ADDIS ABABA UNIVERSITY

COLLEGE OF SOCIAL SCIENCE

SCHOOL OF SOCIAL WORK

Practices and Challenges of the Health Extension Program in Woreda 3, Gullele Sub-City Administration, Addis Ababa, Ethiopia.

By:

Daniel Amare

A Thesis Submitted to School of Social Work, Addis Ababa University

Presented in Partial Fulfillment of the Requirement for the Degree of Master of Art (Social Work)

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Advisor:

Zena Berhanu / PhD/

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ADDIS ABEBA, ETHIOPIA

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Certification

That is to certify that the thesis organized through Daniel Amare Haimete, entitled; Practices and challenges of the health Extension program in Woreda3,Gullele Sub City, Addis Ababa Administration and submitted in partial fulfillment of the requirements for the award of the degree of master in social work, complies with the law of the university and meets the normal requirements of the originality and satisfactorily.

Signed by the Examining Committee:

Advisor	Signature	Data
_____	_____	_____
Internal Examiner	Signature	Data
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External Examiner	Signature	Data
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Declaration

I declare that Practices and Challenges of Health Extension Program in Woreda 3, Gullele Sub City, Addis Ababa Administration and submitted by me to the award of the Degree of Master of Social Work at Addis Ababa University, this thesis is my original work, so it has not been presented for award in any other place.

Daniel Amare Haimete

Signature_____

Date of submitted: October, 2020

Acknowledgment

First and foremost, I would love to reward the almighty God for being with me in these all challenges and subsequent to that I want to increase my first “thank you” to my studies advisor, Zena Berhanu/PhD/ without your steering, unwavering aid and charm I would be lost in this method. Thanks for being the individual that you are. You furthermore, may guide me inside the study procedure. You guided me through a part of this social work program, and the influence you left of me will live with me constantly.

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Abbreviations and Acronyms

CHW**s:** Community Health Workers

FGD**:** Focus Group Discussion

FMoH**:** Federal Minister of Health

HAD: Health Development Army

HEP: Health Extension Program

HEWs: Health Extension Workers

HEP: Health Extension Program

HIV/AIDS**:** Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome

IDIs**:** In-depth Interviews

NDOH**:** National Development of Health

PC: Primary Care

PHC: Primary Health Care

STIs**:** Sexually Transmitted Infections

SNNP: Southern Nations, Nationalities, and People

UNICEF**:** United Nations International Children Emergency Fund

USAID**:** United State Agency for International Development

USSR: Union of Soviet Socialist Republics

WHO**:** World Health Organization

WBOT**s**: Ward-based Outreach Teams

Abstract

The objective of this study was to explore the Practices and challenges of the health extension program in the City area of Ethiopia: particularly in Woreda 3, Gullele Sub City, Addis Ababa City Administration. The study used a descriptive research design with the data collected by an interviewees and document reviews. The data were analyzed in line with the standards of the qualitative descriptive technique. The primary source of data had been health extension professional, clients (services users) and key informants (supervisor, medical health center director and health office header). The secondary source data had been one in five health development army evaluation recording materials and model families of relatives' evaluation checklists. According to this study result, from the perspective of service providers and service users concerning the health extension program the communities they had high recognition at the circle of relatives making plans(current contraceptive including; Implants, inject in a position and drugs) and diseases prevention and manipulate(HIV, TB, cholera and many others).Additionally, the weak point /gaps concerning to health extension from the perspective of the services providers and services users have recognized problems together with; build and preserve bathroom , path, canal ditch and defection, disposal waste un unlawful areas, there isn't always that in the program written enforcement law when absolutely everyone in opposition to the program , maximum of health extension professional were not satisfied by using lack of incentive(improve get right of entry to training, training , transportation, and responsibility).The challenges regarding to address the health extension program as the participants have been responses that, within the community economically hassle (loss of build and hold toilet, slum residence, canal ditch),monitoring and evaluation system, less implements collaboration with stakeholders. Therefore, numerous stakeholders which include Gullele Woreda3 administration, the Woreda health office, Ethiopian health Minster, NGOs ought to work in collaboration to clear up those pressing and urgent problems of the community.

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CHAPTER ONE: INTRODUCTION

1. 1. Background of the Study

The International Conference Primary Health Care, held at Alma-Ata, USSR, in 1978, was Convened in response to an international sense of desperation in the face of widespread inequalities in health and health care that plagued all nations of the world, developed and developing, so the conference responded to a call for a radical change in the content and conception of health services (WHO, 2018).

Concerning to the primary health care (P.H.C) of Canadian nurses association (2003), as stated that primary health care it turned into approach that's a method for the being attentive to and addressing the numerous factors within the social, economic and physical environments, that affect health –from weight loss program, income and training, to relationships, housing, work places, subculture and environment fine. In addition, there are five principle usually associated with the primary health care approach to accessibility, public participation, health merchandising, appropriate technology and intersect- oral cooperation (p.3).

Carried out research by world health organization (2018) , there are many studies performed in the African area faces unique demanding situations that encompass a hastily changing demographic profile with a developing aged population, rural-urban migration, converting environmental conditions, climate exchange and others, these elements make contributions to food lack of confidence, social unrest and disease outbreaks due in component to insufficient water deliver, negative sanitation and lack of different crucial elements necessary for a whole some life(p. 5). In extra, in Africa, there is a disproportionate distribution of these social facilities among the wealthy and poor, men and women ,rural and concrete dwellers, main to a widening of the inequalities and inequities gap inside global locations because of limited preparedness to respond to rapid health adjustments and disparities between urban (70%) and rural (50%) communities that have get right of entry to securely-managed sources of drinking water are also visible in most international locations no longer handiest these the richest quintile in most countries has over 50% get entry to improved sanitation facilities at the same time as the poorest population has less than 30% get admission to. Inequitable distribution of water has big implications on sanitation and hygiene, frequently resulting in a better burden of diseases like

cholera, typhoid, malaria and yellow fever that can unfold to epidemic proportions. In addition the region is in particular vulnerable to outbreaks, with a mean of over forty activities registered at any time, amongst them, the devastating 2014-2015 and 2018 Ebola virus disease (EVD) outbreaks respectively in West and East Africa, every other most important issue is the continuing presence of HIV/AIDS contamination as well as tuberculosis in the region (WHO, 2018).

In Ethiopia, health Extension program (HEP) was launched by the Federal Ministry of health in 2003 with one of the strategies followed in Ethiopia with a view to achieve typical coverage of primary health care (UCPHC) a number of the rural and urban population via 2009, in a context of restricted sources(World Bank,2016).

The overall goal of HEP is to create a healthy society and reduce maternal and child morbidity and mortality rates. In addition the specific objectives are : (1) reduce morbidity and mortality of children and mothers; reduce morbidity and mortality from HIV/AIDS, tuberculosis, and malaria through development of community skills and knowledge; (2) prevent diseases caused by malnutrition, poor personal hygiene, and contaminated food; (3) prevent accidents and emergency illnesses, and administer first aid to the injured and sick; and (4) develop community awareness, knowledge, and skills in rural and urban Ethiopia to prevent contamination from common sources, including human excreta, animal wastes, and pesticides (World Bank,2016, p.39).

In the Addis Ababa City Administration, the program creates intensive sensitization with the slogans of “our health is produced through ourselves” and “all roads result in City heath extension program”. Before launching of the health extension packages, a number of them there were less applied and applied packages like first aid skills, malaria prevention and manage, non-communicable disease prevention and manage and factors that affected the utilization perspective of health extension workers (Aderajew et al,2019).

Consequently, this study explored that practices and challenges of HEP concerning to perspective of clients and health extension workers towards the health extension program, strengths and weakness of the HEP at Gullele district 3 from the perspective of service providers and service users and achievements of the health extension program in Gullele Woreda 3 and measures taken to address the challenges and gaps in the HEP of Gullele woreda3. The reason that inspired me to select this topic was the course community Health and Social Work in Health

Care which brought an interest to me to explore on issues that would attract the social workers to pay attention to for practice.

1.2. Statement of the Problem

Ethiopia's HEP has shown tangible positive impacts on community health, in disease prevention, family health, and environmental hygiene and sanitation (Hailom, 2011).

Hailom (2011)conducted research on the Ethiopia health extension program improving health through community involvement. In line with this study finding in Ethiopia indicated that the government has made HEP the foundation of the country's emerging new health system, even if the local government and community participation is gaining momentum. And also the roles and interests of development partners are crystallizing in order to strengthen HEP and FMOH has embarked training for health officers and midwives as well as cold storage for vaccines is also being addressed through making refrigerators available. Nevertheless, HEP has experienced some finding on the graduation of model families did not happen as planned as expected, that within three years of implementation all households would have graduated. In addition, due to travel time between households and competing demands for family members' time for farming activities, model family training is taking longer than anticipated

Sear & Shaik (2017) conducted research on the health Extension program services delivered by health Extension workers in Asgede Tsi'mbla District: a case of Lim'at T'abya, Tigray, Ethiopia. The result of the research has shown that there are factors hindering the health Extension workers overall performance. The factors that made unsuccessful the health service provision consist of remoteness from their houses, and negative relation with supervisors, communication system and road construction, low remuneration, lack of refresher guides and mistaken attention via kebele administrators to health agendas. Consequently, the above researchers (Sear and Shaik) of their research locating had recommended that, the health extension workers to boom network's health submit usage, health posts need to be geared up with minimal critical medical device with precise cognizance on malaria remedies, a family making plans, deliver, and remedy for common place area diseases.

Rose (2016) conducted research on the Ethiopia health extension program services in the rural population. According to the study, the research has shown that, 24,534 HEWs had

been trained to provide services, leading to extensive increases in health service coverage, not only this, the percentage of the population that is served through the program has improved from 61% in 2003 to 87%.However the program has verified some of health extension packages not successful in health service areas along with provision of insecticide-dealt with mattress nets (ITNs). Further, the proportion of pregnant women and under-5 children the usage of a provision of insecticide-dealt with bed nets have been 40% in malarial regions. The bad manner the institutions have been also determined among exposure to the HEP and toddler vaccination uptake, ITN use via kids and pregnant girls, usage of antenatal check-up (ANC) early in being pregnant, and right disposal of babies' fecal matter.

Study in Ethiopia at the anti natal care (ANC) insurance became 68% and assuring early initiation of prenatal care insurance changed into 34% in addition to the proportion of deliveries executed via HEWs have been 11% and the proportion accomplished by means of expert health personnel accelerated to 18.4%.In keeping with this study the whole immunization coverage reached 66%, and HEWs have been determined to be making an important contribution to improving the effectiveness of TB control at a modest fee. While the HEP has faced a number of challenges, which includes behind schedule production of health posts, behind schedule provision of health kits to HEWs, inadequate supervision for HEWs, and deficiencies in training. The attain of HEWs is likewise constrained in some settings. Additionally, HEW know-how of maternal and neonatal health, abilities, and self assurance in providing offerings observed full-size gaps (Rose, 2016).

Chala (2017) conducted research on the factors affecting health extension worker motivation in selected rural Woreda of Ethiopia. Factors affecting motivation of HEWs were identified at the individual, family, community, and organizational/system levels. Love of work and pride to serve the community is personal level motivators. However, workload and burnout were among de-motivating factors at the individual level. Moral and domestic work supports are a main family level source of HEWs' motivation. At community level, increased respect, acceptance and task sharing motivated HEWs. On the contrary, less acceptability of health service by the community de-motivated HEWs. Slow progress in career advancement; poor supervision, support and governance from leaders, inadequate material availability, no transfer policy, insufficient financial earning were labeled as de-motivating factor in health system/organizational level. Among the motivating factors at the organizational level, regular

supportive supervision of the health center, availability of supplies and on the job trainings were identified.

In spite of these data there is no any research done at the practices and challenges on the health extension program; however, there are researches which are carried out at the health extension program in distinct components of the use of a targeted at the low health provider utilization; weak referral systems; low provider quality; scarcity of drugs, medical supplies, and equipment and the absence of a career trajectory for HEWs; that is way I decided to conducted my thesis on this issue; So this study is aimed to explore the practices and challenges of the health Extension program in Woreda 3, Gullele Sub City; that addresses the strength, weakness and measures taken to address the challenges and perspective toward the health extension program. The result generated may be provided strategic direction of program makers, health places of work, supervisors and medical directors of the health center to become aware of the gaps and plan applicable intervention with the affordable use of health extension offerings in the study Woreda 3 in selectively and the country in extensively.

1.3. The Objectives of the Study

1.3.1. General Objective of the Study

The general objective of the study is to explore the Practices and Challenges regarding to the Health Extension Program Services in Woreda 3, Gullele Sub City, and Addis Ababa, Ethiopia.

1.3.2. Specific objective of the study

This study has six specific objectives:

1. To identify perspectives of the HEWs and clients on the service provision towards HEP
2. To identify the strengths of the HEP in providing services in Gullele Woreda 3 it since, 2009
3. To identify the weaknesses of the HEP in providing services in Gullele Woreda 3 since, 2009.
4. To identify the achievement at past and current implementation as viewed by clients and HEWs, HDA, stakeholders, government and communities on the HEP in Gullele3
5. To explore the challenges in the past and the current implementation of the health

. Extension program services of the Woreda

6. To identify techniques /approaches taken as measures to address the gaps or challenges in the HEP of the Woreda.

1.4 Research Questions

The following questions are used as a guide of this research

1. What is the perspective of clients and health extension workers towards the health extension program?
2. What are the strengths of the HEP at Gullele district 3 from the perspective of service providers and service users?
3. What are the weaknesses/gaps of the HEP in Gullele district3 from the perspective of service providers and service users?
4. What are the achievements of the health extension program in Gullele woreda 3 since 2009?
5. What are the challenges of the health extension program in Gullele woreda 3?
6. What are the measures taken to address the challenges and gaps in the HEP of Gullele woreda 3?

1.5 Significance of the study

The topic of practices and challenges of the health extension program is not studied in Woreda 3, Gulelle Sub City Administration. Hence, end results /effects of this study will deliberate to make assist to the Woreda filling this gap. First, the findings of this study will have a totally loud power full in figuring out the gaps of HEP within the study area and the responses of the policy makers, program organizers, researchers, authorities, health center, non-government, and network(HDA) in addressing the gaps in the study Woreda. Second, can help government bodies of Woreda3,Gulelle Sub City mainly who is running in the health workplace and health center to redefine planning, community mobilization and provide beneficial facts. Third, it creates focus to HEWs, Supervisors and goal the family members through growing appropriate structures and control skills as a platform for powerful health care usage and also make a contribution to the improvement of network-level health coverage interventions.

1.6. Limitation of the Study

The first limitation of this study associated with the dominance of female respondents in the sample size of this study. There were only two adult males from the total 21 interviewees of this study. The second limitation of this study has a methodological due to the fact, the finding of this study mainly represents no longer the complete provider users of the HEP and health extension employees who lives inside the Gulelle Woreda3 and an employed within the health workplace respectively, however participants in the study only determined on by a purposive sample method.

1.7. Scope of the study

This study is delimited to the Addis Ababa city administration, Gullele Sub city in Woreda3. Geographically, this study is delimited in the Woreda 3 residents and work areas. Conceptually, it has centered on the overall views of the HEWs and clients towards at the service provision, the success of the program, strength and challenges, weaknesses of the health extension program offerings.

1.8 Operation of definition

Utilization of HEP; Health post visits by mothers in the community in the last 12 months for health services, such as immunization, family planning, antenatal care (ANC), delivery, postnatal care (PNC), and diagnostic treatment.

Health Care; Aplace where medical service for the ill are provided

Social Worker; An individual who holds the position of social worker and practices social work in the health office

Primary Health Care; orientation to health services research strives to understand the influence of the socioeconomic, physical, biologic and cultural determinants of health within the relevant broader political, socio-historical and economic contexts.

Model Households; Households that attended at least 75% of the training given by HEWs and implemented at least 75% of the HEP packages. Frequency of home visits by HEWs was the number of visits HEWs made in a week or month, and we categorized it into more frequent visits if there was at least one visit per month, and no visits or less frequent visits if there was no visit at all or if there was one visit in more than one month.

CHAPTER TWO: LITERATURE REVIEW

This chapter presents reviews the related literature on the practices and challenges of the health extension program including an overview of primary health care, primary care, services provided, important primary health care, overview of the health extension in Ethiopia and achievement and taken measures for challenges and gaps. In spite of this, in this chapter related literature to the theme of the study has been reviewed. Moreover, this section deals /shows/ that theoretical review, which have relevance to the study are stated as well as empirical literatures related to research questions.

2.1 The Health Belief Theory

The growing increase in lifestyle-related health problems has motivated a shift from treatment-and-prescription centric (reactive) healthcare system to a patient-centric (proactive) system that is based on prevention and promotion of healthy behavior around the world. A variety of health behavior interventions have been designed with a preventive standpoint toward diseases in mind. A typical example is RightWay Café, a game designed to encourage healthy eating in young adult (Peng, W. 2009,p.2).

The designs of most of these interventions are informed by health behavior models and theories adapted from various disciplines. This is because interventions that are informed by theories and models tend to be more successful than those based on intuition (Glanz et al., 2014,p.2).

Several health behavior theories have been used to inform health intervention designs, such as the Theory of Planned Behavior (Ajzen, I., 1991), the Transtheoretical Model (Prochaska et al. 1992), and the Health Belief Model (Rosenstock, 1966). However, the Health Belief Model (HBM), developed in the 1950s to investigate why people fail to undertake preventive health measures, remains one of the most widely employed theories in the design and evaluation of health behavior interventions (Glanz and Lewis, 2002; National Cancer Institute, 2010). The HBM was developed to address problem behaviors that evoke health concerns. It postulates that an individual's likelihood of engaging in a health related behavior is determined by his/her perception of the following six variables: Perceived susceptibility (perceived risk for contracting the health condition of concern); Perceived severity (perception of the consequence of contracting the health condition of concern); Perceived benefit (perception of the good things that could happen from undertaking specific behaviors); Perceived barrier (perception of the

difficulties and cost of performing behaviors); Cue to action (exposure to factors that prompt action); and Selfefficacy (confidence in one's ability to perform the new health behavior). These six health determinants identified by HBM together provide a useful framework for designing both long and short-term health behavior interventions (Glanz, 1995). HBM focuses mainly on health determinants; therefore, it is most suitable for addressing problem behaviors that have health consequences (e.g., unhealthy eating and physical inactivity). HBM has been adapted and successfully applied in the design of health interventions (for example see Peng, W., 2009; Orji et al., 2012).

Importance of Health Belief Model (HBM)

HBM is one of the very frequently used theoretical model in the health behavior change. As on August 10th 2015 in PubMed search on usage of health belief model brought out621 full articles and in CINHAL Plus gave 607 full text articles. These two search results itself proved the considerable high usage of this theory than any other behavioral theory. One of the major reason for this can be this theory is the first theories in the field (Hochbaum et al., 1952). Another important reason can be its applicability in any setting in community, home or even in hospital (Lajunen & Rasanen, 2010).

