EVALUATION OF FAMILY PLANNING PACKAGE OF HEALTH EXTENSION PROGRAM IMPLEMENTATION IN SEKE-CHEKORSA WOREDA, JIMMA ZONE ETHIOPIA

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An evaluation thesis submitted to Jimma University, College of Public Health and Medical Science, Department of Health Service Management and Planning for partial fulfilment of Masters degree in Health Monitoring and Evaluation.

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Abstract

Background: Health extension program is an innovative community based program started in 2003 in Ethiopia. It comprises five components with 16 packages and is implemented by trained female health extension workers who are assigned in health post. Model house hold training, community conversation and outreach services are the main strategies for implementation of the program.

Objective of the study: The objective of this study was to evaluate the level of implementation of the family planning package of the health extension program.

Evaluation Method: A multiple case study was carried out from 2-December -2010 to 20-December – 2010 in Seke-chekorsa woreda, Jimma Zone. Qualitative data was collected from five health post and quantitative data was collected from 374 women at reproductive age group by community survey. Data analysis was carried out by EpiData and SPSS software for quantitative data and qualitative data was manually analyzed.

Result: A total of 374 women were interviewed. 245(65.5%) of women were trained in model family house hold training and from those who trained in model family household 157(64.1%) responded that they have trained in modern family planning package of the health extension program during the traing. Community conversation was conducted in all five health posts interviewed and 239(63.9%) women responded that they were participated in the conversation. 342(91.4%) of the respondents have knowledge on modern family planning and 301(88%) of them were using some type of modern family planning method. From 374 interviewed women 332(88.8) responded that they were visited by health extension workers.

Conclusions and recommendations: The overall level of implementation of health extension program in this woreda is fair. Model family household training was not conducted according to the national standard and community conversation was focused only on HIV/AIDS issues. Home visit activities were not registered. In order to achieve the goal of health extension program health post construction should be completed in the four kebele and there should be strict follow up from woreda health office during model family house hold training and community conversation.

Key words: evaluation, health extension program, family planning.

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Abbreviations and Acronyms

AEA	American Evaluation Association
AIDS	Acquired Immunodeficiency Disease
BCC	Behavioural Change Communication
CC	Community conversation
CHP	Community Health Promoters
C-change	Community Change
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal year
EHSP	Essential Health service package for Ethiopia
FMOH	Federal ministry of health
HEW	Health Extension Workers
HP	Health Post
HEP	Health Extension Program
HC	Health center
HS	Health station
HSDP	Health sector development goal
JCEE	Joint Committee for Educational Evaluation
JU	Jimma University
MDG	Millennium development goal
MHH	Model households
PHCU	Primary health care unit
SSA	Sub-Saharan Africa
UNICEF	United Nations children fund

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1 Background

1.1 Introduction to health extension program

The Health Extension Program (HEP) is an innovative community based program introduced and started in 2003 during HSDP II. The aim of HEP is to create healthy environment and healthful living by making and availing essential health services at kebele level (1).

The implementation of HEP involves deployment of two female Health Extension Workers (HEW) at each Kebele, who are trained for a year at Technical, Vocational and Training and Education Centers (TVET).

The HEP brings the health sector to Kebele level, whereby the HEW represents health sector in the local administration. The HEW, elected members of the Kebele, agricultural development agents, and teachers at the same Kebele constitute a Kebele council bringing administrators and sector specialists together. This ensures close linkages with interrelated sectors and promotes intersectoral collaboration.

The HEP is a community level component of the Essential Health Services Package (EHSP) of Ethiopia. The objectives of EHSP is to reduce the morbidity, mortality and disability resulting from the major health and health related problems affecting most of the population of Ethiopia by improving equitable access to preventive essential health services through community based health services with strong focus on sustained preventive health actions and increased health awareness. The HEP makes the bottom level component of EHSP, and is primarily on preventive and promotive component, while essential curative care is introduced at Health Centre and District Hospital Level. The HEP is managed by the HEW whose station is the HP. The HC and five such HP surrounding the HC make a PHCU thereby making the services package and referral system linked to each other (1,2).

The HEP is designed to cover sixteen health extension packages categorized under three major areas and one cross cutting approach as follows.

1. **Disease Prevention and Control**.

a. TB and HIV/AIDS and other STI prevention and control
b. Malaria prevention and control
c. First Aid and emergency measures

2. **Family Health Service**.
    a. Maternal and child health
    b. Family planning
    c. Immunization
    d. Adolescent reproductive health
    e. Nutrition
3. **Hygiene and Environmental Sanitation.**
    a. Excreta disposal
    b. Solid and liquid waste disposal
    c. Water supply and safety measures
    d. Food hygiene and safety measures
    e. Healthy home environment
    f. Control of insects and rodents
    g. Personal hygiene
4. Health Education and Communication as a cross cutting approach.

HEP is given as a package focusing on preventive health measures targeting households and particularly mothers and children through house to house visist, education and demonstration. The objectives of each package of the program is defined, and the services provided by the HEWs under the differnt packages are put in the guidlines(2,4).

The implementation modality of this program is addresed in a way that it increases the access of the service for the population at grass root level that is:

- An outreach program centered around rapid vocational training of health extension workers 2(two) per kebele and constraction and equiping of health posts one per kebele through accerelated expansion of primary health care facilities.
- Community promotion program center araund voluntery or community promoters working undersupervision or and guidance of health extension workers and providing support to hause holds for behavoral change.

- Training of model households from the community for three(3) months a total of 96 hours. The training is conducted by selecting innovative communurty members and those who have reltion ship with the health extension workers for diffusion purpose and it begins with 40 trainees, then 45 at second raund, 50 at the third raund 55, at the 5th and lastly 60 trainees onece per health extension workers by doing so it was planned to cover the whole kebele not more than three years by model family (3,4)
- Community conversation (CC) or community dialogue is one of the stratagies for the implementation of the program and to create broad mass base in the implementation of the health extension program at the grass-root level. CC enables the community to reflect on and explore cultural and social values, traditional practices, and relationships and their positive and negative contribution towards the community health and development. Furthermore community dialogue enables the community to identify health concerns, explore their underlying causes, and seek local solutions. It also creates resonance; the transfer of change from one community to another (5)
- Provision of static services like treatment of provision of family planning servicies, malaria treatment, assist delivery, early referal and antinetal services.

1.2 Statement of the problem

A maternal death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the site or duration of pregnancy, from any cause related to or aggravated by the pregnancy or its management (6). New estimates show that the leading causes of maternal deaths are haemorrhage and hypertension, which together account for more than half of maternal deaths (7).

Maternal mortality is an indicator of the millennium development goal, MDG goal 5 and currently it shows a great variation between developed and developing countries that is: 1 in 7 mothers in Niger and 1in 48,000 women in Ireland (8).

The most recent UN inter-agency estimates suggest that in 2005, 536,000 women died from causes related to pregnancy and child birth. The vast majority of maternal deaths – more than 99 per cent, according to the 2005 UN inter-agency estimates – occurred in developing countries. Half of these (265,000) took place in sub-Saharan Africa and another third

(187,000) in South Asia. Between them, these two regions accounted for 85 per cent of the world's pregnancy-related deaths in 2005(9).

Ethiopia, one of the SSA countries, has still high maternal mortality and there are 673 maternal deaths in 100,000 live births (10). The main causes of maternal mortality in Jimma Hospital are abortion (14.9%) obstructed labour (34.5%), puerperal sepsis (26.4%). The only indirect cause was cerebral malaria which accounts for 2.3% of death and the rest were due to other direct causes (37).

Every year 200 million women want to delay or avoid their pregnancy but are not using effective contraceptives. One in three deaths related to pregnancy and childbirth could be avoided if women who wanted effective contraception had access to it. An estimated 19 million unsafe abortions take place each year in developing countries. Every year, an estimated 68,000 women die as the result of unsafe abortions and millions more suffer complications. About 90 per cent of abortion-related deaths and disabilities worldwide could be avoided if women who want to had access to effective contraception (11).

But in Sub-Saharan Africa, only 17% married women of reproductive age use modern contraceptive, even though far higher proportions want to avoid becoming pregnant soon or ever. Thirty-nine percent of pregnancies in the region are unintended. In 2008, about 60% of women (47 million) in the region who wanted to avoid a pregnancy either were not using family planning or were using a traditional method. These women accounted for 91% of unintended pregnancies (12).

In 2008, an estimated 41% of all pregnancies in Ethiopia were unintended. More than seven in ten women who want to avoid pregnancy either do not practice contraception or use a relatively ineffective traditional method. These women can be said to have an unmet need for modern contraception. Meeting just half of this unmet need would result in 754,000 fewer unintended pregnancies each year, leading to 178,000 fewer unsafe abortions and 3,300 fewer maternal deaths. If all unmet need for modern methods were satisfied, maternal mortality would drop by almost one-third from current levels, and unplanned births and unsafe abortions would decline by 89–92% (13).

1.2.1 **Local situation of the problem**

According to EDHS 2005 the percentage of women using contraceptive in Oromia regional state (13.6%) is lower than the national average which is (14.7%) and less than a quarter of the rate in the region with the highest contraceptive prevalence, Addis Ababa. And at 41.4 percent Oromia has the highest unmet need for family planning. A quarter of Oromia women would like to have full control over the spacing of births (birth intervals) and another 16 percent would like to stop having children all together(10).

Retrospective study done from September 2002 to August 2006 at Jimma specialized hospital, which serves the population of Jimma Zone and its surrounding, showed that maternal mortality ratio was 885.5/100,000 (37). This indicates that maternal mortality ratio in this area is larger than the national average which was conducted by EDHS. In Seka-chekorsa woreda access for health scurvies was poor before the health extension program. There were only one health center and five clinics were serving the total population.

1.3 Program description

1.3.1 **History of the program**

HEP in Ethiopia was started in 2003 as the result of the implementation evaluation of HSDP II. In full implementation of the program was planned to achieve 100% coverage of all rural kebeles with 2 cadre female HEWs and one HP in each kebele. Currently almost 100 % of all the rural kebeles in Ethiopia are covered by the program.

In order to acheive the intended goal of the program federal ministry of health developed its implementation guideline and the guideline includes the role and responsiblity of each stake holders and some of them are

- It is planned to train 33200 HEW by FMOH.
- It will be neccesary to rationalize the number of profeional mix of staff of health center commonsurate with their new role.
- Existing health stations /HS/will be prograsively upgraded to health center or downgraded to health post as aprioprate.

- Woreda health officies are expected to be staffed with requred management and suppervisory profesional staff.
- Avaliablity of drug and medical supplies will be ensured.

According to 2009/2010 EFY report of Oromia regional Health Bureau, there are 4849 HP and 12535 HEWs wtith coverage of 97% in the region. The HEP in Jimma zone is started in 2005/06 EFY and currently 429 health posts are constructed in the rurall kebeles of the zone and 1012 HEWs are deployed and 102 health extension program suppervisors are trained and assigened in all rural woreda of the zone.

The HEP in Seka-cakorsa Woreda is started in 2006 with trained HEW and currently there are 72 HEW and 32 functional HPs and from the total of 36 rural kebeles HP construction is completed in 32 kebele (88.9%) and in 4(11.1%) kebeles the constriction is not completed. The construction of the health post is done by coordination with the community and government. From the total of 32 health posts whose constriction is completed only 13(40.6%) health posts are fully equipped, 29(59.4%) health posts are not equipped.

1.3.2 **Stage of development of the program**

Even though more than 50% of the health posts of the woreda are not equipped with medical equipments the program is in maturity stage because the main resource needed for the program, HEW, are available in all kebele and the time of implementation started is in 2006 and now it five years implemented.

Table 1: Stage of development of HEP at Seke-chekorsa woreda, December 2010

Sn	***Year***	***HP constructed***	***HEW deployed***	***MHH graduated***	***CC participants graduated***	***Remark***
1	2005/06	6	12	*	*	No data
2	2006/07	10	20	*	*	“
3	2007/08	6	26	4,700	*	“
4	2008/09	5	14	8,633	3,024	
5	209/10	5	**	12,960	3,240	100% achieved in 2008/9
	Current cumulative	32(88.9%)	72(100%)	26,293	6,264	

Source : 2009/10 EFY health sector annual report of Seke-chekorsa woreda

1.3.3 **Program components and logic model**

1.3.3.1 Program components

A comprehensive program description clarifies all the components and intended outcomes of the program and it help to focus the evaluation on the most central and important questions.

Inputs are the people, money, and information needed—usually from others outside the program to mount program activities effectively. It is important to include inputs in the program description because accountability for resources to funders and stakeholders is often a focus of evaluation. Just as important, the list of inputs is a reminder of the type and level of resources on which the program is dependent (14,26).

Activities are the actual actions mounted by the program and its staff to achieve the desired outcomes in the target groups (11,26).

Outputs are the direct products of activities, usually some sort of tangible deliverable produced as a result of the activities. Outputs can be viewed as activities redefined in tangible or countable terms. Outcomes are the changes in someone or something (other than the program and its staff) that will result due to the program's activities. Impacts are long-term effects of the program, such as eliminating the problem or condition altogether or improving the quality of life of people already affected.

1.3.3.2 Program logic model and logical frame work

Logic model is diagrammatic presentation of a program. Logic model provides graphic depiction of relationship between the main strategies of the program and associated goals, objectives, interests, indicators and resources (16).

