ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF SOCIAL SCIENCES

Appraisal of Public Health Service Provisions at Community Level in Masha Woreda of Sheka Zone: SNNPR

Thesis Submitted to the School of Graduate Studies As the Partial Fulfilment of Requirements of Degree of Masters of Art in Geography and Environmental Studies.

By

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List of Acronyms

AIDS ----------Acquired Immune Deficiency Syndrome

AHWO----------African Health Workforce Observatory

BPR----------Business Process Reengineering

CHA ----------Community Health Agents

CSA----------Central Statistical Agency

DHMT ----------District Health Management Teams

EFY ----------Ethiopian Fiscal Year

EHMI----------Ethiopian Hospital Management Initiative

EPRDF ----------Ethiopian People Revolutionary Democratic Front

EQUINET----------Regional Network for Equity in Health in Southern Africa

ETB----------Ethiopian Birr

FGD ----------Focused Group Discussion

FMOH ----------Federal Democratic Republic of Ethiopia Ministry of Health

HEP ----------Health Service Extension Programme

HEWs ----------Health Extension Workers

HFA----------Health for All

HICE----------Household, Income, Consumption Survey

HIMS----------Health Management Information System Monitoring

HIV ----------Human Immune Virus

HP ----------Health Post

HRH---------- Human Resources for Health

HSDP I ---------- Health Sector Development Programme

HSEP ----------Health Service Extension Programme

ICT ----------Information Communication Technology

IEC----------Information, Education and Communication

JICA ----------Japan International Cooperation Agency

KAP----------Knowledge, Attitude and Practice

M &E----------Monitoring and Evaluation

MDGs----------Millennium Development Goals

MOH ----------Ministry of Health

NHA----------National Health Account

NGO ----------Non Governmental Organization

PHC----------Primary Health Care

PHCU ----------Primary Health Care Units

PHRD----------Policy and Human Development Resource Development Project

RHBs ----------Regional Health Bureaus

SIDA ----------Sweden International Development Association

SNNPR ----------Southern Nations, Nationalities and Peoples Region

SPSS ----------Statistical Package for Social Sciences

SSA ----------Sub Saharan Africa

TB ----------Tuberculosis

TTBA----------Trained Traditional Birth Attendants

US ----------United States

WHO ----------World Health Organization

WMS----------Welfare Monitoring Survey

Abstract

The development and provision of equitable and acceptable standard of health service to all segments of population of Ethiopia has been a major objective of the 1993 national health policy. The health sector strategy adopted to implement the policy and focuses on giving comprehensive and integrated public health services by doing in cooperation with the concerned bodies to minimize challenges hindering the service delivery and to give equitable and whole addressing service.

Hence healthy society is the key for development, studying about service provision and its challenges as a planner and indicating possible mechanisms to balance the existing resources and the service need is also beneficial. So, this research study is done on the objective of assessing the status of provision of public health service, identifying the main challenge and analysing its cause as well as determining the possible measures being implemented to deliver fair health service with existing challenges and available resources is done by taking Masha Woreda as a study area.

This paper includes literatures reviewed from different sources, which are related to the studied topic and strategies being implemented to make fair provision of health services. It took 4 sample Kebeles which are selected purposively on distance difference from the capital of the Woreda. One hundred forty two samples were selected randomly from each purposively sampled Kebeles as a primary data sources and written document such as annual reports and strategic plans from the Woreda health department as a secondary data sources.

Data are gathered from these sources by using both open ended and closed ended questionnaires semi structured interviews of households of the Kebeles. The data gathered from the mentioned sources are analysed by using SPSS tools like cross tabulations, tables showing percentages and frequencies.

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CHAPTER ONE

3. INTRODUCTION

3.1. Background of the study

Health care service is a component part of basic social services and has direct relationship with the growth and development of a given country as well as the welfare of the society. Effective planning and implementation of health services require an overall collaboration of relevant and concerned national and international organizations. One of the strategies to ensure this collaboration is harmonization of health policies, strategies and implementation modalities in national and global perspectives to create synergy and to enhance the efficiency and effectiveness of health service delivery.

Ethiopia has poor health status compared to other low income countries of the world, even within sub Saharan Africa which can be largely attributed to preventable infectious ailments and nutritional deficiencies. Collective challenges of widespread poverty along with general low income levels of the population, low education levels (especially among women), inadequate access to clean water and sanitation facilities and poor access to health services have contributed to high burden of ill health in the country. (FMOH, 2005)

Access to health care can be understood in terms of economic access to the users in terms of affordability and geographic access in terms of proximity to providers. The poor most of the time tend to have the least access to health services. (Gesler and Meade1988 as cited in Lin, 2002)

The Ethiopian health care delivery system has historically been unable to respond qualitatively or quantitatively to the health related needs of the society due to its' centralization and fragmentation and reliance on vertical programs and there was not much collaboration between public and private sectors. The reasons for such problems are the backward socio-economic development of the country resulting in one of the lowest standard of living, poor environmental conditions and low level of social services. These prevailing situations have been aggravated, in recent times, by the high population

growth, the long and nonstop civil war and the Ethio- Eritrean war which highly contributed to underfunding of health sectors. The other cause of such poor health situation in Ethiopia can be attributed to the isolation of large segment of society from the modern health sector due to wide spread illiteracy among the population. This in turn prevents the dissemination of information on modern health practices. This is also caused by shortage of trained personnel and insufficient funding by the government on health sector to avail the crucial health infrastructures for the effective and all reaching health service provisions. The question of distribution of health institutions which are in use currently in the country is also there. In a way most of the sounding health institutions are concentrated in urban centres while 85% of the population are rural dwellers.
(Tasew, 2003)

One of the main concerns of government is an efficient allocation of scarce resources of a country to increase health levels. In sub Saharan Africa, health service challenges and health status are related oppositely where the challenges are higher than the status of health of individuals. Even if it is improving, now a day by extensive efforts of the government, it is not an eye catching improvement. (Hiwot, 2005)

Having in mind all the health problems and opportunities being given at national level, this research is conducted to raise issues regarding the challenges and other related themes of this crucial service sector, health service provision, in a study area far from the opportunities.

3.2. Statement of the problem

In developing countries the public health problems are severe still, especially among women and children in which more than 500,000 women die during pregnancy or at the time of child birth each year and more than 10,000,000 children die of preventable diseases before their fifth birth days in the world. Even though health workers are the key to functional health systems and provision of necessary services, there are problems with insufficient numbers of health professionals and proper handling of the existing workers in addition to inadequate quality of services provided due to different challenges in many developing countries. (JICA, 2006)

In 1993, Ethiopian health policy declared equitable, acceptable and accessible health services to all who need them. In order to implement the declaration directly, the government is engaged in constructing more health institutions in order to improve physical accessibility and other related health service provision challenges. But, from the fact that there is no equitability between demand and availability of medical services and health personnel in different parts of country, no clear basis on the decision of planning and distribution of health care facilities over the years. (Asmerom, 1994)

It is important to address the very high unmet health care needs in rural Ethiopia by the rapid expansion of primary health care services. Tackling the challenges and minimizing the effects of lacks of public health service provisions, such as expansion and improving physical availability of essential health facilities and its services will reduce the distance between facilities and the users. (FMOH, 2005)

According to Guagliardo (2004) cited in Hibret (2007) a number of barriers can impede progression from potential to realized access to health services. These include availability, accessibility, affordability and acceptability. The first two dimensions are spatial in nature while the third is economical and the fourth is attitudinal or normative adoption to cultural settings. Availability refers to the number of local service points from which a client can choose. Accessibility is travel impedance (distance or time) between patient location and service points. Affordability refers to the purchasing power of the

people while acceptability refers to the willingness of the population to use the service if made available to them.

3.3. Objectives of the study

The objectives of this research can be categorised as general and specific.

3.3.1. General objective

The general objective of the study is to understand the status of public health service provisions and problems associated with their efficiencies in Masha Woreda.

3.3.2. Specific objectives

- To assess the distribution of health facilities in the Woreda.
- To identify the main challenges of public health service provisions in Masha Woreda.
- To identify the causes of the challenges of public health service provisions in the Woreda.
- To evaluate the measures being implemented for minimizing the effects of the challenges.
- To suggest some practicable ways and means to overcome the challenges.

3.4. Research questions

1) How is the distribution of health facilities in Masha Woreda?
2) What are the challenges of public health service provisions in Masha Woreda?
3) What are the main causes of the challenges of public health service provisions in the Woreda?
4) Are the measures being undertaken to minimize the effects of these challenges sufficient? If not, what other measures can be suggested?

3.5. Significance of the study

This research work is significant for:

- It will provide fare understanding about the status of public health service provisions in the Woreda.
- It can draw due attention of the concerned bodies to challenges of public health service provisions to create mechanisms to improve public health service provisions so as to minimize the impacts of the challenges.
- It will go a long way to provide a clear picture of the problems to the Woreda Health Department so as to identify the gap between what is being done and what is required.
- It can invite both governmental and nongovernmental concerned bodies which are involved in such issues to put integrated efforts along with the Woreda administration to minimize the risk of such challenges.

3.6. Limitations of the study

In this study the researcher faced the following limitations.

- Lack of enough money and computers to undertake the research especially addressing the questionnaires and analysing the data.
- Hence much of the respondents are illiterate, data collection through questionnaire method needs personal intelligence to assist the respondent in responding.
- Most respondents especially office personnel were reluctant and careless in volunteering to respond to the interviews.
- The time when the researcher did this work was harvesting time. So it was very difficult to undertake different mechanisms to apply further data collection methods like FGD in which selected individuals come together to discuss the topic.
- Since most of the sampled Kebeles are far from the Woreda capital, Masha town the researcher faced lack of transportation facilities to go to the sampled Kebeles because there are no motorable roads in the Kebeles, more so during rainy season.
- Some people did not consider the uses of this work and were reluctant to give information.

3.7. Conceptual frame work

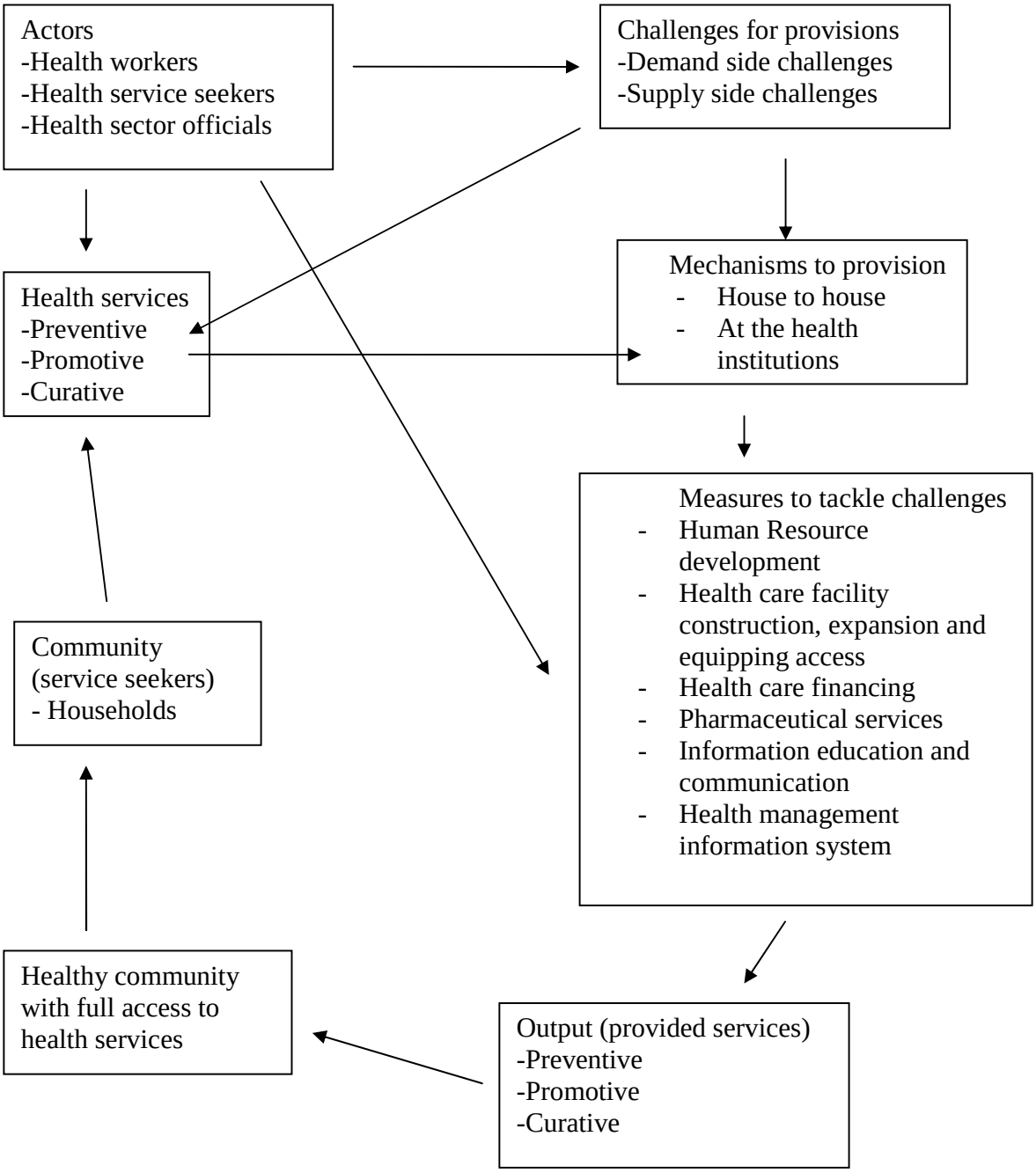


Fig 1.1 Conceptual framework of health service provision (Source, Author)

Health services are one of the important parts of social services. These health services include preventive, promotive as well as curative components which are delivered

through the efforts of health sector actors especially health workers through house to house or within health institution delivery. According to the above figure health service provisions have different interrelated issues. Basically, there are three actors in health service provisions in the area. These are health service extension workers, the community and health sector officials. These actors play an important role in creating efficient, effective, accessible and sustainable health systems.