Community Based Interventions Success

There are many common elements for all successful community and home based interventions. The use of many strategies together with the background of theory of behavioral change is essential for success. In a community and home based intervention programs, the design and the evaluation methodology used will directly decide the effectiveness of the program. Interventions are highly effective when they are coherent into the community, home and the methods are customized to address the special community attributes (Taylor, 2011,p.3). RCTs' bring out the most informative and reliable results. In the recent years community especially home based intervention programs are gaining its momentum in the protection of health, prevention of injury and promotion of safety (Cao, Chen, & Wang, 2014,p.5).

2.2. Historical background of Primary Health Care and Primary Care

The term primary health care (PHC) and primary care (PC) are often used interchangeably, which leads to confusion (Canadian Nurses Association, 2005).The PHC approach means being attentive to and addressing the many factors in the social, economic and physical environments that affect health –from diet, income and schooling , to relationships,

housing , work places, culture, and environmental quality and in 1978, the World Health Organization (WHO) adopted the primary health care (PHC) approaches as the conceptual basis for effective health care delivery. Canadian Nurses association views PHC “as a foundation” for the entire health system and “as a model” for improving health care delivery. While PC system refers has traditionally been reviewed as provider-driven; based on clinical diagnosis and treatment; institutionally oriented; individually focused; and emphasizing service provision (Canadian Nurses Association, 2005, P. 1).

Research conducted by world health organization in 2014 and 2018 at international level on the health confirmed conference on the primary health care, meeting in Alma-Ata strongly reaffirms that health, which is a state of complete physical, mental, social well-being and is fundamental human right, economic and social development based on a new international economic order as well as the people have the right and duty to participate individual and collectively in the planning and implementation of their health care and is considered as essential health care based on practical, scientifically sound and socially acceptable methods and technology; And is made universally accessible to individuals and families in the communities through their full participation (WHO, 2018,p.8).

2.2.1 Universal coverage of the population, with care provided according to need.

This is the call “for equity, no one should be left out, no matter how poor or how remote”. And if all cannot be served, those most in need should have priority which means the all in health for all. Here, also, is the basis for planning services for defining populations, and for epidemiological concepts based on a population denominator that are required for, among others, determining differential needs (WHO, 2018, p. 2).

2.2.2 Services should be promoted, preventive, curative and rehabilitative

Services should not only be curative, but should also promote the population's understanding of health and healthy styles of life, and reach towards the root causes of disease with preventive emphasis and treatment of illness and rehabilitation are important as well; communities rightly expect treatment services and indeed may be less interested in other services unless accompanied by curative services, and dealing with residual damage of illness through rehabilitation is an essential part of what health care can offer to support functionality and the dignity of life (WHO, 2018,p.67).

2.2.3 Services should be effective, culturally acceptable, affordable and manageable

Services that are not effective make a mockery of universal coverage and health of all because; ensuring effectiveness requires careful planning and management of programmers' that are directly relevant to local problems. Additionally, information is required that tells PHC decision-makers what the state of the problem was at the beginning and then what has happened after the intervention: without such information, the decision-maker may be blind to either success or failure in dealing with the problem. The effectiveness cannot be at the cost of cultural acceptability; Indeed the two are mutually dependent, services must be affordable in local terms, because of limited governmental resources and because the community will often have to share in the costs and services must be susceptible to management; Without effective management even well planned, programmed can fall apart (WHO, 2018).

2.2.4 Communities should be involved in the development of services so as to promote self-reliance and reduce dependence

The community's role must be more than that of responding to services planned and designed from the outside. Even though the network need to be actively worried in the complete manner of defining health troubles and wishes, developing answers, and enforcing and comparing programs. Even foreign to the way health services are usually formed. But the issue is fundamental and begs the question of whether health services are to be integral to the social development of communities or simply another set of services provided from outside, for them to accept passively, or which they may ignore as being irrelevant to their needs and aspirations.

It is this issue, the role of the community, that probably contains the greatest potential for the contribution of health to development, and at the same time is the point around which the greater conflict is likely to arise among those with diverse points of view about how to deliver PHC (World Bank, 2014).

2.3 Approaches to health should relate to other sectors of development

The causes of ill health are not limited to factors that relate directly to health, and the paths to be taken to deal with ill health must not be solely health interventions. While there are various problems related to education for literacy, income supplementation, clean water and sanitation, improved housing, ecological sustainability, more effective marketing of products, building of roads or waterways, enhanced roles for women, these changes may have a substantial

impact on health. And communities can often respond more readily to broad approaches to the problems of development than to the more fragmented sector-by-sector approach and identified the strength of these interactions needs to be appreciated; There are situations in which health is so inextricably tied to other aspects of development that there will be limited opportunity for advancing either health or development unless progress is made along both lines (World Bank, 2014).

2.4 Importance of the Primary Health Care

The PHC seeks increasing equity in the health sector, reducing public spending, increasing universal coverage of health services, reducing deficiencies in health status and above all, involving people in the field of health promotion and delivery of care. World health Organization (WHO) in its 2008 health report entitled “primary health care, now more than ever” reaffirmed importance of PHC. However a large share of the financial resource is paying for the secondary health care, while the PHC can reduce up to 70% the global burden of disease with much less cost. The report necessitates health system to take four steps towards fulfilling the PHC goals, including; universal coverage of people based on their needs, with no attention to ability to pay, making health systems more people –centered, so that health care is more responsive to the social and local changes, integrating public health with primary health through policy making and making the governments more reliable through negotiation –based leadership (Iran J public health, 2017).

2.5 Challenges of implementing a primary health care system

The of lack stable resources, according to staff at the management level, the PHC strategy was limited by an important constraint on the financial sustainability of the hospitals, even if in planning the strategy, it was assumed that hospitals would finance some of the working time of professional within the health care teams, with resource coming from the sale of services , and budget is a real issue, that means ,in the hospital crisis, the second challenge was high turnover of work force the lack of stable resources and the constrains imposed by the national policy of labor market deregulation and flexibility, to gather with the imperative of financial sustainability faced by hospitals, have resulted in the high turnover as well as a lack adequate o –going training for the health work force, the third challenges is health workers faced unsatisfactory working condition such as temporary contract without social security, the fourth

challenges is coordination problem, the process of coordination with actors from other sectors had initial advance and At the beginning , institutions agreed to have a joint periodical meeting among all stake holders to identify needs and design collaborative intervention and the five challenges is instrument communities participation was dominated by the individual interests of their leaders or influenced by other district institution and political parties and according to some home health care team members, communities abandoned collective goals when they realized they could receive private benefits (Iran J public health, 2017).

2.6. Overviews of Health Extension Program in Ethiopia

The HEP is one of the strategies adopted by the government of Ethiopia (GOE) with a view to achieving universal coverage of primary health care among its rural population by 2009, in a context of limited resources (World Bank 2016).

The overall goal of HEP is to create a healthy society and to reduce maternal and child morbidity and mortality rates not only this and also the HEP is a flagship program of GOE. It was launched by the Federal Ministry of Health in 2003 in the four big agrarian regions, and then expanded to pastoral communities in 2006 and to urban areas in 2009. This is a program that is deeply rooted in communities, providing primary level prevention activities to household members. The program encourages families to be responsible for their own health and in addition to community activities, HEP also provides health post–based basic services, including preventive health services such as immunizations and inject able contraceptives, and limited basic curative services such as first aid and treatment of malaria, intestinal parasites, and other ailments. Case referral to health centers (HCs) is also provided when more complicated care is needed, so that the services provided under HEP include 16 essential health packages under four major program areas (World Bank, 2016). This health package identified under blow listed;

1. Diseases prevention and control- to reduce morbidity, disability and mortality

- ✓ HIV/AIDS and other STIs (sexually transmitted infections) prevention and control
- ✓ TB prevention and control
- ✓ Malaria prevention and control
- ✓ First aid and emergency measures

2. Family health services-to strengthen and gradual expansion of family planning, maternal and child health, youth and nutrition services.

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

3. Hygiene and environmental sanitation

- ✓ Safe excreta disposal
- ✓ Solid and liquid waste disposal
- ✓ Water supply and safety measures
- ✓ Food hygiene and safety measures
- ✓ Healthy home environment
- ✓ Control of insect and rodents
- ✓ Personal hygiene

4 Health Education and communication- the main objective of this component is to bring about behavioral change through intensive and continued investment of knowledge to the community (p. 14)

2.6. Key actors in the implementation of the health extension program

2.6.1 Health extension workers

The HEWs are the key drivers of the program, so that two HEWs are deployed for each health post serving 3,000 to 5,000 populations as well as they are recruited based on nationally agreed criteria that include residence in the village, capacity to speak local language, graduation from 10th grade, and willingness to remain in the village and serve communities. Selection is done by a committee comprising members nominated by the local community and representatives from the woreda (district) health office, the woreda capacity-building office, and the woreda education office (WHO, 2016).

2.6.2 Health development army (HDA)

Refers to an organized movement of communities forged through participatory learning and action meetings. The army is designed to improve the implementation capacity of the health sector by engaging communities to identify local challenges and corresponding strategies. It is also designed for scaling up best practices from one part of the country to another. A functional HDA requires the establishment of health development teams that comprise up to 30 households residing in the same neighborhood. The health development team is further divided into smaller groups of six members, commonly referred to as one-to-five networks. Leaders of the health development teams and the one-to-five networks are selected by their team members. The main criteria for selection of leaders are whether individuals belong to a model family, are trusted by team members, and are able to mobilize communities. The formation of health development teams and one-to-five networks is facilitated by HCs, HEWs and kebele administration (WHO, 2016).

2.6.3 Government and community

The government finances the program by covering salaries of all hues, and is responsible for the management and supervision of the program. Communities' financial contribution to the program is often not in monetary form, but rather in in-kind contribution such as labor, food, and accommodation. One significant element of HEP cost is salaries for HEWs. The cost of HEWs is Br 7.5 or US$0. 38 per capita. A comparison of the payroll bill for HEWs with overall government health expenditure shows that the salary payment for HEWs accounts for 21 percent of recurrent expenditures, and 32 percent of the woreda-level recurrent expenditure, though with large variations between woredas (WHO, 2016).

2.7 General Perspective of Clients and Health Extension Workers towards the Health Extension Program

2.7.1. Perspective of Health extension Workers

In 2010, South Africa's National Department of Health (NDoH) launched a national primary health care (PHC) initiative to strengthen health promotion, disease prevention, and early disease detection. So, the health extension workers enjoyed their work and found it meaningful, as they saw themselves as agents of change and they also perceived weaknesses in

the implementation of outreach team oversight, and desired field-based training and more supervision in the community (SANDoH, 2017).

In Ethiopia the majority of HEWs felt that the workload was too much, and required more skill. About 75 percent of HEWs believed they were overloaded with assigned tasks. Moreover, 78.6 percent of HEWs claimed that the type of duties and responsibilities assigned to them requires more training than the training they had received and about 70 percent of within-village transportation is by foot. About 94 percent of transportation between village and district is also by foot, so that they were felt unhappy their overload work (World Bank, 2016)

2.7.2 Perspective of Clients toward the HEP

In South Africa as ward-based outreach teams (WBOTs), aims to support a preventive and health-promoting community-based PHC model by using community-based outreach teams. The WBOTs are staffed by generalist community health workers (CHWs) under the supervision of facility-based nurses, who support PHC and CHWs to provide health education, promote healthy behaviors, assess community health needs, manage minor health problems, and support linkages to health services and health facilities One-fifth (20%) of CHWs reported receiving coaching or skills development from their supervisors, and 8% had received a formal evaluation of their work (SANDoH, 2017).

2.8 Strength and Weakness of the HEP in Ethiopia

2.8.1. Strength of the HEP in Ethiopia

Improved access to health services in remote villages has significantly corrected the skewed distribution of health facilities and human resources. Human resources for health doubled as a result of the deployment of more than 34,000 HEWs a 2010 study indicates that about 92 percent of households were within an hour's (5 km) distance from a health facility. HEP has enabled Ethiopia to increase primary health care coverage from 76.9 percent in 2005 to 90 percent in 2010. Physical access to health facilities ranged from 84.5 percent in Benshangul Gumuz to 96.2 percent in the Southern Nations, Nationalities, and Peoples (SNNP) region in 2010 (USAID, 2016).

Access to toilet facilities overall, two-thirds (66.4 percent) of the rural population now have access to improved toilet facilities with higher percentages among people in Tigray (77.6 percent) and SNNP (77.1 percent). Those people who did not build a toilet facility gave as

reasons, lack of awareness of the importance of latrine use, followed by high cost, lack of skill to build one, lack of land space, and cultural reasons (FMOH and UNICEF 2010) (USAID, 2016). Improved use of health services in rural communities' coverage, which are contraceptive prevalence rate, doubled in five years, from 15 percent in 2005 to 29 percent in 2011. While among urban women this rate rose only slightly in the period (from 47 to 53 percent), it doubled among rural women (from 11 percent to 23 percent) (USAID, 2016).

2.8.2 Weakness of HEP

Some high-impact interventions such as clean and safe delivery are not implemented well by HEWs and the barriers identified are little demand from the community and inadequate skills of the HEWs. The FMOH has designed and implemented a number of strategies to improve this situation, but subsequent evaluations show no significant improvement, perhaps indicating the limits of what HEWs can offer in this area, because HEP's basic approach is to enable families to take full responsibility for their health by transferring knowledge and skills, it considers each household a unit providing health services. To this end, HEWs target households, provide training for over 90 hours, and move on once the household has mastered the skills and is certified. The certification is based not only on hours of training, but also on demonstration by the household of practical behavior changes with respect to the package of 17 interventions, such as constructing and using a latrine, hand washing, immunizing children and mothers, and using insecticide-treated bed nets in malaria-prevalent areas (USAID, 2016).

2.9 Practice of the Communities and HEWs on the Four Main Areas of the Health Extension Program

2.9.1 Practice of HEWs

Community health workers (CHWs) have worked in community settings to reduce health care disparities and are currently being deployed in some clinical settings as a means of improving access to and quality of care. Guided by the chronic care model, Baylor Health Care System embedded CHWs within clinical teams in community clinics with the goal of reducing observed disparities in diabetes care and outcomes. This study examines findings from interviews with patients, CHWs, and primary care providers (PCPs) to understand how health care delivery systems can be redesigned to effectively incorporate CHWs and how embedding CHWs in primary care teams can produce informed, activated patients and prepared, proactive

practice teams who can work together to achieve improved patient outcomes. CHWs also provided patients with social support and connection to community resources. Integration of CHWs into clinical care teams improved patient knowledge and activation levels, the ability of PCPs to identify and proactively address specific patient needs, and patient outcomes (Collina, et al, 2014).

United State Government (2002-2009), in the rural areas activities of community health workers (CHWs) are tailored to meet the unique needs of the communities they serve. A CHWs' role also depends on factors such as whether they work in the healthcare or social services sectors. Generally, CHWs hold the following roles;

- ✓ Creating connections between vulnerable populations and healthcare systems
- ✓ Facilitating health care and social service system navigation
- ✓ Managing care and care transitions for vulnerable populations
- ✓ Reducing social isolation among patient populations
- ✓ Determining eligibility and enrolling individuals in health insurance plans
- ✓ Ensuring cultural competence among health care professionals serving vulnerable populations
- ✓ Educating health system providers and stakeholders about community health needs
- ✓ Providing culturally appropriate health education on topics related to chronic disease prevention, physical activity and nutrition
- ✓ Advocating for underserved individuals to receive appropriate services
- ✓ Collecting data and relaying information to policy makers to inform policy change and development
- ✓ Providing informal counseling, health screenings, and referrals
- ✓ Building capacity to address health issues (pp.15-16).

2.10Achievements of the health extension program

According to Hailom, B. (2011) conducted studies end result shows that;

> HEP has created greater awareness of how to prevent communicable diseases such as malaria, tuberculosis, HIV/Aids and waterborne diseases. The second area, the communities and household attitudes toward HIV/aids and those living with HIV/AIDS

are changing, as have practice related to prevention of infection in general. From this some of example communities and households openly discussed HIV/AIDS and cared for those living with the virus, knowledge and behavioral practices toward prevention of sexually transmitted infections have improved. The third, beneficiaries reported changed attitudes and behavioral practices in preventive aspects of maternal and child health which means, communities informants and district and regional program more practice mothers and children as well as access family planning, antenatal and postnatal care services has improved and disease incidence is minimized enormously, childhood and maternal death are reduced and the communities has started to use family planning programs efficiently; the number of women using contraceptives and accessing pre- and postal natal care services was increasing, for example FMOH statistics on health and health-related indicators show that antenatal coverage increased from 67.7% in 2008-2009 to 71.4% in 2009-2010 and postnatal coverage from 34.3% to 36.2% in the same period, the fourth has improved sanitation and increased access to safe and clean drinking water from 35.9% in 2004-2005 to 66.2% in 2009-2010 nationally, when access to safe excreta disposal reached 60% which are, households visited had pit latrines; separated animal sheds; improved kitchens, bedrooms and living rooms; and cleanly managed drinking water and household goods.

According to the 2014 World Health Statistics Report;

> Ethiopia has achieved the MDG 4 target three years earlier by reducing under-five mortality by 67% from the 1990 estimate. The UN Inter Agency Group's 2013 mortality estimate reported that Ethiopia's under-five, infant and neonatal mortality rates were 68, 44 and 28 per 1000 live births respectively (pp. 87-88).

According to UN(2015);

> Estimates, Ethiopia have so far reduced maternal mortality by 69% of the 1990s estimate with annual reduction rate of 5% or more. According to the latest UN estimate, the proportion of mothers dying per 100,000 live births has declined from 1400 in 1990 to 420 in 2013.However, EDHS 2005 and 2011 reported maternal mortality rate of 673 and 676 per 100,000 live births respectively, indicating no change between the two surveys(p.14).

Another report from the Lancet (2014);

> Estimated that maternal mortality was 497 in 2013.Significant variation in estimating maternal mortality is observed in different studies, calling for more robust and locally generated information. However, a reduction was observed in maternal mortality in all the studies with different magnitude of reduction. Hemorrhage, hypertension in pregnancy, abortion and sepsis are the leading causes of maternal deaths, which can only be averted through skilled institutional care (p.132).

The achievements in child health are mostly attributable to large scale implementation of promotive, preventive and curative primary health care interventions alongside a positive trend of socioeconomic changes, these include: IMNCI/ICCM (currently being provided in more than 2500 health centers and 12,000 health posts); prevention and management of malaria (with 65% of under 5 children sleeping under insecticide treated nets (ITN) with indoor residual spray (IRS) reaching 47% of houses in endemic areas in 2011); community based nutrition programs and establishment of Neonatal Intensive Care Units. Notwithstanding current improvements, coverage of some other essential interventions such as proper case management of acute respiratory illness (ARI) and diarrhea have been low. In the 2011 EDHS, only 27% of children under age of five with symptoms of ARI sought counseling from a health care facility or provider. Similarly, one-fourth of children with fever and 32% with diarrhea sought care from a health care facility or provider (FDREMoH, 2015).

