision of family planning service by the health extension workers
- To assess the degree and type of support to HEWs by health facilities, Woreda health office and the community

## **4. Methods and materials**

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

The study was conducted in Libido/ Mareko Woreda from March 2012 up to June, 2013. Libido /Mareko district is found in Guraga Zone, SNNP Regional State in southern part of Ethiopia. The Woreda capital, kosha town is found 158 kms south of Addis Ababa and 124 Kms away from the Regional Capital, Hawassa and 286 kms from the Zonal Capital, wolkit. The Woreda is surrounded by in the Waste masekan Woreda, East and North Oromiya region, in South Sileta zone. The Woreda is divided in to 25 kebeles and one town with a total population of 75,306 of which 51 % are females. There were 3 Health Centers, 25 Health Posts and 50 HEWs in the Woreda.

### **4.2 Study design**

The study used a cross-sectional study design. To supplement and substantiate the quantitative data a qualitative method was also used.

### **4.3 Source of population**

The Source populations were all childbearing women aged (15-49 years) in Libido/Mareko Woreda during the study period and The HEWs, 1to5 leaders, kebele administrators and health workers are for qualitative

### **4.4 Study population**

The study populations were all childbearing women aged (15-49 years) in the sampled 10 kebeles of the Woreda.

### **4.5. Inclusion and exclusion criteria**

#### **Inclusion criteria**

All childbearing women aged (15-49 years) and capable to provide information were included in the study.

#### **Exclusion criteria**

All women who were not in childbearing age and incapable of providing information

#### **4.6. Sample size determination**

The sample size was determined by using single population proportion formula. By taking 29% national family planning prevalence (31) at 95% CI ( $z=1.96$ ), 5% (0.05) margin of error (d) and expected non response rate of 10%.

$n = ((Z\alpha/2)^2 p (1 - p)) / d^2$ , Sample size calculation formula for single population.

Where

n= Sample size; z= alpha risk express in z-score

Standard score at level of significance of 0.05 (z) is 1.96

p= prevalence

$$n = ((Z\alpha/2)^2 p (1 - p)) / d^2 = ((1.96)^2 0.29(1-0.29)) / (0.05)^2 = 316$$

Total sample size = 316 + 10% non response = 348 women of childbearing age and 4 focus group discussion which had 10 -12 participant in each group

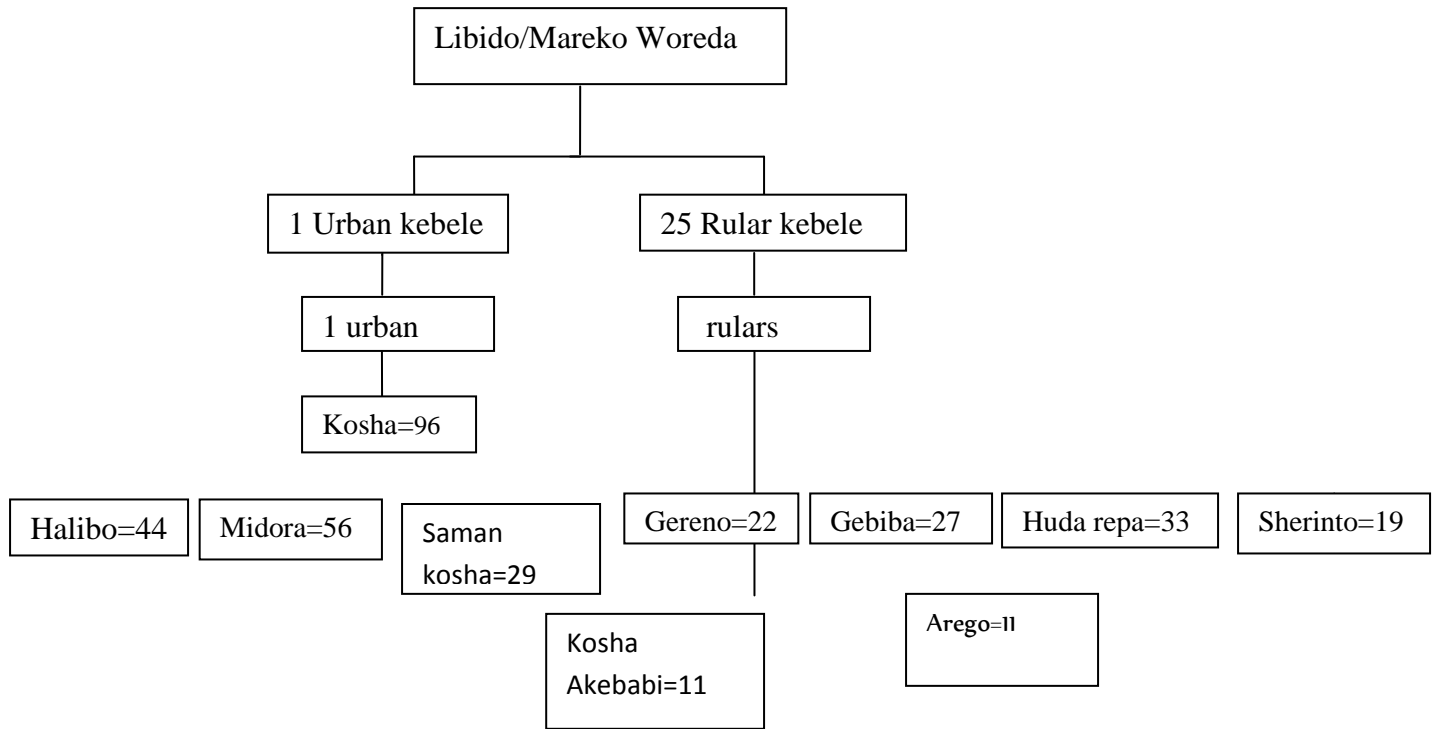
#### **4.7. Sampling procedures**

**Quantitative**

There are 25 rural and one urban kebele in the Woreda. The study was conducted in 10 kebeles which were selected by using simple random sampling method. The women who include in the study were selected by using systematic random sampling methods. The size of sample for each kebele was allocated proportionally based on number of population per kebele.

**Qualitative**

Focus group discussion was conducted in four groups with purposely selected health extension workers, health workers from health center and Woreda health office, 1to5 leaders and kebeles administrator and also annual family planning service report was reviewed.



Total=348 sample

**Figure 2: Graphic presentation of sampling procedure**

#### **4.8. Data collection tools and techniques**

Data was collected using interviewer-administered standardize and pre-tested structured questionnaire prepared by reviewing prior study and other materials on the topic. Pretest was conducted on volunteer women in the Woreda, who were not included in the study and necessary changes were made after the testing. Questionnaire content was socio demographic, knowledge, accessibility and acceptability of family planning service. Focus group discussion was conducted in four groups in each group there was 12 participants. The way of grouped members were HEWs and health workers from the health center and Woreda office in one group and on the other hand 1to5 network leaders and kebele administrators were on the other group and the questionnaire was mainly on the introduction of health extension worker important to improve the family planning service utilization. Data collection was done by investigator with note taker. Furthermore ten year Woreda annual family planning service report document were reviewed by

using checklist and the checklist content was, number of family planning user by year, types of family planning method and completeness of report.

The investigator provided a one day training before the data collection for eight data collectors who were diploma Nurses. Training was provided on data collection procedure including how to approach study participants to get reliable results. A health officer supervisor checked all the questionnaires on daily basis.

#### **4.9 Data Analysis procedure**

Data was entered; cleaned and analyzed using SPSS version 20 software by investigator and descriptive statistics was used to describe baseline demographic data, logistic regression was used to assess utilization of family planning services.

#### **4.10. Study Variables**

➤ **Dependant variable**

- ✓ Utilization of family planning services.