Challenges are impedances which hinder a successful provision of health services to the community. Such hindrances are generally demand side and supply side challenges like infrastructural deficiency, managerial failures, policy problems, shortage of human resources and the like. Having these challenges, the actors implement different strategies to overcome them. These include Human resource development, health care facility construction, expansion and equipping access, health care financing, pharmaceutical services, information education and communication, health management information system and the like.

Finally if carefully provided, qualified and accessible health service systems can create healthy environment from which healthy community emerge.

3.8. Methodology

This thesis aimed at Appraisal of public health service provision in Masha Woreda of Sheka Zone in SNNPR. This Zone is selected as the study area because of the researcher's significant familiarity with the Zone and awareness about the prevalence of the problem in the area especially at Masha Woreda.

As data is the base for any research, the responses of this research are obtained by administering structured questionnaires and key informant interviews (KII).

3.8.1. Data sources

Crucial data for this thesis work is gathered from two sources. These are sources of primary data and sources of secondary data. Primary data sources for this work are the responses of sampled individuals from Masha Woreda who were with the researcher to

give crucial primary information on public health service provisions at a community level in the Woreda. These primary data sources included all the three actors which are believed to be the influential actors of health issues in the area. These included sampled health workers working in the sampled Kebeles, health sector officials working at the health department of Masha Woreda in addition to the sampled population.

Secondary data comprised all available health related literature like journals, bulletins and books, which the researcher gathered from different health related institutions in the Woreda and, concerned and voluntary individuals to give further literature. The secondary data sources also included annual plans and reports from the Woreda health department about the performances of the Woreda health institutions and their main challenges during the respective fiscal years.

3.8.2. Tools of data collection

Those data which are useful for this study were collected from sampled population by applying three mechanisms for primary data. These were:

3.8.2.1. Questionnaires

Both open ended and closed ended questionnaires were prepared by the researcher in Amharic language. Then, the researcher assigned two assistants to help the researcher in collecting data by administering the questionnaires to the respondents. These assistants were given a training on how they will undertake the data collection, like handling the respondents, approaching the respondents and politeness during the data collection.

The questionnaires were of three types, in accordance with the actors such as;

1. Questionnaires for health extension workers working at health institutions of the sampled Kebeles.
2. Questionnaires for households dwelling in the Kebeles and using the health service institutions of the Kebele.

3. Questionnaires for health sector officials working at the Woreda health department where decisions are made and the overall health related issues in the Woreda are monitored.

Then the questionnaires were distributed among the randomly sampled population of each purposively sampled Kebeles. While distributing the questionnaires, the researcher and the assistants were caring whether the respondent is literate (can respond to the questionnaires by him or herself by reading and writing) or not (need assistance of the researcher or the enumerators). By doing so the questionnaires of illiterates were filled immediately by the researcher's administering and that of literates were collected by giving certain time gap through appointment not more than two weeks .

This process was accomplished by contacting the requisite persons as and where they were available say homes, farms etc. The questionnaires for health workers and health sector officials were filled by going to the institutions where they are working. In a researcher administered data collection the assistants were also translating the questionnaires to the respondents language which is their mother tongue, in this case the Shekinono as well as elaborating the idea of the questions to the respondents, writing the respective answers and making clear the purpose of the data in specific and the research in general to make the respondents respond openly without considering the negative outcome of replying to the questionnaires. Then finally the questionnaires were collected from the respondents before the appointed time passes.

3.8.2.2. Interviews

First, checklists were prepared in Amharic language for the implementation of semi structured interview. This will help to fix the issues to be raised in the interview from being extremely wide and go out of the objectives. The interviewees included farmers at farming, people at streets on journey and health service users at health posts. In the same way to the questionnaires, here the assistants were taking care of the safety and security of the interviewees like how to approach, be polite and handle them friendly. At the interview time the role of the interviewer was to direct the ideas in accordance with the

checklists and coding the main issues raised and relating to the topic to be studied. In such mechanisms the responses of the interviewees were coded by an interviewer for further study.

3.8.3. Method of data analysis

The data collected from the field was analyzed by using different mechanisms of data analysis. Quantitative data were analyzed by using SPSS methods of data analysis like frequency, percentages and the results were presented in tables. Qualitative data were also analyzed by qualitative elaboration of the responses to indicate the detailed idea of the respondents.

3.8.4. Sampling techniques

Sampling technique for this study consist two steps. First the sample Kebeles from among the 19 Kebeles of the Woreda were selected purposively based on their distances from the town, Masha the capital of the Woreda and the seat of the Woreda health department where health related decisions are made and the overall health activities are monitored. Accordingly, two nearest and two farthest Kebeles were selected. From each Kebeles a proportional numbers of individuals or households were selected randomly. The distance factor for purposive selection of Kebeles was applied to assess the effect of distance on service provisions and uses.

3.8.4.1. Sample size

This Woreda in which the researcher is going to do the study has 19 rural Kebeles at different distances from the Woreda capital, Masha which is a chartered town and the seat of the Woreda health department.

Table 3.1 Estimated numbers of households in sample Kebeles

Name of sample Kebeles	Estimated Number of households
Yeshi Akako	516
Ateso	967
Wolo	1234
Yepo	182

From the four selected Kebeles, the research is conducted by taking 120 households, 3 health extension workers and 2 health sector officials for questionnaires and 14 households, 2 health extension workers and 1 health sector official for interviews. Proportional allocation method is applied to each sample Kebeles to get the required sample households of the respective Kebeles. This method is described as follows.

$$n(X) = \frac{N(HHs)}{THHs} \times T(S)$$

Where:

n (X) = Number of samples to be taken from each Kebele

N(HHs) = Number of households in the Kebele

T(S) = Total sample taken from whole sample Kebeles

THHs = Sum of households in all sample Kebeles

3.9. Organization of the study

This paper contains six chapters. Chapter one includes the proposal part, chapter two; three and four contains review of related literature, methodology and description of the study area, chapter five presents the discussions and findings and the last chapter provides conclusion and recommendation aspects.

CHAPTER TWO

4. REVIEW OF RELATED LITERATURE

4.1. What is public health?

The term public health is generally understood as a broad concept. Most health professionals understood public health as an individual patient focus in contrast to the agreed characteristic of public health as population focused theme. Traditionally, the term public health describes work done by health professionals. Some other local authorities and environmental professionals use the term 'well being' often to describe the same phenomenon. Public health can be conceptualized as an action and as resources. Public health actions refer to activities to improve health by professionals and lay people, and by individuals, groups and communities to improve the health status of a society through effective and fully addressed proper health services. It is within this idea of public health actions that the rational for partnership and multidisciplinary practice is established. Public health resources refer to the sources of information and expertise that contribute to public health action. (Orme, Powell, Taylor and Grey, 2007)

The definition of health is set out by the world health organization (WHO) as '…… a state of complete physical, mental and social wellbeing but not merely the absence of disease or infirmity.' In public health service provisions, work is being undertaken in major areas such as addressing inequality in health, tackling challenges of renewal and sustainability in communities, and taking on board the impacts of globalization on health. Improving the public's health and wellbeing is a high profile feature of government policies. Public health actions recognize those factors in peoples' social, economic and physical environment that have a significant impact on their health and which can create deep inequalities. Public health actions also involve a range of large amount of people from many different disciplines and professions working in collaboration with the public and across agencies as well as organizational boundaries. In order to make the goals of public health actions successful, there should be a diverse public work force with an expanded range of expertise and skills. (WHO, 1948)

4.2. Health system organization in Ethiopia

According to Feldstein (1988), there are three basic choices that determine the organization of health and medical services. These include the determination of both the amount to be spent on health and medical services, and the composition of those services, the selection of best methods for producing health and medical services and the selection of the method for distributing health services among the population.

It was only towards the end of the imperial period in Ethiopia, that a comprehensive health service policy was adopted through the initiatives from the world health organization after subsequent references to the development of health with the provisions of basic health services through the network of health centres and health stations and the need to give due attentions to prevention, alongside curative services. However, this scheme was precluded with the down fall of the regime without having a possibility to be tested. (http://www.etharc.org)

According to Habtamu (2007), Ethiopia had adopted Primary Health Care (PHC) as the national strategy to achieve equitable access to health services by all people of the country as early as late 1970's.

During the Ten Year Perspective Plan of 1984-94 the health system had six tier referral systems introducing community health services in Health Posts (HP) at the Base of the referral system. This component is staffed by trained Community Health Agents (CHA) and Trained Traditional Birth Attendants (TTBA) who were to be supported by communities.

This policy also emphasized PHC and indicated:

- Community participation
- Inter-sectoral collaboration
- Gradual integration of vertical programs and specialized health facilities
- Delivery of essential health care at affordable cost

At that time, however, this approach didn't sustain due to inconsistent and insufficient support from the health system including supportive supervisions, in-service training, lack of remunerations and incentives and the structure of MOH which was limited to central and regional levels.

The current reform has minimized most of these problems, revitalized the community health services and reorganized the management structure of the health sector.
(Habtamu, 2007)

The government of Ethiopia has adopted a strategy of integrated health services centered on primary health care. The six-tier system was replaced by four-tier system. The four-tier system consists of primary health care units which is health centre with five satellite health posts, primary hospitals, general hospitals, and specialized referral hospitals. However, the private sector and voluntary organizations also play a significant role in general health care delivery. (AHWO, 2010)

Ethiopian Health policy is committed and directed towards decentralization and democratization, focusing on preventive and promotive components of health care and, development of equitable and acceptable standards of health services to reach all segments of the population. (FMOH, 2005)

In order to decentralize the health care service system in Ethiopia, decision making processes in the development and implementation of the health care system are shared between the Federal Ministry of Health (FMOH), the Regional Health Bureaus (RHBs) and the Woreda Health Offices. As a result of recent policy measures taken by the government, the FMOH and the RHBs are made to function more on policy matters and technical support, while the Woreda health offices have been made to play the pivotal roles in managing and coordinating the operations of the primary health care services at Woreda levels. With the devolution of powers to regional governments, public health service delivery, including health care, has to a large extent, fallen under the jurisdiction of the regions. The approach has been to promote decentralization and meaningful participation of the population in the local development activities. Due to the governments' commitment to further decentralize decision making power, Woredas are

currently the basic units of planning and political administration while for administration of public health care, there is a Regional Health Bureau (RHB) at Regional level. (FMOH, 2006)

The Health Sector Development Program (HSDP) was formulated in 1997/98, and the healthcare and financing strategy in 1998 to implement the published policy. This programme under HSDP I extended for the first five years (1997/98–2001/02) and prioritized disease prevention as well as decentralization of health services delivery. After realizing that the targets set in HSDP-I were not met, new strategy, HSDP-II (2002/03–2004/05), was developed with an added aim of including NGOs in the implementation of basic health packages. Finally, the latest strategy HSDP III (2005/06–2009/10) was developed stressing the need to increase national health spending, the strategic role of NGOs as partners in achieving universal primary healthcare coverage, not only in planning but also in implementing healthcare deliveries particularly at the Woreda level and also emphasizing the need to strengthen government-NGOs collaborations. (WAMAI, 2009)

4.3. Health Service Provision

Health services, whether promotion, prevention, treatment or rehabilitation, may be delivered at home, the community centres, the workplaces, or at the health facilities and are the most visible part of any health care system, both to users and the general public. Effective health service delivery depends on having some key resources: motivated staff, equipments, information and finances, and adequate drugs. Improving access, coverage and quality of health services also depends on the ways services are organized and managed, and on the incentives influencing providers and users. (WHO, 2011)

According to World Bank's publication (2003), there are at least three key outcomes of effective health service provisions. i.e.:

A) Equity: improving the health of the population as a whole and reducing variations in health status by targeting resources where needs are greatest.

B) Efficiency: providing patients with treatments and cares that are both effective and of good value.
C) Responsiveness: meeting the needs and wishes of individual patients and users.

Throughout the world, governments are reassessing their roles in health service provisions. They are being forced to do so under growing pressures, including cost escalation and increasing user dissatisfaction with services.