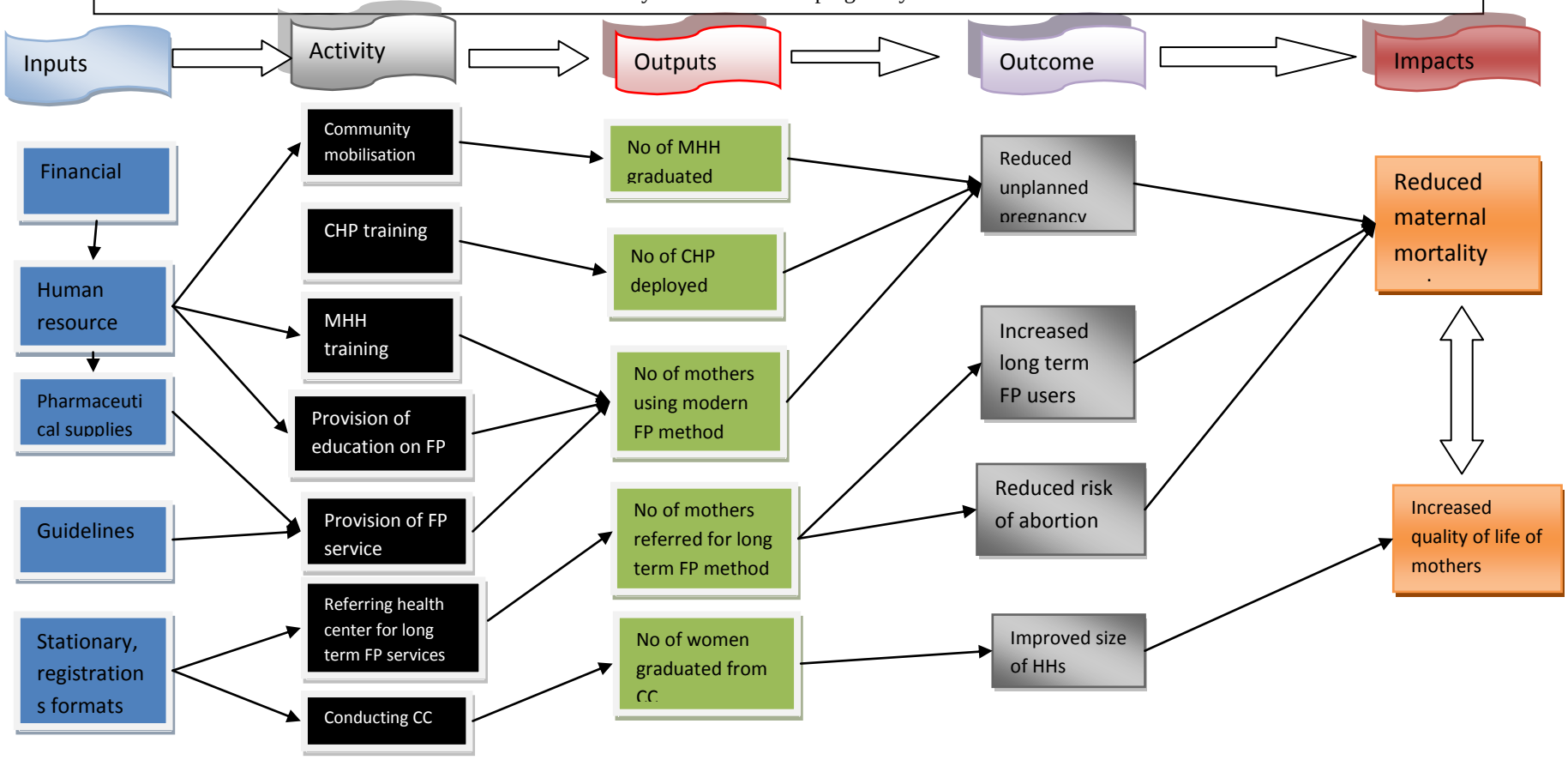
A logic model describes the sequence of events for bringing about change by synthesizing the main program elements into a picture of how the program is supposed to work. Creating a logic model allows stakeholders to clarify the program's strategies; therefore, the logic model improves and focuses program direction. It also reveals assumptions concerning conditions for program effectiveness and provides a frame of reference for one or more evaluations of the program. A detailed logic model can also strengthen claims of causality and be a basis for estimating the program's effect on endpoints that are not directly

measured but are linked in a causal chain supported by prior research (17). The logic model of family planning package of the health extension program was developed from the family planning package guideline and it is described in figure 1 and the conceptual frame work for family planning services and supply factors was described in figure 2 and 3 respectively.

Figure 1: Program logic model of the family planning package at HP level at Seke chekorsa woreda December, 2010

Problem statement: Maternal mortality is still unchanged with regardless of many efforts made. The problem is more serious in developing countries where health services are not accessible. In Ethiopia it is around 673 per 100000 live births. The main causes of maternal death in Ethiopia are abortion, obstructed labor haemorrhage, sepses and hypertension.

Goal: To contribute for the reduction of maternal mortality due to unwanted pregnancy.



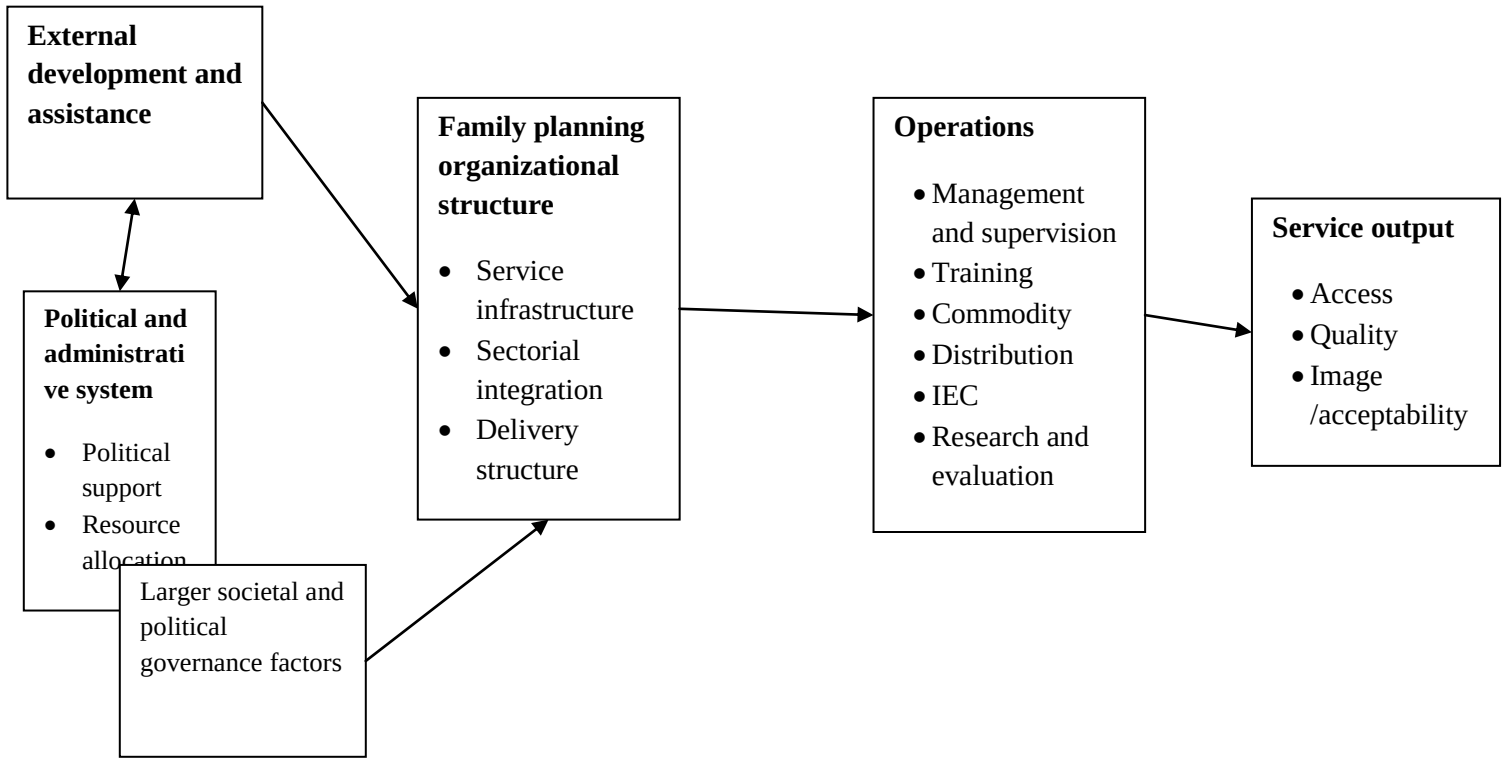


Figure 2 : Conceptual frame work for family planning, December 2010

1.3.4 Objective of the HEP in Seke chekorsa woreda

General objective: To provide basic preventive health services for the population of Seke-chekorsa woreda.

Specific objectives: Some of the specific objectives which are related to the family planning package are:

- To construct 4 HP at 4 kebele of the woreda to increase the coverage to 100% at the end of 2010/11 EFY.
- To equip 29 HP with essential medical equipments to increase functioning HP from 36% to 80% at the end of 2010/11 EFY.
- To train 12960 MHH at the end of 2010/11 EFY.
- To participate 3600 CC participants at the end of 2010/11 EFY.
- To provide modern family planning methods for 25673 women at reproductive age at the end of 2010/11 EFY.

1.4 Rationale of the evaluation

Health extension program was implemented for five years in Seke-Chekorsa woreda. However; evaluation has not been done on its implementation of any package of the program in the woreda. This evaluation thus identified the progress and its level of implementation with the following significance.

- It identifies the implementation level and major implementation problems.
- It provides information for the next strategic plan.
- It gives clue for the rest woreda in the zone.

2 Stakeholders analysis

Key stakeholders for evaluations of public health programs fall into three major groups:

- Those involved in program operations
- Those served or affected by the program
- Those who are intended users of the evaluation findings: Persons in a position to make decisions about the program

Stakeholders can help or hinder an evaluation before it is conducted, while it is being conducted, and after the results are collected and ready for use. Because so many public health efforts are complex and because public health agencies may be several layers removed from frontline implementation, stakeholders take on particular importance in ensuring that the right evaluation questions are identified and that evaluation results will be used to make a difference. Stakeholders are much more likely to support the evaluation and act on the results and recommendations if they are involved in the evaluation process. Conversely, without stakeholder support, the evaluation may be ignored, criticized, resisted, or even sabotaged (26).

Major stakeholders identified and engaged during this evaluation were discussed in stakeholder analysis matrix.

Table 2: The main stake holders in the implementation of the HEP the family planning package in Seke-chekorsa woreda, 2010

Sn	*Stakeholder*	*Role in program*	*Role in evaluation*	*Level of interest*	*Ways of communication*
1	Woreda health office	• Mobilize community to construct health post • Select and train human resource • Supervision • Supply provision	• Define evaluation • Source of data • Disseminate and utilize evaluation findings • Provide information on history of program • Describe context of the program and expected outcomes • Determine evaluation criteria for success and failure	Are highly interested to use the finding for improvement	Meeting, phone direct communication
2	Health centers	❖ Provide technical support ❖ Provide pharmaceutical materials ❖ Provide supportive supervision	❖ Source of data ❖ Disseminate and Utilize evaluation finding ❖ Provide information on history of program ❖ Describe context of the program	Are highly interested to use the finding for improvement	Meeting
3	Health post	➢ Implement the program ➢ Train CHPs ➢ Provide the service in static and outrch program ➢ Communicate both vertically and horizontally about the program	✓ Source information ✓ Utilize evaluation findings	Have interest to use the finding	Meeting/direct communication
4	Woreda administration	Mobilize the community for	Source of data	Are highly	Meeting

Sn	***Stakeholder***	***Role in program***	***Role in evaluation***	***Level of interest***	***Ways of communication***
		material support community Financial support Administrative support	Utilize evaluation findings Disseminate evaluation findings	interested to use the finding for improvement	
5	Zonel health department	❖ Provide factory materials for health post constriction ❖ Train health extension workers ❖ Provide pharmaceutical materials for health post ❖ Provide supportive supervision	❖ Utilize evaluation findings ❖ Source of information ❖ Describe the program history	They have interest to use the finding and to disseminate to others	Phone/
6	Feya integrated (L10K)	• Training on maternal andchild health activities • Trains CHPs	✓ Source of data ✓ Utilize evaluation findings	Interested to use the finding	Phone/
7	Community	• Defuse knowledge they know • Service utilization	✓ Source of information		Direct communication

3 Literature review

Studies conducted in different part of the world and Ethiopia indicate that the contraceptive acceptance and practice of women is highly influenced by availability and accessibility of the service for clients and implementation of health extension program in Ethiopia is one of the strategies to increase the access of the service in rural part of the country.

Study conducted by World Development Group on Impact of HEP revealed that HEP had significant effect on the demand of preventive child health services, maternal health services. Beside this the program significantly increased women's ANC need and awareness of modern family planning methods (28).

One study conducted on Contraceptive prevalence in Dembia District, northwest Ethiopia in April 2004 indicated that 44.8% of rural kebele have information about family planning and 309(23.1%) had ever used modern family planning method. From those who had used modern family planning method most of them (64.2%) used injectable contraceptives (29).

Study conducted on Women's knowledge, preferences, and practices of modern contraceptive methods in Woreta, Ethiopia in April 2007 showed that 89% of respondents are aware of modern contraceptives. Among respondents, 88% knew of at least 2 methods, and 12% knew only one method. More than 90% of respondents reported positive attitudes toward modern contraceptive use. The major reasons for non use of modern contraceptive methods (MCMs) were being single and a desire for more children. Injectables were the most commonly preferred modern contraceptive (63.2%) followed by oral contraceptive pill (21.2%). Few women reported a preference for the use of condoms (9.5%) or implants (6.1%) (30).

Another study conducted in North Uganda on knowledge and utilization of modern family planning methods by Frederick Kintu Mubiru and Jimmy Odong in August of 2007 identified that Data suggest that while many women report having heard of some modern methods of family planning (88.8%), few have been given information on how to use methods. Only 6% of the women in this survey reported having been instructed on how to use the methods. Current use of family planning was low, with condoms, pills and injectables being the most commonly reported methods. It was noted that while main

sources of methods for current users were health units and hospitals, some women (5.7%) reported that they obtained Pills and injectables from Traditional Birth Attendants or traditional healers. Reported current use of long term and permanent methods was very low. Use of implants, IUDs and tuballigation was only at 7.7%. Data on barriers to use of modern methods of family planning showed that fertility related reasons were highest at 62.6%. Other reasons were opposition to use at 34%, method related reasons at 15.9%, lack of access at 11.7% and lack of knowledge at 11.2%. Socio-demographic data showed that young women were more likely to report fertility related reasons and opposition to use, while older women were more likely to report method related reasons and lack of access as barriers to use of family planning. Lack of access was not a major barrier among the educated (31)

Md Yunus investigated on his study, Factors Related to the Acceptance of Family planning Methods among married women of reproductive age group in Methapukur Upizila Rangipur District, rural Bangladesh, conducted in Jan 2006 that the prevalence of family planning was 56.3%. The majority of acceptors stated don't want child as a reason of using family planning and oral pills are the most popular methods. More than half of the respondents had fair knowledge and had positive attitude towards family planning. Most of the respondents in this study who receive service from service center resided less than 3km from service center. Finding in this study also showed that there was significant relationship between acceptance of family planning and age of married women, duration of marriage place of service and waiting time (27).