➤ **Independent variables**

- ✓ Socio demographic characteristics: Age, religion, sex, educational status, marital status, annual income
- ✓ Community support to HEWS
- ✓ Kebele administrators support
- ✓ Health development army support
- ✓ role of the HEWs
- ✓ Health center and Woreda health office support

#### **4.11. Data quality management**

To enhance the reliability of the tools used in this study; questionnaires were prepared by reviewing prior study and other materials on the topic. Moreover, the instruments were pre-tested on a similar population (5% of the actual sample size) which was not included in the study. The data collectors and supervisors were trained to familiarize with the tool and the overall purpose of the research project. Continuous checking of the completed questionnaires (10% of the questionnaire was filled each day) was carried out by the Principal Investigator. After completion of data collection, all data filled was checked for completeness.

#### **4.12. Ethical consideration**

Ethical clearance was obtained from the Ethical Review Committee of Addis Ababa university school of public health In addition, communication through letter was do to get permission from Woreda administration and oral consent was obtained from each participant

## 5 RESULTS

### 5.1 Quantitative study;

#### 5.1.1 Socio demographic characteristics

A total of 348 women in child bearing age participated in the study giving a response rate of 99.7%. The mean age of the respondents was 27.66 year. From the total respondents, 325 (93.4%) were married and the mean number of children per woman was 3.35. Two hundred thirty six (67.8%) respondents were Muslim and 207(59.5%) were Libido/Mareko by ethnicity. More than half 198, (56.9%) were unable to read and write. Farming is the main occupation for 223 (64.1%) of respondents and 130 (37.4%) respondent has annual income between 3001-5000 Eth. Birr.

**Table 1: Socio demographic characteristic of respondent in libido/Mareko Woreda 2013**

Factors	Number	percentage
Age		
15-24	83	23.9%
25-34	206	59.1%
35-49	59	17.0%
Marital statuses		
Single	23	6.6%
Married	325	93.4%
Family size		
1-4	128	36.8%
5-8	183	52.6%
>8	37	10.6%
Number of children		
0-4	250	71.8%
5-8	93	26.7%
>8	5	1.4%
Educational statuses		
Unable to read and write	198	56.9%
Read and write	39	11.2%
Grade 1-8	85	24.4%
Grade 9-12	19	5.5%
Religion		
Orthodox Christian	55	15.5%
Muslim	236	67.8%
Protestant	49	14.1%
Catholic	8	2.3%
Ethnicity		
Amhara	18	5.2%

Seleta	44	12.6%
Gurage	55	15.8%
Libido/mareko	207	59.5%
Others (wolayita , hadiya and Oromo)	24	6.9%
<b>Occupational statuses</b>		
Farmer	223	64.1%
Merchant	39	11.2%
Government employee	10	2.9%
house wife	59	17.0%
Other(student, day labor )	17	4.9%

### 5.1.2 Knowledge of Family Planning Methods

Among the participants, 324(93.1%) heard about family planning and among these 100(30.86%) knew injectable methods, 75(23.1%) knew Implanol, injectable & pills, 56(17.3%) knew injectable & pills and 31(9.6%) knew tubal ligation, implanol, injectable, IUCD, condom & pills. On the other hand 58(16.7%) replied they often learned health education on family planning at health facility, 242(69.5%) respondent learned sometimes and the rest respond never. HEWs gave the education for the majority 216(62.1%) respondents.

**Table 2: knowledge of contraceptive methods of respondent in libido/Mareko Woreda 2013**

<b>Factors</b>	<b>Number</b>	<b>Percentage</b>
<b>Heard about methods of family planning</b>		
Yes	324	93.1%
No	24	6.9%
<b>Methods known</b>		
Short acting methods	310	61.9%
Long acting methods	155	30.9%
Permanent methods	31	6.2%
Natural methods	5	0.9%
<b>Family planning health education by health facility</b>		
yes often	58	16.7%
Sometime	242	69.5%
Never	48	13.8%
<b>Does health extension workers education on FP</b>		
Yes	216	62.1%
No (Health center and others)	132	37.9%
<b>Available facility for family planning service</b>		
Yes	324	93.1%

No	24	6.9%
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### 5.1.3 Accessibility and Acceptability health facility

Three hundred twenty four (93.1%) of the respondents know about the presence of a health facility providing family planning service in the community. Among these 324 respondents 185(57.1%) identified health post followed by health center 136(39.1%). From the total participants, 222(63.8%) reported that they visit health post frequently and 125 (35.9%) reported that they visit health center. Two hundred sixteen (62.1%) respondents got family planning counseling at health posts and 110(31.6%) were getting from a health center and the rest from private clinics. Among these 216 respondent 188(87%) replied that they have got good counseling from health extension workers while the remaining 28(13%) didn't get good counseling.

Among the respondents 61(17.5%) replied they are highly satisfied with the family planning service, 209(60.1%) responded being satisfied and 52(14.9%) replied not satisfied and 26 (7.5%) respondents reported to feel bad towards the service.

**Table 3: Accessibility and acceptability health facility of respondent in libido/Mareko Woreda 2013**

Factors	Number (%)	Percent
<b>Facility to get family planning service</b>		
Heath post	185	57.1%
Health centre	136	42.0%
Others(Hospital, HDA and Private)	3	0.9%
<b>Nearest health facility frequently visited</b>		
Heath post	223	64.1%
Health centre	125	35.9%
Private clinic	1	0.3%
<b>Mostly get consult about FP</b>		
Heath post	216	66.6%
Health centre	110	33.9%
Private and HAD	18	5.5%
<b>Good counseling</b>		
Yes	188	92%
No	28	8.0%
<b>Satisfaction on family planning service</b>		

Highly satisfied	61	17.5%
Satisfied	209	60.1%
Not satisfied	52	14.9%
Bad	26	7.5%

#### 5.1.4 Family Planning service

The majority 223(64.1%) of the respondents were participate in family planning related activity and 125 (35.9%) were not. From these 223 respondent 115(51.6%) were participated in mobilizing others to use family planning, 52(20.4%) were participated in Discussion on FP issues or Mobilizing others or Informing about FP service to use family planning methods. On the other hand, 108 (48.4%) respondent replied moderate participation, 78(35%) replied active participation, 29(13%) replied very active participation.

From three hundred forty eight respondents 201 (57.8%) were use contraceptive always while 13 (3.7%) of the respondent use sometimes. On the other hand, 134 (38.5%) reported that they were not currently using any method to avoid or delay pregnancy. From 214 respondent 166 (77.6%) of the respondent using a contraceptive method were using injectable contraceptive methods while 31(14.5%) of them were using implanol and 15(7%) were using oral contraceptive pills. most of the respondent 139(69.15%) who use the contraceptive methods use the method without stopping for 1-24 month while 44 (21.89%) respondent use the method without stopping for 25-48 month. Interestingly, the initial sources of information for majority of the respondent (64%) using contraceptives were the health extension workers followed by radio (15.4%) and health facility (10.3%). Other sources are health development army and friends/neighbors.

**Table 4: Family planning service usage of respondent in libido/Mareko Woreda 2013**

Factors	Number	Percentage
<b>Participation on family planning related activities</b>		
Yes	223	64.1%
No	125	35.9%
<b>The way you participate</b>		
Discussion on FP issues	28	12.5%
Discussion on FP issues or Mobilizing others or Informing about FP service	52	20.4%
Mobilizing others	115	51.6%
Informing about FP service	28	12.5%
<b>Rate your participation</b>		
Very active	29	13%

Active	78	34.8%
Moderate	108	48.4%
Passive	6	2.7%
Very passive	2	0.9%
<b>You currently doing something or using any method to avoid pregnancy/delayed</b>		
yes always	201	57.8%
Sometimes	13	3.7%
No	134	38.5%
<b>Which method you or your parent currently using</b>		
Tubal ligation	2	0.9%
Implanol	31	14.5%
Injection	166	77.6%
Pills	15	7.0%
<b>Month of current methods without stopping</b>		
1-24	139	67.0%
25-48	44	20.6%
>48	31	14.4%
<b>Initial source you receive the information</b>		
Media	33	15.4%
HEW	137	64.0%
HF	22	10.3%
Friends or neighbors	19	8.9%
HAD	3	1.4%

### 5.1.5 Factors associated with FP utilization

Bivariate analysis was done by applying binary logistic test to assess any association between Socio demographic variables and Family planning service utilization. Amongst the socio demographic variables, age group, marital status as well as religious status and family size are significantly associated with Family planning utilization ( $p$ -values < 0.05). those who were in the age group of 35-49 were about 0.59 times less likely utilize family planning service when compared to those who are in the age group of 25-34 (COR=0.41 (95 CI; 0.27-0.88)). Regarding marital status, single women were about 0.80 times less likely utilize family planning service when compared with those who were married (COR=0.20 (95 CI; 0.08-0.52)) as well as those who have more than 8 family size were about 0.40 times less likely utilize family planning service when compared with those who have between 1-4 family size (COR=0.60 (95% CI (0.38-0.96))) and catholic religion followers were about 6.17 times more likely utilize family planning

service when compared with those who were orthodox Christian (COR=6.17(95 CI; (1.13-33.64)). In the bivariate analysis number of child, education, occupation and household income were not significantly associated with Family planning utilization (p-values< 0.05).