Confronted by any national health policy for many decades, weak healthcare system infrastructures and low government spending, Ethiopia has poor health outcomes even by Sub-Saharan Africa's standards. Crucially, Ethiopia has taken critical steps in policy and programs to improving the country's health status. Nevertheless, a World Bank study simulating different scenarios to meet the United Nations Millennium Development Goals (MDGs) on health in the country shows that unprecedented levels of aid flow would be needed. (WAMAI, 2009)

4.4. Current health service provision challenges and priorities

Health care delivery has been highly affected by the shortage of primary health care facilities due to the lack of trained personnel and financial limitations. Widespread illiteracy and the relative isolation of large segment of the population from the modern sector also pose a significant challenge to the disseminations of information on modern health practices. Within the National Health Sector Development Programme (HSDP), Human Resource Development has been placed as one of the key components. The human resource issue had been further reinforced by the ongoing health sector reform, which emphasizes stronger and more efficient human resource management structure**.** **(**EHMI, 2006)

According to the study of Policy and Human Development Resource Development (PHRD) Project the challenges to public health service provision can be broadly categorized into demand side challenges and supply side challenges.

4.4.1. Demand side challenges

i. Household expenditure on health

Data on Household expenditure on health were collected by CSA in 1995/96 HICES and WMS. In the HICE survey, total house hold spending on health accounts to 32,364 birr per month or 0.7% of the total household expenditure. Of this total household expenditure, 0.77% and 0.68% are spent on health in urban and rural areas respectively. Poor people spend less than 1/3 of the amount spent by the richest quartile on treatment per illness episode. As a proportion of total expenditure on the treatment, the spending pattern implies a slightly higher spending by the poor on medicines while the richer spend more on treatment and transport. Treatment at hospitals is more expensive than at health centres. Hence hospitals will be visited for relatively more serious illnesses and therefore require more expensive treatment. Treatment at the home by a health worker: the nearest health centre or the pharmacies are the cheaper sources. Finally average expenditure on private or public facilities is not significantly different, while treatment at NGO facilities is generally more expensive. (PHRD, 1996)

4.4.2. Supply side challenges

The supply side challenges of health service provisions are the following:

iv. Managerial and institutional frame work

The managerial setup of Ethiopian health services has historically been centralized, with most health issues at the lowest levels being handled by the health ministry in Addis Ababa. According to the findings of primary health care review undertaken in 1985, there were a number of organizational and management problems which aggravate the risk of challenges of health service provision such as lack of enough health personnel, lack of provision facilities and the like. (WAMAI, 2009)

According to SNNPR health bureau report of the work shop (2002), one of the major challenges we had in Ethiopia in general and the region in particular, in delivering health service is lack of competent supervisors in the first place and lack of standard inputs on the other hand. Supportive supervision, as opposed to the administrative, traditional and

inspection model, is an approach that emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and those being supervised on agreed-upon standards of performance. The maximum potential performance of health workers and their supporting staff, and the quality and quantity of preventive and curative health services are ensured by a vital linkage between health services managers and implementers. Its importance in strengthening the capacity and performance of District Health Management Teams (DHMT), Zonal Health Management Teams and Health Service Delivery Management Teams in cyclic approaches of planning, implementing, and monitoring is highly crucial. There is not yet an agreed upon, locally suited supervision model that can maximize performance within the given resource constraints.

A number of countries have constitutionally recognized the importance of community participation in social policy development and decision making. Community participation benefits the organization and delivery of health services. Innovative ideas may arise and, new and positive initiative may be stimulated from community through participation. There can be better problem solving and crisis management and greater levels of project management and goal attainment. Services can be provided at lower costs, and added resources can be brought into the system, in part through the availability of volunteers. Equally important resources are most likely to be more effectively utilized when the community is given greater social control the planning and implementation of health services. (PHRD, 1996)

Just like the government, the nongovernmental community in Ethiopia is also employing community-based strategies to help improve health outcomes where access to health services and information is weak. Community participation and work at the local level facilitates change in attitudes towards gender norms that adversely affect health. Ethiopia faces major health concerns. (Chaya, 2007)

According to Meresa Ataklty (2008), public policy decisions are made through a political process because of the nature of the goods and services that are provided efficiently, effectively and justifiably in a sustainable manner.

The overall health care crisis in Africa are collectively categorized into 13 major health system factors that still undermine efforts to reduce the disease burdens are:

A. Gaps in governance and leadership in health sector.
B. Insufficient sustainable financial resources and the insufficient allocation, and use of existing financial capacity.
C. Lack of social protection for the vulnerable and in catastrophic situations.
D. A shortage of appropriately trained and motivated health workers.
E. Poor commodity security and supply systems and unfair trade practices.
F. Weak health systems' operation.
G. Marginalization of African traditional medicines in national health systems.
H. In adequate community involvement and empowerment.
I. Capacity of private sector, including NGOs is not fully mobilized.
J. Paucity and inadequate use of available evidence and information to guide actions including ICT use.
K. Coordination with other sectors and harmony with partners not yet attained.
L. Lack of inter-sectoral actions and coordination.
M. Disruptive global policies and actions.

v. Availability of facilities and services

Chaya (2007) stated that especially in rural areas of low income countries access to health services is complicated by, a Weak infrastructure and limited distribution systems. There are few Government health outlets and the existing are widely dispersed. Private-sector sources often favour wealthier urban areas, resulting in uneven service availability within a country. The diversity of socio-economic environments, climates, and terrains among regions in Ethiopia greatly impacts health conditions and outcomes. Poor health coverage is of particular concern in rural Ethiopia, where access to any type of modern health institution is limited at best. Health systems and roads are underdeveloped, and transportation problems are severe, especially during the rainy season.

At present, health services are provided by a health infrastructure that comprises of health posts, health stations, health centres, rural hospitals and central referral hospitals. The

health posts and health stations are the frontline units and theoretically each higher unit supports the one below it. There are problems in the condition of these health facilities like status of the buildings, leaking roofs, electrical problems, plumbering and sanitary problems on each of these items. (PHRD, 1996)

vi. Availability of health personnel and other staff

Human resource is a vital component in the delivery of health services. In Ethiopia, the health service delivery system is characterized by shortage, maldistribution, and lack of necessary skills in its manpower. The maldistribution is in favour of urban centres and the overall number, and quality of the available health personnel is grossly in adequate. In the area of health personnel production, staff attrition becomes a common problem and it is more risky in rural hospitals. Low salary followed by lack of educational opportunities and poor career are considered as the main causes for attrition. So, actions like salary improvement, training such as refresher courses, in-service training, workshops etc should be taken.

In general terms, there are two sources for production of health personnel. These are domestic sources involving outputs from formal and informal education structures, upgrading through on job or other programmes, and external sources involving national trainees returning from abroad and immigration of foreign health personnel. So, the major sources of supply are limited to the graduates from various types of local health teaching institutions. Therefore, sound manpower study and careful appraisal of existing health manpower training facilities is a prime importance. (PHRD, 1996)

4.5. Health Service Extension Programme as an opportunity

An innovative community based approach called the health service extension programme (HSEP) is introduced in Ethiopia in 2004 with a view to taking health services closer to the population. To further ensure increase in the coverage of essential services, the government has launched a project for an accelerated expansion of primary health care facilities to be implemented over the coming five years with a huge infrastructure and human resource development programme. (FMOH, 2005)

The main objective of HSEP is to improve access and equity to provide essential health interventions provided at Kebele and household levels with focus on sustained preventive health actions and increased health awareness.

The implementation of the health extension program has components; namely provision of community based health package, capacity building of potential families to be role model households, and service delivery at the health post level. Health extension workers spend more than 70% of their time by making home-to-home visits and communicating health messages to their communities. Health Extension Workers provide family health services mainly antenatal care, immunization, distribution of bed net and anti malaria drugs at the health post level**.** (Abebe Bekele, Mengistu Kefale, Mekonnen Tadesse, 2008)

HSEP includes 16 packages in four main areas.

1. Hygiene and environmental sanitation

   This area shares seven of the sixteen packages. These are:

   - Proper and safe excreta disposal system
   - Proper and safe solid and liquid waste management
   - Water supply safety measures
   - Food hygiene and safety measures
   - Healthy home environment
   - Arthropods and rodent control
   - Personal hygiene

2. Disease prevention and control

   This area shares four of the sixteen packages. These are:

   - HIV/AIDS prevention and control
   - TB prevention and control
   - Malaria prevention and control
   - First aid

3. Family health services

   This area shares five of the sixteen packages. These are:

   - Maternal and child health
   - Family planning
   - Immunization
   - Adolescent reproductive health
   - Nutrition

4. Health Education and Communication. (FMOH, 2005)

4.6. Suggested strategies to overcome the challenges of public health service provision

The health service systems have a potential for creating dependency which has resulted in exploitation of people by the health professionals. It has been used for both political purposes and to promote commercial interests. It is of utmost importance to identify, isolate and neutralize the negative aspects of the health service and reinforcing their positive contributions to the health development of the population. (SIDA, 1978) Considering the overwhelming challenges the following are principally put strategies.

2.6.2 Develop and implement health human resource development strategy

Health sector is one of the labour intensive sectors that heavily rely on the availability of adequate and skilled human resources. (FMOH, 2005)

It is known that the most critical issue in organizational success is the determination of its human resources. Funds committed can only be successful if the human resources are evenly distributed. In most African countries, the discounted salaries wages often lag behind the inflationary trend over the same period. Recent findings showed that about 20% of African born physician and 10% of nurses work outside their country. Hence, this lack of health care workers in developing countries, particularly in Sub-Saharan Africa, is an emergency that demands an urgent action. (Meresa, 2008)

Expanding physical health infrastructure and developing a cadre of Health Extension Workers (HEWs) who will provide basic curative and preventive health services in every rural community are strategies that the HEP is applying to meet these challenges. Prevention and control of communicable diseases such as providing malaria bed nets, health education, and contraceptives, with active community participation, are priorities of the HEP. The HEP will assign two HEWs to each health post. In addition, thousands of other health care service staff, mostly at the health centre level, will receive training as part of the HEP. (Chaya, 2007)

According to HSDP III of FMOH, this a strategy aimed at increasing HEW to population ration to 1:2,500 and midwives to women of reproductive age group from 1:13,388 to 1:6759 in Ethiopia in its implementation years. In order to implement this strategy, the government is applying its full effort by increasing the number and building the capacity of training institutions, using the existing health institutions to train the health workers, provision of adequate trainers and regular on the job training and fulfilling the necessary facilities for all the training institutions. (FMOH, 2005)

4.6.1. Health care facility construction, expansion and equipping access

This strategy aims at increasing access and the quality of health services through the rehabilitation of existing health facilities and construction of new ones and provision of the necessary inputs such as medical equipments and furniture. (FMOH, 2005)
According to Meresa (2008) basic physical health care facilities include:

- Adequate sized and well ventilated rooms for patients admitted according to different aspects
    1. Based on nature of disease classes required
        - ✓ Medical classes
        - ✓ Surgical classes
        - ✓ Maternal delivery and recovery classes
    2. Based on age level
        - ✓ Paediatricians and adult treatment rooms

- Laboratory and diagnostic equipments like microscope, x-ray machine and ultrasound
- Toilet rooms for staff and patients
- Adequate and reliable electric supply with its reserves
- Refrigerators of different sizes
- Ambulances
- Staff residents at tertiary health care facilities
- Stores of drugs and other supplies
- Laundry machines
- ICT and computer centres
- Health waste disposal facilities
- Integrated staff quarters
- Kitchen rooms and related furniture are among others.

To implement the strategy of Health care facility construction, expansion and equipping access, the FDRE government is following the implementation strategies such as building the capacity for construction and renovation of health facilities, providing transportation facilities and providing maintenance services to strengthen referral and outreach activities, enhancing the capacity of district health offices in the expansion of PHC facilities and services and other implementation strategies.(FMOH,2005)

4.6.2. The health care financing strategy

In recent years there have been a number of important developments in health care financing in African countries. Now days, the key health care financing patterns in Sub-Saharan Africa are as follows:

- In the majority of countries (about 60%), the health sector share of total government expenditure is below 10%.
- In about 35 % of African countries, donor funding accounts for over a quarter of total health care funding.

- There is limited insurance coverage in African countries, especially in relation to mandatory health insurance. However, community pre-payment schemes have been on the increase in recent years.
- One of the single largest sources of financing is that of out-of-pocket payments, which exceed 25% of total health care expenditure in more than three-quarters of sub-Saharan African countries. (EQUINET, 2005).

The health care financing strategy of Ethiopia, that was developed and implemented since 1998, has the aim of increasing resource flow to the health sector; improving efficiency of resource utilization; and ensuring sustainability of the finance system in order to improve the coverage and quality of health services.

The strategy was developed based on the realization of low government spending on health, low per capital health expenditure in the country, and the highly skewed health resource allocation in favour of the urban centres. In order to alleviate these problems it proposes alternative financing methods, mechanisms of resource mobilization, efficient utilization and ensuring sustainability.