The Federal Democratic Republic of Ethiopia Ministry of Health (2015) the dramatic increase in immunization coverage has also significantly decreased fatalities associated with vaccine preventable diseases. Currently, Ethiopia is providing 10 antigens targeting major killer diseases during childhood. Four new vaccines (PCV 10, Rota, and Penta) were introduced since 2007 in addition to the already existing six traditional antigens. The introduction of these new vaccines coupled with ICCM programs and expansion of the Health Extension Programmed is expected to further lower childhood morbidity and mortality due to pneumonia and diarrhea. The recent HMIS report of EFY 2006 showed that the coverage of Pentavalent 3, PCV3 and Measles vaccine coverage has reached 91.1%, 85.7% and 86.5% respectively. Fully immunized children under one year of age also reached 82.9% in EFY 2006. Though the coverage is improving, the program is challenged with dropouts, shortage of supplies, vaccine stock out and cold chain breakages. Availing newborn corners at health centers, establishing neonatal intensive care units in hospitals and more recently, the expansion of community based newborn care by health

extension workers (HEWs) is ongoing and expected to contribute to a decrease in neonatal mortality. However, there is still a gap in availing quality health services for newborns in many facilities.

2.11 Challenges of the Health Extension program

In spite of more successes, the HEP had also challenges since the launch of the program according to conduct research by (Yibeltel etal 2019) there were resource gaps including medical equipment and drugs, limited supportive supervision, absence of a well-established referral system, high turnover of HEWs, absence of clear career structure for HEWs, unattractive salary scale, and, inadequate delivery and curative services in 2008 and in 2012, health posts did not have basic infrastructures like water supply, electricity, and waiting rooms for women in labor and data from service availability and readiness assessment, in 2016, also indicated that the mean availability of trace items for basic amenities, infection prevention, malaria diagnosis, and essential medicines at health posts was 37, 29, 52 and 46.5%, respectively

Living and working conditions of HEWs were not conducive during the early phase of the implementation of the HEP, according to a study published in 2007 the HEWs were deployed in remote areas where housing was very important in motivating and retaining them in the communities and addition recent study, published in 2017, on job-related wellbeing indicated that stress and burnout were recognized among healthcare workers. Notwithstanding this, there was an unmet need for interventions to manage burnout or emotional difficulties and also in a study published in 2008, it was identified that the majority (88%) of HEWs had poor knowledge of danger symptoms and signs, and complications in pregnancy. Moreover, most HEWs did not feel confident enough to undertake delivery independently because of limited practice during the training. Even later, in a study published in 2013, it was found that the skill and competency of HEWs handle maternal health services was less trusted. In another paper in 2015, only 50.5% of study participants perceived that HEWs were competent to deliver curative and delivery services. A recent study identified that pre-service

education did not prepare HEWs for all the tasks that comprise their scope of practice (Yibeltel et al 2019).

United State Agency International Development in Ethiopia (2014) conducted research on the limited motivation and commitment of some urban health extension professional (UHE-ps) related to work, personal, or health system problems, Weak link between UHE-ps and health centers in some primary health care units negatively affects provision of necessary support to UHE ps, In addition inconsistent pre-service training and lack of regular and standard training materials for on the job training /refresher training as well as lack of coordination among different sectors, such as municipality, water and sanitation, and education programs hinder program progress, lack of community-based health information system to monitor UHE-p performance, limited promotional opportunities for UHE-ps to upgrade their position within the health system.

Ethiopia Minister of Health (2016) as identified that;

> On the family planning (FP) programmed faces challenges that must be overcome to meet the country's FP goals of a 55 percent CPR and knowledge of family planning is an important determinant for increased FP use and 48percent. The majority of Ethiopians know of at least one method of contraception, with 97 percent of the 8 Coasted Implementation Plan for Family Planning in Ethiopia women being able to name at least one method. 49percent knowledge about long-acting reversible and permanent methods is significantly lower, with only 39 percent of women knowledgeable about intrauterine devices (IUDs) or sterilization and also modern contraception uptake is hindered by misconceptions, misinformation, and misinterpreted side effects, 50 percent some traditional cultural and religious beliefs also serve as substantial barriers to increasing the modern CPR (p.39).

In Ethiopia, gender inequalities commonly affect women's ability to make decisions in the household this is related that, power dynamics, often limits a woman's ability to choose to use contraceptives, leading to lower FP uptake in households where there are negative social cultural sentiments about women's decision- making abilities. In addition, 51 percent In Ethiopia,

women's empowerment and contraceptive use correlate positively, religion also can act as a significant barrier to family planning. Even if, there is a well-accepted belief in some parts of Ethiopia that religion prohibits the use of modern FP methods, this belief creates an impediment to demand as well as in Ethiopia; most health facilities have the capacity to provide short-acting FP methods, as well as the basic infrastructure and provider interest to offer long-acting reversible contraceptives (LARCs).In addition, HEWs, a cadre of providers who deliver primary health care, especially in areas of the country where access is limited, are vital in improving FP access by the rural population. However, accessibility varies across regions, with emerging regions, especially lacking access to FP services. There are also variations amongst population groups; for example, youth have less access to family planning. Moreover, availability of and access to a range of FP methods is a problem; the majority of FP users still depend on short-acting methods, particularly injectables, and the use of long-acting reversible and permanent methods remains extremely low. Implants are the most popular LARC, with 12 percent of contraceptive users opting for this method (EHoM, 2016).

The Ethiopia health of Minister (2016) conducted the research that as described as follows;

> On access to family planning (FP) counseling is also a critical element of a successful FP programmed such as; Numerous supply-side barriers hinder access to FP services in Ethiopia; For example, clients are often unable to access counseling and receive commodities due to geographical distances and lack of supplies or equipment of the facilities. Although the HEW programmed has dramatically increased access to FP information and short-acting methods (condoms, pills, and injectable), women seeking long-acting reversible and permanent methods often travel long distances to reach health facilities providing a full method mix. Additionally, sporadic stock outs of FP commodities at facilities and long wait times for service further impede access(p.56).

Reducing inequities related to poverty, gender, age, and marital status; counseling; and access to and use of family planning are continuing challenges such as ; Unmarried sexually active youth also face a unique set of challenges related to access, due to provider bias and cost of FP services through the private sector, example 3, 55percent "Emerging regions" include Afar, Somali, Benishangul-Gumuz, and Gambela; these regions are often grouped together as target geographical areas for health service improvement, as they are sparsely populated, have less health infrastructure, and are home to pastoralists, all of which pose unique challenges to

ensuring that health services are available and accessible. Not only this youth are more likely to access FP services through the private sector, plus twenty-three percent of modern contraceptive users ages 15–19 accessed family planning most recently through the private sector as compared with 13.4 percent for all age groups (EH oM, 2016, P.2).

2.12Measures taken to address the challenges and gaps in the HEP

United State International Aid Development (2014) as conducted the research on the Ethiopia urban health program (EUHP) will advocate for a better work environment to be set-up for UHE-ps by government bodies at different levels, provide office furniture, supplies and other necessary office materials based on need.

As United State International Agency Development (2014,p.13) conducted research in Ethiopia on the HEP will advocate to enhance and boost commitment and motivation of UHE-ps, CEUHP in collaboration with government bodies at different levels organized recognition events for best performing UHE-ps, facilitated experience sharing events, identified administrative bottlenecks that de-motivated UHE-ps and worked with responsible bodies to address them, organized training opportunities and supported them to grow in their professional career and to establish stronger linkage between UHE-p and health centers, CEUHP provided evidence based recommendation to FMOH to shift reporting and supervisory relationships of UHE-ps from Kebele/village administration to health centers.

Summary of literature

In Summary, The above affords critiques related of literatures concerning to on the practices and challenges of the primary health care and primary care, traditionally lower back floor of primary health care and primary care, principle health for all in primary health care, perspective of health extension professional and service providers, strength and weaknesses regarding to HEP from perspective of services users and offerings vendors and success of the health packages.

The literature review indicates that there has been no longer greater study conducted on the practices and challenges of the health extension program int he city, although,a number of behavior, research there has been targeted at the specific of the elements of the health extension program.

Empirical and theoretical literature parts were genuinely defined in the each topic and from the explained components of segment in the literature more emphasized the primary health care of services applied, achievement of the inside the world and demanding situations within the community health addresses for all. Both empirical and theoretical literature used for distinctive performed studies, articles, books and evaluation inside the exceptional country, most of them are African, Asian, Europe and Ethiopia.

CHAPTER THREE: RESEARCH METHOD

Under this chapter the research method, data source and data type, sampling techniques, instruments for data collection, procedure of data analysis and method of data analysis are presented.

3.1. Research paradigm /philosophical stance

In order to understand the different approaches adopted by qualitative researchers, it is helpful to have some understanding of the philosophical debates underpinning the development of social research in general. The issue of how the social world can be studied raises a number of philosophical questions. Some of these relate to 'ontology' – what is the nature of the social world and what is there to know about it? Others relate to 'epistemology' – how can we learn about the social world and what is the basis of our knowledge? Differences in researchers' answers to these questions have led to the divergent 'schools', 'interpretive frameworks' and approaches to qualitative research (Rachel, et al, 2013, p. 24).

The philosophical stance of the researcher is a constructive approach because of the subjective understanding of the phenomena from the population under study as they understand and perceive it in their setting. The researcher believes that reality should be conceptualized in its context. Every individual, group and community has their own explanations on the practices and challenges regarding to health extension program for their situation. They can understand and theorize things in their own context on why and how things are occurring.

3.2. Research Design

This study employs cross sectional descriptive study design, because it facilitates to become aware of the practices and challenges of the HEP in Gullele Woreda 3 including the general perspective of HEWs and clients towards to the health extension program.

3.3. Method of research

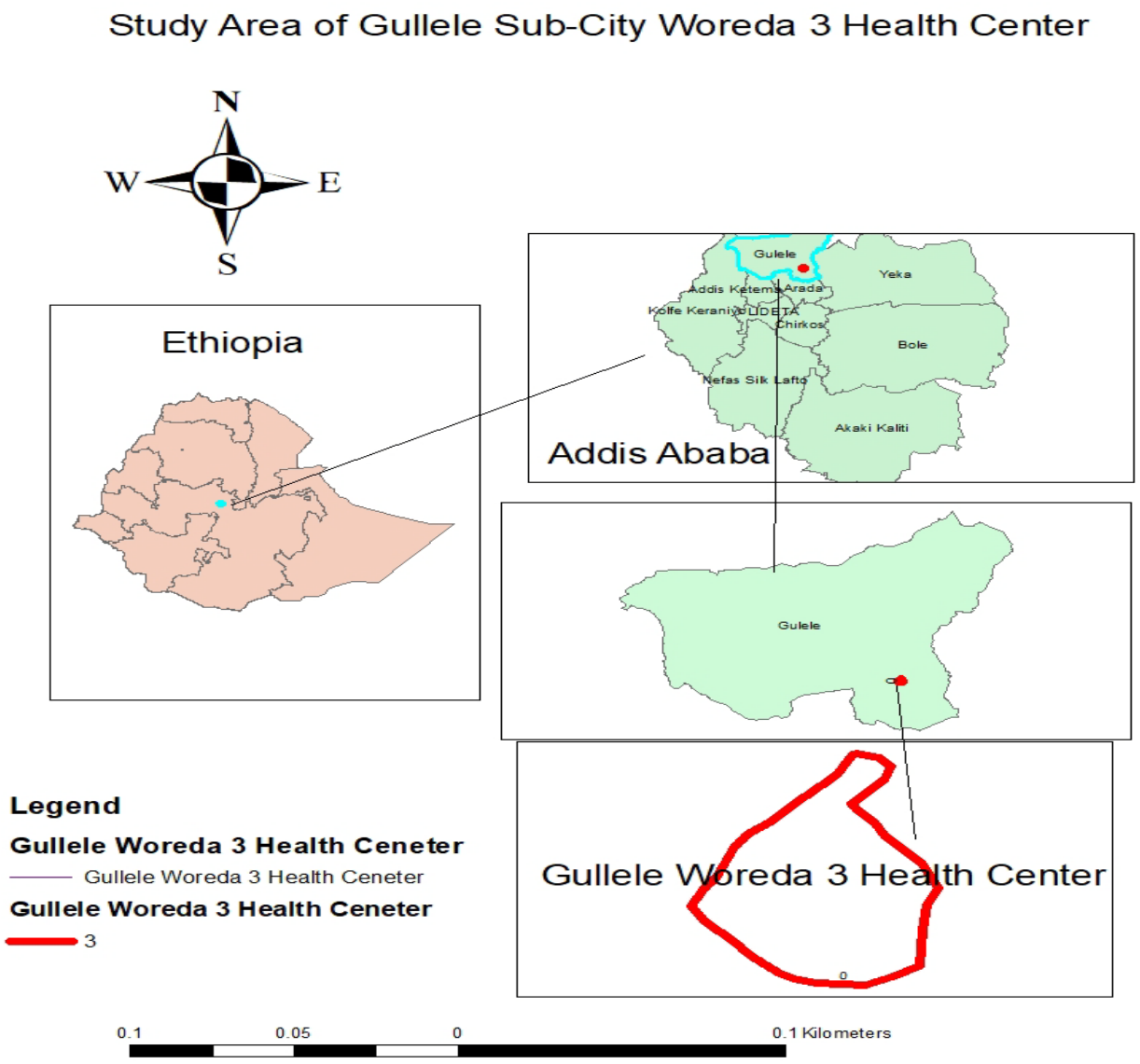
This study has used qualitative method to explore the practices and challenges of the HEP, it presented the perspectives of HEWs and clients towards to health development army, structure of health extension program, strength and weaknesses towards the HEP from the perspective of services providers and service users, and challenges of the health extension program in Gullele Woreda 3.It helped the researcher to explore the study participants (HEWs, clients and key

informants) emotions, feelings, and perspectives closer to the health extension program of study the area.

3.4. Study Area

This study was conducted in the Gullele Woreda3, Gullele Sub City Administration, and Addis Ababa city. The main reason to select Woreda 3 from other Woreda (areas) was my best friend who has been working in the Woreda he was advising me to conduct a research in the area as he knew that the health extension workers are working very hard. The 2012 E.C First Quarter Report of the Woreda included the following figures: Male 18373, female, 19123, children under 1 age were 838, children under five age were 2682, women from 15-49 ages reached to 12977 and the number of pregnant women was 874. Generally, it had a total population of 374969. Now, the Woreda has 12 health extension professionals and 2 health extension program supervisors. Moreover, based on secondary data from Woreda 3 health offices the researcher has seen that since 2009, the Woreda trained and graduated a total of 174 model families. Gullele Woreda 3 is bordered on the south by the Addis Ababa University except for a short stretch in the middle where it shares a border with Manen secondary school on the west by the Gullele Woreda 5 which separates it from the Kechene (Medahnelam) church and on the North Gullele Woreda 1 and the East by the American Embassy. Administratively, the Woreda is organized into nine katana with twenty one administration offices which are government owned. As report from Worada health office hygiene and sanitation, Malnutrition and HIV/AIDS have been the main health problems of the Woreda.

Figure1 Location of the study



Source; own computation (2020)

3.5. Sampling

This study employed purposive sampling technique. For the in-depth interview the researcher selected 6 out of 12 HEWs working within the health office and 12 service users (clients) from the 174 model families living in Gullele Woreda 3.For the interview from key informants the researcher selected 1 health office head, 1 medical health center head and 1 supervisor working within the health center and health office respectively in Gulelle Woreda3 for the interview.

3.6. Source of Data and Techniques of data gathering

3.6.1. Source of data

The study uses primary and secondary sources to explore practices and challenges of the HEP in Gullele Woreda 3.

3.6.1.1. Primary data

To full fill the objectives of this study, primary data sources were used for first hand information (Syed, 2016). The primary sources of this study were services users, HEWs and key informants (health office header, supervisor and medical director of health center).

In-depth Interview

I collected first hand information through qualitative data gathering technique, i.e. with a face to face interview through the use of open ended question. The questions had been open ended inquiries to collect records from the provider users by means of the use of the interview. The primary hand information extensive interview with provider services and service users in Woreda 3, the Gulelle Sub City has conducted. The researcher became the one to conduct the interview and to take notes to increase the high-quality of information. The participants have been purposive decided on in collaboration with supervisors, health extension workers and health office head of Woreda3. The in-depth interview participants of the Woreda3, Gullele Sub City had been requested approximately the overall perspective of providing users, health development army, communication and training, practices, challenges, strength, and achievements of health extension program.

Key Informant Interview

Key Informant Interviews involve interviewing people who have particularly informed perspectives on an aspect of the program being evaluated. Key informant interviews resemble a conversation among acquaintances, allowing a free flow of ideas and information (Pact, 2014). This study used key informants who have deep information and knowledge about the HEP. These individuals are from the health office administrator, medical director and health extension supervisor. The same questions are asked throughout all the interviews, but the interviewer is free to ask follow-up questions in order to get as much information as possible from the informant.

The key informants were requested about the practices and challenges, the strength and weakness, the achievements of the health extension program in Gullele Woreda 3 since 2009, gaps within the HEP and measures taken to address the challenges and gaps within the HEP of Gullele Woreda 3?

3.6.1.2. Secondary Data Source for document review

In this study, data from the secondary data was collected from different written documents related to the topic under the study from distinct written files associated with the subject below the observe along with; reports, and evaluation checklists, manuals, and performance evaluation reports concerning structure of the HEP on the health put up workplace degree, supervision and monitoring crew activities at exclusive degree of carrier provision, activities of model households in Woreda3, Gulelle Sub City and different associated topics had been reviewed to collect important facts to answer the research questions.

3.7. Data Collection Procedures

In this study, used 18 in –depth interviews were done with health extension workers and service users. From in-depth interview 12 service users and 6 health extension workers. Three key informants such as; medical director of health center, health office head and supervisor of health office the interviews were conducted. All interviews with respondents conducted in Amharic. Data collection instruments were developed considering local language. The instruments were originally prepared in English then it is translated into Amharic language. Before the actual data collection, the researcher pre –tested the interview guides. The pre –tested the interviews was conducted with one HEW in to purposive selected from Woreda who are not participants in the study. The data had been collected using audio recorder and then transcribed

daily after the interviews in Amharic. The researcher later on translated the transcripts into English.

3.8. Data Analysis

The researcher analyzed the facts primarily based on the study objectives. At the end of accomplishment, notable facts series the usage of interviews with the key informants(supervisor, health office head and medical director) and in-depth interview with the service users and health extension workers as well as file overview. The researcher translated the interview notes from Amharic to English each day. After completely studying into the transcribing the facts, 21 codes had been built. These 21 codes, then categorized into 3 categories on their similarity and relationship. By way of looking between these categories, 6 major groups were analysis: the perspective of the HEWs and clients regarding to the HEP, strength and weakness concerning to health extension program from view of the services providers and service users' inside the Gullele district3, achievements and measurement of the taken the gaps closer to HEP in Woreda 3 would analysis base on similarity, difference and association, query objects and document review the researcher analyzed via descriptive manner.

3.9. Quality Assurance

The researcher has attended a seminar on qualitative research methods facilitated by the School of Social Work. Language has not been a barrier to communicate with the interviewees as the interviewer is good in speaking, listening, writing Amharic language. The interviewer interviewed each participant for 35-50 minutes to well explain the topic under study. All interviews were conducted in an environment free of disturbance. The researcher any interview data are capture to use voice record and key points with notebook and after the end of the interviews to show capture voice for interviewers. Data code and thematically categorize based on their meaning and the researcher from the start of concept paper that means from draft stage and processes of data collection communicated by varying the method with my advisor. So that, both the find and discussion was present in accordance with the study objectives.