Regarding knowledge about family planning, heard about family planning and health education on family planning were significantly associated with Family planning service utilization (p-values< 0.05). Those who didn't heard about FP were 6.91 times more likely utilize family planning service when compared with those who have heard about FP (COR=6.91(95 CI;(2.51-18.98)). These who haven't get health education on FP at health post were 3.18 times more likely utilize family planning service when compared with those who were educated often (COR= 3.18(95 CI;(1.38-7.36)). On the other hand, those who didn't get health education on FP at health post were 2.356 times more likely utilize family planning service when compared with those who were educated (COR= 2.356(95 CI; (1.207-4.596))

Binary logistic regression was also done to test association between accessibility and acceptability of health facility and family planning service utilization. From the accessibility and acceptability of health facility variables; place of Family planning service, place of consultation for FP, satisfaction on family planning service as well as participation on family planning related activities were significantly associated with Family planning service utilization (p-values< 0.05). Those who didn't know place of family planning service delivery were about 4.30 times more likely to utilize family planning service when compared to those who knew service delivery place of FP (COR=4.30(95 CI;(1.73-10.66)). Those who got consultation about FP at privet clinic were 3.525 times more likely utilize family planning service when compared with those who got consultation at health post (COR=3.52( 95% CI;1.18-10.51)). Those who badly satisfied on HF service were 4.24 times more likely utilize family planning service when compared with those who were highly satisfied (COR=4.24(95% CI; (1.48-12.13)). Those who badly satisfied on HF service were 6.74 times more likely utilize family planning service when compared with those who were satisfied (COR=6.74 (95% CI; (2.76-16.47)). Likewise, those who badly satisfied on HF service were 4.04 times more likely utilize family planning service when compared with these who were not satisfied (COR=4(95% CI; (1.89-8.63)). Those who were not participate on family planning related activity were 3.728 times more likely utilize family planning service when compared with those who were participated on family planning related activity (COR=3.73(95% CI; (2.35-5.92)),

Regarding accessibility, nearest health facility was not significantly associated with Family planning utilization (p-values < 0.05).

### **5.1.6 Multivariate analysis**

Numerous associations were found to be significant in the bivariate analysis. Therefore, Multivariate approach was applied to determine which factors best explained and predict family planning service utilization while adjusted for other factors. Consequently a number of variables like, age, marital status, religion, information about family planning and participation on FP related activity were found to be significant on multivariate analysis; those who were in the age group of 35-49 were about 0.67 times less likely utilize family planning service when compared to those who were in the age group of 25-34 (AOR=0.33 (95 CI; (0.17-0.67))). Regarding marital status, single women were about 89.22 times more likely utilize family planning service when compared with those who were married (AOR=89.22 (95 CI; (1.61-4956.04)) and catholic participants were about 0.88 times less likely utilize family planning service when compared with those who were orthodox Christian (AOR=0.12 (95 CI; (0.02-0.78))). Regarding knowledge, those who didn't heard about FP were 0.86 times less likely utilize family planning service when compared with those who have heard about FP (AOR=0.14 (95 CI; 0.14(0.04-0.47))). Similarly, those who didn't participate on FP related activity were 0.80 times less likely utilize family planning service when compared with those who were participated on family planning activity (AOR=0.20 (95 CI; (0.11-0.35))

**Table 5: Bivariate and multivariate analysis of variable of respondent in libido/Mareko Woreda 2013**

Factors	Utilization of FP service		Crude OR (95% CI)	Adjusted OR (95% CI)
	YES	NO		
<b>Age distribution</b>				
15-24	40 (48.2%)	43 (51.8%)	1.19(0.61-2.32)	
25-34	143(69.4%)	63 (30.6%)	0.41(0.27-0.88)*	0.334(0.17-0.67)*
35-49	31 (52.5%)	28 (47.5%)	1	1
<b>Marital Status</b>				
Single	6(26.1%)	17(73.9%)	1.0	1
Married	208(64%)	117(36%)	0.14(0.04-0.51)*	89.22(1.61-4956.04)*
<b>Family size distribution</b>				
1-4	70(54.7%)	58(45.3%)	0.60(0.38-0.96)*	
5-8	122(66.7%)	61(33.6%)	0.82(0.40-1.73)	
>8	22(59.3%)	15(40.5%)	1	
<b>Number of child distribution</b>				
0-4	156(62.4%)	94(37.6%)	1.15(0.70-1.86)	
5-8	55(59.1%)	38(40.9%)	1.11(0.18-6.74)	
>8	3(60%)	2(40%)	1	
<b>Religious status</b>				
Orthodox Christian	37(67.3%)	18(32.7%)	6.17(1.13.64)*	0.12(0.02-0.78 )*
Muslim	139(59.9%)	97(41.1%)	1.43(0.77-2.67)	
Protestant	36(73.5%)	13(26.5%)	0.74(0.32-1.73)	
Catholic	2(25%)	6(75%)	1.0	1
<b>Occupation of the head of the house</b>				
Farmer	142(63.7%)	81(36.3%)	0.457(0.45-1.34)	
Merchant	24(61.5%)	15(38.5%)	0.40(0.40-1.09)	
Government employee	5(50%)	5(50%)	0.44(0.44-1.40)	
House wife	36(61%)	23(39%)	0.70(0.70-3.370)	
Other(student and day lobar)	7(41.2%)	10(38.8%)	1	
<b>Educational status</b>				
Unable to read and write	118(59.6%)	80(40.4%)	1	
Can read and write	29(74.4%)	10(25.6%)	0.51(0.23-1.10)	

Grade 1-8	56(65.9%)	29(34.1%)	0.76(.45-1.30)	
Grade 9-12	8(44.4%)	10(55.6%)	1.84(0.70-4.87)	
Twelve complete	3(37.5%)	5(62.5%)	2.46(0.57-10.58)	
<b>Income range distribution</b>				
300-3000	55(61.8%)	34(38.2%)	1.0	
3001-5000	76(58.5%)	54(41.5%)	1.15(0.66-2.00)	
5001-10,000	63(63.6%)	36(36.4%)	0.92(0.51-1.67)	
>10,001	20(66.7%)	10(33.3%)	0.81(0.34-1.93)	
<b>heard methods of FP</b>				
Yes	209(64.51%)	115(35.5%)	6.91(2.51-18.98)*	0.14(0.04-0.47)*
No	5(20.8%)	19(79.2%)	1	1
<b>Facility to get FP service</b>				
Yes	207(63.9%)	117(36.1%)	4.30(1.71-10.66)*	
No	7(29.2)	17(70.8%)	1	
<b>Nearest health facility frequently visited</b>				
Health post	133(59.9%)	89(40.1%)	1	
Health center	81(64.3%)	45(35.7%)	0.84(0.53-1.32)	
<b>Mostly get consult about FP</b>				
Health post	133(61.6%)	83(38.4%)	3.52(1.18-10.51)*	
Health center	72(64.3%)	40(35.7%)	0.88(0.55-1.42)	
Others(private clinic)	9(45%)	11(55%)	1.0	
<b>Health education on FP at HF</b>				
Yes often	45(77.6%)	13(22.4%)	3.18(1.38-7.36)*	
Sometimes	144(59.5%)	98(40.5%)	2.36(1.21-4.60)*	
Never	25(52.1%)	23(47.9%)	1.0	
<b>Satisfaction of FP service</b>				
highly satisfied	52(85.2%)	9(14.8%)	4.24(1.48-12.13)*	
Satisfied	123(58.2%)	86(41.8%)	6.74(2.76-16.47)*	
Not satisfied	24(46.2%)	28(53.8%)	4.04(1.89-8.63)*	
Bad	15(57.7%)	11(42.3%)	1	
<b>Participate in family planning</b>				
Yes	162(72.6%)	61(27.4%)	3.73(2.35-5.92)*	0.20(0.11-0.35)*
No	52(41.6%)	73(58.4%)	1	1