According to the vital statistics of USA 2010, There are 62 million U.S. women in their childbearing years (15–44)Seven in 10 women of reproductive age (43 million women) are sexually active and do not want to become pregnant, but could become pregnant if they and their partners fail to use a contraceptive method. Virtually all women (more than 99%) aged 15–44 who have ever had sexual intercourse have used at least one contraceptive method. Overall, 62% of the 62 million women aged 15–44 are currently using a method. Almost one-third (31%) of these 62 million women do not need a method because they are infertile; are pregnant, postpartum or trying to become pregnant; have never had intercourse; or are

not sexually active. Thus, only 7% of women aged 15–44 are at risk for unintended pregnancy but are not using contraceptives. Among the 43 million fertile, sexually active women who do not want to become pregnant, 89% are practicing contraception (32)

4 Evaluation questions and objectives

4.1 Evaluation questions

This evaluation has two questions which are expected to be answered at the end of this study. Those are:

- Are the required resources available for the implementation of the program?
- Does the family planning package of heath extension program is implemented according to the national implementation guideline?

4.2 Objective of the evaluation

The main objective is to evaluate the level of implementation of health extension program the family planning package in Seke-chekorsa woreda.

Specific objectives are

- To evaluate the availability of resource for the implementation of the program.
- To evaluate accessibility of the service.
- To evaluate acceptability of the service by the target population.
- To judge the level of implementation based on pri- agreed criteria.

5 Evaluation methods

5.1 Study setting

Secka-chakorsa Woreda is one of the 17 Woreda in Jimma zone, Oromia regional government. The total population expected to live in the Woreda in the year 2010 is about 222,299. The Woreda is divided into 37 administrative kebeles from which 36 are rural. The capital town of the Woreda, Seka, is 18 km away from zone town Jimma and 368 km away from Addis Ababa. Share boundaries with Dedo and Kersa in East, with Gere and Gomma in West with Manna and Gomma in North and with Shabe and Sonbe in South.

The socio-demographic condition of the Woreda: - The weather condition of the Woreda is that most of the population found in Woina Dega (71.4%) and the rest is in Dega (21.4%) and kola (5.2%). The dominant religion in this Woreda is Muslim followed by Orthodox and the rest Protestant and other religion followers. Almost all population of the Woreda are agrarians and the main cash crops of the Woreda are Coffee and Chat (19).

Regarding the health services, currently there are 32 health posts, 5 clinics, 3 type "B" health centres and one type "A" health center. The professionals who providing the service for this population are 72 health extension workers, 8 HEW supervisors, 03 health officers, 24 all type of nurses, 03 lab technicians, 5 environmental health and 3 pharmacy technicians.

5.2 Evaluation focus and approach

Evaluation focus

Any given evaluation may focus on either activities (process evaluation) or outcomes, or both. Indeed, most evaluations will include some emphasis on both process and outcome measures. Process evaluations focus on the program's activities and are used to assess whether a program is being implemented as intended. (26)

Process-based evaluations are geared to fully understanding how a program works -- how does it produce that results that it does. These evaluations are useful if programs are long-

standing and have changed over the years, employees or customers report a large number of complaints about the program, there appear to be large inefficiencies in delivering program services and they are also useful for accurately portraying to outside parties how a program truly operates (20) . There are numerous questions that might be addressed in a process evaluation. These questions can be selected by carefully considering what is important to know about the program. Based on the information from different literatures and objective of the evaluation this study focused on process of the family planning package of the HEP implementation.

Evaluation approach

Formative evaluation can be conducted before the implementation of the program or during the implementation to assess whether the program is working. Formative evaluations aim at clarifying the needs of the target population, improving program operations, and enhancing the quality of service delivery.

The focus of this evaluation is to evaluate the program implementation during the course of the intervention. Therefore, the approach of this evaluation was with formative approach for programme improvement.

5.3 Evaluation dimension

Because it is evaluation of implementation according to the national implementation guideline, this evaluation used compliance as main dimension and the Penchansky access dimensions and sub dimensions are availability, accessibility, acceptability and compliance. The reason in which this dimension chosen was because it disaggregates the broad concept of access into asset of dimensions that can be given specific definition and for which operational measurement can be developed (21).

Definition of sub dimensions

- *Compliance;* - compliance refers to following to the given instructions/guideline or procedures that is setted to attain that specific activity or program job. And adherence to a pre-set standards or procedures. (21)

- *Availability*: - according to Roy Penchnsky availability refers to the number of health care service points which needy people can choose that mean quantity of need or demand related to quantity of supply. It includes the availability of inputs like human resource, materials needed for the service and availability of activity

- *Acceptability*: - according to Roy Penchnsky acceptability is the relationship of client's attitude about personal and practical characteristics of providers and the actual characteristics of existing providers, as well as to provider's attitudes about acceptable personal characteristics of clients.
- *Accessibility*:- Roy Penchnsky defined accessibility is the relationship between the location of supply and the location of clients, taking account of client transportation resources and travel time and distance

5.4 Evaluation design

According to World Bank monitoring and evaluation team, design is defined as a logical sequence that connects the empirical data to study's initial research or evaluation question and ultimately to its conclusion. Common types of research strategies include: survey, experiment, archival analysis, history and case study strategy. Each strategy has peculiar advantage and disadvantage and different way of collecting and analyzing empirical evidence following its own logic. The choice of each strategy depends on:

- The type of research question
- The control the investigator has over actual behavioral event
- The focus of contemporary as posed to historical phenomenon (22)

The following table displays the three conditions and show how each is related to the five research strategies being discussed.

Table 3: Relevant situations for different research strategies (adapted from Case Study Research) December 2010

Research strategy	Form of research question	Requires control of behavioural event	Focus on contemporary event
Survey	Who, what, where, how many how much	No	Yes
Experimental	Why, how	Yes	Yes
Archival analysis	Who, what, where, how many how much	No	Yes/no
History	How, why	No	No
Case study	How ,why	No	Yes

The design selected influences the timing of data collection, how to analyze the data, and the types of conclusion can be made from the findings. A collaborative approach to focusing the evaluation provides a practical way to better ensure the appropriateness and utility of evaluation design (22).

Based on the above information from different sources and comparison of the study designs, study design used for this evaluation was multiple holistic case study design. The cases of the study were health posts. Case study strategy helps to understand complex social phenomenon and it allows the investigator to retain the holistic and meaningful characteristic of real life events such as individual life cycle organizational and managerial processes neighbourhood change.

Basically, case study is an in depth study of particular situation rather than a sweeping statistical survey. It is a method used to narrow down a very broad field of research in to one easily researchable topic (23).

Community survey was conducted in order to get information from the community in some of the indicators like on geographical accessibility, acceptability of the service by community and MHHs and CC training procedure.

5.5 Study period

The study period of this evaluation was from 2-December-2010 to 20-December- 2010.

5.6 Population

5.6.1 **Source population**

All women at reproductive age group (15-49yr) for community survey, health extension workers for in-depth interview and model house hold and CC training registrations for document review were the source population of study

5.6.2 **Study population**

- Selected women in reproductive age group for community survey
- Selected HEWs from selected health posts for in-depth interview
- 2009/2010 EFY registrations for model house hold training, CC, home visit

5.6.3 **Study unit**

The study unit or the unit of analysis is Seka-chekorsa Woreda health office and the findings from survey, expert interview, and document review were used complementarily.

5.7 Sampling technique and Sample size

5.7.1 **Sampling technique**

Considering multi- stage sampling was used to select kebeles and the number households for respective kebele.

Stage one: From the total of 36 rural kebeles, 5 kebeles were selected purposely based on 2009/2010 performance of family planning (1kebele with highest performance, 3 kebele with medium performance and 1 kebele with critical performance).

Stage two: After kebele were identified, systematic random sampling technique was applied to select households for community survey. The numbers of households' interviewed from each kebele were proportionally determined based on the total population of each kebele.

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The sampling technique is presented in figure 4 and detailed field work is described in data collection field work.

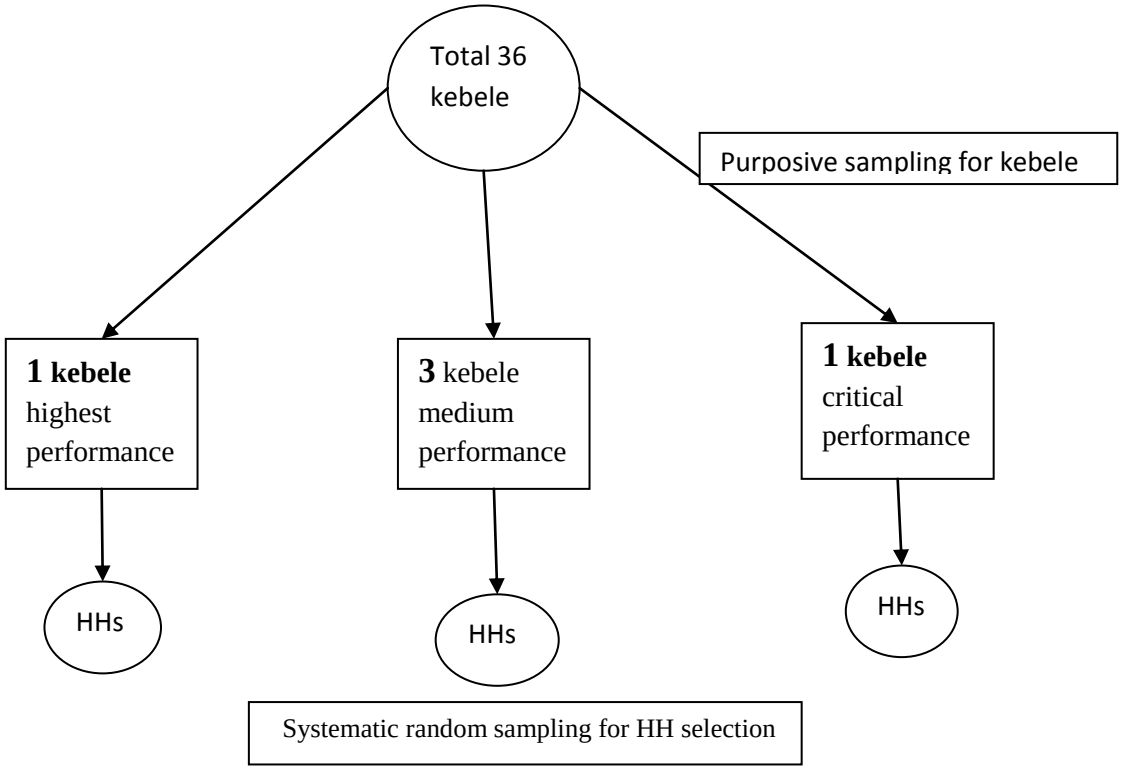

Figure 3*: showing sampling technique for kebele and house holds, december 2010*

5.7.2 **Sample size**

For community survey the sample size is:

$$n = \frac{(za/2)2 * p(1-p)}{(e)2}$$

Where n no of sample

Zα/2 1.96 at 95%

e= 5%

D (design effect) =2

P= 13.6% (0.136) from EDHS 2005, the proportion of modern family planning acceptors in Oromia region

$$n = \frac{(1.96)2 * 0.136(1-0.136)}{(0.05)2} = 181$$

Considering non respondent rate 10% =18

The total sample become 2*(18+181) = 398

The proportion of the sample/respondents for each kebele is described in table 4

Table 4: Proportion of sample for selected kebele of Seke-chekorsa woreda, 2010

Sn	Name of kebele	Population	Sample	No of HHs	Interval	Remark
1	Buyo kechama	***5298***	110	1177	11	Highest
2	Gibe Bosu	***3684***	77	819	11	Medium
3	Kofe	***4559***	95	1013	11	Medium
4	Kosaro	***2730***	57	607	11	Medium
5	Gura Ula Oke	***2846***	59	632	11	Critical
	Total	***19117***	398			

In-depth interview was carried out on 10 HEW (two from each health post) who were working in those five selected kebele. For document review all 2009/2010 documents on model household training, community conversation and home visit registers were reviewed.

5.7.2.1 Inclusion criteria

The inclusion criteria was that health posts with out other health profesionals for health post selection and for household survey was women in reproductive age 15-49yrs and those who were resident for at least 6(six) month in the kebele were included

5.8 Variables of the study

5.8.1 **Independent variables**

Independent variables of the study are

- Marital status of women
- Age
- Religion
- Ethnicity
- Educational level
- Model house hold training
- Community conversation
- Availability of family planning services and supplies
- Preference of family planning method
- Participation of women in model household traing
- Participation of women in community conversation

5.8.2 **Dependant variables**

Dependant variable which was assessed by this study was

- Practice of modern family planning method

5.9 Data collection techniques

Data collection was conducted on the basis which the method can generate reliable and acceptable data for the intended indicator.

Qualitative data were collected through an in-depth interview with HEW and document review; In-Depth interviewing involves asking open ended questions, listening to and recording the answers and then following up with additional relevant questions (24). An interview guide was prepared to make sure that each of the interview sessions will use the same question to get information from the different individuals. List of questions/topics that need to be covered were identified and listed as instruments. The questions were not asked as written. Documents from 2009/2010 EFY were reviewed mainly for MHH graduation, CC, FP users register. Community survey was conducted for quantitative data.