3.10. Ethical Considerations

The researcher has taken a letter from School of Social Work, Addis Ababa University, to Gullele District 3 health office. The researcher kept the privacy of participants based on the agreement made before starting each of the interviews, which is, securing informed consent

including by audio tape recording. Participants of the study have been asked for their consent before the study. During the consent process, the researcher provided them with information regarding the purpose of the study, why and how they are selected, and what is expected of them and that they can withdraw from the study at any time. Participants were also assured about confidentiality of the information obtained in the course of the study by not using personal identifiers in the analysis and presentation of the data.

3.11 Challenges in the Study

There were different types of challenges through which the researcher passed in the process of this study. The first challenge was that, some of the services users' participants in the research were expecting payment to be willing for the interviews. The second challenge, some of the health extension professional participants of the study were not some how willing to be interviewed as well as they were not voluntary to finish interviews within the agreed upon time. The third challenges were related to key informants and because of COVID-19 they had to reschedule for more than four times the conduct of the interviews.

CHAPTER FOUR: DATA PRESENTATIONS AND FINDINGS

This chapter presents the findings of the study. It has the following sections: Background of participants, finding from perspective of HEWs and clients towards health extension program, the strength and weakness of the service as seen from the services providers and service users of the HEP at Gullele Woreda 3, achievement and challenges identified of the HEP as well as measures taken to address the challenges/gaps/.

4.1. Background of the study participants

Regarding the marital status of the respondents, from 21 participants, 13 were married, 7 were singles, and the remaining 1 was divorced. Additionally, all of the participants were Orthodox Tewahido Christianity followers.

Concerning the sex of the respondents, the majority of them (19) were female while the remaining 2 were males. Regarding their age, the largest numbers of the respondents (11) are in the age range 28 to 35 years, while 3 of them from 21 to 27 years, the age categories 44 to 50 years and 51 to 57 years contain 2 individual each. The majority of participants' were government workers. This could help to understand the concept of health extension program in better way. The general background of information about those health extension workers, service users and key informants who participated in the study is described in the following table:

Table 1; Background information about health extension workers

Participant code	Sex	Participants	Age	Marital status	Position	Education background	Religious background
01	Female	HEW	31	Married	Government	Degree	Orthodox
0 2	Female	HEW	30	Single	Government	Degree	Orthodox
03	Female	HEW	26	Single	Government	Diploma	Orthodox
04	Female	HEW	24	Married	Government	Diploma	Orthodox
05	Female	HEW	34	Married	Government	Diploma	Orthodox
06	Female	HEW	26	Single	Government	Diploma	Orthodox

Concerning the background of health extension workers, they were government employees and females, and orthodox adherents. Half of these health extension workers were married while the remaining were singles.

Table 2; Background of information about key informants

Participant code	Sex	Participants	Age	Marital status	Position	Education background	Religious background
07	Male	Key informant(health office head)	30	Single	Government	Degree	Orthodox
08	Male	Key informant(medical director)	35	Married	Government	Degree	Orthodox
09	Female	Key	40	Married	Government	Degree	Orthodox

		informant(supervisor)					

From the key informant respondents, two of them were married while the remaining one of them was female. The positions of these participants were health office head, medical director head and supervisor.

Table 3; Background of information about service users

Participant code	Sex	Participants	Age	Marital status	Position	Education background	Religious background
10	Female	Service user	32	Married	Enforcement	6th	Orthodox
11	Female	Service user	42	Divorce	Householders	3rd	Orthodox
12	Female	Service user	29	Single	Trade	Diploma	Orthodox
13	Female	Service user	37	Married	Enforcement	8th	Orthodox
14	Female	Service user	35	Married	Government	Illiterate	Orthodox
15	Female	Service user	49	Marriage	Trade	Illiterate	Orthodox
16	Female	Service user	42	Marriage	Government	8th	Orthodox
17	Female	Service user	34	Marriage	Householders	6th	Orthodox

18	Female	Service user	50	Marriage	Enforcement	4th	Orthodox
19	Female	Service user	40	Single	Trade	10th	Orthodox
20	Female	Service user	40	Single	Householders	12th	Orthodox
21	Female	Service user	37	Marriage	Trade	7th	Orthodox

4.2 General perspective of service users concerning to HEP at the definition and types

Accordingly, the majority of service users, participants of this study stated this is hard to define the health extension program. They are known at once or in a roundabout way most of the contents of the health extension packages and listed them like these; the community based program of disease prevention and control, unwanted being pregnant control system, clean of an environment, prevention of diseases like HIV/AIDS, hygiene and environment safety like; Personal hygiene.

4.3. General perspective on the structure of the HEP

4.3.1 Perspective on the health development army

Hence, one health extension worker at the initial (preliminary) interview concerning the perspective of HEW on the health development army for health extension program, as participant stated that HDA “the backbone of this system”. Even supposing, after this system launched, the participants of the HDA had been training the 16 health extension program with the members of the HDA at the own family planning, diseases prevention and control with exceptional stakeholders together with non-authorities organization.

As the majority of HEWs participants of the study responded that their general perspective on the health development army are very important to minimize the work load from different stakeholders.

One of the HEW mentioned that [code3];

> The health development army (HDA) is the backbone of our work because they facilitate everything in the communities before we went into at the work area and if this group didn't have involved in communities, it will aggravate the challenges to address the health extension program as planned.

According to the responses of the majority of HEW participants, the HDA were practicing different activities in the communities after they have taken training on the health extension program applying technique such as creating awareness at coffee ceremony and shared a good practice for others health development army because most of the health development army members were graduated model families. Besides, HDA members selected from the communities who have organized the members of the group which were voted by members of the health development army group. The person voted from the healthy development army who have capacity of organizing the communities and the health development army members also raised theirs, experiences and practices.

Consequently, based on the perspective of HEWs are on the HDA they have strong high-quality perspective to carry out this system of HEP which includes; Discussing with participants on the prevention and control diseases like HIV/AIDS, TB, and non-communicable diseases like diabetes, blood strain and like others and pick out those who first-rate practices share others individuals on the packages practices. The health extension workers they were arranged the discussion point at the circle of relatives making plans, who had been used circle of relatives planning asking question, those who used circle of relatives making plans what sorts contraceptive family planning and what kinds benefits for the circle of relatives attachment and monetary benefits like pleasant the family interest and in others way the discussion factor who had been they didn't get the services provides the circle of relatives planning the members and that they endorse and sharing their very own experience what forms of blessings after used contraceptive and which one circle of relatives planning changed into very comforted for health.

For that reason, most of health extension worker members of this study stated that, the health development army participants on the hygiene, sanitation, and waste disposal was one of the discussion point areas. Most of HDA members were employed by safety net so that they have real experience on the disposal of waste from their own house, and fence and the environment. When epidemic diseases occurred in the areas such as cholera and others diseases, this group uses various communications such as mass media to address the whole community's awareness of the members of the health development army. They also will discuss who was the winner, as well as ranking the rest of the members without any reservations. They have strongly liked due to the fact of the system of collaboration making coffee ceremony at two weeks, even if the members offered the necessary material along with: Bread, sugar, grass for coffee ceremony and different vital substances by means of their very own money for the coffee ceremony without the presence of coercion.

The service users said that, shared they enjoy what they had been working as people, organizations and communities on the HEP like; Own family planning, prevention and control diseases at the communicable disease (HIV/AIDS,TB, HVB, and cholera) and non-communicable disease (bleed pressure, diabetes, breast and ladies reproductive organs most cancers) and the groups.

According to a service user [code 14] describes that as the follow:

> Our membership to the group developed our communication skills, understand our life styles, enhanced bonding with other members, enhanced our social interaction since we together drunk coffee, participating in the wedding, grievance, and provide financial support for the person who needs support due to something bad happened in their family.

Regarding their perspective on the HAD, one of the key informant participants in the interview stated;

> The network of health development army is very important for HEWs and client service providers to address the planned program of health extension packages at the allowed time. Health office head [code8]

Majority of key informant individuals have been agreed that, the HDA individuals in the health sector one of the actors to addresses with for special campaign of TB, Polio, Pertusis, Tetanus, Hepatitis B and Measles. Additionally, as members of the HDA they were working together with in the group in each other's, for these reasons, it enhance psycho social interaction, sharing of value, traditional and cultural and helping together by their own experience on the prevention and control diseases, family planning, personal and environment hygiene and communication and training.

Accordingly, the preliminary interviewed of the respondent from the health extension worker perspective regarding the HDA structure, mentioned that; it is a very important structure for the prevention and control of disease in the communities. Before launching the HDA, there were different types of health problem that affected community, which are communicable and non-communicative (from communicable HIV/AIDS, TB, Cholera and non-communicable care (others accident, blood pressure, diabetes and mental health) commonly happened in the community. Moreover, most of the community was not using family planning properly as well as hygiene and sanitation waste disposal. Before the structure of the HDA was launched, it was very difficult to manage the problem in the communities regarding to liquid waste disposals as individual and group.

One of the HEW mentioned that [code 1];

> When I went to provide a door to door service the community, some of the people closed their doors on me due to the misunderstanding of my work.

4.3.2 Generally perspective of clients and HEWs regards to the relationship with staff and workers

4.3.2.1 Generally perspective of HEWs regards to the relationship with health office staff

According to the majority of participants of this study regarding to the relationship with the team of worker office that, they have typically high quality responses to the problem. The HEWs mentioned that, the relationship in the beginning stage with supervisors and HEWs helped them to share their experiences, information, tolerance and duty. Additionally, they have a good relationship with others staff, participants in the health office including; nurses, midwifery and

primary health care professionals, the medical director and health office head. Based on the responses, with the aid of the individuals of the HEWs on interview operating with number one health care professional has created properly social bonding, experiences and knowledge. These top relationship used for extra communicated on the work area, how to follow this program of health extension and they have taken specific sorts of dimension on the faced problem at work area and reducing remarks and thought of communities at services provision. Normally the high-quality effect of the good relationship with supervisors, number one health care professional, HEWs, nurses, midwifery and others team of workers reduced their work load, maximized the bonding inside body of workers, increasing tolerance within the work area, and articulated their question with time and sharing their experience. Because of those practices of working together, they have performed dramatic adjustments in the members of the HDA.

One HEW [code 5] said;

> If we did not have a good relationship, we would have not stayed together ten years.

From the clients participants in the research study, their perspective on the enhance relationship with the staff, it has a positive impact on the practices of HEP, from these practices more shared experiences in the one to thirteen and one of five networks. Most of the participating clients have also reported that they have achieved a good relationship with health extension workers to address community problems such as hand washing, environmental sanitation, personal hygiene, and family planning namely; pills, implants, condom, injections and IUD. Additionally, according to the participants of the interviews from community members have the best relationship of HEWs and midwifery, supervisors, nurses, primary health care professional and others staff of members of the health office.

The respondent of the client [code10] said;

> If the health extension workers didn't train, advice, counsel and control and helped me to use the HIV / AIDS medicine, I would have been dead before eight years ago.

4.4 Strength of HEP from the perspective of services providers and service users

4.4.1 Communities based program

Regarding the strength of the health extension program, participants of this study have been given various questions regarding the views of service users about the service provision of the health extension program.

One service user [code 14] said;

> Most of a time when the health extension workers' creating awareness in our health development army of short, medium and long term family planning, making decisions in the family role. They provide a chance to make our own decisions on in solving our problem for ourselves according to the ground rule of health development army.

The study participants further explored that, the members of the health development army were composed of individuals who live in close resident and shared social interaction with each other who drunk coffee, supported by *edir*and *ekub*, participated in the different events such as; grievance and celebration to gather. Therefore, the practices of communities by themselves on the health extension program were created open for discussion on the personal hygiene and environmental sanitation, family planning and disease prevention and control.

Service user [code 14] has responded that as an example during the interviewed;

> In my neighborhood some residents reside in one house with greater than 4 family individuals due to the financial trouble. Due to that at different times within the family, there were personal hygiene and sanitation troubles and undesirable pregnancy. I am a model own family at the practice of HEP, so I have communicated them because; I speak the same language, share the identical subculture and value. Consequently, my neighborhood residents progressively participated inside the health development army and

communicated with themselves at the circle of relatives planning, personal hygiene and environmental sanitation. Steadily they modified their behavior which includes the use of family planning, a number of them rent others residence, a number of the families got separated their kitchen from toilet room, smooth their house each day and now preserve their personal hygiene and others health activities participated.

Generally, the majority of the participants have stated that, the program has given them a chance for communities to solve health problems, to share information among themselves, to bring about attitudinal, behavioral and psychological change upon the members of the community.

Additionally, from the perspectives of service providers of participants in the research study stated that, the strength of health extension program has created community participation in planning, evaluation and monitoring by health extension workers, nurses, primary health care professional and mid-wavers.

The service provider participant [code 2] also added to the study as stated that as following:

Our role was to coordinate, manage and facilitate the activities of the program in the communities.

Moreover, the service has contributed working with service users in different method like; contribution of finance in the residential area for the purpose of building toilets, canal ditch and bought material for the coffee ceremony to the panel discussion and training.

4.4.2 Diseases prevention and control

As to the majority of service providers (HEWs) respondent; the major area of strength of the program is in the prevention of communicable and non communicable diseases in the community. The prevention and control of such diseases were done largely by awareness creation campaigns in the community in various settings such as organization, hotels, pensions, restaurants and shops worked with different stakeholders.

The main strength of health extension program in the communities before happened personal hygiene and unwanted being a pregnant problem with the groups mentioned with together by their personal HDA individuals on the washed their hand each day, clean their clothes, washed dish substances and smooth kitchen room and bedroom. So they decorate their attitude by sharing their stories and education on the used pills, injection, condom and implants. Also, members of service users as stated that with a none journey into others service offers area (health center and health facility) the HEWs were giving them training on the HIV/AIDS, TB, cholera, and others communicable and non-communicable disorder before spread into own family and communities.

Reinforcing this, most of the participants have agreed that the program has contributed for the decrement of communicable diseases in the community, such as HIV/AIDS, TB, Cholera, and others communicable and non communicable diseases through providing awareness training on these issues. The program has also contributed in the areas of environment protection, proper waste disposal as well as other pressing societal problems.

The service users [code 19] participant said as the following;

> Based on my opinion, the major strength of HEP is diseases prevention and control. HEP also helped my daily family life activities without paying money. We get medical services provisions with health extension workers, without any fear, we address about communicable and non-communicable diseases, problems of social interaction and measurement of action on householders problem.

4.4.3 Strength of HEP with regards to training

The training is a strength of the program which is frequently discussed by the research participants. According to the service providers of the program they have given training on the injectable contraceptives; treat malaria, dysentery, intestinal parasites, first aid and emergency, maternal and child health, family planning, nutrition, personal hygiene and solid and liquid waste. All these trainings should be given according to experiences of health development army

members which are; family model, life cycles, education background, interest of individual and group, talent, capacity and cultural perspective.

Most of the participants of service providers that from sixteen packages sub topic highly trained that in the communities on the family planning, solid and liquid waste disposal which are water supply and safety measures, food hygiene, health home environment and personal hygiene because as mentioned that participants on the study this topic more related that daily activities of communities and life.

According to one of the HEW participants [code 4] said as follows;

> Personally, when I am giving training for community more focusing on creating awareness on the health extension program which are given for health development army (one to five and one to threaten network) and model family. First prepared myself before has given the train, in addition to respect the level of skills, knowledge, value, and culture of communities. Based on the program contents and time from my experiences, the packages covered three to five rounds. Not only that my duty those who trained by me after graduating the program of health extension facilitating to the second round those who graduated trainers they were given training for the members of the health development army and others stakeholders which are edir, ekub and private organization.

The majority of services user participants in the research have mentioned that, the health education and communication has worked more on the contraceptive of family planning, hygiene and sanitation waste disposal. These trainings were given in both theoretical and practical formats on personal hygiene and environmental sanitation, first aid and emergency, empowerment of women, skills and attitude on the practices of health packages, behavioral changes of perceived scientific method of health and social interaction in the communities. These trainings were delivered in Amharic and in more participatory methodology such as group discussions and brainstorming.

4.5 Gaps in the health extension program

4.5.1 Punishment framework gap

According to HEWs participant on this research study stated that; The main gap of the health extension program within the program consisting of loss of punishment framework in practices whilst the groups against the program, best example consists of, a number of humans in the Woreda they were disposal stable and liquid waste like timber, glasses, vegetable products, animal end product, grasses and liquid waste. A number of the humans after the safety net and cleanser people easy the area without any shame at road, across the residents area and business centers waste disposal, the extra of them in summery duration without any permission disposal the liquid merchandise(the quality instance urine)but, that they had given introduction awareness no extra modifications.

A HEW [code4] supported the above gap stating the following points one participant, again supplemented the above mentioned as follows;

> I have almost ten years of experiences in this Woreda as health extension worker. For me, the day to day difficult circumstances in my working area because, without any responsibility some of the people in the Woreda they were disposal, solid and liquid waste like wood, glasses, vegetable products, animal end product, grasses and liquid waste; Human and animal excreta, household wastewater, cooking oil, fats and grease. Even if when I was asked why disposal, waste at any area their responses that some of them said that sorry and some of them they were not volunteering their manage waste in their houses.

According to the program client participants, most of the community members at individual, family, and community levels have sufficient knowledge on the types of waste disposal as well as the place for waste disposal. However, they did not practice on the right places some of them litter waste in the street without any permission around houses and office disposal vegetables, metal, liquid waste, wood, plastic and other waste materials.

One of service user [code 15] participant said;

ቆንጠጥ የሚያደርግ ሕግ ቢኖርኖሮ አብዘኞቻችን በበራችን ለይቆሻሻ አንደፋም ነበርto emphasize the absence of rules and regulations which control the disposal of liquid and solid waste.

4.5.3 Mandatory framework gap

The majority of the participants of HEWs in this research study agreed that, the gap of the health extension program as a program is the absence of mandatory framework, in which the program has no privilege or legal support to permit the community members to build public toilets canal ditch, open defecation, kitchen room, and slum houses

The information from HEWs, code 4, stated the following points;

> The absence of toilets, houses, toilet, canal ditch and others maintain problems were headache in my work most of the time as an individual, family and communities when I went in to the field (door to door) for services providing of the HEP have been asking questions repeatedly about these problems. Even if, the project started in solving these problems, there were frequent delays from their schedules.

From the service user participants of the study [code17] responded that;

> When we need to construct our kitchen room, toilet, canal ditch and others construction, but government body not given answer on time and as well as delay for a long time for maintenance and construction.

According to the key informant; most of the community members if they are asked by a government body when expanding building, maintaining and constructing new buildings the will obey what they are instructed to do so. However, the program has no mechanism to control the personal and community issues to enforce proper behaving.

4.5.4 Lack of motivation

The majority of the participants stated that since the program was launched in 2009, there were various types of training packages given by Addis Ababa Administration City Health Bureau. The participants of the HEWs were reported, there is a shortage of supply, even

if the lack of any medical equipment to provide full services, continual training and career advancements. A limited opportunity with others services providers like; Nurses and others staff it has not equally computation, not only these computations they have no chance to register for education with others health center workers.