The health services in Ethiopia are financed from four main sources:

- ❖ Government (Federal and Regional)
- ❖ Multilateral and bilateral donors (grants and loans)
- ❖ Nongovernmental organizations (NGOs), both international and local
- ❖ Private contributions (e.g. out-of-pocket spending). (AHWO, 2010)

The health care financing strategy and the subsidiary guidelines, that were produced to realize the execution of the strategy, will be vigorously implemented in the period of HSDP III. Furthermore, the government is committed to introducing an appropriate health insurance system both for formal and informal sector employees. (FMOH, 2005)

4.6.3. Pharmaceutical services

A well functioning pharmaceutical service is the cornerstone for any worthwhile health service. Thus, this intervention aims at ensuring regular and adequate supply of effective,

safe and affordable essential drugs, medical supplies and equipment in the public and the private sector and ensuring their rational use.

A comprehensive logistic master plan was developed and implemented in Ethiopia during HSDP III. The plan is to increase availability of essential drugs from 75% to 100% in public health facilities; to scale up the supply of imported and locally produce drugs; increase safety, efficiency and quality investigation from the present 40% to 100%; and to reduce the overall drug wastage from 8% to 1%. (FMOH, 2005)

4.6.4. Information, Education and Communication

This component aims at improving the knowledge, attitude and practice (KAP) on personal and environmental hygiene and common illness and their causes; and promotion of political and community support for preventive and promotive health services through educating and influencing planners, policy makers, managers, women groups and potential end users.

Hence, the main targets are provision of appropriate health communication materials to 100% of the HEWs and equipping 100% of the Kebeles implementing HSEP with portable IEC equipment; increasing the KAP of the population on HIV/AIDS, malaria and TB by 50% of its 2005 status; and to increase adolescent awareness and knowledge on HIV/AIDS and sexually transmitted infections from 77% to 95% and 80% respectively. (ibid)

4.6.5. Health Management Information System and Monitoring and Evaluation

The Health Management Information System / Monitoring and Evaluation (HMIS/M&E) strategy fits within the objectives and priorities set by the Health Sector Development Program's (HSDPIII) strategic plan. (FMOH, 2008)

The objectives of this component, is thus to ensure efficient, effective, transparent, accountable and ethical service delivery at all levels of the health system; to develop and

implement a comprehensive and standardized national HIMS and M and E system. This component aims at informed policy formulation, planning, programme implementation, monitoring and evaluation and at improving the knowledge and skills of health managers in these areas. It also aims at enhancing community involvement in the management of health facilities and public health interventions. (AHWO, 2010)

Ethiopia had a health information system in which morbidity and mortality statistics could be captured and used at national level. As the previous system was tedious and required so many variables to be collected, with the new reform of Business Process Re-engineering (BPR) the health management information system has been reformed with a big reduction in data collection tools and limited variables at regional and national levels. (ibid)

CHAPTER THREE

6. DESCRIPTION OF THE STUDY AREA

6.1. Sheka Zone

Sheka Zone is located in Southern Nation's, Nationalities and People's Regional State (SNNPRS). Astronomically, the Zone lies between 7^0 24'-7^0 52'N latitude 35^0 13'-35^0 35'E longitudes. Altitudinally, it lies between 900-2750m. This Zone is bounded onto north by Oromia Regional state, onto south by Bench Maji Zone, onto east by Keffa Zone and onto west by Gambella Regional State, and has a total land area of 2175.25 km^2. Out of this land area, 47% is covered by forest including bamboo trees.

This Zone has both highland and low land types of land features. Highlands account about 2/3 of the total area of the Zone and the rest is covered by lowlands. It is one of the almost all year rainfall receiving area with heavy rain lasting for about 8-10 months of the year. The annual temperature range of the Zone is between 12^0c -29^0c. Agro climatically 993.44 km^2 or 45.67% is covered by Woinadega, 522.06 km^2 or 24% by Dega and the rest 659.75 km^2 or 30.33% by kola type of climate.

The Agricultural practice in the area depends upon the Agro-ecological type of the Zone. However, the predominant practice is mixed farming, crop production, livestock and other economically important activities such as, beekeeping for honey production (traditionally in the forest), spices collection and coffee harvesting. Most of the subsistence and income-generating activities of Shekacho community is endowed largely with the natural forests.

Sheka Zone has three Woredas (districts), namely Masha, Andiracha and Yeki. In total the Zone has 56 rural Kebeles, 5 urban Kebeles and 2 chartered towns or city administrations, Teppi & Masha.

According to 1994 national census, the total population of Sheka Zone is 131,864. Among these, 95% are rural dwellers and 5% are urban dwellers. As far as population distribution within the Zone is concerned, Masha and Andiracha Woredas are sparsely settled dominantly by Shekacho ethnic group (more than 85%) in each Woreda, whereas

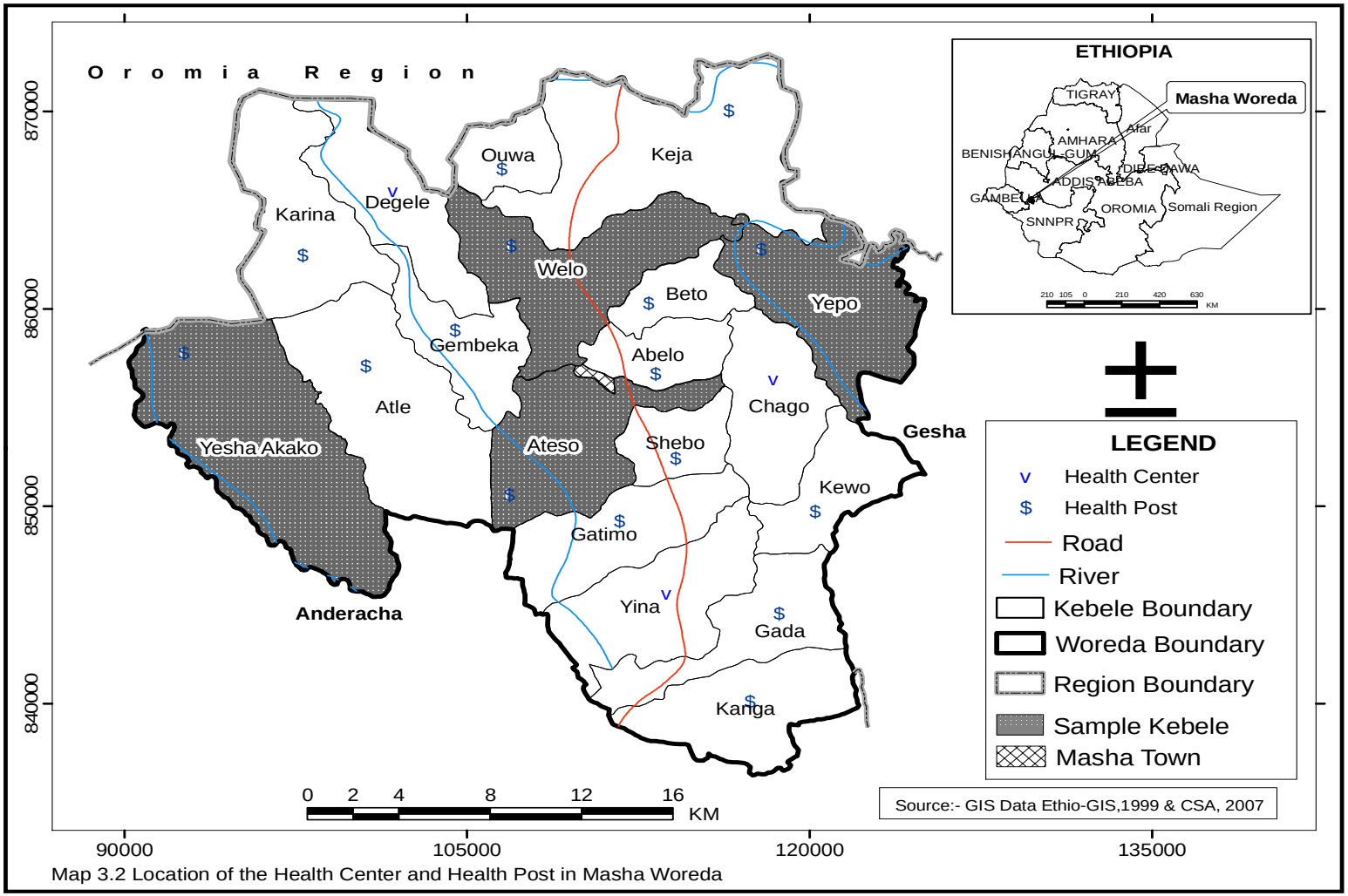
Yeki is known for accommodating people of different nationalities. The dominant ethnic group in Sheka Zone is the Shekacho. Amharic is spoken as second language in addition to Sheki nono. The overall-ethnic composition is Shekacho 34.7%, Kafacho 20.5%, Amhara 20.5%, Oromo 9.6%, Sheko 5%, Bench 4.8%, Majangir 2% and others 2.9%.

6.2. Masha woreda

6.2.1. Physical features

Masha, the administrational centre of Sheka Zone and the capital of Masha woreda is located 676 kms southwest of Addis Ababa and 950 kms from Hawassa , the capital of Southern Nation's, Nationalities and People's Regional State (SNNPRS) in which the Zone of Sheka is situated.

This Woreda is bordered onto east by Gesha Woreda of Keffa Zone, onto west by Sele-Nonno Woreda of Oromia region, onto south by Diddo-Lallo Woreda of Oromia region and onto north by Andracha Woreda of Sheka Zone. The Woreda has a total land area of about 90,802.82 hectares. Out of this land area about 23.9% is cultivated, 2.8% is grazing land, 40.5% is covered by forest, 5.5% arable land, 5.9% non arable land and 21.4% is settled land area. This Woreda lies between 1600-2400m above sea level and receives 2000mm rain fall. Agro climatically, the area is largely Woina dega type comprising about 75% of the total area, 22% and 3% are in Dega and kola types. The Woreda receives all the year round rainfall. There is large forest cover in the Woreda. The relief feature of the Woreda is a rugged terrain comprising hilly areas which impose their respective influence on agricultural and settlement patterns of the population. The Woreda is drained by relatively bigger rivers in the Woreda like Meneshi, Wonani, Tatamayi and Gahamayi.



Map 3.2 Location of the Health Center and Health Post in Masha Woreda

6.2.2. Economic features

Agriculture is of main economic values in Masha Woreda as the majority of the population of the area is engaged in it. This agricultural activity is mainly of a mixed type which targets at cultivating staple food crops for almost all the population, 'inset' and rearing of animals.

There is also an activity of bee keeping using modern as well as local bee hives from which an average farmer gets about 25-45 kg of honey per season. The area is also known for its significant meat and milk products from the domestic animals like goat, sheep, cow and others. In addition to agricultural activities, there are also transactions among rural dwellers in small Kebele markets in which people buy and sell products like coffee and honey. The centre of this Woreda is Masha town; it serves as a large market place, and seat of governmental institutions like Zonal administration and nongovernmental organizations like micro enterprises, private clinics, hotels and the like.

Even though the inhabitants of this Woreda are economically self sufficient, the infrastructural development is very low. There is no electric supply except in the Woreda capital, telephone stations, health centres, pure water supply and other basic infrastructures. There is no high school in all the 19 Kebeles except one high school at Masha city administration serving all the students of the Woreda. There are 3 health centres dispersed among the Woreda to serve all the population of the Woreda. In addition there ill equipped and worker deficient health posts in all Kebeles.

6.2.3. Demographic features

Masha Woreda has 19 Kebeles located around the capital Masha town and the Woreda has a total population of 42,435: out of which 20,920 are males and the rest are females. There is no any study done so far but it is believed that the majority of the inhabitants in the Woreda are indigenous nationals of the area; i.e. the Shekacho people speaking Shekinnono. According to Masha Woreda census bureau, a single household in Masha Woreda has on average 5 children per family. This indicates that more should be done to

implement a service of family planning among households to balance their economic capacity to sustain the life of their respective family and the number of families.