In table 4 below all the dimensions, indicators, data collection methods and source of the data are listed

Table 4*: Evaluation question, dimension, and Data source and collection method for each indicator of HEP evaluation in* Seke-Chekorsa woreda, December 2010

Evaluation question	***Evaluation dimension***	***Indicator***	***Data collection technique***			
			HEW interview	Document review	Survey	
Are the required resources are available for the implementation of the program?	Availability	No of HP fully functioning		X		
		Proportion of HEW trained and deployed		X		
		Proportion of community health promoters deployed	X			
		Proportion of MHH graduated			X	
		Proportion of model women graduated as MHH family			X	
		Proportion of mothers who got their first choice of service they want	X		X	
		No of dates which stock out of family planning supply occurred in the HP in the last 3 months	X	X		
		Proportion of available family planning services recommended by FMOH	X	X		
Does the family planning package of the HEP is implemented according to the national guideline?	Accessibility	Proportion of women who get family planning service in walk able distance			X	
		Proportion of households visited by HEWs			X	
		Proportion of CHP	X	X		
		No of women who referred to HC for long term family planning methods		X		

		Proportion of sessions on CC for family planning		X		
		Proportion of women who are participated/participating on CC		X	X	
	Acceptability	No of women who use any type of modern family planning		X	X	
		Proportion of mothers who are satisfied by the service the provided(perceived satisfaction)			X	
	Compliance	Proportion of women who are informed about the side effects of modern methods of family planning			X	
		Proportion of women who know the possible alternative of the modern family planning methods which are available in the nearby HP			X	
		proportion of MHH who are graduated after completion of 75% of training time (72hrs)		X	X	
		proportion of CC participants graduated after completion of 75% training hrs		X	X	
		Proportion of fully documented registers of MHH, CC FP users		X		

5.10 Data collection instruments

- Women interview /survey questionnaire were adapted from EDHS 2005 which is developed by CSA for women interview and Mohidol university which is developed to asses factors related to acceptance of family planning method among married women of reproductive age(27).
- HEW interview and document review were developed from HEP implementation guideline the family planning packege and USAID service delivery tool for family planning service provider interview.

5.11 Data collection filed work

Five (5) diploma health professionals as data collectors and two (2) BSc health professional as supervisors were selected and recruited for community survey. The criterion to involve them as the data collector was considered previous experience in data collection. Two day training for supervisors and data collectors was given by the principal investigator. The training was focused on explaining the purpose, use and confidentiality of the study and data collectors in turn explained it to the clients and obtained verbal consent to increase response rate. Furthermore, the training was emphasized on how to fill the data and check for its completeness and to brief what the tools are saying. Data collectors conducted only community survey and the rest, in-depth interview and document review, were conducted by principal investigator. Data collection from community was started after the identification of the proportion of sample from each kebele. After the proportion of the sample from each kebele was calculated and the interval factor was 11 that is every 11^{th} household in selected kebele were picked. The first household was picked by lottery method and the direction of the household was identified by throwing pen and its head direction was taken. After the sampled house was reached then:

- If the number of women in reproductive age were more than one in sampled household including mother, the respondent was the mother
- If in that house no mother (absent) the elder girl in the reproductive age were interviewed

5.12 Operational definition

Operational definition of some of terms and phrases which were used in the study

Kebele: is the lowest administrative unit with authorised leaders in which HPs are administratively responsible to them.

Health post: is the lowest government health institution which is constructed to serve one kebele with 5000 population.

Health extension supervisors: are health professionals who are assigned after traing for three months on HEP.

Community conversation: is scheduled and organized community dialogue on health related problems which occur in that community, at the end it reach on final decision.

Community health promoters: are voluntary and elected by the community and trained by health extension workers on HEP components to serve the community they belong.

Model households: are families which are trained by HEW on health extension components for three month and graduated after completion of the training at least 75% of training hours.

Walk able distance: Is a distance in which the health services available, which is not more than 5/five/ km radius in the community from HP.

Stock out: absence of family planning supply in the service provision place or at health post

House visit: is planned activity by health extension workers to advice, remained and supervise community members at their home. In average one HEW can visit 6-8 houses per day

Modern family planning methods: are family planning methods provided by health professionals including counselling on the services provided.

Long term family planning methods: are family planning methods which are used for more than one year with one dosage **Access**: is a geographical accessibility/location/ of the services

Acceptability: is the perception of women on the services provided in the health post and their practice

5.13 Data management and analysis

The qualitative data which were collected by HEW interview and document review were analyzed by manually. The collected data were checked, cleaned and transcribed and then

changed to text form. Similar ideas were categorized and connected together based on their interlinked relationships. Then description were prepared based on similarities and presented in text form.

Quantitative data were coded based on data collection instrument. The data entry was done in EpiData3.1 version and the data was exported to SPSS for windows version 16.0 for analysis. Descriptive statistics were computed, Tables and frequencies were used to describe the findings and graphs and charts were also used. Summaries of findings were compared with the preset criteria-standards to judge the level of achievement. For evaluation decision making purpose, the indicators were summarized into few (manageable size) indicators which can fit the basis for judgment.

5.14 Judgement matrix

It is important to recognize the evaluative themes in process evaluation questions. To answer these questions the evaluator must not only describe the program's performance but also assess whether it is satisfactory. This in turn requires that there be some bases for making judgment (25).

Similarly this evaluation used stakeholders concern to assign all parameters of judgment and give weights to all engaged indicators. So, weight for each dimension was set after discussing with stakeholders before the study ensues. Total weight assigned was out of 500 and the estimate which was used to each indicator is shown in table 5 below.

In order to judge the level of implementation the judgements parameters were agreed on

- ≥85%=successfully implemented
- 75_84.9%= good implementation
- 55-74.9%=fair implementation
- 30_54.9%=Critical
- <30% not implemented and the overall level of implementation was shown in table 13 of result part

Table 5: Relevance matrix for all dimensions of study HEP evaluation of Seke-Chekorsa woreda, December 2010

SN	***PROGRAM COMPONENT***	***EVALUATION DIAMENSIONS***			
		AVALIABILITY	ACCEPTIABILITY	ACCESSIBILITY	COMPLIANCE
1	INPUTS	RRR	R	R	R
2	ACTIVITY	RRR	RRR	R	RRR
3	OUTPUTS	RRR	R	R	R
	Total relevance score	9R	5R	3R	5R
TOTAL RELEVECE = 22 R					

Key = RRR refers highly relevant
RR refers relevant
R less relevant

Value for availability $= \frac{9R}{22R} * 100 = 41\%$ from 500 it become 205

Value for accessibility $\frac{5R}{22R} * 100 = 23\%$ from 500 it become 115

Value for acceptability $= \frac{3R}{22R} * 100 = 14\%$ from 500 it become 70

Value for compliance = $COMPLIANCE = \frac{5R}{22R} = 22\%$

From 500 it becomes 110

Indicators

Indicators for this evaluation are developed and adapted from health extension program the family planning package prepared in 2003 by FMOH and from implementation guideline of the health extension program developed by FMOH in 2007 Amharic version.

1. No of HP fully functioning : this are health posts which provide all the HEP services in rural kebeles
2. Proportion of HEW :- numerator is number of HEW and denominator is total rural kebekes multiplied by 2
3. Proportion of HEW who got additional training of family planning.
4. Proportion of CHP :- numerator is no of CHP in one kebele denominator is households divided by 50
5. Proportion of MHH graduated :- numerator model families trained and graduated by accomplishing at list 75% of training hours and certified by woreda health office denominator total families in the kebele
6. Proportion of model women graduated as model family
7. Proportion of sessions on CC for family planning:- numerator no of sessions on family planning during CC in the kebele denominator total CC cessions conducted in the kebele.
8. Proportion of women who are participated/participating on community conversation
9. No of women who use any type of modern family planning
10. No of women who referred to HC for long term family planning methods.
11. No of dates which outstroke of family planning supply occurred in the HP in the last 3 months
12. Proportion of available family planning services recommended by FMOH
13. Proportion of mothers who got their first chose of service they want
14. Proportion of mothers who are satisfied by the service the provided(perceived satisfaction)
15. Proportion of women who are informed about the side effects of modern methods of family planning

16. Proportion of women who know the possible alternative of the modern family planning methods which are available in the nearby HP
17. Proportion of women who get family planning service in walk able distance
18. Proportion of households visited by HEWs

5.15 Data quality control

Three day training on data collection for house hold survey was given for 5 diploma nurses and 2 health officers. Document review and expert interview were conducted by principal investigator. The tools designed for the study were translated in to Afan-Oromifa and translated back to English to test its consistency. The study was begun by conducting pre testing in non study area. It was undertaken in one health post and 25 households which were out of the study area in the woreda. This pre- testing is intended to ensure the clarity and the appropriateness of the questions wording. Furthermore it also helped in identifying the validity and reliability of the tools and its logical sequence to reduce the potential confusion that might exist in actual study. The actual time needed to complete one respondent was, 26 minute, was allocated based on this pre-test. In addition, supervisors collected the completed questioners and submitted it to the principal investigator on daily basis. Then the principal investigator checked the questionnaires filled for accuracy, consistency and completeness. The questionnaires and the soft copy of the data are kept in proper access.

5.16 Ethical issues

Ethical approval was secured from the ethical clearance committee of college of public health and medical scince, Jimma University. Formal letter from JU was obtained and

submitted to Seke chekorsa woreda health office. Similar letter was obtained from Seke-chekorsa woreda for those selected kebeles. Data collectors introduced the purpose of the study to the interviewed women and health extension workers which helps to get reliable information. Informed consent was obtained from each respondent verbally. Women were informed to have the right to give up the interview at any time they wish and they were informed that failing to participate in the study doesn't affect any service they got from that health post. Confidentiality was assured that whatever information obtained it will be kept confidential.

5.17 Dissemination of findings

For evaluation results to be used they must be disseminated to and understood by major stakeholders and the general public. Dissemination refers to the set of activities through which knowledge about evaluation findings is made available to the range of relevant audiences. Dissemination is a critical responsibility of evaluation researchers. An evaluation that is not made accessible to its audiences is clearly destined to be ignored. Accordingly evaluators must take care in writing their report and make provision for ensuring that findings are delivered to major stakeholders (25).

So as to maximize the utilization of the findings, evaluation findings were communicated with the primary stakeholders, Seke-chakorsa woreda health office, during analysis and any finding which needs immediate action were informed. After data final approval of the thesis all the stakeholders, Seke health center, Seke-chakorsa woreda health office, Jimma zone health Department and Jimma University will be provided the report and one day symposium will be organized by the primary stakeholder and the principal investigator will explain all the findings and the higher political officials in the woreda will participate in the symposium**.**

6 Results of the evaluation

Availability

All rural kebele (36) of the woreda was covered with two health extension workers, which is 100% and construction of health post was completed in 32 kebele (88.8%). From the total kebele who finished HP construction only 13(36.1%) were fully functioning and the rest were not functioning due to unavailability of medical equipments.

In the five kebele selected and interviewed there were two health extension workers per health post and all of them, 10(ten) were interviewed. In the five health posts the HEW responded that they were implementing the health extension program through the four implementation strategies that are home visit, model family household training, community conversation and static services at health post.

All interviewed health posts were opened for two day in a week and all the recommended services by FMOH were delivered for community. And family planning services were one of the services provided for community. The major family planning activities performed were counselling, pills provision, Depo-Provera, male condom and referral services for those who need for long term family planning methods.

All health posts were equipped with recommended family planning commodities and there were no expired and non functional supplies during the study period.

Waiting seats were not available in Gura ula oke health post and Buyo kechama health post have no separate room for family planning service and the rest health posts were fully equipped and they have separate room for counselling. Kofe, Gibe bossu, Buyo kechema and Kusaro health posts have enough training materials but Gura ula oke health post have no any type of training material for model family house hold training.

Table 6 : Modern family planning users, available method and referred mothers for LAFP method in selected kebeles of Seke-chekorsa woreda December, 2010

Name of kebele	Family planning users		Referred and LAFP users	Available FP method
	No	%		
Buyo kechama	261	33.68	18	Male condom, pills, Depo-Provera
Kusaro	174	43.61	14	Male condom, pills, Depo-Provera
Kofe	226	33.88	6	Male condom, pills, Depo-Provera
Gura ula oke	140	33.65	Not registered	Male condom, pills, Depo-Provera
Gibe bosu	313	58.07	12	Male condom, pills, Depo-Provera

Table 7: Availability of family planning commodities supplies in selected kebeles of Seke chekorsa woreda, December 2010

Item /infrastructure/equipment	***Name of health post***									
	Gibe bosu		***Kusaro***		***Gura ula oke***		***Kofe***		***Buyo kechame***	
	available	Not available	available	Not available	Available	Not available	available	Not available	Available	Not available
Medical Equipments										
Stethoscope	√		√		√		√		√	
Disposable syringe	√		√		√		√		√	
Thermometer	√		√		√		√		√	
Blood pressure gauge	√		√		√		√		√	
Dildo/penis model		√		√		√		√		√
Delivery coach	√		√			√	√		√	
Examination bed	√		√		√			√		√
Adult weight scale	√		√			√	√		√	
Contraceptive commodity										
Pills	√		√		√		√		√	
Male condom	√		√		√		√		√	
Depo-Provera	√		√		√		√		√	

Table 8: Availability of family planning IEC materials and infrastructure in selected kebeles of Seke chekorsa woreda, December 2010

Item	***Name of health post***									
	Gibe bosu		***Kusaro***		***Gura ula oke***		***Kofe***		***Buyo kechame***	
	availa ble	Not availa ble	availa ble	Not availa ble	Avail able	Not availa ble	availa ble	Not availa ble	Avail able	Not availa ble
IEC materials										
Poster	√		√			√	√		√	
Flip chart	√		√		√		√		√	
Broachers	√			√		√		√	√	
Information sheet	√		√		√		√		√	
Job aids	√			√				√	√	
Counseling card	√		√			√	√		√	
Infra structures										
Functional toilet	√		√		√		√		√	
Waiting seats for client	√		√		√		√			√
Separate place for counseling	√		√		√		√			√

Compliance

The sources of data for this dimension were from community survey and document review by comparing with the national health extension program implementation guideline.