Based on the important thing informants, the participant stated that the incentive of those workers is declining unexpectedly. The client participates in this study additionally confirmed that there's no actual motivation of the government organization, except for oral and reporting functions only. There is a want for ok motivation of employees in addition to of the improvement armies of health extension.

4.5.5 Human resource gap

The majority of participant HEWs mentioned that, as obligatory within the health extension program written one health extension work for 5 hundred homes preserve gives services to deal with education and cognizance introduction at the personal hygiene, own family planning and disease prevention and manipulate. However a while one health extension worker has 1000 householder carrier supplied due to loss of health extension workers.

Therefore, overload of work, distances of travel from one to others kebele or block. Additionally, key informants participant mentioned that, in the structure of the health extension program as mandatory needed around sixteen health extension workers in the one health office. However, on the met, panel discussion, monitoring and evaluation and others program the health office head and supervisors they were asked, but no one they were not responded up to now. .

The majority of the client participants in the interview answered the question on the human assets “we didn’t get more offerings provided for the health extension employees due to the fact, we are seeing one health extension worker for extra than six years”.

In summary, the human resource gap has been stated by all respondents as a pressing problem of the program. This shortage of human resource is causing work overload, reduced quality and follow-up programs inefficiency.

4.6Achievements of the health extension program

4.6.1 Disease prevention and control

4.6.1.1 Reduce morbidity

The majority of the participant HEWs stated that, earlier than launching this system, The causes of morbidity which includes; heart illnesses, most cancers, continual decrease respiratory diseases, stroke, diabetes and Alzheimer's problems within the groups. The hassle of morbidity on this motion at the time of the pregnant mother nothing came about loss of life trouble because of, by using giving educated and communication in addition to the screening, take a look at and bodily sports. Consequently, it has proven dramatic adjustments at the reduction of morbidity within the communities. Additionally, the service users (clients) participant stated that, they have an awareness about communicable and non-communicable diseases such as; diabetes, HIV/aids, cancer, TB, and others likes. Therefore, most of the clients conclude that in this movement genie reported those who indicated symptom of any diseases physically went to the health center for communicated with the leader of the health development army and health extension workers.

Participant client [code16] stated as follows;

> Before the health extension program released that, we have been now not aware about the motive of the morbidity occurred, so that we had been treating ourselves with traditional medicine like holy water.

Additionally, service user [code 13] stated the following point;

> We didn't hear at this movement those who are pregnant mother for the cause of communicable and non-communicable diseases recorded morbidity.

The participant key informants mentioned that, at this movement, no one pregnancy mother passes away for the reason of any communicable and no communicable disease because of the communities also attended technology output like TV, radio, and social media about a pregnant mother treated and care before and after birth

4.6.1.2 Reduce child mortality

According to the majority of the HEWs neonatal mortality has declined more slowly than mortality among children age under five years. And children who died within the first twenty eight days of birth before launching the program suffer from conditions and disease associated with lack of quality care at birth or skill care and treatment immediately after birth and in the first days of life. Additionally, the main causes of mortality in children, such as pneumonia, diarrhea, birth defect and malaria and malnutrition have been reduced through awareness creation program.

Consistent to the health extension worker, the client participants also confirmed that malaria, malnutrition, pneumonia was the major cause of child mortality due to knowledge related gaps as well as absence of treatment however, these cases are dramatically decreasing due to the presence of health extension workers.

The key informant's participant mentioned that, accelerated progress the neonatal survival and promotion of health and wellbeing requires strengthening the quality of care as well as ensuring the availability of quality health services or the small and sick newborn.

4.7.1.3 Reduce disability

The other achievement of HEP is related to the reduction of disability in the community. According to the health extension workers mentioned that, with a traffic management agency on the cause of disability trained and awareness creation in communities.

The client of participants of the study also acknowledged that, poverty, malnutrition, poor sanitation, crowded living conditions and violence which mean the destruction of homes, schools, health centers and poor access to health center for service were the major causes of impairments. Therefore, the community without a worry in their circle of relatives impairments communicated government and non- authorities organization.

The key informants also reported that, various types of disability happened in the community due to accidents, fire and traffic accidents. Women and children are the most vulnerable part of the community due to their status and other cultural factors. Therefore, these

kinds of disabilities were greatly reduced due to the activities made on prevention (diseases), secondary prevention (impairment), tertiary prevention (disability or handicap).

4.7.1.4 Reduce HIV/AIDS

One of the greatest achievement of the health extension program is the reduction of HIV/AIDS new cases reductions, and elevation of knowledge about the transmission and prevention of the virus. Accordingly, the majority of the health workers have stated that, the program has provided various awareness training programs on the virus through women empowerment and other activities advices and counseling service. Eventually, their effort has produced a reduction in the new cases of the virus. Additionally, the program facilitated HIV/AIDS transmission trainings, help the delivery of its vaccines, as well as other anti-HIV campaigns. Consistent with the health extension workers, the client participants also reported that various new knowledge has been provided by the program such as transmission routes like; sharing, needles and sharps materials, unprotected sexual intercourse. Additionally, these client participants have been provided with a knowledge regarding symptom of HIV/AIDS like headaches, difficulty swallowing, fever, night sweats, fatigue, appetite and weight loss, chronic diarrhea and vomiting.

Lastly, key informants of this study have stated about the contribution of the program in the reduction of HIV/AIDS risks especially on the youth fraction of the society. According to these key informants, now almost everyone knows how the virus is transmitted, the prevention and controlling methods. Additionally, various social media technologies such as; telegram, Skype, Imo, Face book, and others are being utilized among primary and secondary school students, university students and night club workers have been provided with knowledge about unwanted pregnancy and HIV/AIDS.

4.7.1.5 First aid and emergency

The other areas of achievement of the health extension program are in the field of first aid and emergency. The majority of the health extension worker respondents in the interview have reported that sudden health problems were handled by the trained individual of the community members themselves. While in the residential regions came about the blood wind, heartbeat,

diabetes and headache had been handled and advices more complex health trouble inside the communities as well as they had been taken measures to move private and authorities medical institution for better health remedies.

The clients participant of this study also claimed that the have been given to sufficient trainings on how to handle such matter.

One of service user participants [code20] has described as the follows;

> As soon as upon a time my neighborhood, own family changed into not present in their domestic, however a girl who stayed inside the house laid low with a coronary heart problem. After I hear her sound, I went to enter their residence, finding she become fainting. After some time of supporting her with a primary resource, she awoke.

On this issue, the key informant participants also showed that in the ten year practices of the health extension program they have greatly changed the behavior of the people. When one person in every place happened by car accident, burn fire, heart problems, diabetes and other human and nature made somewhat supported by the people. In summary, one of the golden achievements of the health extension program is the training of first aid support for an individual who seeks immediate medical attention and contribute to the reduction of impairments and even it can eliminate the chance of died.

4.7.1.6 Family planning

Regarding family planning, health extension workers have recognized the changes made by the program in the areas of family planning;

One of the health extension workers, i.e. participants [code4] stated it as follows;

> When we started our work which tried to create awareness in the communities in the family planning most of them were afraid and they were not voluntary to communicate with us.

Additionally, the participants stated that most individuals in the community use traditional contraceptive method like; calendar method and outside ejaculation and other method

to try to prevent pregnancy during sexual intercourse. After the launch of the program modern method of contraceptive such as; Implants, Intra uterine device (IUD), male condom, emergency contraceptive pills and injections were introduced to the majority of the community members. These contraceptive methods are effective in preventing pregnancy, and some of them such as male condoms prevent sexually transmitted diseases in addition to preventing pregnancy.

Service user [code17] said as follows;

> When I have sexual intercourse with my husband, I was free from memorizing the harsh problems and worries of unwanted pregnancy.

Additionally, the key informants of this study also stated that since our country implemented health extension program the awareness of the community about contraceptive methods have been skyrocketing. Since then, various modern, effective and cheap contraceptive methods were introduced to the community.

4.7.1.7 Adolescent reproductive health services

According to the health extension workers various stakeholders (both governmental and nongovernmental) are working together in the program to create awareness about HIV/AIDS , Gonorrhea (bladder opening),Chlamydia, pelvic inflammatory diseases and Genital warts creation awareness at the primary and secondary school as well as in different institution such as private metal work, wood work and youth center.

Additionally, the client participants of this study have stated that after the implementation of the program, many adolescents have trained to discuss freely about reproductive related issues. Furthermore, these adolescents have been provided with pressure in the school, play areas and recreation activities, trainings in relation to HIV infection and practicing healthy sexual behaviors.

The key informants also supplemented the above finding in which the program worked a lot in the areas of adolescent reproductive health. Most of these key informants have acknowledged that as part of the society (adolescents) are the most vulnerable as well as the

most productive part of the society, working on the adolescent reproductive health is vital to our society in general.

4.7.1.8 Nutrition

Health extension workers said that, within the communities created focus with the aid of campaigns at the pregnant mom properly use of greater calcium, folic acid, iron and protein. Further, advising others food likes leafy inexperienced, vegetables, enriched cereals, breads and pastas, beans, citrus culmination. These respondents have also acknowledged that women are encouraged to apply Iron since it creates extra blood to supply the child with oxygen.

A service user [code 20] has reported the following;

> When I used to be at my being pregnant time, in our homes if the balance of food plan has not anything even supposing we have been fed brown rice, bread, Injera and cereal in addition to also up to 6 months as well as I used to be feeding my kids most effective breast.

In addition, service user participant [code16] has reported the following;

> I have two children so that after birth up to six months I did not practice or fed them any food, since this nutrition should be given to them after six months.

The key informants of this study also have mentioned that nutritional campaigns of the program have created many positive outcomes on the provision of balanced nutrition for women and children such as iron and other medicinal products.

4.7.1.9 Malaria

The majority of health extension workers have reported that the program has created awareness regarding the most common symptoms of malaria, including; Headache, nausea, vomiting, abdominal pain, diarrhea, muscle pain, bloody stools and convulsion. In Addis Ababa the causes of malaria have rarely happened.

The majority of the clients' as well as key informants have acknowledged that the program works on the relation to reducing the risk for malaria infection as well as a treatment mechanism if the infection actually occurred.

4.7.1.10 Solid waste disposal

The majority of the health extension workers have acknowledged that the major sources of solid waste are commercial center, hotels and private factories (woodwork, metal, tradition clothes manufacture shed), which are the physical composition of vegetable, paper, rubber / plastics, wood, bone, textile, metals and glass.

One of the HEW has stated as below [code6];

> We can observe solid waste mountains everywhere we go. Some time we can't go nearby, these areas without smelling a stinky smell of these wastes gathered and placed here and there.

According to participants, the solid waste disposal mechanism is composed of first filter or separated from the family house and resident's compound.

Additionally, client respondent mentioned that the stable waste or non-liquid material that present within the house, commercial status quo, group and streets ,that are vegetable, plastic, metallic, wood, paper, fabric, and glasses they have been practices waste management cooperation inside the clean –up campaign , shop garbage in a plastic bag, special between, compost the natural fraction in very own lower back backyard, separated waste in and non - organic, wet and dry, preserve plastic, paper, hold house and immediate surroundings clean (drains, streets in front of houses and brings garbage to communal collection point for transfer.

Participant [code 12] indicated this as follows;

> Strong waste is our family income generated due to the fact I am an employment inside the safety net of waste management cooperation.

And another participant from the service user stated that [code 14];

I have two sacks which are green and yellow; the green sack is used for vegetable wastes and the yellow sack is used for plastic, metal, wood, paper and textile.

In addition, according to the key informant, they see waste disposal not just as waste because poor people generate income through the gathering of the wastes from door to door, to lead their family economically as well. Therefore, according to these respondents the work of the project in terms of waste disposal is twofold, one it is used for environmental protection, while the other is the generation of income for the poor people of the community.

4.7.2.1 Food hygiene

Almost all of the study participants have reported that, they have created awareness in the areas of the sources of food hygiene problems like; contamination during slaughtering or harvesting, processing, storage, distribution, transportation and preparation. In the household, the awareness program also addresses cleaning before and after food preparation in order to prevent food born diseases, decreasing infected such as diarrhea, Typhoid fever, cholera, Amoeba, Tapeworm, and Anthrax.

The majority of the clients have mentioned that, HEWs have created cognizance at the outcomes of bad meals hygiene like infection of meals at some stage in meals preparation, intestinal worms, skin diseases via away of scratching the skin, easy lines of body, feet, eye, garments, teeth, mouth, genital areas and the likes and additionally recognized issues that emanate from are terrible hygiene consists of; typhus, relapsing fever, bad odor, and frame itching.

Moreover, the key informants responded that concerning the personal hygiene they have been large adjustments in the groups on the keeping finger nails, use soap for hand washing after visiting the latrine due to the fact, the discount in germ load, the bit reluctant to clean regularly their feet than with their fingers and other food hygiene associated matters.

4.7.2.2 Personal hygiene

Regarding the program contribution about the personal hygiene, the majority of HEWs respondents minimized the risk of infection and enhances overall health in the communities due to the practice of basic personal hygiene habits

More than half of the client participants stated that, they were keeping their personal hygiene as they have got inexpensive again floor deliver their organized sparkling food, before and after organized smooth the kitchen room, eating regions ought to be kept easy and free of vermin and insects, eating houses ought to have easy water by way of washing , consuming clean water and separated sanitation facilities away from the kitchen place and ingesting homes need to with adequate lighting fixtures.

The key informants also have reported that there were many practices in communities to keep clean of their body from hair up to nail since the launched of the health extension program by health extension workers, supervisors, and other stakeholders.

4.7.2.3 Control of insect and rodents

The majority of HEWs participants stated about the control of rodents, the various communicable diseases in the study areas like Typhus, malaria, trachoma, blindness and skin contamination all are transmitted via bugs. Considering that the houses of most of the residents have been slum so they have awareness rats and mice are most adverse animals like monetary damage (vegetable, saved food are heavily destroyed) even though fixtures and garb.

The clients' participant interviewed there had been practices one-of-a-kind method to govern bugs like stack it to reduce the surface place of contact with flies and cowl it with plastic sheets, use suitable containers until they're picked to be disposed, rubbish and sewage, human and animal excrement, put food and utensils in fly evidence containers, use nets and displays on widows and different opening, doorways- anti-fly curtains. And additionally the rodent to prevent mass motion and spread of rodents, killing have to be accomplished expatriates, that are the reservoirs of plague, murine typhus, use persist with kill, burn fire on their harborage or whole and use rodenticides to kill them.

The important thing informants' responses that on the answer the question, there were practices that many things on the control of insect and rodents are in the communities controlling rat population is preferable than killing individual rats in a house as well as control insect avoid dense vegetation, human and animal excrement. Therefore, most of them happened that from the problems of insect and rodent were in the community's dysentery, diarrhea, typhoid, cholera, and certain eye infection.

4.8 Challenges of HEP in the Gullele Woreda 3

4.8.1 Sanitation challenges

In line with the client participant response that the challenges of the health extension program in Woreda 3 that cause of availability of makes use of the community with the residents become very low and the ability of provider supplied environment sanitation, lack of infrastructure consisting of; The safe excretes disposal, public lavatories, children faeces, defecation areas, communal lavatories. And the provision of lights in the toilet area, even supposing inadequate water delivers excessive. Similarly, as participants reported a lack of making political commitments and regulation, mobilizing finance resource, tracking development, paying attention to gender. The abilities one of the required to enhance sanitation due to the fact more of the family sanitation require softer, human beings based totally talents and take engineers in areas in order that their sense uncomfortable and unusual. And addition indeed, past individual motivations which make the intended beneficiaries of sanitation and hygiene merchandising reticent and cultural distinction stand up for gender; variations inside the perspective of ladies and men on the sanitation and the view of the adult and youngsters vary too, family instances also are divers.

The service user participant [code 13] stated as follows;

> We were not successful in the disposal of liquid inside the worst come in summery season most of liquid disposal within the residents, hotel, pension, restaurant, private area like small industry mixed with the rainfall fall in to our houses which includes urine, fesses, and in addition to our homes very slum because of this when the rainfall relatively from the roof of house felt black dust cloth known as tekresha.

In addition, the health extension workers have stated troubles consisting of; Loss of arrangement for cleaning and upkeep because of this the monetary viability of shared and communal sanitation facilities changed into charge to hold- cleaning and pet –emptying, call for of for use of latrines would increase and machine for cleansing breaks down.

The key informants participant at the research study as mentioned that, lack of information within the groups, leaders, and private sector because that, as degree of Addis Ababa Administration get entry to of sanitation are low however at each places or avenue of canal ditch with plastic, veggies, steel ,wood, and different like float, and shortage of politically and budget precedence these nearly the government body, they have no get right of entry to interest to build canal ditch at the primary place of road, sometime the authorities whilst the groups requested responses that not anything price range.

4.8.2 Equipment of challenge

The participant of HEWs on this study described that they lacked medical equipments when the health extension workers are going into the communities; like the absence of ultrasound, and bags to carry on equipments and items. According to the HEWs, most important for health extension workers when went into the communities they have not bags which are contained medical supplies like cotton, family planning contraceptive such as; condom, pills, and others prevention supply. Consequently, the entire participants of health extension employees stated that, any equipment of scientific materials and education substances hands with the aid of their own bags, in order that the satisfaction of medical resources decreasing.

The key informants said that, the biggest problem of in the health extension program was the inability to full fill the equipments of medical supplies in the health post that are used by health extension workers and supervisors.

4.8.3 Economical challenges

Regarding to the challenges of the health extension program as noted by way of the initial respondent of HEW on the interviews, the main challenges become economic trouble which means that the HEWs, leaders of HDA, supervisors and others important stake holders have now

not accesses to education at the packages', which makes tough to create focus and provide new information in to the groups with collaboration others stakeholders. Other economic demanding situations encompass the extreme poverty of the community, wherein most of the communities lived a tough life in terms of their monetary level, residing in the slum homes, although when the house damage maximum of them have no economic way to preserve their broken house in addition to construct lavatories, kitchen room, and canal ditch

The in-depth interview individuals had been requested approximately the financial demanding situations that, because the economic system is one in every of vital concerned with issues related to performance and effectiveness to cope with health program at the agenda and need to groups. In step with them the demand and supply unbalance in the prevention and manipulate of diseases due to the fact, the greater building toilet, canal ditch and open defecation via communities with their very own economic which means that the government extra of them helps employee health extension workers, supervisors and education and provided vaccine. But the maximum communities' they have got an economic hassle as an individual and family. All of the participants stated that there are not any get admission to food elements, natural water, homes (greater of slum houses), and rest room. Whilst wants to amass useful resource for building lavatories and open defecation within the residential place, it was taken a long time, quite they were no longer voluntary series Birr.

The health extension workers responded that, the economically challenges within the groups and government turned into cope with a few program of health extension because, the communities they have economically troubles to construct bathroom as character and communities, food resources main of resistances from disease (construct immunization), maximum of them in health middle if they haven't any get admission to vaccine their no risk bought vaccine from private health sector , extra slum houses are kebele house in order that the authorities has prohibited the rebuilding or maintains those house, in these reason insect and rodent and erosion increased in a few houses.