Name of the Kebeles	1999 E.C			2000 E.C			2001 E.C			2002 E.C		
	Sex			Sex			Sex			Sex		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Ouwa	578	579	1157	593	594	1187	608	610	1218	624	625	1249
Keja	1440	1376	2816	1477	1412	2889	1515	1448	2963	1554	1485	3039
Wolo*	1666	1764	3430	1709	1810	3519	1753	1856	3609	1798	1904	3702
Degele	1777	1868	3645	1823	1916	3739	1870	1966	3836	1918	2017	3935
Karina	480	552	1032	492	566	1058	505	581	1086	518	596	1114
Yeshi Akako*	607	612	1219	623	628	1251	639	644	1283	655	661	1316
Atle	948	954	1902	972	979	1951	998	1004	2002	1023	1030	2053
Gembeka	839	952	1791	861	977	1838	883	1002	1885	906	1028	1934
Ateso*	991	1081	2072	1017	1109	2126	1043	1138	2181	1070	1167	2237
Abelo	775	817	1592	795	838	1633	816	860	1676	837	882	1719
Beto	401	411	812	411	422	833	422	433	855	433	444	877
Yepo*	307	299	606	315	307	622	323	315	638	331	323	654
Chago	988	968	1956	1014	993	2007	1040	1019	2059	1067	1045	2112
Shibo	817	802	1619	838	823	1661	860	844	1704	882	866	1748
Gatimo	1015	1026	2041	1041	1053	2094	1068	1080	2148	1096	1108	2204
Yina	1300	1367	2667	1334	1402	2736	1368	1439	2807	1403	1476	2879
Kewo	547	586	1133	561	601	1162	576	617	1193	590	633	1223
Gada	767	758	1525	787	778	1565	807	798	1605	828	818	1646
Kanga	466	530	996	478	544	1022	490	558	1048	503	572	1075
Total	16709	17302	34011	17141	17752	34893	17584	18212	35796	18036	18680	36716

(Source: CSA 1999 EC Projected by Sheka ZoFED data collection and dissemination process)

* Sample Kebeles

Table.4.1 Population of Masha Woreda by Kebeles (1999-2002)

CHAPTER FOUR

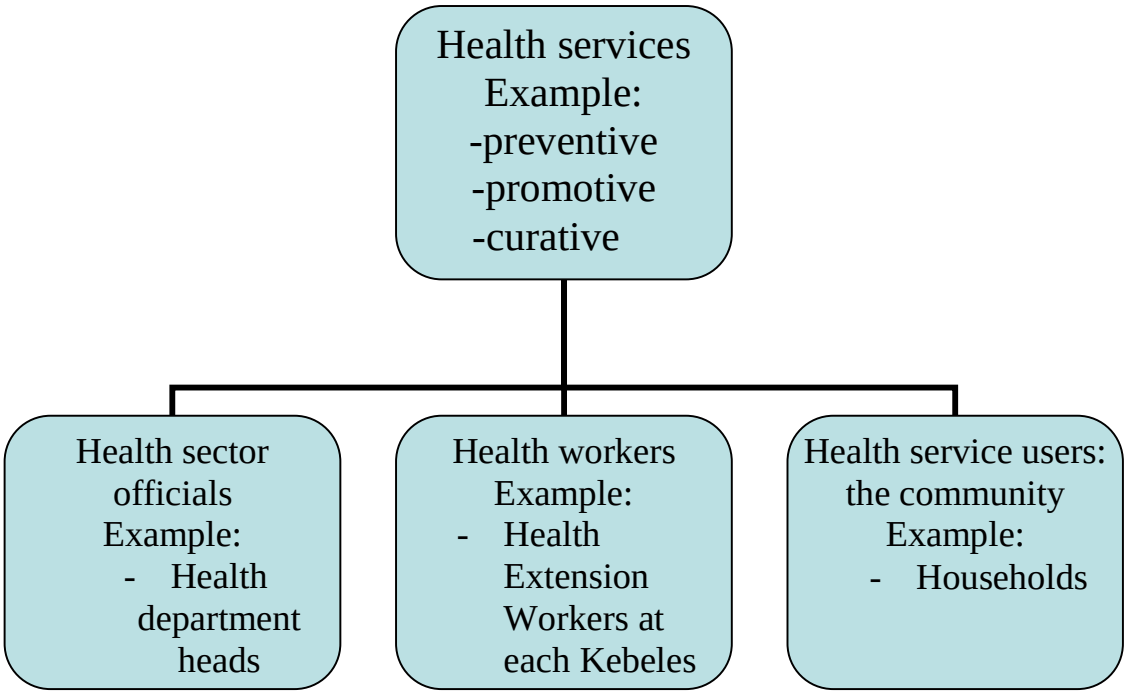
7. FINDINGS AND DISCUSSIONS

Overview

This thesis is focused to assess the situation of public health service provisions at community level in Masha Woreda by carefully indicating the challenges, measures being undertaken to minimize the challenges and suggested mechanisms for future challenge minimizations.

In order to do this, the researcher identified the actors in this service sector and collected data from the actors of the area by questionnaires and interviews, and analysed them both quantitatively and qualitatively to come up with the results.

Fig. 4.1 Actors in health service provision in Masha Woreda



(Source, Author)

There are three actors that play major roles in the provision of health services in Masha Woreda. These include

- Health sector officials working at the Woreda level who are responsible for tasks such as planning, allocating budgets, employing health personnel, implementing the plans, monitoring the overall works of the Woreda health institutions.
- Health workers including health service extension workers (HEWs) and their supervisors who are shouldering a role of addressing the service to the households.
- Community (service users) for which the service is being addressed.

7.1. Socio economic characteristics of the respondents

7.1.1. Religion

Table 4.1 Distribution of sample household heads by Religion

Name of Religion	Frequency	
	No	Percent
Orthodox Christians	52	43.3
Protestant Christians	67	55.8
Muslims	1	0.8
Total	120	100.0

(Source, Field survey 2010)

According to the researcher's survey data (table 4.1), Protestant Christian constitute the major share (55.8%) followed by Orthodox (43.3%) and Muslims 0.8%. The participants in the interview are all farmers which happened as a chance factor in their random selection process.

7.1.2. Sex of household heads

Table 4.2 Distribution of sample Household heads by Sex

Sex	Frequency	
	No	Percent
Male	102	85.0
Female	18	15.0
Total	120	100.0

(Source, Field survey 2010)

Table 4.2 shows that overwhelming majority of Household heads (85%) are males. These male household heads include father or elder son. They have the roles of farming or cultivation, harvesting, business life sustenance activity.

In some families female household heads have equal responsibility with families headed by male household heads to manage their families. Accordingly, this accounts relatively the lowest share (only 15%) of the sampled population.

7.1.3. Family size of sample household heads

Table 4.3 Distribution of sample Household heads by family size

Family size	Frequency	
	No	Percent
Below 3	22	18.3
Between 3-5	38	31.7
Above 5	60	50.0
Total	120	100.0

(Source, Field survey 2010)

With regard to the family size of the concerned households, the largest share (50%) is that of households having >5 members. It is followed by household containing 3-5 members (31.7%) per family and <3 members (18.3%) respectively.

It is obvious that large family size may result insufficiency of basic needs of family members unless the households increase their income production by having extra efforts in their day to day works. As can be concluded from the figure and interview of households, the habit of family planning is poor in the area. So, people tended to have large family numbers.

7.1.4. Age of sample household heads

Table 4.4 Distribution of household heads by age groups

Age groups	Frequency	
	No	Percent
Between 15-64 years	77	64.2
Above 64 years	43	35.8
Total	120	100.0

(Source, Field survey 2010)

About 64.2% (77) of the sample household heads are within the age range of 15-64 years which is known as 'working age' or 'independents' and the rest 43 individuals or 35.8% are above 64. So, this implies there are relatively higher numbers of working age household heads who can perform key activities in a family, like farming and harvesting. There are also factors which hinder the household heads from performing such activities. This includes lack of work ethics and the like. This ethical behaviour, in turn, influences the economic level of the household.

7.1.5. Occupation of sample household heads

Table 4.5 Distribution of sample household heads by occupation

Occupation	Frequency	
	No	Percent
Agriculture	98	81.7
Business	15	12.5
Government worker	7	5.8
Total	120	100.0

(Source, Field survey 2010)

Agriculture is the back bone of Ethiopian economy in general and rural areas in particular. According to the survey, 98 individuals or 81% out of sample household heads of Masha Woreda are engaged in agricultural activities. This figure is the highest of all economic activities performed in rural areas of the Woreda.

Another activity being performed in this area is business activity in which about 12.5% of the rural households are engaged which involves transactions of domestic farm products like cereals and manufactured goods like textiles, consumable goods and agricultural equipments generally in the small rural markets and village shops.

A small share here is accounted for by government employees like health extension workers, agricultural professionals and teachers who dwell in the Woreda Kebeles and have their own families depending on their salaries.

7.1.6. Education of sample household heads

Table 4.6 Distribution of sample household heads by education levels

Education level	Frequency	
	No	Percent
Illiterate	43	35.8
Primary school complete	60	50.0
Secondary school complete	12	10.0
Higher Education graduate	5	4.2
Total	120	100.0

(Source, Field survey 2010)

Education is crucial for better living in the world, economically as well as systematically. Even then, due to lack of awareness about its advantages, most of the rural dwellers are not concerned about it. This can be reflected by their reluctance to send their children to the schools. Even if they send their children, they don't give careful follow up to it and don't motivate them to continue their Education. This situation led most of rural dwellers to stay remain illiterate or only to complete their primary level education without continuing up to college and university levels.

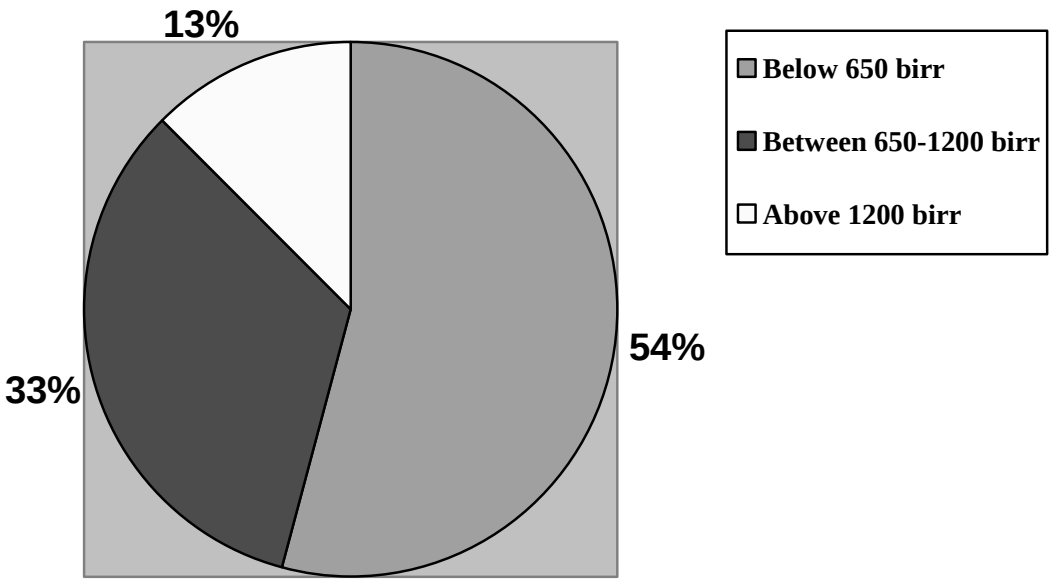
The survey results of this research also show similar patterns where there are 43 illiterate household heads out of 120 respondents and 60 (50%) have completed their primary school Education. Only 10% and 4.2% have attained their 12 and higher education graduations respectively. Higher education graduates included government workers like health professionals, teachers and agricultural workers who graduated from their respective training institutions.

This situation indicates that more should be done to make them aware of the needs of education in human life and society. Education is the base for decision makings in uses of different social services like health services, Education etc as well as adoption to modern

inputs in farming techniques. The interest towards using existing social services is greater among in families of with better Educational backgrounds.

7.1.7. Family monthly income

Fig 4.2 Distribution of sample households by monthly income



(Source, Field survey 2010)

The income of households depends on the economic activities they are engaged in and thus, it varies from household to household. It reflects the financial capacity of households for fulfilling their basic needs, like clothing, food, shelter and higher wants of services like education, health, electricity etc. The decisions on use of such paid services depends on the income level of the.

As the main economic activity of the majority of the population in rural areas of Ethiopia is agriculture, their income source depends only on this activity. Their income varies according to their agricultural outputs, which is a question of farm size, use of modern techniques and inputs etc. The availability of modern systems in rural areas is still very

low. Hence, farmers of Masha Woreda increase their productions only by increasing their farm which is vulnerable to natural hazards or calamites.

Accordingly, as the figure 4.2 shows, the highest number of households (65) constituting 54.2% of total sample fall within the income range of below 650 ETB per month for all sources. Forty individuals (33.3%) have income between 650 - 1200 ETB per month followed by 15 households (12.5%) getting above 1200 ETB per month.

7.2. Health services accessibility to households' and service provisions.

7.2.1. Cluster form of health service delivery system

As to the responses of interviewees, the mechanisms developed for health service provisions at health centres are very weak. It doesn't consider the socio economic situations of the households and physical features of the area. The responses of the interviewed health sector officials, pointed to the cluster system of health service provision in the Woreda, arranged, keeping in view, the geographical proximity of the Kebeles to each other. In this pattern there are 3 clusters consisting of 1 health centre each at their nucleuses serving about 5-9 Kebeles around the health centre.

Even though this clustering system is the best for allocating existing health centres with the Kebeles to give service for the whole community, it is not carefully studied to consider the environmental impediments beyond geographical proximity like roads, relief features and population of the respective Kebeles. So, it is unattainable in such a way that it takes more time to go from Kebeles to their nucleus health centre. This may lead to the refusals of households to use the services.