Socio-demographic characteristics of respondents

A total of three hundred seventy four women at reproductive age (15_49yr) were interviewed during the study period with 94% respondent rate. The mean age of respondents was 30.06 year (SD±6.0). The vast majority ethnic group was Oromo which accounts 94.4% from the total respondent and the rest were Amhara, Kaffa, Dawuro, and others. Muslim is the dominant religion with 96% of the respondent and the rest 4% were orthodox. More than half of the respondents 53.2% were illiterate and 36.4% of the respondents were primary level and the rest were secondary and above which accounts for 8.3% and 2.1 % of the respondents respectively.

From the total of interviewed women 347 (92.8%) of the respondents were married and followed by 4.5% widowed and the rest 1.9% single and 0.8% were divorced. 93% of the respondents were housewife which was followed by merchants with 5.3% and the rest employed and daily lubber workers accounts 0.8% each. The socio-demographic characteristics of the respondents are described in table 9.

Table 9 Socio demographic characteristics of respondents at Seke-chekorsa woreda Dec 2010

Character	Frequency N= 374	Percentage %	Cumulative %
Ethnicity			
Oromo	353	94.4	94.4
Amhara	5	1.3	95.7
Kefa	2	0.5	96.2
Dawuro	4	1.1	97.3
Others	10	2.7	100
Marital status	***n= 374***	***100***	
Single	7	1.9	1.9
Married	347	92.8	92.8
Divorced	3	.8	.8
Widowed	17	4.5	4.5
Age of respondents			
<20	40	10.7	10.7
21-25	71	19.0	19.0
26-30	119	31.8	31.8
31-35	57	15.2	15.2
36-40	69	18.4	18.4
41-45	17	4.5	4.5
>45	1	.3	.3
Educational status			
Illiterate	199	53.2	53.2
primary,1-4	136	36.4	89.6
Junior level,5-8	31	8.3	97.9
secondary level,8-12	8	2.1	100
Occupation of the respondents			
Unemployed	348	93	93
Employed	3	0.8	93.8
Daily lubber workers	3	0.8	94.6
Merchants	20	5.4	100
Religion			
Muslim	359	96.0	96.0
Orthodox	15	4.0	100
Total	**374**	**100**	

From the total of 374 women interviewed 245(65.5%) were trained in model family house hold training and from those who trained in MFHH 157(64.1%) responded that they have trained in modern family planning package of the HEP during the training and the rest 88(35.9%) responded that it was not included in the training. According to the respondents response for the time of training 144(58.8%) of the respondents were trained and graduated after three months and the rest 39(15.9%), 31(8.3%) and 31(8.3%) responded that they have trained for two month one month and two weeks respectively. 341(91.1%) have information about modern family planning and 301(80.4) of them were using some method of modern family planning method. The result showed that there is significant association (p-value = 0.000) between model family training and practice of modern family planning method.

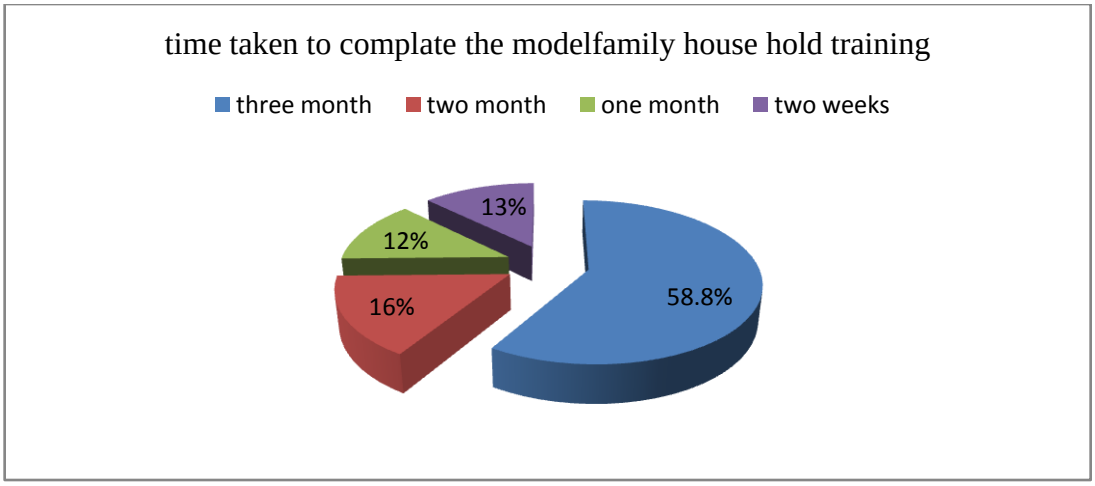

Figure 4: Showing the trend of model family house hold traing at selected kebeles of Seke-chekorsa woreda December 2010

From 301 women, who were using any type of modern family planning method 146(48.6%) have practiced some type of side effect of method used and the rest 155(51.5%) have not practiced and from those who practiced side effect 5(3.5%) discontinued using any type of modern family planning method. 245(81.9%) of those who are using modern family planning method responded that they were counselled that the side effect of the modern family planning method may occur.

From 374 interviewed women 341 (91.2%) know at least one method of modern family planning method which is provided in the health post and 297(79.4%) of the respondents know that pills and Depo-Provera (injectable) are available in the health post but only 62(16.6%) of the respondents know all of the recommended methods condom, pill and Depo-Provera are available in the health post.

Model family household training:- Selection criteria for model household training was not the same in all health posts responded to this study; and selection criteria was in village/Goti/ in Kusaro and Kofe health posts and by identifying the innovative in Buyo kechama, Gura ula oke and Gobe bossu health posts.

The training mechanisms in the five health posts interviewed were theoretically in the heath post and by demonstration at community or household level.

From the five health posts interviewed only Kusaro health post were training 60 model families per health extension worker per one phase and the rest Buyo kechema 150, Gibe bossu 90, Gura ula oke 72 and 75 trainees in Kofe per health extension worker per one phase. All of the interviewed health extension workers responded that the coverage of MFHH in respective kebele is currently 100% and at least one of the family heads (mother or father) were trained and graduated in model household family package and all of the interviewed health extension workers responded that the training time to complete all of the packages take 3 months and all of the HEP packages were given equal period of training.

Community conversation: - community conversation was conducted in all five health posts. The conversation mechanism carried out was not the same in the health posts

In Buyo kechama health post the health extensions were training four community leaders from each Gotti/ village and then those four persons were leading the conversation in each village. The health extension workers responded that there was no formal report communication with this community leaders and the follow up for participants was not established. And the current coverage of community conversation of this kebele was 48%.

In Gibe bosu health post community conversation was lead by health extension workers male and female participants have the same proportion and all of the village have their own

conversation date and time fixed by participants and there was strict follow up mechanism developed to prevent absenteeism. And the CC coverage of the kebele was 70%.

In Gura ula oke kebele the participants who were participating in CC were not constant, date and time for conversation was not fixed absenteeism were not monitored and conversation topics were not registered. There was no fixed number of participants and the coverage of the kebele was not known.

Kusaro and Kofe have the same trend in community conversation that was each health extension workers have their own CC that was lead by them and they were following the participants until they complete the phase. The coverage of CC was 65% in Kusaro and 45% in Kofe.

The interviewed health extension workers responded that the family planning package was incorporated and have given equal cession during community conversation and model family household training in 5 interviewed health posts.

Table 10: The trend and coverage of CC and MFHH in selected kebele of Seke-chekorsa woreda December, 2010

Name of kebele	***No of HEW***	***MFHH***		***CC***	
		Trainees/phase/HEW	Coverage (in %)	No of participants/phase	Coverage
Buyo kechama	2	150	100	Not clearly identified	48
Kusaro	2	60	100	”	65
Kofe	2	75	100	“	45
Gura ula oke	2	72	100	“	Not known
Gibe bosu	2	90	100	“	70

Documents from five health posts were reviewed. The documents reviewed were model household training registers, community conversation registers, modern family planning method user registration and referral registers. Document review for model household

training revealed that there was no scheduled and identified package of the HEP was registered for MFHH training except name of the trainees.

In community conversation registers only HIV related topics were registered in Buyo kechama, Gibe bosu Kofe and Kusaro health posts and in Gura ula oke health post there was no topic registered. Model family house hold training registers were not available in all heath posts interviewed and the health extension packages that the trainee's trained were not identified and attendance were not established in all health posts.

Accessibility

Most majority of interviewed women, 372(99.5%) responded that they were walking by foot to reach the health post and it is walk able for them and transportation was not the problem to reach the health post and only 2(0.5%) women responded that they are using animal transportation. The average time which took to reach the health post was 23.97min (SD±14.87min) and the minimum and maximum time taken was 1 min and 90 min respectively. The other way to measure accessibility is by home visit which was one of the implementation strategy and from the total of 374 interviewed women 332(88.8%) responded that they were visited by health extension workers and the rest 42(18.2%) responded that they were not visited by health extension workers. From those visited women 229(69.9%) responded that they have discussed on issues related to family planning during the visit and the rest 103(30.8%) responded that they didn't discussed on issues related to family planning.

In health extension interview the HEW have responded that they have conducted home visit from 6-12 house hold per day/HEW in all of the 5 kebele and they were giving services like pills and condom during home visit but these activities are not documented in all interviewed and observed health posts Except Buyo Kechema health post all the health posts were not registered home visit activities.

Referral linkage was established in five health posts interviewed and four health posts out of five interviewed were registered those referred for long term family planning method.

All the 5 kebeles have one trained community health promoter in each village, which have 40-50 households, ranging from 22 in Gibe bossu to 28 in Buyo Kechema.

Community conversation was conducted in all five health posts included in this study and from the total of 374 interviewed women 239(63.9%) responded that they were participated in the conversation. From those who were participated in CC only 107(44.6%) responded that they were discussed in the issues related to family planning and the rest 133(55.4%) responded that family planning issues are not discussed. Conversation time was ranging from 1 month to 12 month according to the respondents with mean of 7.44 month (SD±4.54 month). The discussion time of the community was ranging from twice a month which account 172(72%) to 5(2.1%) occasional meeting. The result showed that there is no significant association (p-value = 0.122) between community conversation and practice of modern family planning practice.

Table 11 showing the frequency of meeting of community conversation at selected kebeles of Seke-chekorsa woreda December 2010

Frequency of meeting in CC	Frequency	Valid Percent	Cumulative Percent
once a month	53	22.2	22.2
twice a month	172	72.0	94.1
three times a month	9	3.8	97.9
Occasionally	5	2.1	100.0
Total	239	100.0	

Acceptability

Knowledge about modern family planning method was addressed and 342(91.4%) of the respondents have knowledge on MFP method and the rest 32(8.6%) have no any information on family planning method. 301(88%) of those who have knowledge or information on family planning were using some type of modern family planning method

and the rest 41(12%) were not using any type of modern family planning method. The main reasons for non use MFP method in those women who have information/knowledge on family planning were need for many children, due to religious reason and husbands were not voluntary. Reason for non use of MFP method is shown in table 11.

Table 12: Showing reason for not using family planning method at Seke chekorsa woreda, December 2010

Reason for non use of modern family planning method	Frequency (N= 41)	Valid Percent	Cumulative Percent
need for many child	16	39.0	39.0
husband is not voluntary	9	22.0	61.0
it is not recommended in my religion	16	39.0	100.0
Total	41	100.0	

Among women who were using any type of modern family planning method 269(89.4% were using from health post in their kebele and the rest 32(10.6%) were using from other health institutions and the reason not to use in the health post in their kebele were 13(41.9%) were due to that they don't want that others in their kebele know that they are using family planning and 12(38.7%) were due to that they have started using in other health institution before the services were started in the health post and the rest 6(19.4%) were due to that they think the services were not quality/good in that health post.

Most of the women, 261(96.7%) who were using family planning service from health posts in their kebele got their first choice in the health post and 262(97.4%) were satisfied in the services provided in the health post and the rest 6(2.2%) and 1(0.4%) were satisfied with exception and not satisfied in the services respectively and the exceptions were that the health posts were not opened all the time.

The preference of the most of the respondent was Depo-Provera which accounts 215(71.4%) of the respondents and pills 54(17.9%) and the rest Norplant and IUCD 30(10%) and 2(0.6%) respectively.