One of the key participants has put idea as follows;

> Whatever the system would be and how nice the policy is in creating health service for communities, if the communities could not generate

> income, no one can address the vision of the government in these areas. And health always needs finance to build health center, sanitation services, facilitates training, create awareness and personal hygiene also need financing, and building canals ditch. (Participant code 9)

4.8.4 Monitoring and evaluation challenges

The client of participants have explained that, for the reason that launched this program the complete parts of stakeholders have travelling the practice of health extension program weekly or day by day .But time to time decreasing with health development army(one to five and one to threaten network), version own family, those who infected HIV/aids and ketena leaders and feedback from the leaders already at this movement for propaganda demand because they haven't any responses that what the groups need and asked simple when the top authorities body pushed for short of time talk with some human beings, however not anything answers.

The service user participant [code 15] said the following;

> I am a model family in the community through applying health extension program for as model family to inspire, empower and manage with health extension workers and supervisors regarding to HEP, but at this time I do know even if monthly some time they were not coming to my house and to other members of the community as well.

According to service user participant [code 10] stated the following;

> I was infected by HIV /AIDS before ten years and I have been working in solid and liquid waste disposal in safety net, use ART drug as well as more communicate health extension workers and even if the HEWs supported me by different materials by making communication with different non-government organization and when perceived failed to take my HIV drugs on time , they were call me on my Mobil phone ,but since three months ago things went badly.

Moreover, social workers participated in this study have responded that, time to time decreasing in monitoring and evaluation in the community based totally on the practices of sanitation, own family making plans, HIV/AIDS inflamed for the cause of lack of motivation in the network, HEWs, leaders and supervisors.

4.9. Plan and achievement

The purpose of this section is to support the end result gained from the interview sessions study proof based files from the area of study, in order that there are one of a kind documents that weekly they had been recoding minutes with one to five health development armies on plan was evaluated at weekly whose have been accurate executed their program and assigned the version of the weekend in line with the woman point. And on the quarter of the year the whole stake holders (HDA, special places of work workers, elders, private sector like hotel, pension, restaurants , cafe, safety net workers, leaders and school) presentation of work by health office head which were recorded on the time table they were become aware of the strength and weak point of implementation from those strength as written on the schedule strong waste management, family making plans, HIV/aids ,and communication and training from others program particularly performed according to deliberate of health office. And health developments army, in step with settling necessities of version own family' evaluation half of the year there had been recognized in keeping with their typical performance. And the in line with recording to at the agenda the weakness components of as written at the paper sanitation trouble , those factors lack of information, lack of canal ditch, economic , collaboration of stake holders , dedication of humans and monitoring and evaluation system they were no longer continuities in line with settled agenda .Evaluation of primary school students at the sexually transmitted diseases (HIV/aids), symptom of infected HIV human, prevention of HIV/aids, prevention of being pregnant, modern-day contraceptive family making plans, organization stress within the school for unwanted sexually sex, non-public hygiene ,and solid waste how disposal from the school. Typically on the plan and the success the agreement of the health extension workers, supervisors and primary health care service providers worked on the diabetes check, TB and polio they had been furnished offering door to door.

4.9.1 Activities of model family in their houses

4.9.1.1 Hygiene waste disposal

More model family they had been surprisingly achieved special activities of hygiene waste disposal and according to written document showed that at given rank under "A" model family has occupied more numbers of their work the solid waste management because of more model family they were worked onsite handling, storage and processing methods are under taken at house hold level and waste could categorized solid non –hazardous, liquid non-hazardous, solid hazardous and liquid hazardous waste. In addition, they were practicing the method of hygiene waste disposal include; from the solid waste management insanitary method like a hog feeding, dumping and sanitary method composting because planting vegetable, and method of excreta disposal was open defecting, sanitary method; pit latrine and water seal latrine.

4.9.1.2 What are the measures taken to address the challenges and gaps regarding the HEP**?**

In line with the HEW participant of preliminarily interview said that, to cope with the main challenges of the health extension program is making plans to with HEWs, supervisors, health office head, medical director, non-government body and groups work with together with the aid of sharing their competencies, expertise, exchange first-class practices and monetary help. In addition, the government bodies are planning to help assets like finance, medical equipment and one-of-a-kind types of medicines provided.

All of the participants (key informant, HEWs, and clients) at the observe almost their responses that, on the measures taken to cope with the challenges and gaps in the HEP, they have got the equal view at once or circuitously because of the challenges they were raised that the equal troubles. As solution from the responses they had been raised that From Addis Ababa city administration modifications the law of construction toilet, canal ditch and open defection in to health bureau or articulate responsibility and duty of the way could have each construction and health bureau they have share the proper to selection making among them, this it will be growing services offer in the communities, motivation is considered one of engine in service provider in communities .So that everyone stake holders and government body should they have got responsibility from this the authorities frame(Addis Ababa city administration) duty as a

new articulate (check) the policy to addresses their requested questions of health extension workers, and supervisors on the obligations due to the fact, as mentioned that they have the identical again ground training graduated and the difficult ship of work extra than nurses, mid-waver and others work in health center, in order that the government will helps like teachers permission freely bus at the work day and spent time, the government like nurses, mid –waver and others professional will deliver same hazard recruitment at health centers, the government body(woreda, sub city, and city administration health bureau) helps retain training extra for health extension workers due to the fact, first they had been no longer graduated by means of health extension program and health it need with the aid of itself new information, competencies, management, supply and understanding.

Economically challenges in the communities this is very want to attention any government frame from Woreda as much as federally stage due to the fact, the communities their lived homes slum, at a few crowed residents area inside the one house roof they have been lived more than two families, they had been no longer potential constructing new residence and keep their formal homes, they have lack of infrastructure like individual toilet, group toilet and frame route this was got here from some humans are not make a contribution birr, in order that the government and non government, they improve above allows in keeping with schooling history, age, health background and motivation (interest) on the safety net, exchange, creation, employment in the government and private sector and lifestyle clothes manufacture. And the maximum of the health development army(one to five and one to threaten network) for the cause of the economic problem they had been converted residence rent from one to others residents areas, in order that like edir, ekub, shango and prefer other social interaction affected.

Medical equipment as HEWs they were raised that, lack of the bags that incorporate different fabric together with condom, contraceptive, cotton, needle and like others, so that although the woreda administrator has the ability to shop for bags their very own budget. At the monitoring and evaluation as stated, that the clients (services users) time to time decreasing from health extension employees as formal, in order that the government body (supervisors, health office and scientific director) monitoring and compare based on the time table the HEWs. Sanitation challenges the big trouble of the communities as participants of research studies, they were raised that, for epidemic disease one of the factors, in order that the government of Addis

Ababa city administration could be built canal ditch; Within the residents place, primary street, road and other that affected communities by means of disease.

Summary of findings

In summary, finding of interviews with key informants, services providers and services users showed that they have nice perception on the health development army due to they had been creation recognition's on the communicable and noncommunicable disease, present day technique contraceptive circle of relatives planning, strong waste disposal management and enhancing social interplay of the network with collectively.In addition, the program makes use of a network primarily based approach respecting the subculture, norms, cost, and existential fashion of the area people. It has also participated the network in the planning and implementation, diseases prevention and control phases of the assignment. It additionally provides awareness creation packages that specialize in the prevention of illnesses, as well as after the prevalence of sure illnesses in the network at level various levels of the community, inclusive of the health development army, character, own family and the community as a whole as well as for non-public organization along with; hotels, pensions, restaurants and trade stores.The program additionally develops education guide for HDA, HEWS, model own family and supervisors.

Concerning the gaps of the HEP, as stated by these study participants, the program did not include the punishment framework as regulation to punish the wrong doers such as individuals who litter garbage in prohibited areas, on the streets, and around residential areas. The second gap of the program is the absence of mandatory framework, in which the program has no privilege or legal support to permit the community members to build public toilets canal ditch, open defecation, kitchen room, and slum houses. The third gap acknowledged by the participants was the lack of policies and strategies from the government health extension workers and supervisors to carry out their duties. There is a lack of training, education upgrade, facilitated transportation, duty (over time), awards and house allowances. Lastly, there are human resource gaps, as this study, participants stated that, there is only one health extension worker for 500 households which creates enormous burdens and de-motivated these HEWs.

Regarding the main achievements of the HEP in the community during its implementation stages so far, it has accomplished in reducing cause of morbidity through diseases prevention and control, such as; Heart diseases, cancer, chronic lower respiratory, stroke, diabetes, HIV/AIDS and TB, as well as reduce cause of mortality in children such as; Diarrhea, birth defect, malaria, absence of quality of care and malnutrition. Second, it reduces disability, via awareness creation programs on the cause of conflict, car accident, poor sanitation, and unsafe environment. Third, it reduces HIV/AIDS in the community. It also creates knowledge to bring behavioral changes, attitude and information as well as it provided condoms, ART-vaccines for those who are infected. The fourth accomplishment of the program is in the areas of first aid and emergency, in the community. The whole health development armies, health extension workers, supervisors and public health officers were trained. In family planning, the program has introduced modern methods of contraceptive family planning such as; Implants, IUD, male condom, emergency pills and injections. Sixth, in terms of adolescent reproductive, the program provided awareness programs in the schools, youth center, hotels, association on the HIV/AIDS, Gonorrhea, Chlamydia, pelvic inflammatory, Genital warts, and HPVs, Additionally, the program trained adolescents in regard to peer pressure, chewing chat, drinking alcohol and other habits. Seven in regard to nutrition, based on the responses of the participants of the study, the program helped the community to practice good nutrition for pregnant and breastfeeding mothers. Such as during pregnancy and after birth the mothers and children fed calcium, folic acid, iron, protein, and other like leaf green, vegetables, enriched cereals, breads and past, beans and fruit. Eight, concerning solid waste disposal, the program dramatically changes on their mind in waste management like; plastic, wood, bone, textile, metals, and glasses. Ninth, in relation to food hygiene, the program created awareness regarding the contaminated during slaughtering, processing, storage, distribution and preparation.

There are various challenges in the Gullele woreda 3 for HEP, from this, sanitation problem such as; lack of public toilets, canal ditch, open defecation and pure water. Second, economic challenges such as; most community living in the slum houses, unbalance supply and demands, unemployment and lack of resources. Third, equipment challenges like bags and ultrasound

CHAPTER FIVE; DISCUSSION, CONCLUSION AND IMPLICATION

5.1 Discussion

Under this section this study discusses findings of the study by using relative the ones of applicable literatures.

Research question one; what is the perspective of clients and health extension workers towards the health extension program?

According to the finding of the study, almost all of the participating clients and health extension professionals have their perspective regarding to the health extension program, health development army (one to five and one to threaten network) and the structure of the HEP (HEWs, supervisors and health office header) the participants they have got strong positive perspective.In addition, in this study as participants stated that the members of the HDA, they have been performed distinct activities together with; developing recognition for the individuals of the HDA, shared proper practices to others residents on the own family planning, strong waste disposal, communicable and non-communicable disease but as individuals said that during line of studies finding, health development army the extra result recorded through participation at schooling and advent consciousness approximately strong waste disposal activities.This is similar when compared to the study done by the World Health Oganization (2016) in this finding refers to an organized movement of the community forged through participatory learning and action meeting, the main criteria for selection of leaders are whether individuals belong to a model family are trusted by team members, and are able to mobilize communities. Further, as it turned into state that by means of (Maes et al,2018), conduct studies at the voluntary in Ethiopia women development army had been labored greater inside the communities on the reduce maternal and toddler mortality, work burden, food in protection, stressful life activities, house troubles and income generated as well as concerning to the structure of the health extension workplace of the health workplace chief, supervisors and health extension profession the identical of the attitude of individuals inside the line of finding research.

The general perspective of the clients and health extension profession the relationship of the staff

According to HEWs and service user participant perspective regarding to relationship with HEWs, nurse, mid-waver, supervisors and health care professional there is effectively harmony with each other. In addition,in this study the first line of the health development army, they were communicated to health extension workers by face to face and telephone. The second, communicating with supervisors, health care professional and leaders of the woreda. And as the respondents of the health extension workers they were communicated with at the first line with supervisors, second and third with a health office head and health center medical director respectively. The result of this research indicated the presence of the relationship of staff at the work area,they have the positive impact on the achievement of the health extension program such as; Enhancing social bonding and supported by finance the same as the result of Zewdie et al (2013) conducted on the mothers experience and satisfaction with health extension program. Which means the result of this study showed that, the service users they have been more interaction with health extension workers on the received information, perceived skill to diagnose community problem, perceived respect, and shared intimacy as well as the health extension workers were highly communicated with together with the social-interaction.

Research question two; What is the strength of HEP from the perspective of services providers and service users?

According to this study finding, the strength of health extension program includes it makes a specialty of the community based activities, which means that the groups with the aid of their own participation build toilets, canal ditch, taking education, vote the leader of the health development army members. Despite this, any activities of the health practices inside the communities reputable their cultures, values and customs. Even if, more than the other outside frame, their communities and health extension workers to collectively perceive the demanding situations, any circle of relatives making plans have given for provider users primarily based on the interest. Plus within the organization the service users shared enjoy in the areas of personal hygiene and environmental sanitation, disorder prevention and manage which include communicable and non-communicable. World bank (2016) behavior research study performed on the health extension program towards the strength of HEP it had highly communities participation and empowerment, Though this program primary level preventive services and basic clinical services were provided to communities and households and encourage families to

be responsible for their own health by promoting knowledge dissemination and adoption of hygiene practice, proper environmental management, actively involved in the implementation in the HEP. But in this study the community's selection processes of health extension workers while in the woreda health office employees graduated the clinical nurses, public health and others like. This is different from conduct the research study by World bank (2016) I think more health extension workers in the rural Ethiopia recruitment from grade ten and the policy itself has own graduation institution health extension program.

Research question three; what are the gaps/weakness regarding to the health extension program

According to this research finding ,the participants described that, the program it has not written punishment frame work which means, when the communities, the government frame, non-government body and service providers they make illegal movement without duty like vegetable, paper, glass, human and animal excreta, waste water, cooking oil, fat and grease individuals who disposal on the streets , around their citizens residence,a workplaces and market region at hand is not any law and rule machine within the structure of HEP for punishment. The second weakness spot of this program is lack of mandatory body work is the health workplace it has now not right to permission for the groups to construct bathroom , canal ditch , open defecation, kitchen room or even if when humans want to preserve their residence with group or person delay permission of creation workplace as much as more than month , that is more time produced conflicted with health extension workers and supervisors due to react with together based totally at the weakness of the health extension program nobody conducted research study. Despite the fact that, the Ethiopia urbanization health extension program policy(2008) as well as Addis Ababa City Administration, health extension packages (2004E.C) also there no written that any a single sentence about what to do whilst the communities and the provider vendors s in opposition to the program. I think the hassle of the gaps, lack of communication between the coverage makers of the health sector, construction office, regulatory body, exchange office and different like. The third weakness of the health extension program lack of motivation device as a program inclusive of; the brand new employment health extension professional they are taken training only one spherical, there no get entry to training on the new statistics because health it is related with human, the health extension professional they've restrict possibility with others provider provided within the health facility like; nurses, mid-waver and public health on the

education upgrade. In this take a study as respondents raised that, the fourth gap is the human resource. As written that in the health extension program(2012), one health extension worker service five hundred households and even if one health extension worker offerings extra than two kebels, in this cased the groups they don't have any get entry to offerings and the health extension workers with the aid of themselves have no given complete provider for communities for the reason of the work load in the groups. Conduct research on the elements affecting health extension employee motivation in selected rural districts of Ethiopia by way of ChalaTesfaye (2017), this end result of the studies executed the same as the research at the practices and challenges of the health extension program concerning to the motivation of the health extension workers. From this finding of the look at de-motivation is affected on the individuals, family, communities and an employer /gadget stage because, less acceptability of the health services through the communities, sluggish development in profession advancement that are;negative supervision, support and governance from the chief, no transfer coverage and insufficient monetary earning. But behavior at the factors affecting motivation fitness extension people because the practices and challenges of the HEP there isn't assessed schooling upgrade, transportation and house allow cement. From my view, the purpose that the study completed in the rural district, without Addis Ababa City administration due to the fact, they've their own training coverage and college based at the health extension program. In this research study the gaps of the health extension program are human resource because of this, one health extension worker offerings five hundred families as in the urban HEP policy, in cased of this the HEWs more of them tough control of the communities because their numbers. In this of study as stated the researcher used as reference executed by means of USAID (2016) in relevant the literature the weakness of the program regarding to human assets there isn't always said, however as gaps describe the loss of attention on the assemble toilet, hand washing, the usage of insecticide –treated mattress nets in malaria normal. I think the researcher executed before 4 years ago,now the numbers of people increased,the wishes of the service users greater enhancing, mind-set and conduct of the communities.

Studies question 4; what are the achievements of health extension program in the Woreda3, Gullele Sub City?

On this research of the end result confirmed concerning to the success of the health extension program carrying out on the disease prevention and control, in cased of this there had been extra decrease factors that morbidity like; Diabetes, HIV/aids, most cancers, TB, and other communicable and no communicable disease, in order that as members of the study stated that, right now, no mother died from using any disorder at being pregnant time.The second one, the result of this of this program changed into carried out lessen mortality of children because of the decline that factors malaria, malnutrition, pneumonia, diarrhea,beginning illness and HIV-inflamed.Further conducted with the aid of Hailom.B.(2011), research carried out on the fulfillment of the health extension program, there have been done the prevent communicable disease like;Malaria,tuberculosis,HIV/aids,and also the ones dwelling with HIV/aids are changing the mind-set and conduct changes.From this, each studies result we keep in mind that,they've the same views concerning to disease prevention and control, however the difference there have been now not indicated what number of humans's are used HIV/AIDS vaccine. And also on this observe as individuals said that, more executed both communicable and no communicable consisting of; TB, diabetes, most cancers, malaria, reduces HIV/aids due to the improving mindset and behavioral modifications, empowerment of girls by monetary and training, prevention by the use of condoms, with drawl from sexually intercourse and one to at least one live with couples. While as carried out via Hailom(2011), in his research achieved confirmed that the outstanding fulfillment of communicable sicknesses and briefly put they way to govern HIV/aids, and empowerment of women.

The third, fulfillment of the HEP, which might be the lessen incapacity due to the fact labored with nurses, health practitioner, psychiatric professional and stakeholder caused by automobile coincidence, medication, dosage, radiation, battle and nutrition.In order that as respondents responses that there are modifications in the communities.Dr.Yohannis.F.(2009) was undertaking research on the prevalence and effect of incapacity in north- western Ethiopia.As this studies result,most people of disabled humans have troubles with activities of day by day existence, specifically toileting, bathing, and dressing. From this study, we understand that, the motive of disability in woreda 3, difference from the conducted by using Dr.Yohannis, I suppose

it might be the variety between both research findings in Addis Ababa crowded of transportation, access of medicine deliver,exceedingly enterprise elevated.Even as the research executed conduct of rural place greater human beings don't have any access bathroom service in addition to bathing due to the fact had washed body in the river in addition to a relaxed area.