The connecting roads are very long and not suitable. They are muddy and pass through rugged terrains, and distant. As Masha town is the capital of the Woreda, there are Kebeles clustered far away from their nucleus health centres but near Masha town. For example: Keji is at about 1 hour distance from Masha town but is included in cluster of Chago which is at about 3 hours distance from Keji. Here, there is a problem with the availability of roads connecting the clusters with their respective Kebeles. This indicates

that this cluster system did not consider the user side incapability to be addressed by the services due to the above factors.

Table 4.7 General features of health institution in Kebeles of Masha Woreda

Name of the cluster	Name of the nucleus health centre	Included Kebeles	Directly connecting Roads with the nucleus health centre	Distance from its nucleus health centre in hours on foot	Health institution of the Kebele	
					Health post	Health centre
Degele cluster	Degele health centre	Degele			✓	✓
		Atile	Yes**	1:30hrs	✓	
		Karina	Yes	1hr	✓	
		Gembeka	Yes**	2:00hrs	✓	
		Yeshi Akako	No	2:00hrs	✓	
Chago cluster	Chago health centre	Chago			✓	✓
		Yepo	Yes	1:00hr	✓	
		Kewo	Yes	1:00hr	✓	
		Shibo	Yes	1:30hrs	✓	
		Uwa	No**	2:30s	✓	
		Keji	No**	3:00hrs	✓	
		Wollo	Yes	1:30hrs	✓	
		Beto	Yes	1:30hrs	✓	
		Abelo	Yes**	1:30hrs	✓	
Yina cluster	Yina health centre	Yina	Yes		✓	✓
		Kanga	Yes	1:30hrs	✓	
		Gada	Yes	1:00hr	✓	
		Gatimo	Yes	1:00hr	✓	
		Ateso	Yes **	2:00hrs	✓	

** shows Kebeles which have long distances from their nucleus health centre

(Source, Masha Woreda health department)

7.2.2. Distance of health institutions

Table 4.8 Distribution of sample households by time taken to travel to the nearest health institution

Time taken	Frequency	
	No	Percent
Below 1 hour	86	71.7
Between 1-3 hours	34	28.3
Total	120	100.0

(Source, Field survey 2010)

As health service is a very significant need of human beings, there should be an efficient and fair service delivery system which can keep the service seekers in a close proximity to the delivery points. Unless and otherwise, a service seeker cannot be effectively provided with the services and gaps will be created between the seekers and providers of the services.

In most of the rural areas the relief features and the settlement patterns are not regular. The relief features in the area are mountainous and difficult to be traversed by the sick to reach the health centres. The settlements of the Kebeles are also dispersed in which it becomes very difficult to provide all the social services needed by the individuals as per norms. In Masha Woreda most of the Kebeles are geographically wide spread and the population is settled in a fragmented pattern as is exemplified by about 28.3% or 34 sample households, who reside within a range of 1-3 hours distance from the nearest health institution (health post in this case) when travelled on foot. The rest 71.7 % are settled within 1 hour travel distance from the health posts of the respective Kebeles.

7.2.3. Mode of Transport

Table 4.9 Distribution of sample household heads by mode of transport used to reach health institutions

Mode of Transport	Frequency	
	No	Percent
On foot	73	60.8
Pack animals	47	39.2
Total	120	100.0

(Source, Field survey 2010)

As the travel distance to the service point increases, the seekers will either tend to ignore using it or make suitable environments to use it by going up to the service point like using pack animals and forced to go on foot. But the level of ignorance may depend on the type of needed service whether it is most basic or not. For example there is a difference in households' readiness to go to the town in need of health service and electric or telecommunication service. People will tend more to go to town to use health service than telecommunication service.

In this Woreda, according to the results of the sample survey, all the sampled households use health services even if it is far away from their villages. The service seekers use either pack animal (39.2%) or travel on foot (60.8%). The Woreda lacks auto vehicular transportation routes except the Gore-Teppi main motorable road passing through the Masha town.

The probability to use pack animals depends on the households' economic level to have such pack animals like horse, mule and donkey. Those, economically incapable to buy such pack animals, are forced to go on foot.

7.2.4. Health human resources in the Woreda

Table 4.10 Health workers to population ratio in the sample Kebeles

Sampled Kebeles	Population in 2002	Healthy extension workers	HEWs to population ratio
Yeshi Akako	1316	2	1:658
Ateso	2237	1	1:2237
Wolo	3702	2	1:1851
Yepo	654	2	1:327

(Source, Masha Woreda health department)

As to the responses of interviewees, there are two female health extension workers in their Kebeles who were trained for one year at Technical and Vocational Schools. They were selected from their respective Kebeles according to their educational status.

Health worker to population ratio is the proportion of the number of people being taken care of by 1 health worker. It is obtained by dividing the total population with the number of health workers. Accordingly this ratio in sampled Kebeles of Masha Woreda is indicated in table 4.10; the ratio in Kebeles having only one HEW is relatively higher than that of others. This, in turn, adds work burden on the respective HEW to service the total population alone.

The areas of the Kebeles are very large and the households are residing at different distances from the health posts. So, the health extension workers have to work more to serve this large number of population in a large living area. For example one service delivery mechanism by health extension program is to visit households' houses and families for health related consulting and educative issues, which is a time taking process.

On the other hand, when the health extension workers are visiting the houses for health issues, the work at the health post is virtually stopped. Then the service seekers at the health post stay without service providers. So, there should be enough number of health

extension workers to fill the gap. The interviewees suggested that the government should increase the number of workers to 4 or 5.

Table 4.11 Number of total health personnel in the Woreda

Professions	Number
Health Service Extension Workers	35
Midwives	3
Clinical Nurses	5
Supportive Staffs	3
Pharmacist	1
Cleaners	2
Junior Clinical Nurses	1
Public health service worker	4
Guards	3
Health Service Extension supervisors	3
Total	64

(Source, Masha Woreda health department)

As to table 4.11, there are only three health extension supervisors supervising 35 HEWs in 19 Kebeles. This figure shows very limited supervision in the Woreda where 1 health extension work supervisor has to supervise at least 6 Kebeles in a Woreda which has high and increasing population pressure, lack suitable transportation facilities as well as has large areal coverage with rugged terrain.

The pressure of work on the supervisors was also confirmed by the responses of some Health Extension workers, who claimed that these health extension work supervisors are very busy going here and there to supervise the work at all Kebeles.

Table 4.12 Required health service manpower in Masha Woreda according to BPR in Educational levels.

Required manpower (Professions)	Educational level	Current Numbers	Required at Woreda level
Health Officer	Degree	0	9
Midwives	Diploma	3	9
Clinical Nurses	Degree	5	15
Laboratory Technicians	Degree	3	9
Pharmacists	Degree	1	6
Messengers	-	2	6
Junior Clinical Nurses	Diploma	1	3
Public Nurses	Diploma and Degree	1	3

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(Source, Masha Woreda health department)

The above table 4.12 relates to the required number of health workers in a given health centre in accordance with standard put by MOH in BPR and the current manpower available. Accordingly, there is a big gap between the required and the present. This shows little works in health worker employing activity of the department

In order to minimize the problems of money in employing HEWs the health department should do efforts like asking for additional budget from government, participating some NGOs which can give any help to the sector, enabling the health institutions to strengthen their financial capacities by creating their income source and the like.

7.2.5. Availability of health extension workers

Table 4.13 Opinions of sample household heads on Presence of health workers when needed

Opinions	Frequency	
	No	Percent
Yes always	43	35.8
Some times	65	54.2
Not at all	12	10.0
Total	120	100.0

(Source, Field survey 2010)

According to undertaken survey, from the sampled Kebele dwellers, about 35.8% agreed that the HEWs are always available at their institutions waiting for serving the service seekers, while 54.2% confirmed their occasion presence but remaining 10% completely denied their presence at the health institutions. Truly, it may not mean their reluctance, to provide services rather they might be for serving the community by house to house visit for health issues. To this extent, the responses of health service extension workers on this issue, refers to the pressure of work at the office and in the field. Further, they argue that to cover the wide extent of Kebeles is beyond the capabilities of only 2 and some only 1 HEW. This should also be looked by careful follow-up by the supervisors on the day to day performances of health extension workers.

Health extension workers at the health posts are the last choices to the villagers to receive health services from their respective health posts. So, there should be a close relation between the HEWs and the societies in utilization of services and other health related issues. The health workers should also be aware of their role in the society and the responsibility given by the body that employed them. These include work ethicises like punctuality, cordial behaviour and the like.

Table 4.14 Distribution of sample household heads by places of health services

Health service places	Frequency	
	No	Percent
From the health institution of the Kebele	58	48.3
From the health institution other than the Kebele	62	51.7
Total	120	100.0

(Source, Field survey 2010)

Even though there are health posts in each Kebeles, some of the inhabitants prefer to use health institutions of other Kebeles, especially the health centres at the capital of the Woreda: Masha.

The figure in the table 4.14 shows that, 58 (48.3%) of the households use health institutions other than the health post at their own Kebeles and the rest 62 (52.7%) use their health posts. This indicates that the presence of any health institution in a given area doesn't mean that the society is fully satisfied with the service provisions at the institutions. So, there should be assessments of the performances of the sector within the given inputs.

With regard to the constraints of transportation, it is observed that people either go on foot or use pack animals to reach the service point of their Kebele. But there are more significant challenges than the transportation constraints that make the society to prefer the next farther but relatively the better service point: such as availability of medicines and efficient treatments.

Table 4.15 Distribution of sample households by occupation and location of service institutions

Family occupation		Health service institutions used				Total	
		Health institution of the Kebele		Health institution other than the Kebele			
		No	% of column	No	% of column	No	% of column
Agriculture	No	53	91.38%	45	72.58%	98	81.67%
	% of rows	-	54.08%	-	45.9%	-	100.00%
Business	No	3	5.17%	12	19.35%	15	12.50%
	% of rows	-	20%	-	80%	-	100.00%
Government work	No	2	3.45%	5	8.06%	7	5.83%
	% of rows	-	28.55%	-	71.45%	-	100.00%
Total	No	58	100.00%	62	100.00%	120	100.00%
	%of rows	-	48.33%	-	51.67%	-	100.00%

(Source, Field survey 2010)

Based on the distribution in table 4.15, it can be inferred that service seekers have better preference for health posts of their Kebeles as on the whole 51.67% of sample households attend the health post out of their Kebeles. An analysis based on occupations reveals that farmers, probably due to financial constraints, has to rely more on the health posts of their own Kebeles as 54.08% of the sample farmers are using it. Things are quite different with households engaged in occupations other than farming. For example 80% of the sample households engaged in business have preference for health posts of other Kebeles. A similar pattern is also presented by government workers as 71.45% are using

the health posts other than that of their own Kebele. Such attitudes might be attributed to their financial ability to choose among the best, irrespective of transport or other costs.

Table 4.16 Distribution of sample households by family Monthly income and place where family members get health service

Family Monthly salary		Place where family members get health services				Total	
		From the health institution of the Kebele		From the health institution other than the Kebele			
		No	% of column	No	% of column	No	%of column
Below 650 birr	No	32	55.17	33	53.22	65	54.16
	% of row	-	49.23	-	50.77	-	100
Between 650-1200 birr	No	19	32.75	21	33.87	40	33.33
	% of row	-	47.5	-	52.5	-	100
Above 1200 birr	No	7	12.06	8	12.9	15	12.5
	% of row	-	46.7	-	53.3	-	100
Total	No	58	100	62	100	120	100
	% of row	-	48.3	-	51.7	-	100

(Source, Field survey 2010)

According to family monthly income and place where family members get health service Cross tabulation, there is another reflection of the choice for service points in terms of income levels of households in which those poor farmers who have less than 650 ETB per month use the health posts of their Kebeles. This is due to transportation constraints and the cost of going to health posts out of their Kebele. Accordingly, the researcher also interviewed whether low income level forces households not to use health institutions:

and realized that people borrow money from relatives and get health services. But as the income level decreased much, households tend to refuse using health institutions.

Generally, as we move from low income family to high income family the preference to use their Kebele health post will decrease. This is because of the need to get service from a next higher service point. The transportation difficulty is minimized for such households by their ability to buy pack animals with the money they earn. Accordingly, 53.3% of sample households with income ranges <1200 birr prefers health posts out of their Kebele.

7.2.6. Occupation vs. Monthly income

Table 4.17 Distribution of sample households in occupation and monthly income

Occupation		Monthly income						Total	
		Below 650 birr		Between 650-1200 birr		Above 1200 birr			
		No	% in column	No	% in column	No	% in column	No	% in column
Agriculture	No	58	89.24	28	70.0	12	80	98	81.7
	% in row	-	59.24	-	28.6	-	12.2	-	100
Business	No	5	7.7	9	22.5	1	6.7	15	12.5
	% in row	-	33.33	-	60.0	-	6.7	-	100
Government worker	No	2	3.1	3	7.5	2	13.3	7	5.8
	% in row	-	28.6	-	42.8	-	28.6	-	100
Total	No	65	100	40	100	15	100	120	100
	% in row	-	54.2	-	33.33	-	12.5	-	100

(Source, Field survey 2010)

Analysis of occupation by income reveals that, among the sampled farmers, 59.2% earn <650 birr per month while 28.6% and 12.2% earn 650-1200 birr and >1200 birr respectively. Among the business people, there is dominance of middle group (60%), only 33.3% and 6.75 are earning <650 and >1200 birr respectively. As to the government workers, 42.8% have income 650-1200 birr while 28.6% each are sharing the other two categories.