## **5.2 Qualitative study:**

### **5.2.1 Health Extension Workers and Health workers from health center and Woreda health office**

A total of 20 participants were participated in two groups, which consisted; HEWs, health center staff & Woreda health office staff. The research questions were organized under seven major categories with probing questions. In each group; the discussion was started after introducing each other and the researcher followed provoking questions to HEWs. Almost all of the HEWS mentioned that, *“we gave implanol, injectable, condom and pills at health post and also injectable, condom and pills home to home. Most of the client get service at health post beside this we gave health education on different types of family planning methods”*. In addition to this majority of HEWs reported that, *technical support from the Woreda and health center they obtain was enough; some of them reported it was least while those who were from Arego and Shirinto suggested that the support they receive was good. From the participant one HEW reported that, “beside what my friends said Woreda provide training, stationery materials and call for meeting on how to improve family planning activities. Most of HEWs said that, “the wareda office staff visit to our health post and gave support on registration and reporting”*

*All HEWs reported that “Furthermore the newly indorsed health center and health post linkage was important for us because one health center staff assigned to each health post who support weekly based program in addition to this health center support us by contraceptive logistic and they provide reporting format”. In addition, they gave us orientation on how to progress and work on improvement of our activities to got preferred change”. Another HEW continued to say, “they also call community leader, kebele administrator and religious leader together to discuses on the activity of health post and how to work together to be more effective”.*

*HEWs also reported that “kebele administrator support us mobilizing the community to participant on family planning issues furthermore we have meeting with them regularly. During our meetings, not only reporting but also we discuss on the problems we faced on our progress. We raise and discuss one by one situation that appeared to be barrier to our work and solutions to these problems together”.*

*On the other hand one HEW said, “There was a health development army (HDA). This army networked in to 1to5 group with one leader. Leader was best performer due to this he help us by insisting the members to use family planning methods and leading by example”.*

*HEWs continued to say “the main challenge was commodity shortage especially implanol, GV, savelon .The other main challenge raised during the discussion was religion related issue and work related like Agricultural work (tefass, mertzer and the like) which hinder our effort to achieving our best coverage of family planning. Some of them mentioned side effect as one factors to hinder the provision of family planning service”.*

*The Woreda staff said that “` they gave supportive supervision at monthly based for all package not only for family planning`”.*

*At the end the Woreda health office manager delegate “compare the family planning service before the introduction of HEWS and after introduction and said that “`I believe that all the packages had been implemented especially family planning were one of the main package as far as my knowledge concerned contraceptive coverage improved time to time after the introduction of HEWs. It takes a long time to change human behavior for better utilization of the program services. But now, what was being observed was that the people are using family planning services in all kebeles at the Woreda”.*

### **5.2.2 Chairman of the Kebele and 1to5 network leaders**

Totally 24 participant were participated in FGD which held in two kebele the group discussion member were chairman of the kebele and 1to5 network leaders. The research questions were organized under four categories with probing questions. In each group; the discussion was started after introducing each other and the researcher followed provoking questions to group, during the discussion one of the 1to5 network leader said that, “we work with HEWs by educating our network members about family planning usage and disadvantage of having more children. After having detail discussion with each other if anyone wants to use family planning method we link them to HEWs”. Not only that but also leader lead the member in an exemplary way. One discussant explained, “As to our kebeles great change were observed after the arrival of HEWs”. Furthermore all 1to5 leaders mention that, “regarding improvements of family planning

activities participants confirmed that great improvement or change has occurred after the arrival of HEWs". *The improvements observed include; "increased awareness about choice and use of family planning service". The majority of the participants agreed that, "all women in the kebele currently can get family planning services within their kebele "*.

The kebele chairman said that *"we support HEWs by mobilizing the community and giving orientation for the community to perform the activity as well as by working the activity with HEWs. As a result of this, most of the women who live in the kebele benefited from the service provided by the HEWs especially family planning service. dida midore"*.

Another one from halibo kebele said, that *"Change has occurred. Every women who want contraceptive in the kebele can get from the HEWS. Previously it was distant for us to go to health center in addition awareness about FP was low to seek service but now there is health post just in our kebele as well as HEWs are came to our home and HEWs provide family planning service at home and facility based"*

### **5.2.3 Overall HEWs role in family planning service**

*During the FGD, the HEWs were asked about the overall situation of FP in their respective kebeles. Accordingly, they mentioned that, "the community has awareness and actively participating in the program including regular household visit and health post services. Nowadays, community awareness about FP was better and they know about the advantages and disadvantage of having many children". On the other hand, the Woreda health office manager delegate confirmed that, "after HEWs assigned to kebele, they have seen many important progress in FP service utilization as compared with at the beginning of the program. This progress was achieved due to a great role of HEWs" and also the 1to5 network leader confirmed that, the role of health extension was visible.*

#### 5.2.4 Document review

A total of 10 year annual report of family planning coverage of Woreda were reviewed by using checklist

1995 Eth.c	1996 Eth.c	1997 Eth.c	1998 Eth.c	1999 Eth.c	2000 Eth.c	2001 Eth.c	2002 Eth.c	2003 Eth.c	2004 Eth.c
Document not found	16.1%	26%	20% 6 month report	20%	26.4% 9month report	46.7% 6 month	35%	37	38

When we see the complete year report it seems that the family planning service coverage was increasing from time to time. In line with this, when I subtract family planning coverage before the introduction of HEWs from 2004 Eth.c family planning coverage 22% which was high difference when compared with after the introduction of HEWs. This difference was might be due to the HEWs

## 6 Discussions

This was a cross sectional study done to assess the role of health extension worker in utilization of family planning service in Libido/Mareko Woreda, Guraga zone, SNNP regional state. Focusing on where the most women obtained family planning service, 57.1% women who receive family planning service at the health post and the initial sources of information for majority of the women (64. %) using contraceptives were the health extension workers followed by radio (15.4%) this shows that the health extension workers role were high. This was very important because Knowledge of family planning is preconditions to get access and using an appropriate contraceptive method in successful way. In Other way the most of respondent got health education by health extension workers this shows that the health extension workers role were high The contraceptive prevalence rate was 57.8% of which the majority (77.6%) of the respondents was using injection form of contraceptive method followed by Implanol (15.4%). The prevalence was high as compared with other study done in different parts of the country and EDHS 2011 of regional (26%) and national (29%) coverage. The method mix distribution depicted the increased long acting family planning service uptake whereas, previous studies done around North shewa zone oromia regional state showed that, the majority uses injectable and followed by pills form of contraceptive method (32) which seems to be a shift from use of pills to Long acting .

In focus group discussion the participant mention the role of HEWs in family planning service utilization is big share since arrival. this result is consistent with study done in Jimma and review done on responding to the maternal health care challenge in the Ethiopian Health Extension Program which showed Since the introduction of HEP, there has been an increase in the proportion of women who have utilized family planning service (10)

The multivariate regression analysis identified the socio-demographic variable, age group, marital status and religion were significantly associated with family planning service utilization. In addition, the knowledge factors information about family planning service and participation of family planning related activity were significantly associated with family planning service. Finding of this study showed that women in the age range 25-34 were more likely to use family planning when compared to women in age range of 35-49 years. The result was consistent with 2011 EDHS report. This shows that current contraceptive use was lower among older women

than among those at the intermediate age groups(31) and also a study done in Dubti Afare regional state which show Maternal age was strongly correlated with maternal health care utilization. Since the younger and the older women differ in their experience and influence of the health seeking behavior was likely to vary between younger and older women(33).