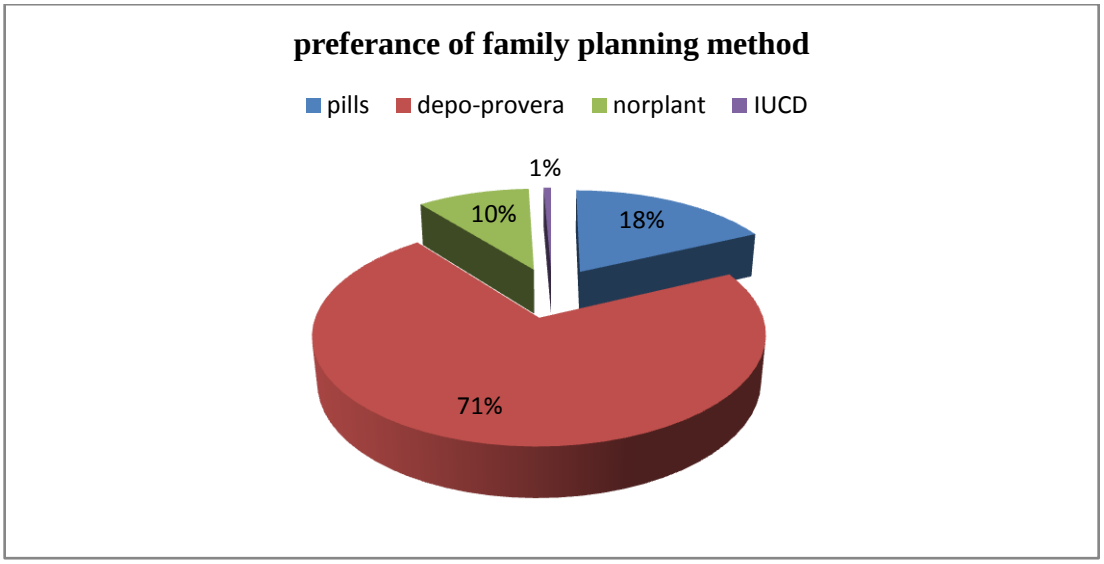

Figure 5: Showing the preference of modern family planning method in Seke-chekorsa woreda December 2010

Table 13 judgement matrix for each dimension of the HEP implementation with respective indicators in Seke chekorsa woreda Dec 2010

Dimension	***Indicator***	***Value /weight***	***Standard***	***%(available)***	***Achieved***		***Judgement***
Availability	No of HP fully functioning	25	100% HP should be fully functional	From 36 HP only 13(36.1%) were fully functioning	9	**36.1**	**critical**
	Proportion of HEW	25	100% kebele and HP should have 2 HEW	100% of kebele have 2HEW per HP	25	**100**	**Successful**
	Proportion of MHH graduated	25	100% of HH should be graduated in the three years	100% of kebele was covered by model families	25	**100**	**Successful**
	Proportion of model women graduated as MHH family	30	all kebele should be covered by model family HH	65.5% of women were graduated in MFHH	19.65	**65.5**	**Fair**
	Proportion of mothers who got their first chose of service they want	20	85% of the target women should get their first choose	96.7% of women using modern family planning method from HP have got their first choose.	20	**100**	**Successful**
	No of dates which outstroke of family planning supply occurred in the HP in the last 3 months	40	• No stoke out = 40 • One stoke out = 20 • Stoke out of two supply = 10 • If three stoke out = 0	No stock out occurred	40	**100**	**Successful**
	Proportion of available family planning services recommended by FMOH	40	1.All recommended available = 40 2.Two recommended available = 20 3.Only One recommended available =10 4.If three stoke out = 0	All recommended are available	40	**100**	**Successful**
	Overall total for availability	**205**			**178.6**	**87.1**	**Successfully implemented**
Compliance	Proportion of women who are informed about the side effects of modern methods of family planning	30	All modern family planning method users should informed about the side	81.9 were counselled about the possible side effect of the method they used	**24.57**	**81.9**	**Good**

			effect of the method they used				
	Proportion of women who know the possible alternative of the modern family planning methods which are available in the nearby HP	30	All women who are using modern family planning method should know all chooses in the health post	Only 16.6% of interviewed women know all the recommended were available in HP	**4.8**	**16.6**	**Not implemented**
	Proportion of MHH who are graduated after completion of 75% of training time (72hrs)	25	All families should train for 3 month or at least 72 hours to graduate	There was no attendance	**0**	**0**	**Not implemented**
	Proportion of CC participants graduated after completion of 75% training hrs	25	All CC participants should participate at least 75% of the 10 month discussion which is conducted twice a month	Attendance was established All graduated were discussed for at least 15 cession	**25**	**100**	**Successful**
	Total for compliance	**110**			**54.37**	**49.4**	**Critical implementation**
Accessibility	Proportion of women who get family planning service in walk able distance	**15**	All of the women should get the service at walk able distance	99.5% get the service at walk able distance	**15**	**99.5**	**Successful**
	Proportion of households visited by HEWs	**15**	6_8 house/HEW/day Those visited households should be registered including the services they got	No registered households visited 88.2% responded that they were visited by HEW	**6.6**	**44**	**Critical**
	Proportion of CHP	**15**	• 2 CHP for 50 house hold	One CHP for 40- 50 households	**7.5**	**50**	**Critical**
	No of women who referred to HC for long term family planning methods	**15**	• Referral linkage established and registered =15 • Only linkage =7.5	Referral linkage was established in all HP not	**13.5**	**90**	**Successful**

			• No linkage = 0	registered in all			
	Proportion of sessions on CC for family planning	**20**	• Each package (17) should have equal discussion session	There is no schedule and cession for each package All the registered topics were HIV related	**0**	**0**	**Not implemented**
	Proportion of sessions on MFHH training for family planning	**20**	• All packages should have independent and equal training period	There is nothing documented except name of trainee	**0**	**0**	**Not implemented**
	Proportion of women who are participated/participating on CC	**15**	• 50% of the participants should be women and all women in kebele should participate in CC in the three year period.	Proportion of women is not clearly identified in all HPs	**7.5**	**50**	**Critical**
	Total for accessibility	**115**			**50.1**	**43.6**	**Critical implementation**
Acceptability	Proportion of women who are using any type of modern family planning method	**45**	All women in reproductive age should use modern family planning method	88% are using modern family planning method	**39.6**	**88**	**Good implementation**
	Proportion of mothers who are satisfied by the service provided at health posts (perceived satisfaction)	**25**	All women using at health post should be satisfied with the service they got	97.6% of women who used family planning method from HP in their kebele were satisfied	**24.4**	**97.6**	**Successful**
	Total value for acceptability	**70**			**60.6**	**91.4**	**Successfully implemented**
The overall total for implementation of the package		**500**			**355.2**	**71**	**Fair implementation**

7 Discussion

This evaluation study has tried to assess the overall implementation of the health extension programme implementation focusing on the family planning package. Different data collection methods were used to gather information. Dimensions assessed by this evaluation were: availability of the necessary inputs, compliance of the service with the national guideline, acceptability of the service by clients and accessibility of the service for clients.

Availability dimension: One HP should be constructed and equipped per kebele to serve about 5000 population. The standard is that a HP should have three rooms made of corrugated sheets of iron roof, cement floor and at least mud wall. And it was regionally targeted that all of the rural kebeles must be covered by the end of 2008 (3). However this evaluation has found that 88.9% .of the rural kebele of this woreda had constructed health post and only 36.4% of the health posts are fully functioning. This indicates that this woreda is far behind the national target and not achieved the plan to be achieved. In the contrary all of the rural kebele have 2HEW per kebele and this plan was 100% achieved it is judged successfully implemented. Preliminary assessment conducted by Abebe Bekele, Mengistu Kefale and Mokonen Tadesse in SNNPR at selected zones in Feb 2008 identified that there were one to two HEW per kebele and it was also identified that the study zones have deployed and achieved an average 63% of HEW so far. This difference in achievement of HEW deployment may be the target planned to cover all rural kebele with two HEW was for 2009 and the study was conducted at 2008(33).

Training of model households from the community takes three(3) months a total of 96 hours. The training is conducted by selecting innovative communurty members and those who have relationship with the health extension workers for diffusion purpose and it begins with 40 trainees, then 45 at second raund, 50 at the third raund 55, at the 5th and lastly 60 trainees onece per health extension workers by doing so it is planned to cover the whole kebele not more than three years by model family (3,4). This study reveals that model house hold graduation of the woreda is 100% covered with trained model house holds the target which was planned by ministry of health to cover the hole kebele and it is inline with

planne and sucsussesfuly implemented. The main reasons behind this sucsses were the avaliability of HEW based on the stundared that is 2HEW per kebele.

The ultimate goal of the HEP was to reduce those health burden of women and child, therefore training of women on modele household family is more effecient because if father(head) of the household train on this trainig with out the involvement of women there may be gap on transmision of the massage he gained but if the mother from that family participated she will apply the lesson she lernet from trainig on her self and child and the implementation will be sucsusseful. The result of this study showed that only 65.5% of interviewd women trained on MFHH taining and 30.6% of interviewed do not know wether their houseband trained or not and 4.7 % interviewed women responded that those trained husbaned didn‘t informed what they have trained to their wifes. This indicates that not all trained men are transforming what they have lernet to their family.

The avaliability of all the recomended family planing method for health post (pills, Depo-Provera, male condom) are the main factor in health posts to provide the servicies. This study revealed that all recomended family planning methods were avaliable in all health posts and no stok out were occured during the last three months. And as reasult 96.7% of family planning users from health posts have got their first choice from that health post. According to the finding it was jadged as successfully implemented. The perferance of the family planing method in this woreda was identifeid as majority of users, 71.4%, prefere injectables followed by oral pills which acounts 17.9%. This finding have similar result with study done on Women's knowledge, preferences, and practices of modern contraceptive methods in Woreta, Ethiopia by Berhanemeskel Weldegerima, identified that Injectables were the most commonly preferred modern contraceptive (63.2%) followed by oral contraceptive pill (21.2%)(30). This finding also agree with the finding from study conducted on contraceptive prevalence in Dambia district in north west Ethiopia, by Yigzew Kebede(29). And with other study conducted in North West Ethopia on quality of family planning service by Misganew Fantahun(38). The possible reason for this can be that injectables are taken in three month interval.

Ingeneral the avaliability of resouurces and servicies were sucssesfuly implemented in this woreda and this is due the avaliability of HEW in all rural kebele

Compliance of activities to national implementation guideline:-

Model family household training was one of health extension programme implementation with philosophy of training one household representative on all HEP packages for three month at least two hours per day. The planned target was to start with 40 trainees, then 45 at second round, 50 at the third round 55, at the 5th and lastly 60 trainees once per health extension workers by doing so it is planned to cover the whole kebele not more than three years by model family. This study found that the implementation of this strategy was not in line with the national guideline that is an average of 89.4 trainees ranging from 60 in Kusaro to 150 in Buyo kechema kebele per HEW per one phase were trained moreover in all interviewed kebele there is no identified and registered training topic and training dates were available. The possible reason for this are that the absence of supervision during training period and the intension to cover the plan in its time (b/c they started model family HH training late at 2000,) This indicates that the training was not done according to national guideline and it is very difficult to say that the woreda is covered by trained model family households. Based on the findings from document review and HEW interview it was judged critical and it needs immediate action. The aim of community conversation is that community by itself discusses on all health issues concerning to that community for at least ten month (currently changed to five month) the discussion period or cessions must be twice a month and finally reach on decision how to avert that problem(5). In the contrary this study found that all the issues discussed and registered in CC registers in this woreda were related to HIV/AIDS no other issues were addressed and discussed. In addition there is no scheduled cession for identified topics to be discussed. And from those who were participated in CC only 107(44.6%) responded that they have discussed in the issues related to family planning and the rest 133(55.4%) responded that family planning issues are not discussed. This indicates that the principle of CC was not expanded to other health problems it is still focusing on HIV related issues.

It is true that each contraceptive has its own side effects. The service providers need to inform the clients and other eligible people who did not start using contraceptives, about the possible side effects of each method. By doing so clients can choose, in consultation with the provider the method that is most appropriate for her/him. When side effects occur,

the clients could come to the provider without too much fear since they have prior information about the method they are using (34,35). This study also identified that 81.9% of modren family planning method users were counselled about the possible cide effect of the method they used and the rest 8.1% were not counceled about the possible sideefect of the method they are using. And from those who practiced side effect 5(3.5%) stopped using any type of modern family planning method. This indicates that 8.1% of modren family planing method users are at risk of stoping using if side effect happened. Study conducted on Dambia district also revealed that side effects caused by the methods were also mentioned by a significant number of women as a reason for discontinuing or not having the desire to take contraceptives in the future (29).

Knowledge about available family planning method is the base for client to choose the method they want unless the client has enough information on available methods it is difficult to choose. The finding of this study identified that from 374 interviewed women 341 (91.2%) know at least one method of modern family planning method which is provided in the health post and 297(79.4%) of the respondents know that pills and Depo-Provera (injectable) are available in the health post but only 62(16.6%) of the respondents know the recommended methods condom, pill and Depo-Provera are available in the health post. This indicates that information about the available family planning method on women is poor which lead the clients to use the only method they know and it is judged as critical.

In order to graduate in model family household, one trainee should participate at least 75% of training sessions (72 hours) of model family house hold training hours and at least 75% (15 cessions) of community conversation sessions. This study revealed that there is no monitoring system established for MFHH training and it need urgent solution for the next phases but for community conversation the system is established and well functioning.

All activities performed specially MFHH training and graduation is not performed based on the national implementation guideline and community conversation was performed only for HIV related issue based on these finding the compliance dimension is judged as critically implemented.

Accessibility dimension: -.From the tool of seven indicators used to evaluate this dimension, only geographical accessibility of the service in this woreda was identified as successfully implemented that is almost all respondents agree that the distance is not a problem and 99.5% didn't used any type of transportation but foot. And in average one women were walking for 23.97 min (SD=14.87min) and referral linkages were established in all studied kebele and follow up mechanism was established were successful. Even though the HEW were responded that they are visiting 6_8 households per day per HEW and the HEW were working home visit 3 to 4 day per week each there was no registered home visit activity which indicates the services provided for that community so it is difficult to assume the services were provided. The other implementation strategy which was designed to increase the access for community was CC in which community discuses in all health related issues to reflect the community concern for action and in this case CC was focused only on HIV/AIDS issues only and the participants were not clearly identified and followed for completion of discussion period, which is much far from the national implementation strategy. In order to increase the community knowledge, according to the national implementation guideline, MFHH training should focus in all of the HEP packages but in all kebele included in this study there is no training topic (package) clearly identified. Based on the findings the overall level of implementation of this dimension was judged as critically implemented and it needs quick action to improve the service.

Acceptability of the services/acceptability dimension: - This study identified that 91.4% (n=342) have information about modern family and from those 88% (n=301) of those who have information on family planning were using some type of modern family planning method in this woreda. The main reasons identified for non use of modern family planning method were 18(40%) need for many children, 17(37.8%) due to religious reason and the rest 10(22.2%) were due to their husbands were not voluntary. Study conducted on Women's knowledge, preferences, and practices of modern contraceptive methods in Woreta, Ethiopia in April 2007 showed that the major reasons for non use of modern contraceptive methods (MCMs) were being single and a desire for more children. What is different in this study is that being single is not reason and 6 out of 7 interviewed single women were using modern family planning method. The other difference is that religion

factor in this study was identified as reason for non use but not in comparing study this indicates that there is a gap between Christians and Muslims in which in current study 96% of the respondents were Muslims and in other study 92.8 were orthodox Christians (30). And another study conducted in Jimma by BEEKLE A.T. and MCCABE C. Awareness and determinants of family planning practice in Jimma, Ethiopia revealed that 82.3% of the respondents have information on modern family planning and this study also identified the most commonly cited reasons for not using modern contraceptives were the desire for more children, fear of side effects, opposition from partner and religious beliefs (36). This difference may be due to time difference and currently the issue of family planning is being advocated in all places and the cultural influences are minimized. Based on the findings the acceptability of the program in target group is judged as successfully implemented.