Table 4.18 Distribution of sample households by the reasons why they use institutions other than their Kebele

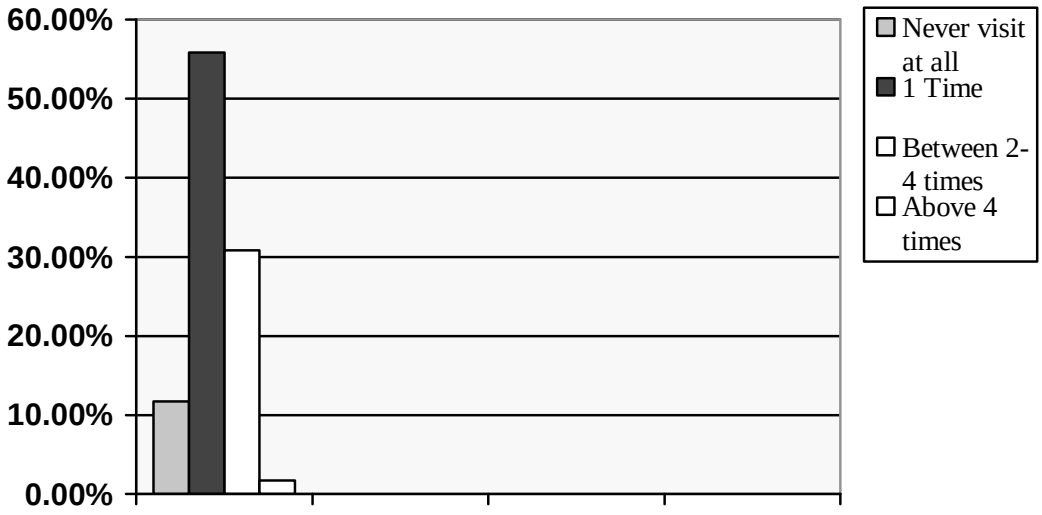
Reasons	Frequency	Percent
Inefficiency of medicines of the Kebele health post	8	12.9
Higher service cost	2	3.2
Skilfulness of workers	12	19.3
Non availability of needed medicines in the institution	40	64.5
Total	62	100.0

(Source, Field survey 2010)

There are different reasons raised by the users of other health posts with regard to their preferences to health post of other Kebeles. This included the belief in curing capacity of medicines being given, the expensiveness of the service costs, incapability of the workers to fulfil their task professionally (professional knowledge) and the deficiency of medicines which are frequently needed by the service seekers. These factors account 8 (12.9%), 2 (3.2%), 12 (19.3%) and 46 (64.5%) respectively from the sampled household heads.

Due to the absence of private or any other governmental pharmacy in the area, majority of households (51.7%) use private pharmacy or other health institution of the nearest Kebele for health services or purchase of medicines.

Fig 4.3 Distribution of sample household heads by Monthly visit to their house by health extension workers



(Source, Field survey 2010)

One of the activities of HEWs which targeted at preventive strategy is enabling the household prevent disease transmission. This is done by creating awareness through health educations by health extension workers through house to house visit. This awareness creation can be achieved by HEWs' careful follow-up of the successes' of households and also households' should appropriately implement what is taught by HEWs. Accordingly this data in bar graph (fig. 4.3) indicates that (67) or 55.8% of the samples' houses are visited by HEWs 1 time, (37) or 30.8% between 2-4 times, (2)1.7% above 4 times and (14) 11.7% not visited at all per month. In the above line chart as we move to higher frequency of visiting family houses the percentage will decrease. This shows gaps in follow-up the activities of households in health issues by HEWs.

Table 4.19 Provisions of health education to the dwellers by health extension workers

Type of Answer	Frequency	
	No	Percent
Yes	82	68.3
No	38	31.7
Total	120	100.0

(Source, Field survey 2010)

Health education is a means by which health extension workers give a clear knowledge of health related issues. These issues include disease prevention, personal hygiene and environmental protection. This education promotes a healthy environment for the healthy life of the society. This health education can be administered by health extension workers or other guests in a health institution or in the households' houses.

About 68.3% of the samples agreed on presence of health education at their Kebeles. Health knowledge of a household determines overall activities that an individual make towards every aspect of diseases beginning from knowing the nature and type of disease to its controlling mechanisms.

Table 4.20 Personnel who give health education for the households

Resource person	Frequency	
	No	Percent
Health extension workers	74	61.7
Other guests	8	6.7
Total	82	68.3

(Source, Field survey 2010)

Concerning the resource person administering health education, according to the data in table 4.22, 90.2% of the households who agreed with the presence of health education in

the kebele, indicated that it is given by health extension workers for the remaining 9.8% it was by guest personnel. This shows the absence of sharing experiences among health workers of Kebeles and reluctance to invite professionals from Woreda health centres or elsewhere as guests to educate the community on health related issues. Sharing experiences help the communities to know the experiences of other health professionals towards addressing issues and working for public benefits. Since, health extension workers are one year graduates from Technical and Vocational Schools; they may not have in-depth knowledge of their professions. So, they should invite experienced guests both to get additional knowledge for themselves and health education for the communities.

Table 4.21 Distribution of sample households by the attitudes to use health institutions when needed

Type of Answer	Frequency	
	No	Percent
Yes	78	65.0
No	42	35.0
Total	120	100.0

(Source, Field survey 2010)

Concerning the opinion on whether to use health institutions as and when needed, 65% of the sample population were positive, believing on the importance of this service sector and have an interest to use it. The rest 35% showed their indifference.

Some of the challenges which result in such indifference to health services include income level (paying capacity for the services) of the households; as the decrees in income leads to the decrease in using social services hence cannot pay for the use, availability of service points at short distances for easy access, education level of the service seekers and the like.

7.3. The main challenges of public health service provisions at the Kebeles

7.3.1. Lack of health infrastructures in health posts

The health sector officials indicated that the major challenge to the smooth functioning of the provision of health service in the Woreda is related to supply side, caused by lack of financial resources to purchase the required supplies. These required supplies include medicines, needles, gloves, refrigerators and the like. The financial allocations and the donations from NGOs didn't fully address the overall gaps. In order to overcome the financial shortages, the Woreda department is working towards searching for donating agents and planning to implement a process by which health posts should financially build themselves by renting their free lands which they have at their compounds for farming.

Another challenging factor in this Woreda's health service provision is the lack of health infrastructures, inefficient numbers of the existing materials and the like. Due to this challenge, only minor treatments are given at the health posts and more complex problems are referred to the next higher health institution.

In this system, there is lack of enough medical services at the health posts. There are no private or government pharmacies nearby to get the needed medicines. This problem is very serious among farmers during emergencies, like falling from the trees, cuts, bleedings and other accidents. In the cluster health centres, also there are the same problems in which the medical supplies and the service users are oppositely related shortages of medicines are also visible.

Other problem related to the infrastructural supply at the heath centres is the untimely replacement of some finished materials. Even the old instruments in the institutions are reused. This is caused due to financial constraints in the institutions. So, the government and the officials at the respective levels should reassess these challenges and make appropriate interventions, as suggested from the households of some selected Kebeles.

These respondents also put a suggestion to solve these problems. As rural areas have combined problems of transportation and others impediments the government should have to formulate appropriate budget allocation formula and maximize the budgetary capacity to the sector. Generally, basing on the responses of the interviewees, the health sector officials should put pressure on government to consider such backward areas in service provision and they have to expose the entire problem by raising them on the annual conferences and meetings at National and Regional levels. There should be a sector wise cooperation to tackle such deficiencies. Such cooperation can be by granting, lending and borrowing money to and from each other.

7.3.2. Service coverage at the health posts

The service coverage at the health post level is both preventive and promotive types. Even though this strategy is crucial and very timely to prevent diseases and to make households knowledgeable in health issues, it should give prior concern to curative interventions. As we know, most of dwellers in rural Kebeles of Ethiopia are victims of infectious diseases and epidemics. So, treatments at the health post should extend beyond treating minor diseases and health education to intervention to complex aliments.

7.3.3. Poor relationship between health workers and the community

According to the interviews, personal problems related to the health extension workers are many. As health extension workers are keys to the health service provisions of the rural society, they should be cooperative to people whom they are serving. In this regard, most of the health extension workers lack proper medical ethics of politeness and adjustability. Their way of handling the service seekers is very poor, harsh and even revengeful at times due to their personal neighbourhood problems. Such revenges may go even to the level of on some pretext or the others like lack of materials; working hours etc. Another major aspect is their punctuality and presence at the centre. Invariably they abstain from the institutions on weekends, salary days etc.

7.3.4. Work dissatisfaction as the problem for careless service provision

Similar to the responses of households, the heath extension workers also believe in the shortage of skilled manpower per Kebele to serve the large population. Another cause of dissatisfaction, reported by them was the insufficiency of their monthly salary, which is less than 1000 birr per month by working every day. So, in order to sustain, they are also engaged in some agricultural activities like cultivation of vegetables. Here, the two activities clash, resulting in gaps like absenteeism and non-punctuality. Even if they know that it is improper, but they have to do it for their survival. Other cause for their dissatisfaction is the lack of opportunity to upgrade their educational qualifications. This arouses among them the feeling that they have to end up as HEW only. Such ideas impede their performances.

7.3.5. Social problems of Health Extension workers and lack of community collaboration in health service sector

Deficiency of basic needs like housing is another problem for health extension workers. This indirectly affects the delivery of service provisions and can result in change the Kebeles or change of their professions for better living conditions.

Concerning this, the interviewees, suggested that the Kebele administration should take care of fulfilling such basic needs of health extension workers.

Another challenge posed by health extension workers was the carelessness of the Kebele dwellers and administration in caring this service sector as their own property probably, because of lack of sense of ownership among the dwellers of the Kebele. There is also lack of coordination among households using these services, health workers working at the sector and health sector officials monitoring the sector.

7.3.6. Households' reluctance

One of the challenges related to the households is: the reluctance of some households to use the provided services and to implement the suggestions of the health service

extension workers on their health affairs. This, in turn, retards the rate of successes. It results in moral unrest among the health extension workers who expect faster results of their hard work.

As the interviewees said, more should be done to tackle the challenges of this service sector in Kebeles with respect to the growing demands of the population to the service. This includes: discussion with the Kebele administration to cooperate and play their own role in minimizing the challenges of this service sector, reporting the challenges to the highest body before they become very serious, closely working with the society to be flexible in receiving and implementing what they have learnt from the health extension worker.

7.3.7. Challenges of ever-increasing demands

As the interviewees said that more should be done to tackle the challenges of this service sector in Kebeles with respect to the growing demands of the population to the service.

7.3.8. Managerial gap to handle health workers and to manage the sector

At Woreda level, the health sector is staffed by professional workforce with their specific roles. These staffs include rural health development, transmitted disease prevention and control board, multi-sectoral HIV/AIDS control and prevention board, health human resource management board and the like.

Another challenge indicated by the interviewees is the inappropriate handling of the health extension workers by the management at the Woreda health department. Accordingly, there is no close professional relation among the workers and the officials. They are working independently. Since any service provision needs a close interaction between the serving and the management, the health workers and the managerial body should closely interact towards the efficient service provision in this Woreda.

According to the interviewees there are supervisors assigned by the Woreda health department to supervise the activities of each Kebele. But these supervisors are not careful in supervising.

There are also problems related with lack of qualified health sector managers who are accountable and transparent.

The interviewees also indicated that the problem of transportation is also very serious for both supplying the needed materials and making assessments especially at summer seasons. In order to confront the problem of transportation vehicles the officials are using bicycles and pack animals to go to rural villages for the assessment purposes.

Another problem which health sector officials forwarded is the absence of problem solving researches in the sector to study the ongoing situations. They indicated that the workers have no interest towards research works on different issues of health services.

The health department has to motivate the researchers and sponsor the works by pointing out researchable topics which can be urgent and problem solving in this service sector for the research and finally rewarding them accordingly.

CHAPTER FIVE

8. CONCLUSIONS AND RECOMMENDATIONS

8.1. Conclusions

Health service is one of the crucial components of public services that need collaborative efforts of concerned bodies to its success. As a public service, health sector can face many challenges in its provision for the community.

This thesis is done on the appraisal of the provision of health service in Masha Woreda of Sheka Zone in SNNPR. After careful analysis of collected data, the researcher drawn the following conclusions related to the study issue in the area.

The study area is located on south western Ethiopia and inhabited by majority of Shekacho people. The economic activity in the area is mixed farming which includes cultivation of food crops and animal rearing. These food crops include maize, wheat, barley, teff and the like. There is also production of cash crops like coffee and honey. Animal products include sheep, goats, hens, cows and others for their milk and meat products.

This Woreda has a total population of 38,131 which consists of 18,733 male and 19,398 female populations in 2003.