Marital status also in this study shows statistically significant association that means the married women were more likely to use family planning service as compared to single women. This study was consistent with a study done in Kenya showed the marital status of the woman increase the likelihood of using family planning services(34) and also study done in Pakistan showed married women was more likely use family planning service(35)

Religion also showed significant association with the FP service utilization which shows orthodox Christian were more likely use family planning service. This study was consistent with study done Dubeti Christian religious an important factor in the use of maternal health service(33) and the study done in Nigeria religious beliefs and cultural beliefs forbidden utilization of family planning service(36)

Those who got information or who have awareness about family planning service use family planning service more likely than their counter part. This study was consistent with studies done in northwest Ethiopia and Jimma Town, Southwest Ethiopia which showed that, knowledge of contraceptive has increased family planning service (37, 38) as well as study done in Pakistan showed women who have access to have gained knowledge of family planning methods, potentially reducing cognitive barriers to use family planning service (35) and the study done in Nigeria showed knowledge of contraceptive that has significant influence on the utilization of family planning services by women in Kubwa Nigeria(information influence the proper utilization of family planning services in Kubwa)(36)

Community participation was one of main factor which was associated with family planning service utilization this study consistent with desk review of community participation in family planning which done by UNFPA which showed Community Participation strengthening the capability of women in particular and local communities in general to play a major role in Reproductive Health and Family Planning (RH/FP) service (39)

In this study the FP coverage, initial information on family planning, health education and other factors showed that the role of the health extension were high

## **Strengths**

- ❖ High response rate.
- ❖ The study employed both qualitative and quantitative methods

## **Limitations**

- ❖ Some variables were measured with a single item question, which might reduce the level of reliability.

## **7 Conclusion and Recommendations**

### **7.1 Conclusion**

This study demonstrated that the roles of health extension workers were crucial for the improvement of family planning service utilization in the Woreda.. Moreover contraceptive prevalence rate was higher at study area. This study verified that improvement of family planning service utilization and most important factors influencing family planning service utilization were age, marital status, religion, information about family planning service and participation on FP related activity

In conclusion, this study has shown Access and coverage of FP service and FP information has significantly improved since the introduction of the HEWs.

### **7.2 Recommendations**

Based on the findings of this study I recommend the following areas to receive due attention by the HEWs, supervising health center, Woreda health office.

For HEWs

- Information provision methods should be attractive to emprise contraceptive user
- More focus give for married women

For supervising Health center & Woreda health office

- Community participation at the village level among all stakeholders was very encouraging. to sustain this achievements support and follow up from the Woreda health office, Health centers are required
- Give more attention to sustainable contraceptive logistic management system in order to ensure adequate supplies at health post
- More focus give for religious leader to increase contraceptive user

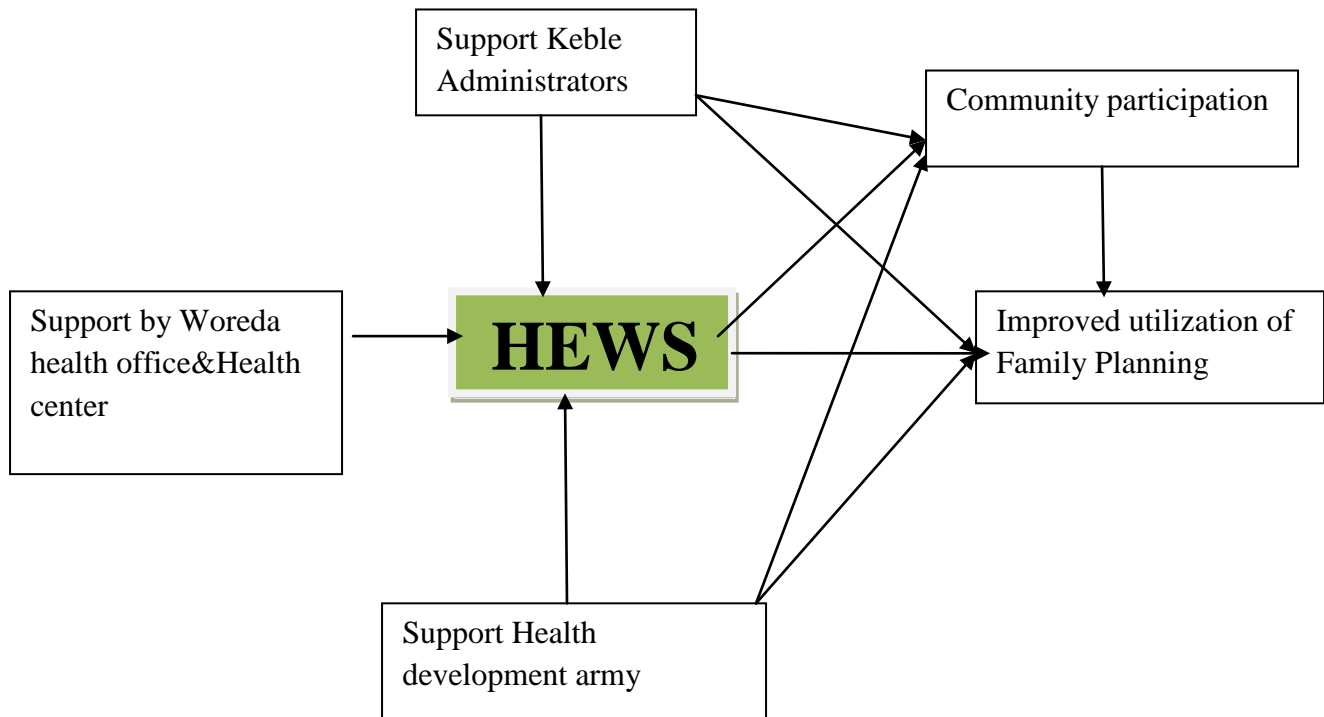
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## Appendix A Conceptual framework



Conceptual framework: The role of Health Extension workers to enhance coverage of family planning service.

## **Annex B: Information Sheet to get Permission for the Research**

This sheet is to be read for the participants of the study. Good morning/afternoon, my name is ---  
----- and I am one of the data collectors for the study being conducted by Addis Ababa University, College of Health Sciences, School of Public Health on the assessment of the role of health extension workers in improving utilization of family planning services in libido/mareko. You are selected scientifically to be participant of this study if you give me consent after you have understood the following information sheet:

**Title of the study:** A cross sectional studies the assessment of the role of health extension workers in improving utilization of family planning services in Libido/ Mareko.

**Back ground of the study:** Family planning service, considered an essential component of PHC and RH, plays a major role in reducing maternal and newborn morbidity and mortality. To reduce maternal mortality community based intervention is basic. Since 2003 the government of Ethiopia has been deploying specially trained new community based health workers named health extension workers (HEWs). This initiative has been called the health extension program. HEP contain 16 package from which family planning is one of the package implemented by the health extension worker. This study will investigate the role of health extension workers in improving utilization of family planning service

**Objective of the study:** To assess the role of health extension workers in improving utilization of family planning services in Libido/Mareko

### **Benefit of the study:**

- The participant will not get any direct benefit for being participant
- The result can be used as a baseline for further studies that can be done in this wareda.
- The result will be used to design method to improve utilization.
- The result will be disseminated to Libido/ Mareko district Health Office.

**Harm of the study:** the study has no any harm except that participant will spend up to 30 minutes in the interview.

### **Rights of the participant:**

- participation has full right
- Not participate

- The participant can stop participating in the study at any time
- The participant can skip question which she does not want to respond
- During the interview, the participant can ask questions which are not clear

**Confidentiality:** - the secrecy of any information forwarded will be maintained

**Persons to contact:**

This research project will be reviewed and approved by the institutional review board of Addis Ababa University. If you want to know more information you can contact the Committee through the address below. If you have any question you may contact the following individuals.