From the findings from the four dimensions addressed in the evaluation, the level of implementation of the program in this woreda was judged as fairly implemented.

8 Conclusions and recommendation

8.1 Conclusion

In general the implementation level of the family planning package of the HEP in this woreda is fair according to the agreed criteria. The availability of human resource needed and recommended family planning methods were available in all health posts interviewed. But only 13(36%) of the health posts were fully functioning from the total of 36 HP in the woreda and still HP construction was not completed in 4 kebele.

Implementation strategies (model family household training home visit, community conversation) were implemented in all health posts. Model family house hold training was not conducted according to the national guideline that is the training topics were not identified in all health posts and community conversation was not expanded for all health problems other than HIV/AIDS. Home visit was performed in all kebele with an average of 6_8 household per day per HEW in all kebele but in all kebele this activity was not registered.

All recommended modern family planning methods were available in all HPs and there was no stock out occurred in the last three months and referral linkage was established in all health posts for those women who need long acting family planning methods. Knowledge about available family planning methods in the nearby health post or in the kebele was in critical condition in which only 16.4% of the respondents know all the recommended family planning methods. Most of modern family planning users from health post were satisfied by the services they got from the HP and almost all did not faced transportation problem to get the services. The most common cited reasons for non use of modern family planning methods were need for more children, husband was not voluntary and prohibition by religion.

8.2 Recommendation

The ultimate goal of this evaluation is to improve the implementation of the health service extension programme based on the findings from the study. To ensure responsibility of activities to be performed, recommendation is identified individually for Jimma zone health department Seke-chekorsa woreda health office, health centres, and health extension workers.

1. Jimma zone health department

- Should equip with medical equipments all health posts which lack medical equipment in Seke-chekorsa according to the standard.

2. Woreda health office

- Seke-chekorsa woreda health office should complete HP construction in 4 kebeles those did not completed construction
- Should avail registration and reporting materials (for Buyo kechema and Gura ula oke health posts).
- There should be strict follow up during model family household training and community conversation.

3. Heath centers

- Health centers should establish strong referral linkage with health posts and there should be feedback mechanism

4. Health posts

- All health posts should train and deploy community health workers with the standard of 2CHP for average of 40 households.
- Families who train less than 72 hours (75%) of training hours should not be graduated as model families.
- Environmental health, family health, major communicable disease control and the health education components of the HEP should have equal training session on model family household training.
- During model family house hold training, training date and topics and attendance of trainees should be registered.
- Community conversation should incorporate environmental health, family health, major communicable disease control and the health education components of the HEP
- Activities delivered in home visit should be registered in the way that answer the question what activities are delivered to whom and when.
- Health extension workers should inform all the available modern family planning methods in the health post for clients using in the health post
- Health extension workers should inform all women who are using modern family planning method about the possible side effect of the method they are using.

9 Meta evaluation

The concept of meta-evaluation was incorporated during the whole process of this study. The main issues addressed are those standards which are recommended by American evaluation association (AEA) and joint committee on standard for educational evaluation (JCEE).

9.1.1 Utility standard

This evaluation identified the potential stakeholders. During identification the snowball technique was applied with the primary stakeholder reaching to the leadership figures to address who are importantly affected by the program either positively or negatively. Discussion with stakeholders during meeting particularly emphasized on the overall purpose of the evaluation to come up with the best evaluation question which really

generates the interests of the most important stakeholders. This in turn ensures the actual utilization of the evaluation

9.1.2 **Feasibility standard**

The evaluation was conducted at reasonable time, manpower and all reasonable cost so that it meant to produce justifiable findings so that the intended users will utilize it. The cost that the evaluation study requires was established based on the activity detail that were carried throughout the process of evaluation.

9.1.3 **Propriety standards**

Data collection of the study was started after the proposal gets passed the Jimma university ethical clearance board approval. Formal written agreement was made with Sake-chekorsa woreda health office emphasizing on evaluation purpose and evaluation questions. The cultural diversity, norms and values of the community were considered during data collection and data collectors were recruited accordingly.

9.1.4 **Accuracy standard**

Accuracy of the study was ensured through checking the consistency of data gathered from different sources. Pre- test of tools was done in similar settings which was not included in the study area.

10 Limitations of the study

Due to the nature of case study it may create difficulty to generalize for the whole woreda and there might be recall bias of respondents in community survey.

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12 Appendixes

12.1 Questioner for community survey

Good morning/Afternoon! My name is _____. I am from Seke-chekorsa woreda health office. I am working for Seke woreda health center. This is to evaluate the health extension program implementation and to recommend solutions to improve the service.

I would like you to answer some questions in order to learn about your experiences because it will help Seke woreda and Jimma zone health department to improve the program.

You do not have to answer any question if you do not want to and you can stop the interview at any time. The information you give is also confidential.

Are you voluntary to continue with questions?

1. Yes _____ continue
2. No _____ thank and stop interview

Date____/____/_____ Questioner no_____

Interviewer_____ Supervisor_____

Sn	Question		If skip to
100	**Socio-demographic**		
101	How old are you?	----/years 98 I don't know	
102	What is your religion?	1. Muslim 2. Orthodox 3. Protestant 4. Others specify	
103	What is your marital status	1. Single 2. Married 3. Divorced 4. Widowed	
104	What is your ethnicity?	1. Oromo 2. Amhara 3. Keffa 4. Dawuro 5. Other specify	
105	What is your educational level?	1. Illiterate 2. Primary 1-4 3. Juner level (5-8) 4. Secondary level (8-12) 5. Tertiary level (12+)	

106	What is your occupation?	1. House wives (unemployed) 2. Employed 3. Daily labor worker 4. Other specify-------	
107	Now are you living with your husband?	1. Yes 2. No	2 → Q110
108	What is the educational level of your husband?	1. Illiterate 2. Primary level (1-8) 3. Secondary level (8-12) 4. Tertiary level (12+) 5. Other specify	
109	What is occupation of your husband?	1. Farmer 2. Merchant 3. Employed 4. Daily labor worker 5. Other specify-------	
110	How many children do you have?	------- children	
111	What is the age of your last baby?	-------- year	
112	Are you pregnant now?	1. Yes 2. No	1 → Q201
113	Are you planning when to have the next child?	1. Yes 2. No	
200	***Questions about knowledge of family planning***		
201	Do you know about family planning?	1. Yes 2. No	2 → Q301
202	If yes what is its use? MULTIPLE ANSWER POSSIBLE	1. It help for spacing b/n children 2. It help to keep mothers healthy 3. It help for economic development 4. Other /specify	
203	What family planning methods do you know? MULTIPLE ANSWER POSSIBLE	1. Condom 2. Pills 3. Injectables 4. Vasectomy 5. Norplant 6. IUCD	

204	What is the source of information? MULTIPLE ANSWER POSSIBLE	1. Health center and hospitals 2. HEW/ health post 3. CHP/CBD 4. From mass media 5. Other specify	
205	Have you ever practiced any type of family planning method?	1. Yes 2. No	2 → Q213
206	What is the method?	1. Condom 2. Pills 3. Injectables 4. Vasectomy 5. Norplant 6. IUCD	
207	What family planning method you prefer most	1. Condom 2. Pills 3. Injectebles 4. Vasectomy 5. Norplant 6. IUCD	
208	Who did decided to use this method?	1. It is me myself 2. Together with my husband 3. My husband 4. The HEW/CHP/CBD (provider) 5. Other	
209	Have you ever practiced side effect of family planning method you used?	1. Yes 2. No	2→ Q211
210	What is the side effect	1. Weight gain 2. Weight loss 3. Distorted menstrual/irregular blood flow/ cycle 4. Headache	
211	Did you told that it may occur when you start using it?/counselled	1. Yes 2. No	
212	So what action did you took for side effect?	1. I have consulted and changed other family planning method 2. I have stopped using any method 3. Other specify	

213	What is your reason for not using family planning	1. b/c I want to have many children 2. my husband is not voluntary 3. it is not recommended in my religion 4. I did not get the access for the service	
300	**Question for access**		
301	Do you know the service that HP in your kebele provides?	1. Yes 2. No	2→ Q303
302	What are the services	1. EPI 2. ANC 3. Delivery service 4. PNC 5. Health education 6. Family planning service 7. VCT service 8. Malaria	
303	What transportation would you use to go to HP	1. In foot 2. Animal 3. By bus 4. Other specify	
304	Do you think distance from your home to HP is not problem to get access?	1. Yes 2. No	
305	How far does it take from your home to HP?	---------- minutes	
306	Have you ever visited by HEWs from HPs?	1. Yes 2. No	2→ Q308
307	What advice did she gave to you during her last visit to your family	1. EPI 2. Maternal health 3. Family planning 4. Nutrition 5. Environmental sanitation 6. Personal hygiene 7. Water sanitation 8. Rodent and insect control 9. Communicable disease control 10. Housing and institutional health 11. HIV/AIDS 12. Malaria 13. Other specify	
308	Have you ever used family planning service from HP in your kebele?	1. Yes 2. No	2→Q313
309	Did you get your firs chose	1. Yes	

	in the health post?	2. No	
310	How do you see the service provision in the health post	1. I am satisfied with the service I got 2. It is satisfactory with exception 3. I am not satisfied with the service which I got	3 → Q312
311	What is the main satisfaction you get from the HP	1. It is easily accessible 2. I got my choice 3. The HEW remind me the appointment date 4. b/c they are females and I can discus freely with them 5. other specify	
312	What is that dissatisfied you in that HP	1. it is not opened all times 2. the services are limited /I didn't get my first choice 3. the approach is not good 4. it is far from my home and I am very tiered journey 5. the compound/service provision area is not convenient (not confidential)	
313	Why you didn't use in the HP?	1. b/c I think that the service are not quality service 2. I do not like the HEWs in that health post. 3. B/c I don't want that anybody in my surrounding be aware of that I am using family planning method. 4. B/c I have started the service before it is started in this HP and I am interested in that service	
314	If you are not using from HP from where are you using the service	1. From other HP 2. HC 3. Hospital 4. Private health institutions	
315	Is there anybody in this village that you can get information about family planning?	1. Yes 2. No	2 → Q317

316	If yes who is it?	1. CHP/CBD 2. Women leaders 3. Agricultural professionals in the kebele 4. Teachers in the village 5. other relatives	
318	Have you ever trained MHH training?	1. Yes 2. No	2 → Q323
319	When did you graduate?	1. 1999 EC 2. 2000EC 3. 2001EC 4. 2002 EC 5. Now on training	
320	Did you receive certificate for completing the training?	1. Yes 2. No	If yes check the certificate
321	What topics are covered in the training?	1. EPI 2. Maternal health 3. Family planning 4. Nutrition 5. Environmental sanitation 6. Personal hygiene 7. Water sanitation 8. Rodent and insect control 9. Communicable disease control 10. Housing and institutional health 11. HIV/AIDS 12. Malaria 13. Other specify	
322	For how long did you train?	1. One month 2. Two month 3. Three month 4. Two weeks	
323	Did your husband trained MHH training?	1. Yes 2. No 3. I don't know	If yes check certificate
324	Did he inform you what he learned from training?	1. Yes 2. No	2 → Q326
325	What topics did he inform to you?	1. EPI 2. Maternal health 3. Family planning 4. Nutrition 5. Environmental sanitation 6. Personal hygiene 7. Water sanitation	

		8. Rodent and insect control 9. Communicable disease control 10. Housing and institutional health 11. HIV/AIDS 12. Malaria 13. Other specify	
326	Have you ever participated in CC?	1. Yes 2. No	2 ⟶Q331
327	When did you participate?	1. 1999 EC 2. 2000 EC 3. 2001 EC 4. 2002 EC	
328	What common topic covered?	1. EPI 2. Maternal health 3. Family planning 4. Nutrition 5. Environmental sanitation 6. Personal hygiene 7. Water sanitation 8. Rodent and insect control 9. Communicable disease control 10. Housing and institutional health 11. HIV/AIDS 12. Malaria	
329	For how long did you participate in the conversation?	-------- month	
330	How frequently did you meet for conversation	1. Once a month 2. Twice a month 3. Three times a month 4. Occasionally 5. If other specify	
331	Did your husband participated in CC	1. Yes 2. No 3. I don't know	1or2 end the interview
332	Did he inform you what he trained?	1. Yes 2. No	1or2 end the interview

333	What issues did he informed for you	1. EPI 2. Maternal health 3. Family planning 4. Nutrition 5. Environmental sanitation 6. Personal hygiene 7. Water sanitation 8. Rodent and insect control 9. Communicable disease control 10. Housing and institutional health 11. HIV/AIDS 12. Malaria	

Finally I thank you for your coordination

12.2 Questions for health extension workers

Name of kebele _____

Total population _____

Women in Reproductive age_____

No HEWs in the kebele _____

No of villages_____

No of CHP_____

1. What strategies are you using?
    a) House visit
    b) MHH training
    c) CC
    d) Static service at health post
2. Are you training MHHs in this HP? A) Yes B) No If yes for how long years?

a) One c) three
b) Two d) four

3. Do you have enough training materials? A) Yes B) no if yes What are there?
   a) Guidelines c) audiovisual aids
   b) Brushers d) posters
   c) Others specify
4. How was the selection of those trainees for training and their number
   a. Number of trainee per one phase _____
   Selection criteria
      a) no selection criteria simply by village
      b) those who are innovative and can take massage
      c) voluntary for training
      d) relatives
5. What is your training mechanism? Would you explain it
   1) Theoretically in health post
   2) Practical at community level where the place is convenient for trainees
   3) Demonstration
   4) Other specify _____
6. For how long time do one phase take to train (in hrs) ?_____
7. Did all components of the health extension components are covered during training? Yes___ no_____
8. Did all the components of the HEP are given the same weight? If not why?
   1) Yes 2) No
9. Do you certify those who graduate after completion of training? If not why?
   1) yes 2) no
10. Are there any women who graduated after completion of the training? 1) yes 2) No
11. Do you think that men who are graduating as MHH family are expanding the health massages for their families? Yes _____ no _____
12. If yes how do you express the change in your community with regard to model house hold graduation?