The fourth, achievement of the first aid and emergency on this research study as responses the participant the health development army and health extension workers they were taken training and given the offerings all of us who confronted troubles with the aid of automobile coincidence,burn,broken the bodily body, blood wind, heartbeat, diabetes and headache. Research conducts through Gemechu.G.(2016),to assess the expertise, mindset and exercise of the primary resource among kindergarten instructors in the lideta sub town. So that, as the result showed that, once they had faced the child in want of first useful resource more of them had given first resource for common injuries which includes; prevent bleeding from the frame, fainting toddler, epileptic baby, choking toddler, human chew, nose bleeds and baby with difficulty of breathing. Conducted studies via Gemechu,showed that more practices the lecturers had been epileptic baby this is further with practices service providers(HEWs). At the same time as however this studies at result confirmed that the carrier companies had been women, those who participated inside the health extension program because of this extra members had educated for 3 up to 6 rounds as well as the individuals from health graduated from health professional in order that as responses that nobody died at emerging problem within the woreda.

In this study, the six the achievement of the health extension program improving own family planning offerings including; Implants, Intra uterine device (IUD), male condom, emergency contraceptive tablets and injections,the provider users with none afraid communicated to health extension workers for the cause of the counseling and recommendation. So that as respondent they were raising their personal view more girls have been used cutting-edge contraceptive method for this at the first level used Implants.Study at by (Alemayehuetal, 2016),on the determinants of own family making plans uses among married girls in Bale. As this study the end result indicates that,the general contraceptive incidence rate became 41.5%, injectable (forty eight.1%), Implants (22.6%) and capsules (20%), the spiritual notion (17.7%) and husband's opposition (38.eight%). At the same time as members of the respondent have been raised that the maximum used Implants contraceptive strategies and on this movement

anybody,they have not used way of life technique together with; religious ideals, count the day (length stream), and husband's opposition. From this two study indicated that, in Addis Ababa the service provider they have been gate get admission to modern own family making plans, media get entry to (statistically), infrastructure like; health facility, sanatorium, medical institution, both non-public and authorities organization, and access education device more than Bale zone.

In line with participants of the take a study concerning to the HEP stated that, the seven fulfillment of the health extension program on the adolescent reproductive it has advent focus and behavioral adjustments on the HIV/aids sexually transmitted infection, Gonorrhea(bladder starting),Chlamydia, pelvic inflammatory disease,Genital warts and human virus at primary and secondary college as well as inside the varies institution. studies done by using (Gelilaetal, 20119), at the determinants of youth reproductive health service utilization in Ethiopia.While the countrywide reproductive fitness method from 2006-2015, confirmed that had given interest the whole underneath adolescent age in any group (teens centers, faculties, industry parking, lodges,and organization) blanketed, however in this studies finding, most of the people of contributors noted that, there has been for the reason that attention for extra of them it's miles focusing on the college(number one and secondary).I assume,it's miles hard to generalize Ethiopia adolescent adjustments their practices and behavioral at the HIV/AIDS, circle of relatives making plans, drug makes use of, and like others.

The eight achievements of the health extension program, as individuals study cited that now and again converting vitamins feeding within the carrier users before and after the beginning of the mothers and their child as health extension workers and nurses as well as supervisors advisers feeding of the calcium, folic acid, Iron and protein,leaf inexperienced, veggies, enriched cereals, breads and pastes, beans had been used as stability weight loss plan. According to a study (FDREMoH, 2015), the success of the health extension become a nutrition program upgrade the pregnant girls purposely used within the country which include; Iron, enriched cereals and porridge. As indicated that this result, reducing mortality and morbidity.These researches are a large difference between them without a touch similarity. I think, the difference between them, the first one, duration of time research accomplished.The second,the study by

means of FDREMoH, focused on the only pregnant ladies and the quantity of feeding nutrition little or no.

The nine achievements of the health extension program, according to respondents of the members, Malaria inside the Addis Ababa City Administration presently free from the malaria. But the network they were conscious and also acknowledged the signs and symptoms which include;headache,diarrhea,muscle pain,blood stools and convulsion.The study,completed with the aid of (Meresa et al, 2018),on the incidence of Malaria in Tselemti woreda, north, Ethiopia confirmed that the end result a total of 41,773 sufferers with leader malaria proceedings were screened for malaria within the three year duration. From the two research end result knowledge that haven't any commonplace indicator,in Addis Ababa city specially Gullele woreda3,as contributors at the interview responses that they had stated that completely no person malaria symptom, might be the studies done at Tselemti two years in the past , lack of the get entry to health device, lack of attention(government and others), and problem sanitation, because of this the result among them massive distinction.

The end of the fulfillment of this study, the solid waste disposal as participant they have been responses that, within the woreda from other programs of the health extension dramatically changes to control the waste products within the residence and personal organization like vegetable, paper, rubber, timber, bone, textile,metallic and glass.Conducted studies accomplished by using (Gorfnesh et al, 2018), on the evaluation of status of stable waste management in Asella town, in order that end result showed that,332 (82.8%),had incorrect stable waste control exercise which might be; loss of adequate know-how approximately solid waste management, no longer having access to door to door, stable waste collection and contributors who didn’t have access to door to door stable waste exercise. But in Addis Ababa city the entire woreda they've prepared by way of government meaning, employed by means of the government in addition to those who organized at solid waste disposal one factors for greater worked in Addis Ababa specially inside the studies observe area, on this cased within the woreda they had get entry to data as well as with the aid of itself part of income generating for plenty community within the Woreda. In addition troubles of the environment sanitation related with meals hygiene but in this study as individuals they have been raised that, they have consciousness a way to maintain their very own food from contaminated at all through slaughtering, processing, storage, distribution

and transportation and similarly the groups they have more consciousness approximately non-public hygiene, which include; before organized meals washing their hand as well as the respondents have records concerning to from the hair as much as leg nail more of them clean as man or woman and circle of relatives. As the gain the health extension program has manipulate of insect and rodents like rats and the groups acknowledged what forms of disease bearing (Typhus, malaria, trachoma, blindness).

Studies question five; what are the challenges of the health extension program inside the Gullele woreda 3?

According to the participants of the study, as mentioned, that inside the studies take a look at, it has sanitation troubles like; loss of the bathroom,the potential of the services furnished, availability of lighting inside the toilet areas, loss of separated lavatory build of men and women, easy and protection problem. Carried out studies done by (Abebe et al, 2015), With the present day country and tendencies of get admission to sanitation in Ethiopia and the want to revise signs to screen progress inside the publish-2015 era, from this locating showed that, greater than half of of the Ethiopian poeple (fifty two.1%) nonetheless used unimproved sanitation facilities in 2004. Most people (35.6%) practiced open defecation, implying that the us is a long way from the MDG target to get entry to advanced sanitation (56%),the general public in city slums (88.6%) used unimproved sanitation facilities. In order that each research effects has the same sanitation challenges.

Health equipment challenges inside the woreda, it has trouble to addresses the target of the health extension program inclusive of; loss of medical equipment, loss of ultrasound and bags, and cotton and economic demanding situations in this take a study at as respondents had been responses that, greater of the humans residing within the slum house, loss of available rest room, canal ditch, food demand and deliver one of the purpose to deal with HEP, natural water, and open defecation. Monitoring and assessment as the respondent had been raised that, it has no longer constant schedules the health extension worker supervisors and leaders in addition to the device of the evaluation no longer as officially started out the program.

5.2Conclusion

This studies has explored the practices and challenges regarding to perspective of clients and health extension workers of the HEP at Gullele woreda3 from the perspective of service providers and provider users, weak/ gaps of the HEP in Gullele district 3 from the service providers and service users, achievement of the health extension program and measures taken to deal with the challenges and gaps. The strengths of this system consist of; it's far a community based totally, priority has been given for disease prevention and control, makes a specialty of presenting education for various segments of the community, involvement of the community inside the planning and implementation of the program, affords supports in regions including vitamins, family planning and disposal of wastages. In spite of these achievements, there are challenges in the network to address the program; financial challenges, loss of health equipment, monitoring and evaluation. This program has weaknesses include absence of motivation on its health extension workers, absence of obligatory processes to put in force its programs as well as punish individuals who muddle liquid and stable wastes that can harm the health of the network.

5.3 Implication to Social Work

5.3.1 Implication to policy

The research finding indicates that, the health extension program it has weakness in the program which includes loss of punishment frame work in practices when the service providers and services users in opposition to the program, exceptional example consists of, some of humans within the woreda they had been disposal stable and liquid waste like wood, glasses, vegetable products, animal quit product, grasses and liquid waste a number of the people after the sefat net and cleanser employees clean the vicinity without any disgrace at avenue, across the citizens location and industrial facilities waste disposal, extra of them in summery length with none permission disposal the liquid merchandise(the excellent example urine)however, they had given advent cognizance no greater adjustments, because of this the woreda administration and health office they didn't any back floor of law for punishment folks that practices within the area, Addis Ababa health bureau have to be articulated the punishment regulation with city residence humans consultant for such activities and regulated effectively.

the second weak point of the health extension program as indicates that, obligatory gaps because of this , while the network want to construct or hold bathroom, canal ditch, open defecation and route they have been wait after sent require greater than two month from construction office, for this cause whilst the health extension workers and supervisors went to communities for labored they were conflicted with community due to the fact, the network they have been raised that, how to disease save and manipulate, in what technique non-public, family and surroundings hygiene maintain without build and maintain, for this reason a number of the humans they have no longer voluntary participated in health development army as formal situation. For this reason Addis Ababa health bureau and construction bureau in collaboration should redefine the formal regulation manner of the network they will get the lively services, however up to redefine the law the two workplaces closely paintings and talk to the get short time the community permission constructs and hold their infrastructure.

From the finding of this studies suggests that, lack of motivation regarding to the health extension workers because of this, in terms of educational upgrade and participation which includes nurses, mid-waver, public health and different like in health center workers , so that the passed off trouble (want) at program Addis Ababa health bureau facilitate training get entry to with collaboration Addis Ababa college to deal with the want of the health extension workers and similarly the weakness of the program, loss of motivation of the health extension people concerning to duty (encouragement), like hospital workers due to the fact, there are nothing gadget to mean encouragement whilst the health extension workers working the equal activities with clinic and in addition to greater HEWs arrived in to work from a long way distance locations on this motive some time while health problem became passed off in woreda for coming at the time it turned into taken long term journey , so that the health bureau ought to facilitate transportation comparable with education bureau settlement for teachers with transportation bureau on the Saturday and Sunday without any pay get the government transportations like lion bus and sheger for those employees further to different economic changes.

5.2 Implication to research

This research changed into conducted, in Gullele Sub City Woreda 3, Addis Ababa City Administration, what I am suggesting to researchers in this subject matter (exercise and

demanding situations of the HEP), As far as I know-how is concerned, there aren't any studies conducted in this area. Consequently, in addition take a study at on this topic may be performed inside the destiny in taking large settings, which includes sub city, city administration, regional or country level.

At the health extension program in addition researches are needed to observe linkage to other social safety and complimentary collaboration and to different offerings furnished, for example collaboration with protection net program, network based medical health insurance,creation bureau, unit nation organization for global development (USAID), small business enterprise, plan and finances and coverage makers are very vital maximum of the groups thus far they have got trouble like human and nature made because of this time to time lowering participation of network due to carrier of governance, poverty(refuge, food, health) and training history.

Inside the health extension program the service users(communities) more of them lived underneath poverty existence maximum of them lived within the slum houses, brief level of earnings technology, expanded western subculture (drug abuse, home sexually),sanitation demanding situations, loss of medically system, loss of get right of entry to to facts,lack of tracking and evaluation gadget. Therefore, various stakeholders consisting of Gullele Woreda administration,the Woreda health office,Ethiopian Public Minster,NGOs must work in collaboration to clear up these urgent and urgent issues of the community.

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Appendix

Annex I: Informed consent form for participants

Consent form for participants of the study

Dear participant!

Good morning /after noon, my name is Daniel Amare; I am a graduate student in the Addis Ababa University School of Social Work. The purpose of this study is to gather information on practices and challenges of the health extension program. If you are agree I would like to interview you about the personal /individual, perspective about the HEP, achievement, strengths and challenges of the HEP etc. The interview / will take place in a private space where nobody can hear us. To make sure that I do not forget or changes what you are saying I will Mobil record your responses. Every that will be said, written down will kept total confidentially. Your name will not be recorded or written down. Only my advisor will be having access to the notes. Finally, dear participant I appreciate your cooperation and willingness in the name of Addis Ababa University, School of Social Work

Thanks for your participation!

Consent and contact

- Do you have any questions that you would like to ask?
- Are there any things you would like me to explain again or say more about?
- Do you agree to participate in the interview?

Declaration to be signed by the respondent

The purpose of the interview was explained to me and I agree at……
(Name of person) is interviewed.

Signature ----------Date ----------

Annex II: Interview guide for interview with HEWs, Clients, and key informants

Annexed: Interview guides with HEWs

Personal information

Sex----------Age ---------- Education----------Name of the district----------

Occupational position ----------work experience ----------

Marital status; single----------married---------- divorce----------Single parent ----------

Religion; Orthodox ----------Muslim ----------Protestant--------Catholic---------others---------

Level of education; Degree-----Diploma----------Level---------

1. Can you tell me your general perspective on the HEP? Probe:A structure of the HEP to address the planning? Such As:

- Health extension army
- Allowing participation of the health workers, staff of office in the planning, evaluation and monitoring
- Relationship / HEWs with staff, nurses, mid –wives, leaders? What are the positive and negative impact on the HEP?
- The distribution of the infrastructures, Medicine, services provides

2. Can you tell me the strength of the HEP at woreda 3? Probe:

- Communities based such as; cultural, value, tradition,knowledge, arts, resources, experience, finance, youth and enhance bonding
- Diseases prevention and control system build
- Health Education and communication- such as; training, panel discussion, awareness creation and exhibition

3. Can you tell me the weaknesses /gaps you observed in the on the HEP at woreda 3? Probe:

- Punishment gap
- Mandate gap
- Motivation gap
- Financial gap

- Human resources gaps

4. Can you tell me the achievements of the health extension program in Gullele woreda3? Probe;

- Diseases prevention and control- to reduce morbidity, disability and mortality
  HIV/AIDS and other STIs (sexually transmitted infections) prevention and control

  TB prevention and control, Malaria prevention and control, First aid and emergency measures

- Family health services-to strengthen and gradual expansion of family planning, maternal and child health, youth and nutrition services. Such as; Maternal and child health, Family planning, Immunization and adolescent reproductive health and nutrition.

- Hygiene and environmental sanitation ; such as; solid and liquid waste disposal , water supply and safety measures , food hygiene and safety measures , healthy home environment, control of insect and rodents and Personal hygiene .

- Health Education and communication- such as; training, panel discussion, awareness creation and exhibition

5. Can you tell me about some situation where you had challenges at work?

- Service provision; such as time management, quality of services, case management and motivation of workers and leaders.

- The systems or level of monitoring and evaluation?

- Participation of stakeholders, youth association, DHA, 1to5 network, non government, a voluntarism and medicine accessibility

- Human power distribution

- Commitment of leaders

- Training , creation of model family , fundraised

- Infrastructures; health post office, road, water accessibility

6. Can you tell me what types of measures /efforts taken to address the gaps and challenges the HEP? Probe; revise the program; structure changes, update training styles, role of the governments, and non governments?

7. Is there anything that you want to tell me understand your experience and the health system better? If yes, please share me some in relation to the topic

Annex III: Interview guide with clients

Personal information

Sex----------Age ---------- Education----------Name of the district----------

Occupational position ----------work experience ----------

Marital status; single----------married---------- divorce----------Single parent ----------

Religion; Orthodox ----------Muslim ----------Protestant--------Catholic---------others----------

Level of education; Degree-----Diploma----------Level---------

1. Can you tell me your general perspective on the HEP? Probe;

- Definition of the Health extension program?
- List the types of health extension packages?
- Health extension army
- Relationship / HEWs with staff, nurses, mid –wives, leaders? What are the positive and negative impact on the HEP
- Allowing participation of the health workers, staff of office in the planning, evaluation and monitoring
- How do you see that an equity of health extension services / distribution of the infrastructures, medicine, service provision?

2. Can you tell me the strength of the HEP at woreda 3? Probe

- Communities based such as; cultural, value, tradition, knowledge, arts, resources , experience, finances, youth and enhance bonding
- Diseases prevention and control system build
- Creating Model family

- Health Education and communication- such as; training, panel discussion, awareness creation and exhibition

3. Can you tell me the weakness /gaps in the on the HEP at woreda 3? Probe:

- Punishment gap
- Mandate gap
- Motivation gap
- Financial gap
- Human resources gaps

4. Can you tell me the weaknesses or gaps of the health extension program?

- Service provision; such as time management, quality of services, case management and motivation of workers and leaders.
- The systems or level of monitoring and evaluation?
- Participation of stakeholders, youth association, DHA, 1to5 network , non government , a voluntarism and medicine accessibility
- Human power distribution
- Commitment of leaders
- Training, creation of model family, fundraised
- Infrastructures; health post office, road, water accessibility

5. Can you tell me the achievement of the health extension program in Gullele woreda3? Probe; participation of communities, HEWs and community trainings, creation of model family, monitoring and evaluation, fundraised, infrastructures and others ------

6. Can you tell me what types of measures have been taken to address the HEP challenges and gaps? Probe; revise the program, structures of health extension health posts, training styles, role of the governments, and non governments?

7. Can you tell me what types of measures should be taken to address the HEP? Probe: increasing participation of communities, modify program, flexible structures, modify policy? What others-----

8. Is there anything that you want to tell me understand your experience and the health system better? If yes, please share me some in relation to the topic

AnnexIV;Interview guide for in-depth interview with key informant for Gullele Woreda 3

Personal information

Sex----------Age ---------- Education----------Name of the district----------

Occupational position ----------work experience ----------

Marital status; single----------married---------- divorce----------Single parent ----------

Religion; Orthodox ----------Muslim ----------Protestant--------Catholic---------others---------

Level of education; Degree-----Diploma----------Level---------

1. Can you tell me your perspective on the HEP?

Probe;

- Health extension army
- 1to5 network/ model family?
- Allowing participation of the health workers, staff of office in the planning, evaluation and monitoring
- Relationship / HEWs with staff, nurses, mid –wives, leaders?
- Equity of health extension services
- distribution of the infrastructures, Medicine, services provision
- Is there any Continues training on the updated manual, documents and research?

2. Can you tell me the strength of the HEP at woreda 3? Probe:

- Communities based such as; cultural, value, tradition ,knowledge, arts, resources , experience , finances , youth and enhance bonding
- Diseases prevention and control system build
- Health Education and communication- such as; training, panel discussion, awareness creation and exhibition

3. Can you tell me your perspective the weakness /gaps on the on the HEP at woreda 3? Probe:

- Punishment gap
- Mandate gap
- Motivation gap
- Financial gap

4. . Can you tell me the challenges of the health extension program

- Service provision ; such as time management , quality of services , case management and motivation of workers and leaders .
- The systems or level of monitoring and evaluation?
- participation of stake holders, youth association, DHA, 1to 5 net work , non government , a voluntarism and medicine accessibility
- human power distribution
- Commitment of leaders
- Training , creation of model family , fundraised
- Infrastructures; health post office, road, water accessibility

5. Can you tell me what types of measures should be taken to address the HEP? Probe; revise the program, structures of health extension health posts, training styles, the governments and non governments?