**Investigator:**

**Gemechu Kufa:** Addis Ababa University, College of Health Sciences, School of Public Health, Department of General Master of public health, Tel -0924152491, P.O.BOX 1234, Email: - gemechukuffa@yahoo.com

**Advisors: Dr Mesfin addissie (MD, MPH):** Addis Ababa University, College of Health Sciences, School of Public Health dean.

**Annex C: Amharic information sheet**

**ለሚጠናው ጥናት ማብራሪያ መስጫ ቅፅ**

**መግቢያ ፤** ይህ የመረጃ ቅፅ የሚዘጋጀው ለሚጠናው ጥናት አስፈላጊ ማብራሪያ ለመስጠት ነው። የጥናቱ ዋና አላማ ምርምሩ በወረዳው ያሉ ጤና ኤክስቴንሽን ሰራተኞች በቤተሰብ ምጣኔ መጨመር ላይ ያላቸው ተዋፆ ምን ይመስላል የሚለውን ለማጥናት ነው።

የጥናቱ ዋና ተመራማሪ፤ አቶ ገመቹ ቁፋ

የጥናቱ አማካሪ፤ ዶ/ር መስፍን አዲሴ (MD, MPH)

ለጥናቱ የገንዘብ ድጋፍ የሚደርገው አካል፤ አዲስ አበባ ዩኒቨርሲቲ

ተመራማሪው ትምህርቱን የተከታተለበት ዩኒቨርሲቲ፤ አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ፤ የህብረተሰብ ጤና አጠባበቅ ስልጠና ተቋም።

ይህን የመረጃ ቅፅ ያተዘጋጀው ከላይ ስሙ የተጠቀሰው ተማራማሪ ሲሆን የጥናቱ ዋና አላማም ምርምሩ በሚካሄድበት በደቡብ የሃገራችን ክፍል በጉራጌ ዞን በሊቢያ/ማረቆ ወረዳ አካባቢ በሚገኙ ጤና ኤክስቴንሽን በቤተሰብ ምጣኔ አጠቃቀም ላይ ያመጡት ለውጥ ለማጥናት ነው።

የጥናቱ ተመራማሪ የማህበረሰብ ጤና የሁለተኛ ዲግሪ ተመራቂ ተማሪ እና አንድ የአዲስ አበባ ዩኒቨርሲቲ የህብረተሰብ ጤና አጠባበቅ ከፍተኛ ልምድ ያላቸው ባለሙያ አማካሪ ናቸው።

**የጥናቱ ዓላማ:**

የጥናቱ ዋና አላማም ምርምሩ በሚካሄድበት በደቡብ የሃገራችን ክፍል በጉራጌ ዞን በሊቢያ/ማረቆ ወረዳ አካባቢ በሚገኙ ጤና ኤክስቴንሽን በቤተሰብ ምጣኔ አጠቃቀም ላይ ያመጡት ለውጥ ለማጥናት ነው።

ጥናቱ በዋናነት የተቀረፀው የአካባቢውን ነባራዊ ሁኔታ በማገናዘብ ጤና ኤክስቴንሽን ሰራተኞች በቤተሰብ ምጣኔ አጠቃቀም ያመጡትን ለውጥ ምንድነው ይህም ካልሆነ በሚገኘው ውጤት መሰረት መሻሻል የሚገባቸውን የፖረግራም አተገባበር በማወጣት እንዲሰተካከሉ ከሚመለከታቸው የጤና አመራሮች እና ሌሎች ባለድረሻ አካላት ጋር በመሆን አዋጭ የሆነ የትግበራ መርሃ ግብር ለመቅረፅ እና ተፈጻሚነት እንዲኖረው ለማድረግ ነው።

ከጥናቱ የሚገኘው ወጤት በየደረጃው ለሚመለከታቸው አካላት በማድረስ ለችግሩ መፍትሄ የሚሆን የትግበራ እቅድ ዝግጅት እንዲያደርጉ በመረጃ የተደገፈ ሙያዊ አስተያየት በመስጠት ጤና ኤክስፔንሽን በቤተሰብ ምጣኔ አጠቃቀም ላይ ለውጥ እንዲያመጡ ለማድረግ ነው።

**በጥናቱ መሳተፍ ስለሚያስገኘው ጠቀሜታ**

በጥናቱ እርሰዎ በመሳተፉ አሁን የሚገኝ/የሚሰጥ ጥቅም እንደሌለ ልግልፅልዎት እወዳለሁ ነገር ግን ይህ ጥናት ተጠንቶ ካለቀ በኋላ የተገኘውን መረጃ መሰረት አድርጎ የሚመለከታቸው አካላት እንዲያውቁት በማድረግ አስፈላጊ የሆነ ችግሩን የሚፈታ የእቅድ እና የአተገባበር እስትራቴጂ ዝግጅት እንዲደረግ ድጋፍ ያደርጋል ።

**በጥናቱ መሳተፎ ሊፈጥረው የሚችለው ተፅዕኖ/ምቹት ስለመኖረ**

በጥናቱ እርሰዎ በመሳተፈዎ/ፉ ምንም ዓይነት ችግር እንደማያመጣ ለመጠቀስ እወዳለሁ፤ ምን አልባት የማቀርብልዎትን ጥያቄዎች ለመመለስ የተወሰነ ሰዓት ልወስድብዎት እችላለሁ፤ በጥያቄዎቹ የሚሰጡኝን ማንኛውንም ዓይነት መረጃ ለማንም የማይደርስ መሆኑን እና ሚስጥራዊነቱ የተጠበቀ መሆኑን ልግልፅልዎት እወዳለሁ።

**ማንኛውን ዓይነት ጥያቄ በፈለጉ ጊዜ ለመጠየቅ እንዲያግዘዎት የሚረዳ አድራሻ፤**

ይህ ጥናት ሳይናሳዊነቱ እና ለህብረተሰቡ የሚጠቅም መሆኑን በአዲስ አበባ ዩኒቨርሲቲ የሚገኝ የጥናት እና ምርምር ደህንነት ፈቃድ ሰጪ ኮሚቴ የታየና የፀድቅ በመሆኑ ማንኛውንም አይነት ጥያቄ ለኮሚቴው ማቅረብ ከፈለጉ ከዚህ በታች በተጠቀሱት አድራሻዎች መጠቀም የሚችሉ መሆኑን እንገልጻለን።

**የጥናቱ ተመራማሪ**

አቶ ገመቹ ቁፋ : አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና አጠባበቅ ትምህርት ተቋም የማህበረሰብ ጤና ትምህርት ክፍል ስልክ - 0924152491, የፖስታ ሳጥን ቁጥር 1234, ኢሜል አድራሻ: gemechukuffa@yahoo.com/kgeme2@gmail.com

የጥናቱ አማካሪ: ዶ/ር መስፍን አዲሴ (MD, MPH): አዲስ አበባ ዩኒቨርሲቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና አጠባበቅ ትምህርት!!!ስልክ-251-5157701፣የፖስታ ሳጥን ቁጥር-9086

**Annex D: Consent form**

**Informed consent form**

Dear participant, you have been identified as relevant respondent for this study. So, I would like to interview you about family planning service utilization in your kebele. This survey is carried out by Ato Gemechu kuffa final year post graduate student at Addis Ababa University. The interview will take approximately 20 minutes. The information you provide is confidential and will only be used for the above-mentioned objective of this survey. You have the right to refuse participation or quit participation at any point of the interview process.

Would you like to participate in the survey?