The health service provision of this Woreda is monitored by health department at Masha town. This health department is responsible for decision making, planning and budgeting of the activities of the sector in the Woreda.

Health service in this Woreda is provided by using 3 health centres and 19 health posts. These 3 health centres are located at three different Kebeles in a way that all Kebeles can be served by the existing health centres. Health posts at each Kebeles are operated by their respective health extension workers. These HEWs are one year graduate from technical and vocational schools and all are females.

Specifically the health service delivery system of the Woreda is called cluster system. This is the system in which all Kebeles at closer proximity to one of the health centres are assigned to use that health centre which is nearest to them. So, health issues which can't be solved by health post are treated by the nearest health centre. In this system it is needed for both health institutions to cooperate together and work properly. The health posts are responsible for serving the society with the existing resources. In Masha Woreda, health service extension programme is supervised by 3 supervisors assigned at each three clusters. These supervisors have a responsibility of assessing the activities of health extension workers and reporting to the Woreda health department if problems face. However these supervisors are not fully devoting their time for this supervision.

As a public sector there are problems which can hinder the full and efficient provision of health services at a community. This includes:

- Lack of skilled health man power especially at health posts of Kebeles and managerial levels.
- Lack of medicinal supply at health posts and shortage of financial capacity to employ health workers at the Woreda level
- Illiteracy of most of the community that created gaps of awareness about health issues.
- Limitation of service provision at health posts to minor treatments while most of the diseases at rural areas are infectious diseases and epidemics those need very urgent and careful control.
- Lack of enough transportation facilities among Kebeles that hinder the free movement of service providers and service seekers.
- Carelessness of health workers to service provision due to work dissatisfaction that is caused by reasons like salary increment and lack of further education.
- Lack of free discussion among the workers and the community on problems that challenge the effective delivery of this service.
- Lack of habit of free discussions of the concerned bodies on every health related problems in the Woreda.
- Lack of problem solving researches on the sector.

- Absence of transparency among top level managers and the lower workers.
- Absence of accountability of workers and habit of working together for their goals.
- Natural challenges that impede supportive assessments especially in rainy seasons. Example roads of rugged terrain, muddy road during summer seasons and the like.

8.2. Recommendations

In this thesis the activities of health workers and health sector administrators in Masha Woreda were assessed. The challenges hindering its full delivery were also raised. There are also views of the respondents collected during data collection on ways how to bring an efficient and effective delivery of health services by minimizing the challenges and its effects in MashaWoreda.

By taking into consideration the challenge minimizing mechanisms posed by the respondents, the researcher given the following recommendations.

- Hence each and every service sector needs careful staffing of the workers to provide effective and efficient services to the community, careful staffing with efforts of transparency and accountability of the workers at all levels of work from managers to implementers in the Woreda health sector is a crucial aspect.
- Much of the financial capacities of health service sectors in Africa is donations from NGOs, so the Woreda health department has to do more to increase the role of NGOs in health sector of the Woreda. This can add value of financial resources of the sector through monetary donation and professional help.
- Since research is a base for problem solving; the Woreda health department has to be responsible for motivation of researchers. This can be done by giving researchable topics, careful advice to their researches, financial sponsorship and the like. So that, further studies will be done on the availabilities of health extension workers in the sector.

- Open and round table discussion of the concerned bodies including selected individuals from the service seeking community is needed on the problems of the sector because if challenges brought to discussion, the discussant can give their own views on it minimization and these views can be the best solution to the problem indicated.
- Creating awareness on health service utilization among the society is crucial. This can be achieved by training of the health extension workers on how to fully utilize the existing health services and health extension workers to further educate the society.
- Identifying a model health post and model health workers and motivate it by awarding like financial, material grants as well as educational opportunities for HEWs. This can motivate other health posts and health workers to follow the experiences of the bests.
- Inviting the communities to play their role in problem solving actions like construction of summer roads within rural villages, construction of health institutions both in labour and finance to minimize the distance barrier of the sector is crucial in the Woreda.
- Since the cluster system of health service provision in the Woreda didn't achieve its aim of providing services to Kebeles with closer proximity, modification of cluster system of health service provision of the Woreda is needed in a way that additional health centres should be constructed for Kebeles which are far from their current nucleus health centre.
- The supervisors should devote their time to cooperate with HEWs in each and every aspect of health service provision rather than staying in Masha town during working time.
- Urgent report of the problems to the higher body is needed, on the side of health workers, for urgent reply is needed and suitable reply must be given from the concerning bodies.

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Appendix I

1. Questionnaires prepared for households

This questionnaire is prepared to collect relevant data for assessing the challenges of health service provisions at community level in Masha Woreda. Information obtained is to be used only for study purpose and it will not be used for other missions in any case. Therefore, you are kindly requested to provide genuine response to the questions accordingly for the success of the research.

So please put the symbol √ in the appropriate box of the answer, as any where needed or elaborate whenever required.

1.1 Households' socio economic profile

1.1.1 Household head's religion

Orthodox Christians ☐ Protestant Christians ☐ Muslim ☐

Other ☐

1.1.2 Sex of households' head

Male ☐ Female ☐

1.1.3 Household size of the respondent household head

Below 3 members ☐

Between 3-5 members ☐

Above 5 members ☐

1.1.4 Age of household head

Belo 15 years ☐

Between 15 -64 years ☐

Above 64 years ☐

1.1.5 Type of occupation households are engaged.

Agriculture ☐ Trade ☐ Government work ☐ Other ☐

1.1.6 Educational status of households' head

No education or illiterate (cannot read and write) ☐

Primary school complete (1-8) ☐

Secondary school complete (9-10) ☐

Higher education graduate ☐

1.1.7 Monthly average income of households'

Below 650 birr ☐

Between 650-1200 birr ☐

Above 1200 birr ☐

1.2 Health service accessibility to households' and service provision.

1.2.1 How much time it takes to travel from your house to the nearest health centre?

Less than 1hour ☐ Between 1-3 hour ☐ More than 3 hours ☐

1.2.2 What is the Health institution of your Kebele?

Health post ☐ Clinic ☐ Health centre ☐ Hospital ☐

Other private institution ☐ None ☐

1.2.3 What mode of transportation do you use to go to the nearest health facility of your area?

On foot ☐ By ambulance ☐

Pack animals ☐ Public bus ☐

By taxi ☐

1.2.4 How much health workers are there in the health institution of your Kebele?

Less than 2 ☐ Between 2-4 ☐ More than 4 ☐

1.2.5 Are these health workers always available at their institution to serve the society?

Yes always ☐ Sometimes ☐ No at all ☐

1.2.6 From where do you get health service if you need it?

From the institution of my Kebele. ☐

From the institution other than my Kebele. ☐

1.2.7 If you don't use the health institution of your own Kebele what may be the reasons?

Inefficiency of medicines of the Kebele health post ☐

Higher service cost ☐

Skillfulness of workers ☐

Non availiability of nde medicines i the institutions ☐

1.2.8 From where do you buy medicines for your health purpose if you need?

From my health institution ☐

From other private pharmacy ☐

None ☐

1.2.9 If you don't buy medicines from the health institution at your Kebele what is your reason?

Our health institution has no medicine what I need ☐

The medicine at my health institution is costly ☐

Our Kebele has no private pharmacy ☐

1.2.10 Are there health service extension workers at your Kebele?

Yes ☐

No ☐

1.2.11 If your answer for Q16 is 'yes', how many health service extension workers do you have in your Kebele?

Less than 2 ☐ Between 2-4 ☐ More than 4 ☐

1.2.12 How many times do the health service extension workers visit your house for health related issues per month?

Never visit at all ☐

1 time ☐

Between 2-4 times ☐

More than 4 times ☐

1.2.13 Is there provision of community health education in your Kebele?

Yes ☐ No ☐

1.2.14 If your answer for Q19 is 'yes', who teaches you?

Healthserviceextensionworkers ☐

Health workers other than health service extension workers ☐

Other guests ☐

1.2.15 If you are sick do you prefer to go to health institution?

Yes ☐ No ☐

1.2.16 If your answer for Q19 is 'NO', what is your reason? Elaborate the reasons.

A…….

B……

1.2.17 What is your perception on health service provisions in your Kebele?**……..**

1.2.18 What do you think may be the causes for poor service provisions in your Kebele? Elaborate it……..

1.2.18. What is needed of the community to improve the public health service provisions at this Kebele? Mention it. ……

1.2.19 Generally, what do you think can be done to improve public health service provisions at this Kebele? Elaborate it? ……

2. Questionnaires for Health workers

This questionnaire is prepared to collect relevant data for assessing the challenges of health service provision at community level in Masha Woreda. Information obtained is to be used only for study purpose and it will not be used for other missions in any case. Therefore, you are kindly requested to provide genuine response to the questions accordingly for the success of the research.

So please put the symbol √ in the appropriate box of the answer, as any where needed or elaborate whenever required.

2.1 What is your marital status?

Married ☐

Not married ☐

Divorced ☐

Other ☐

2.2 Educational level

University graduate and above ☐

College diploma ☐

Other ☐

2.3 Your profession as a health worker.

Doctor ☐ Nurse ☐ Health officer ☐ Health service extension worker ☐ Other ☐

2.4 How many health workers do you have at your institution?

Less than 2 ☐ Between 3-5 ☐ More than 6 ☐

2.5 Do you have a manager at your institution?

Yes ☐ No ☐

2.6 Is your institution fully equipped with skilled man power at all levels?

Yes ☐ No ☐

2.7 Is your institution is spacious enough to hold a lot of service users at a time?

Yes ☐ No ☐

2.8 Do you have sufficient drug supply in your health institution?

Yes ☐

No ☐

2.9 If your answer for Q8 is "No "specify the problems.

A.....

B.....

2.10 Do you have limits on the number of patients that should be served in your health institution per day?

Yes ☐

No ☐

2.11 If your answer for Q10 is "yes" how many patients? ……

2.12 Who is responsible for setting this limit? ……..

2.13 Who determines the price of medicines and service charges to the users?.....

2.14 What considerations have been taken in fixing prices of drugs and service charges?.....

2.15 Does the collected revenue at the institution cover the cost for operating cost of the institutions including prices of drugs?

Yes ☐

No ☐

2.16 If the answer for Q15 is 'No' why?.....

2.17 Do you use the collected revenue for further expansion of the services and quality improvements?

Yes ☐

No ☐

2.18 What important services are missing at your health institution as per the national standards?.....

2.19 Do your institution fulfil all the needs of users?

Yes ☐ To some extent ☐ Not at all ☐

2.20 If your answer for Q19 is other than 'yes', what are the deficiencies? ……

2.21 Do you report such deficiencies, if any, to the higher responsible body?

Yes ☐ No ☐

2.22 If your answer for Q21 is yes, what was the reply? .....

2.23 Do all Kebele dwellers voluntary to use health institution if they need?

Yes ☐ No ☐

2.24 If your answer for Q23 is NO, what may be the reason?.....

2.25 Generally what do you think is the solution to improve public health service provision at this Kebele? .....

3. Questionnaires for health sector officials

This questionnaire is prepared to collect relevant data for assessing the challenges of health service provision at community level in Masha Woreda. Information obtained is to be used only for study purpose and it will not be used for other missions in any case. Therefore, you are kindly requested to provide genuine response to the questions accordingly for the success of the research.

So please put the symbol √ in the appropriate box of the answer, as any where needed or elaborate whenever required.

1. Do you think the distribution of health facilities in the Woreda is fair?

Yes ☐ No ☐

2. If your answer for Q1is 'No' what do you think are the reasons?

.....

3. Mention what programmes are included in strategies and plans of providing health services in Woreda level and how it is implemented at a community level?…….

4. What are the main challenges being reported from the Kebeles to the health department for the need of solution? …….
5. How do you think these challenges can be minimized?.....
6. What issues are considered at Woreda level in planning for fair health service provision in Kebeles of the Woreda? ……..

2. Interviews

2.1. Checklists for household interviews

- Job of interviewee
- Family size
- Number of health workers
- Distance of health post from house
- Preference for health services
- Availability of health workers at health institutions
- Social relations of health workers with the community
- Opinion to government reaction to the existence of accessible and qualified health services
- Relation between health service need and income capacity of households
- Challenges for use of health services
- Opinions towards alleviating the challenges
- Degree of households' implementation of the instructions of health workers to health issues
- Community's role in minimizing the challenges of effective service provision
- Service satisfaction

2.2. Checklists for health worker interviews

- Educational status
- Health institution
- Marital status

- Work burden (weekly load)
- Number of health workers working together
- Medical supply
- Main challenges of provisions
- Mechanisms being implemented
- Report of challenges to the highest level institution (concerning institution)
- Reply of the concerned bodies to the report

2.3. Checklists for health sector officials interviews

- Health service delivery system of the Woreda
- Challenges
- Measures being taken to control the challenges

Declaration

This thesis is my original work, has not been presented for a degree in any other university and that all sources of materials used for the thesis have been duly acknowledged.

Name
Signature
Date

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

| --- | --- | --- |
| Advisor | Signature | Date |