6. Is there anything that you want to tell me understand your experience and the health system better? If yes, please share me some in relation to the topic

AnnexVIII; Document review guide

1. Structure of the HEP at the health post office level?
2. Supervision and monitoring team activities at different level of service provision?
3. Minutes/document of the HEP committees at different level?
4. Activities of model family in their houses?

Interview Guide- Amharic Version

አጠቃለይ ዓላማ

- **የጉለሌ ክ/ከተማ የወረዳ 3 የጤና ኤክስቴሽን ፅ/ቤት የለበትን ተግደሮቶች እና ክንውኖች ደረጃን**

ለማወቅ፡2012 ዓ.ም

የጤና ኤክስተንሽን ባለሙያዎች፤ ተገልጋዮች እና አዋቂ ግለሰቦች ስለ ጤና ኤክስተንሽን ያለቸውን አስተሳሰብ፤የፕሮግራሙ ጥንከሬዎች፤ ኤክስተንሽን ፕሮግራም ድክመቶች፤ ውጤቶች እና ሊወሰዱ ለሚገባቸው አቅጠጫዎች የሚዳስስ መጠይቅ፣ 2012 ዓ.ም አዲስ አበባ ዩኒቨርሲቲ ሶሻል ወርክ ት/ቤት

የመጠይቁ መለያ ቁጥር -——————

የጤና ኬሊው መለያ ቁጥር ——————

የጤና ኤክስቴንሽን ባለሙያዎች በጥናቱ ለመሳተፍ ፍቃደኝነታቸውን የሚገለፁበት ቅጽ

ጤና ይስጥልኝ እኔ ዳንኤል አማረ እባላለው አሁኑ ወቅት በአዲስ አበባ ዩኒቨርሲቲ ሶሻል ወርክ ትምህርት ቤት ተማሪነኝ ስለዚህም ይህን ዳሰሳ ጥናት ዋና አለማ የጤና ኤክስቴንሽን ፕሮግራም ምን ደረጃ እንደለ ለማወቅ ነው፡፡ መጠይቁ በግምት ከ30-50 ደቂቃ የሚወስድ ሲሆን በዚህ ውስጥ የርስዎ ተሳታፊነት ሙለ በሙለ በርስዎ ፍለጎት ሊይ የተመሰረተ ነው፤ በዚህ ጥናት ውስጥ መሳተፍዎም ሆነ አለመሳተፍዎ በርስዎ ሊይም ሆነ ከዚህ ጤና ፅ/ቤት በሚያገኙት ማናቸውም አገሌግልት ሊይ ምንም አይነት ተጽዕኖ የማይኖረው ሲሆን ቃለ መጠይቁን በማንኛውም ሰአት ማቋረጥ ወይም ጥያቄዎችን አለመመስ ይችሊለ፡፡ በጥናቱ ውስጥ የተነሱት ጥያቄዎች የሚሰጡት ምላሽ ሙለ በሙለ በሚስጢር የሚጠበቁ ሲሆን የርስዎም ስም በማንኛውም መልኩ በጥናቱ ውስጥ አይገለጽም፤ እንዱሁም የሚሰጡት ምሊሽ ከርስዎ ማንነት ጋር በማንኛውም መልኩ አይገለፅም

ለተሳትፎት አመሰግናለው!

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት? አዎ☐ አይደለሁም☐

ቃለ መጠይቁ የተደረገበት ቀን ———————— የተጀመረበት ሰዓት ———————— ያለቀበት ሰዓት ————————

የቃል ምልልሱ ውጤት /የውይይቱ ውጤት

1. የተሟላ ☐ 2. በከፊል የተሟላ ☐ 3.ፍቃደኛ ያልሆነ ☐

4. ሌላ☐

ለቃለ መጠይቁ ላይ የሚሳተፉ ተሳታፊዎች የፍቃደኝነት ማረጋገጫ ፊርማ

የተሳታፊው/ቃለ መጠይቁ ተሳታፊ/ ስም----------

ፊርማ----------ቀን----------

ክፍል አንድ፡ የግል ህይዎት ታሪክ

ፃታ፡ ወንድ----------ሴት----------ዕድሜ----------

የጋብቻ ሁኔታ፡ ያላገባ----------ትዳርያለው---------- አግብቶ የፈታ--------- የትደር ጎደኝውን በሞት ያጣ----------

በአሁን ሰዓት ያለዎት የትምፍርት ደረጃ፡ድግሪ--------ዲፕሎማ-------ደረጃ----------ሌላ----------

ሃይማኖት ሁኔታ፡ ኦርቶዶክስ----------ካቶሊክ----------ፕሮቴስታንት----------ሙስሊም----------ሌሎች----

ክፍል ሁለት፡ ከጤና ኤክስቴሽን ሰራተኞች ጋር የሚደረግ ቃለ መጠይቅ

1. እበኮትህን የእርሶን እይታ ስለ የጤና ኤክስቴሽን ፕሮግራም የሚያቁትን ሊነግሩኝ ይችላሉ? ማብራሪያ፡ 1.1. የጤና ኤክስቴሽን ፕሮግራም አደረጃጀት /የልማት ሰራዊት፤የህብረተሰብ ተሳትፎ እና ቅንጅታዊ አሰራር. 1.2. ፍታዊና ጥራት ያለው የጤና አገልግሎት፡ የመዳኒት ስርጭት፣ ግንባታ.1.3.ተከታታይ የአቅም ግንበታ ሥራዎች፡ የተደረጃ ስልጠና፣የምርምር ውጤቶች፣ የስልጠና መመሪያዎች ማዘጋጀት ለይ እና ሌሎች/? .1.4.የእርስ በእርስ ግንኙነት ከጤና ኤክስቴሽን ባለሙያ ፣ ከአመራሩ፣ከአዋለጅ ነርስ እና ከሱፐር ቫይዘሩ ጋር ያለው ቀርርቦሽ ያለው አውንታዊና አሉታዊ ጎን በጤና ኤክስቴሽን ፕሮግራም የሚያመጠው ተግዳሮትና ፋይዳ አለ?---------- እበኮትን ከለ ጥቀሱ ----------

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1. **እበኮትን የወረዳ 3 የጤና ኤክስቴሽን ፕሮግራም የለው ጥንከሬ ምን እንደሆነ ይነግሩኛል? ማብረሪያ፡ 1.የሐይጂንና የአካባቢ ጤና አጠባበቅ 1.1. የግል ንፅህናና መኖሪያ አካባቢ ጤና አጠባባቅ፡-የግል ንፅህና አጠባበቅ፣ የጥርስና ድድ /የአፍ ንፅህና፣ የእጅና ጥፍር ንፅህና ፣የአይን ንፅህና ፣ የፀጉር ንፅህና፣ የልብስ ንፅህና ፣የህፅናት ንፅና.1.1.2.የመኖሪያ ቤት ንፅህና፡ የእንስሳት ማድሪያ 1.2.የደረቅና ፍሳሽ አያያዝ እና አወጋገድ1.3. የምግብና የውያ አጠባበቅ .1.4. የመፀዳጃ ቤት አሰራር፣አያያዝና**

አጠቃቀም.2.የዕናቶችና ህጣናት ጤና አጠባበቅ.2.1.የዕናቶች ጤና2.1.1. ቅድመ ወሊድ ክትትል2.1.2. የወሊድ አገልግሎት 2.1.3. ድህረ-ወሊድ አገልግሎት.2.2. የሕፃናት ጤና 2.2.1.የባክቴሪያ 2.2.2.ተቅማጥ.3.የክትባት 3.1.ፖሊዮ/የልጅናት ልምሻ/3.2ቲቢ/ሳንባ ነቀርሳ/ 3.3. ትክትክ/የመተፈሻ አከላትን የሚጎዳ/3.4.የመንጋጋ ቆልፍ 3.5.ተላላፊ በሽታ3.6.ኩፍኝ.4. የቤተሰብ እቅድ 4.1.የወንድ ኮንደም----4.2.ኢምፓላኖል.4.3. የማህፀን ውስጥ የሚቀመጥ .5. ቲቢና ስጋ ደዌ .5.1. ቲቢ.5.2. የስጋ ደዌ .6. ኤች አይ ቪ/ኤድስ መከላከልና መቆጣጠር 6.1.በእርግዝና ወቅት.6.2.በወሊድ ወቅት.6.3.በጡት ማጥባት ወቅት .7.የመጀመሪያ ደረጃ ህክምና ፡-1ኛ---2ኛ----3ኛ ---መከላከል.8. የአእምሮ ጤና ግንዛቤ ምን አይነት አገልግሎት .9.ተላላፊ ያልሆኑ በሽታዎች መከላከልና መቆጣጠር .9.1.የልብና የደም ዝውውር.9.2.ከፍተኛ የደም ግፊት.9.3. የስኳር በሽታ.9.4.አስም.9.5.ካንሰር .10. የወባ በሽታ መከላከልና መቆጣጠሪያ .11.የወጣቶች ስነተዋልዶ 11.1.የሴት ልጅ ግርዛት.11.2.ውርጃ 11.3. ያልድሜ ጋብቻ.11.4.የአባለዘር በሽታዎች 12. የስነ ምግብ 12.1.ንጥረ ምግብ .12.2. ስብ /ቅባት .12.3. ፕሮቲን .12.4. ማዕድናት 12.5.ቫይታሚኖች 12.6.ውሃ አጠቃቀም

2. እበኮትን ምን አስተያዬት አሎት ሰለ ጉለሌ ወረዳ3 የጤና ኤክስቴሽን ፕሮግራም ክፍተቶች/ ጉድለቶች/ ይነግሩኛል? ማብራሪ፡ ፖሊሲ፡- ፓኬጁ፣የክትትልና ድጋፍ አሰራሮች፣ አደረጃጀት ለምሳሌ፡ የወረዳ ጤና ፅ/ቤት፣ በልድርሻ አከላት፣ ወጣት ማህበር፣የልማት አደራጃጀት፣ መንግስታዊ የልሆኑ ድርጅቶች፣የሰው ሀይል፣ የፖሊቲካ ውሳኔ፣ በጀት ለይ፣ የአከባቢ ጫና/ልማደዊ ክንውኖች፣በሃል፣የቤተሰብ ግንኙነት፣ የአኖኖር ዘይቤ፣ የህበረተሰብ ተሳትፎ፣የመዳኒት አቅርቦት ወይስ በጎ አድርጎት?

3. እበኮትን እንደ ጉለሌ ወረዳ 3 ጤና ኤክስቴሽን ፅ/ቤት ፕሮግራሙ ከትግበራ በሆላ የተገኙ ውጤቶች ምን ምን እንደሆኑ ሊነግሩኝ ይችላሉ? ማብራሪያ፡የህበረተሰብ ተሳትፎ፣የማህበረሰብና የባለሙያዎች ስልጠና፣የተፈጠረ የቤተሰብ የጤና ኤክስቴሽን ሞዴል፣ክትትልና ድጋፍ፣ድጋፍእና የተቋማት ግንባታ?

4. እበኮትን ፕሮግራሙን ወደ ስራ ሲተገብሩ ተግዳሮቶችት የሆነቦት አከባቢ የትኛውነው? የችግሩ በሃሪ ምን አይነት ነው? ምን ተፈጠራ? እንዴት አለፉት? ምን አይነት ስራ ነው የሰሩት ውጤታማ እንድትሆኑ?

5. እበኮትህን ምን አይነት የመብቱ ነው ሊወሰድ የሚቸለው የጤና ኤክስቴሽን ፕሮግረም በሚገባ ተደራሽ እንዲሆን? ማብራሪያ፡አደረጃጀቱን መከለስ፣የስልጠና አሰጠጡን ማስተካከል፣የመንግስትና የግልድርጅቶችን ሀለፊነት ማያት፣ፕሮግራሙን መከለስ?

6. ከሎት ተሞክሮም ይሁን ከተረዱት ሌላ ሀሳብ /ተግባራት መጨመር ይችላሉ----------

ክፍል ሶስት ፡ ከጤና ኤክስቴሽን ሃላፊ ጋር፣ከወረዳ ሱፐረቫይዘር እና ከወረዳ ሜዲካል ጋር የሚደረግ ቃለ መጠይቅ

1. እበኮትህን የእርሶን እይታ ስለ የጤና ኤክስቴሽን ፕሮግራም የሚያቁትን ሊነግሩኝ ይችላሉ? ማብራሪያ፡ 1.1. የጤና ኤክስቴሽን ፕሮግራም አደረጃጀት /የልማት ሰራዊት፣የህብረተሰብ ተሳትፎ እና ቅንጅታዊ አሰራር. 1.2. ፍታዊና ጥራት ያለው የጤና አገልግሎት፡ የመዳኒት ስርጭት፣ ግንባታ.1.3.ተከታታይ የአቅም ግንበታ ሥራዎች፡ የተደረጃ ስልጠና፣የምርምር ውጤቶች፣ የስልጠና መመሪያዎች ማዘጋጀት ለይ እና ሌሎች/? .1.4.የእርስ በእርስ ግንኙነት ከጤና ኤክስቴሽን ባለሙያ ፣ ከአመራሩ፣ከአዋለጅ ነርስ እና ከሱፐር ቫይዘሩ ጋር ያለው ቀርርቦሽ ያለው አውንታዊና አሉታዊ ጎን በጤና ኤክስቴሽን ፕሮግራም የሚያመጠው ተግዳሮትና ፋይዳ አለ?---------- እበኮትን ከለ ጥቀሱ ----------

2. እበኮትን የወረዳ 3 የጤና ኤክስቴሽን ፕሮግራም የለው ጥንከሬ ምን እንደሆነ ይነግሩኛል? ማብረሪያ፡ 1.የሐይጂንና የአካባቢ ጤና አጠባበቅ 1.1. የግል ንፅህናና መኖሪያ አካባቢ ጤና አጠባባቅ፡-የግል ንፅህና አጠባበቅ፣ የጥርስና ድድ /የአፍ ንፅህና፣ የእጅና ጥፍር ንፅህና ፣የአይን ንፅህና ፣ የፀጉር ንፅህና፣ የልብስ ንፅህና ፣የህፅናት ንፅና.1.1.2.የመኖሪያ ቤት ንፅህና፡ የእንስሳት ማድሪያ 1.2.የደረቅና ፍሳሽ አያያዝ እና አወጋገድ1.3. የምግብና የውያ አጠባበቅ .1.4. የመፀዳጃ ቤት አሰራር፣አያያዝና አጠቃቀም.2.የዕናቶችና ህጣናት ጤና አጠባበቅ.2.1.የዕናቶች ጤና2.1.1. ቅድመ ወሊድ ክትትል2.1.2. የወሊድ አገልግሎት 2.1.3. ድህረ-ወሊድ አገልግሎት.2.2. የሕፃናት ጤና 2.2.1.የባክቴሪያ 2.2.2.ተቅማጥ.3.የክትባት 3.1.ፖሊዮ/የልጅናት ልምሻ/3.2ቲቢ/ሳንባ ነቀርሳ/ 3.3. ትክትክ/የመተፈሻ አከላትን የሚጎዳ/3.4.የመንጋጋ ቆልፍ 3.5.ተላላፊ በሽታ3.6.ኩፍኝ.4. የቤተሰብ እቅድ 4.1.የወንድ ኮንደም----4.2.ኢምፓላኖል.4.3. የማህፀን

ውስጥ የሚቀመጥ .5. ቲቢና ስጋ ደዌ .5.1. ቲቢ.5.2. የስጋ ደዌ .6. ኤች አይ ቪ/ኤድስ መከላከልና መቆጣጠር 6.1.በእርግዝና ወቅት.6.2.በወሊድ ወቅት.6.3.በጡት ማጥባት ወቅት .7.የመጀመሪያ ደረጃ ህክምና ፡-1ኛ---2ኛ----3ኛ ---መከላከል.8. የአእምሮ ጤና ግንዛቤ ምን አይነት አገልግሎት .9.ተላላፊ ያልሆኑ በሽታዎች መከላከልና መቆጣጣር .9.1.የልብና የደም ዝውውር.9.2.ከፍተኛ የደም ግፊት.9.3. የስኳር በሽታ.9.4.አስም.9.5.ካንሰር .10. የወባ በሽታ መከላከልና መቆጣጠሪያ .11.የወጣቶች ስነተዋልዶ 11.1.የሴት ልጅ ግርዛት.11.2.ውርጃ 11.3. ያልድሜ ጋብቻ.11.4.የአባለዘር በሽታዎች 12. የስነ ምግብ 12.1.ንጥረ ምግብ .12.2. ስብ /ቅባት .12.3. ፕሮቲን .12.4. ማዕድናት 12.5.ቫይታሚኖች 12.6.ውሃ አጠቃቀም

3.እበኮትን ምን አስተያዬት አሎት ሰለ ጉለሌ ወረዳ3 የጤና ኤክስቴሽን ፕሮግራም ክፍተቶች/ ጉድለቶች/ ይነግሩኛል? ማብራሪ፡ ፖ/ሊ/ሲ፡- ፓኬጁ፣የክትትልና ድጋፍ አሰራሮች፣ አደረጃጀት ለምሳሌ፡ የወረዳ ጤና ፅ/ቤት፣ በልድርሻ አከላት፣ ወጣት ማህበር፣የልማት አደራጃጀት፣ መንግስታዊ የልሆኑ ድርጅቶች፣የሰው ሀይል፣ የፖ/ሊ/ቲካ ውሳኔ፣ በጀት ለይ፣ የአከባቢ ጫና/ልማደዊ ክንውኖች፣በሃል፣የቤተሰብ ግንኙነት፣ የአኖኖር ዘይቤ፣ የህበረተሰብ ተሳትፎ፣የመዳኒት አቅርቦት ወይስ በጎ አድርጎት?

4.እበኮትን እንደ ጉለሌ ወረዳ 3 ጤና ኤክስቴሽን ፅ/ቤት ፕሮግራሙ ከትግበራ በሆላ የተገኙ ውጤቶች ምን ምን እንደሆኑ ሊነግሩኝ ይችላሉ? ማብራሪያ፡የህበረተሰብ ተሳትፎ፣የማህበረሰብና የባለሙያዎች ስልጠና፣የተፈጠረ የቤተሰብ የጤና ኤክስቴሽን ሞዴል፣ክትትልና ድጋፍ፣ድጋፍእና የተቋማት ግንባታ?

5.እበኮትን ፕሮግራሙን ወደ ስራ ሲተገብሩ ተግዳሮቶችት የሆነቦት አከባቢ የትኛውነው? የችግሩ በሃሪ ምን አይነት ነው? ምን ተፈጠራ? እንዴት አለፉት? ምን አይነት ስራ ነው የሰሩት ውጤታማ እንድትሆኑ?

6.እበኮትህን ምን አይነት የመብቱ ነው ሊወሰድ የሚችለው የጤና ኤክስቴሽን ፕሮግረም በሚገባ ተደራሽ እንዲሆን? ማብራሪያ፡አደረጃጀቱን መከለስ፣የስልጠና አሰጠጡን ማስተካከል፣የመንግስትና የግልድርጅቶችን ሀለፊነት ማያት፣ፕሮግራሙን መከለስ?

7.ከሎት ተሞክሮም ይሁን ከተረዱት ሌላ ሀሳብ /ተግባራት መጨመር