Yes \_\_\_\_\_

No \_\_\_\_\_

**Annex E: Amharic consent form**

**የፍቃድ መጠየቂያ ቅጽ**

እንደምን አደሩ/ዋሉ ከሰላምታዬ በመቀጠል እኔ ስለ ቤተሰብ ምጣኔ አገልግሎት ልጠይቀው ነው።ይህ መጠይቅ የተዘጋጀው በአቶ ገመቹ ቁፋ በአዲስ አበባ ዩንቨርሲቲ የሁለተኛ ድግሪ ተመራቂ ተማሪ ነው። መጠይቁ 20 ደቂቃ ሊደረግ ይችላል እርሶ የሰጡትን መረጃ ለማንኛውም ሰው የማይገለፅ እና ለጥናቱ ጠቀሜታ ብቻ የሚውል ነው።

እርሶ በዚህ መጠይቅ ላይ መረጃ መስጠት ያለመስጠት መብቶ የተጠበቀ ነው

መረጃ ለመስጠት ፍቃደኛ ነኝ

አዎ

የለም

**Annex F: Declaration**

I, the undersigned, Public Health student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health.

Name: Gemechu kuffa

Signature: \_\_\_\_\_

Place of submission: School of public Health, College of Health Sciences, Addis Ababa University.

Date of Submission: June, 2013

This thesis work has been submitted for examination with my/ our approval as university advisor(s).

Advisors

Name

Signature

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Annex G: Assurance of Investigator**

The undersigned agrees to accept responsibility for the scientific, ethical and technical conduct of the research project and for provision of required progress reports as pre terms and conditions of the research and publications office of Addis Ababa University.

Name of the student: Gemechu kuffa

Date: June, 2013

Signature: \_\_\_\_\_

Approval of the advisor (s)

Advisors

	Name	Signature	Date
1.	_____	_____	_____
2.	_____	_____	_____

**Appendix H; English Questionnaire**

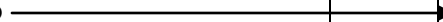

**Interviewer:** For each question, circle on codes of each response or fill information as indicated.

**House hold Questionnaire**

<b>Code</b> ___ / ___ / ___ / _____	
Region _____	Name of kebele _____
Woreda _____	Name of Gote _____
Date _____	Name of household _____
Name of data collector _____	Name of supervisor _____

**Part One: Demographic Questionnaire**

S. No	Question	Response	code	skip
1.	Age	_____		
2.	Marital Status:	<b>01. Single</b> <b>02. Married</b> <b>03. Divorced</b> <b>04. Separated</b> <b>05. Widowed/</b>		
3.	Family Size	_____		
4.	Number of children	_____		
5.	Occupation of the head of the household	<b>01. Farmer</b> <b>02. Merchant</b> <b>03. Government employee</b> <b>04. Housewife</b> <b>05 Others</b>		
6.	Religion:	<b>01. Orthodox</b> <b>02. Muslim</b> <b>03. Protestant</b> <b>04. Catholic</b> <b>05. Other</b>		
7.	Ethnicity	<b>01. Libido/ mareko</b> <b>02. Amhara</b> <b>03. Silita</b> <b>04. Oromo</b> <b>05.gurage</b> <b>06. Other</b>		

8.	Educational level	<b>01.</b> Illiterate <b>02.</b> Can read and write <b>03.</b> Grade 1-8 <b>04.</b> Grade 9-12 <b>05.</b> Twelve completes <b>06.</b> College and above		
9.	How much is your annual income(in birr)	_____		
<b>Part Two: Accessibility and Acceptability</b>				
10.	Now I would like to talk about family planning the various ways or methods that are couple can use to delay or avoid pregnancy <b>Have you ever heard of methods?</b>	01. Yes 02.No 		12
11.	If yes question.10.Which methods (more than one answer is possible)?	01. Vasectomy 02.Tubal ligation 03 Norplant (implant) 04 Injections 05 Pills 06.IUD 07.Diaphragm 08.Condoms 09. Foam/gel/cream 10. Natural method 11 Breastfeeding 12. Other		
12.	Are there any places where you can obtain family planning service?	01. Yes 02.No 		14
13.	If yes question 12.can you pleas mention the place?	01. Health post 02. Health centre 03. Hospital 04. Health dep't army 05.Shop		

14.	What is the nearest health service you use frequently?	01. Health post 02. Health centre 03. Hospital 04. Traditional healer		
15.	Where you mostly get consult about family planning? .	01. nearby health post 02. Health centre → 17 03. Hospital → 17 04. Health development army → 17 05. Other → 17		
16.	If you choose “ <i>health post or # 01</i> ” for question 15, do you get HEWs Supportive enough?	01. Yes. 02. NO		
17.	Does the health post in your community/village provide health education on family planning to the people in your community/village?	01. Yes often 02. Sometimes 03. Never		
18.	Do you satisfied on the family planning service you got from HEWs?	01 Very satisfy 02.satisfy 03.not satisfy 04.bad		
<b>Part three: Family planning</b>				
19.	Do you participate in family planning related activities in your community?	01. Yes. 02. No → 22		
20.	If your answer for question 19 is <b>yes</b> , in what ways do you participate? ( <b>More than one answer is possible</b> )	01. Discussion of family planning issue 02. Mobilizing others. 03. Informing about family		

		planning. 04. Other		
21.	How do you rate your participation?	01. Very active. 02. Active 03. Moderate 04. Passive 05. Very passive		
22.	Are you or your partner currently doing Something or using any method to avoid getting pregnant, or delay pregnancy?	01. Yes 02. Sometimes 03. No		Stop
23.	If yes, question 22 Which method(s) are you or your partner currently using? More than one answer is possible,	01. Vasectomy 02. Tubal ligation 03. Norplant (implant) 04. Injections 05. Pills 06. IUD 07. Diaphragm 08. Condoms 09. Foam/gel/cream 10. Natural method 11. Breastfeeding 12. Other		
24.	Since what month and year have you been using (current methods) without stopping ?	_____		
25.	If you are using any of the means for child spacing or family planning, from what source did you first receive the information about this?	01. Radio 02. Health Extension Worker 03. Health development army 04. Health facilities 05. Friends/neighbors 06. Others		

## **Health Extension Workers and Health centre manager**

1. What type of family planning service do you provide?
2. How do you describe the support you get from the Health centre, Woreda health office Kebele administration and health development army?
3. How you support and follow up the health development army in the kebeles?
4. What is the main challenge to implement family planning activity?
5. How do you describe the progress of family planning activity in the kebeles of your catchment?
6. How frequently do you provide onsite supervision for the HEWs?
7. How do you describe the family planning services provided to the population with the introduction of the HEWs?

## **Chairman of the Kebele and 1to5 network leaders**

1. How does the health development army get involved in the kebele family planning activities?
2. How does health development army work with the HEWs?
3. Do you think the family planning activities in your kebele have improved with the arrival of the HEWs?
4. How you support the health extension worker?

Appendix I; Amharic Questionnaire

ለጠያቂው: መጠይቆችን በሙሉ በጥንቃቄ መላ አባወራ/ እማወራ መጠይቅ

መለያ ቁጥር ___/___/___/___				
ክልል _____		የቀበሌ ስም _____		
ወረዳ _____		የኅጥ ስም _____		
ቀን _____		የአባወራ/እማወራ ስም _____		
የመረጃ ሰብሳቢ ሥም _____		የሱፐርቫይዘር ስም _____		
<b>ክፍል አንድ: መሀበራዊና ኢኮኖሚያዊ መጠይ</b>				
ተ.ቁ	ጥያቄ	መልስ	ኮድ	ወደ ተ.ቁ
1.	ዕድሜ	_____		
2.	የጋብቻ ሁኔታ :	01.ያላገባች 02.ያገባች 03.አግብታየፈታች 04.የተለያዩች 05 በሞት የተለያት		
3.	የቤተሰብ ብዛት :	_____		
4.	የልጅ ብዛት ስንት ነው	_____		
5.	ሃይማኖትሽ ምድንነው	01.ኦርቶዶክስ 02.ሙስሊም 03.ፕሮቴስታንት 04.ካቶሊክ 05.ሌላ		
6.	ስራሽ ምንድን ነው	01.ግብርና 02.ነጋዴ 03.የመንግስት ሰራተኛ 04.የቤት እመቤት 05.ሌላ		

7.	ቤሔር፤	01.ሊቢያ/ማርቆ 02.አማራ 03.ስልጤ 04.አሮሞ 05.ጉራጌ 06.ሌላ		
8.	የትምህርት ደርጃ፤	01.ያልተማረ 02.ማንበብና መጻፍ የሚችል 03.ከ1-8 ክፍል 04.ከ9-12 05.12ኛ የጨረሰ		
9.	የዓመት ገቢ ምን ያህል ነው	_____		
<b>ክፍል ሁለት፡ ተደራሽነት ና ተቀባይነት</b>				
10.	አሁን ስለ ቤተሰብ ምጣኔ ወይም ስለ እርግዝና መከላከያ መንገዶች ላወራሽ ነው ስለ እርግዝና መከላከያ ስምተሽ ታውቂያለሽ	01.አዎ 02.የለም _____		→12
11.	ጥያቄ ቁጥር 10 መልሷ አዎ ከሆነ የትኛውን የእርግዝና መከላከያ አይነት ነው የምታውቁው(ከአንድ በላይ መልስ ይቻላል)	01.መሃፀንማስቋጠር 02.በክንደየሚቀበር 03.መርፌ 04.ኪኒን 05.ዲያፍራም 06.ኮንዶም 07.መሀፀን በር ላይ የሚቀባ ቅባት 08.የተፈጥሮየቤተሰብምጠኔ 09.ጡት ማጥባት 10.በመሀፀንውስጥ የሚቀመጥ 11.ሌላ		
12.	የእርጋዘና መከላከያ ወይም የቤተሰብ ምጣኔ አገልግሎት የምታገኝበት ቦታ አለ	01.አዎ 02.የለም _____		→14

13.	ጥያቄ ቁጥር 12 መልሷ አዋ ከሆነ የት ነው	01.ጤና ኬላ 02.ጤና ጣቢያ 03.ሆስፒታል 04.የጤና ልማት ሰራዊት ጋር 05.ሱቅ		
14.	በቅርበት ያለው የጤና ድርጅት የቱነው	01.ጤና ኬላ 02.ጤና ጣቢያ 03.ሆስፒታል 04.የባሃል ህክምና		
15.	የቤተሰብ ምጣኔ አገልግሎት ምክር ከየት ያገኛሉ?	01.ከጤና ኬላ 02.ከጤናልማት ሰራዊት 03.ከጤና ጣቢያ 04.ከሆስፒታል 05.ሌላ	→ 17 → 17 → 17 → 17	
16.	ከተ.ቁ 15 የጤና ኬላ ከመረጡ ከጤና ኤክስፔንሽን ስራተኞች በቤተሰብ ዕቅድ ዙሪያ በቂ እገዛ ያገኛሉ?	01.አዎ 02.የለም		
17.	ጤና ኬላ ስለ ቤተሰብ ምጣኔ ትምህርት ይሰጣል?	01.አዎ ሁልጊዜ ያስተምራሉ 02.አልፎ አልፎ ያስተምራሉ 03.በፍፁም		
18.	ከጤና ኬላ በምታገኝው የቤተሰብ ምጣኔ አገልግሎት ረክቻለሁ?	01.በጣም ረክቻለሁ 02.ረክቻለሁ 03.አረካሁም 04.ጥሩ አይደለም		
<b>ክፍል ሦስት: የቤተሰብ ምጣኔ</b>				
19.	በቤተሰብ ምጣኔ አገልግሎት እንቅስቃሴ ላይ ተሳትፎ	01.አዎ		

	ታደርጊያለሽ?	02.የለም		22
20.	ከተ.ቁ-19 መልሶ አዋ ከሆነ ምን አይነት ተሳትፎ ነው? (ከአንድ በላይ መልስ ይቻላል)	01.በቤተሰብ ምጣኔ ዙሪያ ውይይት 02.ሌሎችን ተጠቃሚ እንዲሆኑ በመቀስቀስ 03.ስለቤተሰብ ምጣኔ ጥቅም በመናገር 04.ሌላ		
21.	ተሳትፎሽን እንዴት ትገልጫለሽ?	01.በጣምንቁየሆነ ተሳትፎ 02.ንቁ ተሳትፎ 03.መካከለኛ ተሳትፎ፣ 04.ንቁ ያልሆነ 05.በጣም ንቁ ያልሆነ		
22.	እርግዝና ለመከላከል አሁን የቤተሰብ ምጣኔ ይጠቀማሉ?	01.አዎ 02.አልፎ አልፎ 03.የለም		ቁም
23.	ከተ.ቁ 22 አዋ ካሉ የትኛውን የቤተሰብ ምጣኔ አይነት ነው የሚጠቀሙትን (ከአንድ በላይ መልስ ይቻላል )	01.መሃፀንማስቋጠር 02.በክንደየሚቀበር 03.መርፌ 04.ኪኒን 05.ዲያፍራም 06.ኮንዶም 07.መሀፀን በር ላይ የሚቀባ ቅባት 08.የተፈጥሮ የቤተሰብ ምጣኔ 9.ጡት ማጥባት 10.በመሀፀንውስጥ የሚቀመጥ 11.ሌላ		
24.	እየተጠቀመሽ ያለሽውን የቤተሰብ ምጣኔ ለምን ያህል ጊዜ ሳታቸርጫ ተጠቀምሽ	_____ (ወርና ዓመት)		
25.	የቤተሰብ ዕቅድ የሚተቀሙ ከሆነ ስለ ቤተሰብ ምጣኔ መጀመርያ ከየት ሰሙ	01.ከፊዲዎ 02.ከጤናኤክስቴንሽን ሠራተኞች 03.ከጤና ልማት ሠራዊት 04.ከጤና ድርጅት 05.ከጎደኞች/ጎርቤቶች 06..ሌላ		

**ጤና ኤክስቴንሽን ሠራተኞች እና ጤና ጣቢያ ዓላፊ**

1. የቱን አይነት የቤተሰብ ምጣኔ አገልግሎት ትሰጣላቸው?
2. ከጤና ጣቢያ ከወረዳ እና ቀበሌ የምታገኙትን ድጋፍ እንዴት ትገልጹታላቸው?
3. ከጤና ልማት ስራዎች ጋር እንዴት ነው ምትሰሩት?
4. የቤተሰብን ምጣኔ አገልግሎት ላይ ያጋጠማቸው ችግር ምንድነው?
5. ድጋፋዊ ጉብኝት በቤተሰብ ምጣኔ ላይ በየስንት ጊዜ ታደርጋላቸው?
6. የጤና ኤክስቴንሽን የሚሰጡትን የቤተሰብ ዕቅድ አገልግሎት እንዴት ትገልጹታሉ?
7. የጤና ኤክስቴንሽን ሠራተኞች ስራ ከጀመሩ በኋላ ህብረተሰብ በቤተሰብ ዕቅድ ላይ ተሳትፎ ለውጥ አለው ብለህ ታስባለህ?

**የቀበሌ ሊቀመንበር ና የ1ሰ5 ጥምርታ መሪ**

1. በቀበሌ ውስጥ ያሉ የጤና ልማት ስራዎች በቤተሰብ ምጣኔ ላይ እንዴት ነው ሚሳተፉት?
2. ከጤና ኤክስቴንሽን ጋር እንዴት ነው ሚሰሩት?
3. ጤና ኤክስቴንሽን ሠራተኞች እዝህ ቀበሌ ስራ ከጀመሩ በኋላ የቤተሰብ ምጣኔ አገልግሎት ላይ ለውጥ አመጥተዋል ብለህ ታስባለህ?
4. ህብረተሰብ በቤተሰብ ምጣኔ ላይ ተሳትፎ እያደረገ ነው ብለህ ታስባለህ?

## **Declaration**

I, the undersigned, Public Health student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of Master of Public Health.

Name: Gemechu Kuffa Signature: \_\_\_\_\_

Place of submission: School of public Health, College of Health Sciences, Addis Ababa University.

Date of Submission: June, 2013

This thesis work has been submitted for examination with my/ our approval as university advisor(s).

Advisors

Name

Signature

1. Dr Mesfin Addisse