    _____
    _____
    _____
    _____

13. Is there anybody that helps you in training and how you express their help for this program?
    2) CHP 5) women leaders
    3) Community leaders religious leaders
    4) Agricultural professional

14. Do you conduct CC? yes _____ No_____ For how long? _____
15. How do you select participants?

    _____
    _____
    _____
    _____
16. What proportion of your community is still covered by community CC? (as cumulative)_____
17. Did family planning package is incorporated in model house hold training? Yes ____no ___
18. What method do you use to train your trainees about family planning?_____
    _____
    _____
19. Do you have the necessary materials for family planning training in MHH training? Yes _____ No _____
20. Do you conducted house to house visit? Yes_____ no_____ if yes how many house don you visit per day?_____ what family planning activities do you provide during home visit
    1) Counseling
    2) Remind those who have appointment
    3) Provision of pills and condom for those who need
    4) Other specify
21. How do you express those who are graduated from MHH and those not trained on family planning service utilization?

    _____
    _____
    _____
22. What family planning services do you provide?
    1) Counseling
    2) Condom
    3) Pills
    4) Depo-Provera
    5) Other specify
23. Do you have enough stock of supply now? Yes _____ No _____
24. For what method did stock out occurred in the past three month?
    1) Condom
    2) Pills
    3) Depo-Provera
    4) Other specify

25. What is the most frequently used method in your community?
    1) Condom
    2) Pills
    3) Depo-Provera
    4) Other specify
26. How do you differentiate condom users ether for HIV prevention or family planning service?
27. What do you do for those who prefer services which are not found in your HP?
28. Did you inform your clients about the possible side effect of the method you provide to them? Yes ____ no ____
29. If the side effect happened what can you do?
    1) Changing other method
    2) Referring to other health facility (HC)
    3) I advise to continue if the problem is not serious
    4) Other specify -----

I thank you for all your coordination

12.3 Tool for health post inventory

Name of health post_____

Observe/ask the following

1. Opening date of HP_____ opening time_____ closing time_____
2. Is there sign or poster advertising availability of family planning service? Yes____No_____
3. Are there waiting seats for clients? Yes____No____
4. Are there working toilets for clients? Yes____No_____
5. Is there designated area for family planning service? Yes____N0_____
6. Is there private place available for counseling where other clients cannot hear and see? Yes___No_____
7. Which of the following equipments and commodities available?

Sn	Equipment or commodity	Available	Not available	Remark
	Equipments			
	Thermometer			
	Stethoscope			

	Disposable syringe			
	Blood pressure gauge			
	Fethoscop			
	Dildo/penice model			
	Delivery coach			
	Examination bed			
	Contraceptive commodities			
	Pills combined			
	Pills progesterone only			
	Male condom			
	Depo-Provera			
	IEC materials			
	Poster			
	Flip chart			
	Brochure			
	Information sheet			
	Job aid			
	Counselling card			
	Other			

8. Are the commodities drugs stored according to their expiry date? Yes____N0____
9. Is there expired drug? Yes____No_____
10. Service provided starting from 1999EC -2002 EC documents

Sn	Activity	1999		2000		2001		2002	
		No	%	No	%	No	%	No	%
1	MHH graduation								
2	CC participants								
3	Total house visited								
4	Total new FP acceptors								
5	Total continual and repeat acceptors								
6	Total mothers refered for long								

	term FP method								

11. Model house hold training and community conversation

Tool developed to check topics and cessions covered by CC and MHH training

Sn	Date of CC conducted	Topic covered /discussed	Participants		Decision made/consensuses	Reported date
			Male	Female		
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

12. Tool/checklist developed to check model household training

Sn	***Date***	***Topic of training***	***Participants of training***		***Method of training***	***Remark***
			Male	Female		

12.4 Informed consent of the study

Informed consent from all of participants of the study will be assured and the consent form is stated bellow in both in English and local language (afan Oromifa).

Good morning/Afternoon! My name is _____. I am from Seke-chekorsa woreda health office. I am working for Seke woreda health center. This is to evaluate the health extension program implementation and to recommend solutions to improve the service.

I would like you to answer some questions in order to learn about your experiences because it will help Seke woreda and Jimma zone health department to improve the program.

You do not have to answer any question if you do not want to and you can stop the interview at any time. The information you give is also confidential.

Are you voluntary to continue with questions?

3. Yes _____ continue
4. No _____ thank and stop interview

Translated informed consent in Oromifa language is stated below

Akkam bultan/akkam oltan! Maqaan koo _____jedhamaa. Kan dhufee biro fayyaa anaa saqqaa choqorsaa irraayi. Kan dhufeef maddallii sagantaa pakeejii ekstenshinii fayaa hojii irra olchuu fi kallatti hojii fi yaada furmaata kenun tajaajila foyessuf.

Kanaaf gaafillee armman gadii debisun muxanno isiin qabdan baru barbaachisaa ta'a, kunimmo anaa kessani fi biro fayyaa zoni jimma tajaajila foyeessuf gargaara.

Gaafii debisuu hin darbaadnee irra darbe dandenya. Akkasumas yoo barbaachisaa ta'ee sitti mul'ate yeroo barbaadetii gaafi fi deebi dhaabu dandessaa. Odeeffannoo atti icittin egamaa.

12.5 Translated tools (in to afan Oromifa)

Gaafiile hawaasa dhiyaatee

Akkam bultan/akkam oltan! Maqaan koo _____jedhamaa. Kan dhufee biro fayyaa anaa saqqaa choqorsaa irraayi. Kan dhufeef maddallii sagantaa pakeejii ekstenshinii fayaa hojii irra olchuu fi kallatti hojii fi yaada furmaata kenun tajaajila foyessuf.

Kanaaf gaafillee armman gadii debisun muxanno isiin qabdan baru barbaachisaa ta'a, kunimmo anaa kessani fi biro fayyaa zoni jimma tajaajila foyeessuf gargaara.

Gaafii debisuu hin darbaadnee irra darbe dandenya. Akkasumas yoo barbaachisaa ta'ee sitti mul'ate yeroo barbaadetii gaafi fi deebi dhaabu dandessaa. Odeeffannoo atti icittin egamaa.

Gaafii fi deebi calqabuu dandenyaa?

1. **Eyyen_____gaafi deebi calqabi**
2. **Lakkii _____ galatedhuti gaafi fi deebi assumattii dhaabi**

Guyyaa_____/_____/_____

Nama gaafi deebi ademsisee_____

Supervisarii_____

Lakkofsa addaa gaafii_____

Lakk.	Gaafii		Yoo utaalu/irra darbu barbaade
100	**Gaafilee bu'uraa**		
101	Umriin kee meqaa?	----/waggaa/ 98 hin beku	
102	Amantiin kee maalii?	5. Muslim 6. Ortodoksii 7. Protestaantii 8. Kan biro ibsii	
103	Haalli heruma kee maal fakaata	5. Kan hin herumne/funee 6. Kan herumte/fudhee 7. Kan hikte/hikee 8. Kan jalaa du'ee	
104	Sabni kee maalii?	6. Oromoo 7. Amaaraa 8. Kafaa	

		9. Daawuro 10. Other specify	
105	Sadarkaa barnoota?	6. Kan hin baranne 7. Sadarka tokkoffaa 1-4 8. junarii (5-8) 9. sadarkaa lamaffaa (8-12) 10. sadarkaa sadaffaa (12+)	
106	Ogumma hojii?	5. Hadha manaa (kan hin qaxaramnee) 6. Qaxaramaa/tu (kan mindaa qabu) 7. Hojataa guyyaa 8. Kan biro ibsii-------	
107	Abba manaa kee wajji jiraataa?	3. eyyee 4. lakkii	2 → gaafii110
108	Sadarkaa barnootaa abbaa manaa kee maal fakkaata?	6. Kan hin barranne 7. Sadarkaa tokkoffaa (1-8) 8. Sadarkaa lamafaa (8-12) 9. Sadarkaa sadaffaa (12+) 10. Kan biro ibsi_____	
109	Ogummaan hojii abbaa manaa keeti maali?	6. Qotee bulaa 7. Daldalaa 8. Qaxaramaa(abba mindaa) 9. Hojataa guyyaa 10. Kan biro ibsii-------	
110	Ijoolle meqa qabdaa?	-------	
111	Umriin da'ima keeti isaa xiqaa meeqa?	-------- /waggaa/	
112	Garaadha ni qabdaa?	3. eyyee 4. lakkii	1 → gaafii 201
113	Kanatti ansitee yoom akka dhaltu karoora qabdaa?	3. eyyee 4. lakkii	
200	***Gaafii qusanno maatii ilaalchise***		
201	Qusanna maatii ni beektaa?	3. eyyee 4. Lakkii	2 →Q301
202	Yoo eyyee jette, fayidaan issa maal? DEEBII TOKKO OL NI DANDA"AMAA	5. Addaan fagesani dhaluuf gargaara 6. Fayyaa hadholee eguf gargaara 7. Gudina dinagdetiif gargaara 8. Kan biro ibsii	
203	Qusanno maatii akkami beektaa? DEEBII TOKKO OL NI DANDA"AMAA	7. kondomii 8. Pillsii 9. Kan limeen kenamu 10. Sanyiin dhiraa akka hin bane	

		gudunfu 11. Dawaa ciqilee irratti awaalamu 12. Kan gadaamessa kessa galu	
204	Odeffanoo essaa argataa? DEEBII TOKKO OL NI DANDA”AMAA	6. Bufata fayyaa fi hospitaala irraa 7. Hojatoota eksteenshinii fayyaa fi kelle fayya irraa 8. Hojataa fayya gandaa 9. Midiyaa adda addaa irraa 10. Kan biro ibsii	
205	Kanaan dura qusanno maati fayadamtee bektaa??	3. eyyee 4. lakkii	2 → Q213
206	Kam fayadamtee?	7. kondomii 8. Pillsii 9. Kan limeen kennamu 10. Sanyii dhiraa akka hinbaane gudunfu 11. Kan ciqilee kessa awaalamuu 12. Kan gadaamessa kessa awaalamu	
207	Qusannoo maatii kam filataa?	1. Kondomii 2. Pillsii 3. Kan limeen kennamu 4. Sanyii dhiraa akka hinbaane gudunfu 5. Kan ciqilee kessa awaalamuu 6. Kan gadaamessa kessa awaalamu	
208	Qusanno kan akka filatu kan murtesse enyu?	6. Ofi kiyya 7. Abbaa warra kiyya wajiin 8. Abbaa warraa kiyyatu murtesse 9. Hojatoota fayyaa (provider) 10. Kan biro ibsii	
209	Midhaa qusannoo maatii fayadamtu irraa si qaqabe jiraa?	3. eyyee 4. lakkii	2→ Q211
210	Midhaa si gesse maalii?	5. Ulfaatina dabalu 6. Ulfaatina hir’isu 7. Laguu yeroo isaa egatu dhisu 8. Bowoo mataa	
211	Yeroo calqabaa irratti halli akkasi akka siqunmu gorsii siif kenameraa?	3. eyyee 4. lakkii	
212	Tarkaanfii maal fudhatte?	4. Hojataa fayyaatti himee akka jijiramu godhera 5. Qusanno maatii fayyadamu dhiseeraa 6. Kan biro ibsi_____	

213	Qusanno maati maalif hin fayadamne?	5. Ijolle baay'ee waan barbaaduf 6. Abbaan warraa kiya fayadamu waan hin barbaadneef 7. Amantin kiya hin hayyamu 8. Tajaajila argachuuf rakkisa dha	
300	**Gaafilee tajaajila fayyaa dhiyessu madaaluuf gaafataman**		
301	Tajaajila kellaan fayyaa naanno kee jiru maal akka ta'e sirritti bektaa?	3. eyyeen 4. lakki	2→ gaafii 303
302	Tajaajilli kennu maal fa'a?	9. Talaalli 10. Tajaajila hadholi ulfaa 11. Tajaajila da'umsa 12. Tajaajila hadholi dahaniif 13. Barumsa fayyaa 14. Tajaajila qusanno maati 15. Tajaajil gorsaa fi qoranno dhigaa 16. Busaa dhabamsisu fi yaalu	
303	Kellaa fayyaa demuuf maal fayyadamtu?	5. lukaan 6. gaangee/farada 7. konkolaataa 8. kan biro ibsii_____	
304	Fagenyii kellaan fayyaa qabu ittin fayyadama irratti rakko dha jette yaaddaa?	3. eyyen 4. lakkii	
305	Kellaa fayyaa dhaqabuuf yeroo hamam sitti fudhataa?	---------- (daqiqaa)	
306	Hojatonni eksteenshini fayya dhufani isiinlaalani beku?	3. eyyeen 4. lakkii	2 → gaafii 308
307	Barumsii hojatonni fayyaa yoo dhufan isiin keennan maalfaa?	14. Talaali ilaalchisee 15. Fayyaa hadholii ilaalchisee 16. Qusanno maati ilaalchisee 17. Haala nyaataa ilaalchise 18. Egumsa fayyaa naanoo 19. Qulqulina dhunfaa illalchise 20. Qulqulina bishaani 21. To'anno ilbisotaa 22. Dukuba dadarbu ilaalchisee 23. Fayyaa manaa fi dhaabata itti hojatu 24. HIV/AIDS 25. Waa'ee busaa 26. Kan biro ibsii----------	
308	Kellaa fayyaa demtee	3. eyyeen	2 → gaafii 313

	qusanno maatii fayyadamte beettaa?	4. lakkii	
309	Filanno toftaa qusanno maatii kellaa fayyaa naannoo kee jirutti argataa?	3. eyyeen 4. lakkii	
310	Haala keninsa fayyaa kellaa fayya naanno kee jiru akkamitti ilaalta?	4. Tajaajila kennamun gamaderaa 5. Baayee nama hin gamachisu 6. Tajaajila kennamun hin gamadne	3 ⟶ gaafii 312
311	tajaajili Kellaa fayyaa naannoo kee kanatti kan sigamachisee maali?	6. Tajaajila argachuun salphaa dha 7. Fillanno kiyyaa argadheraa 8. Hojatonni eksteenshinii fayya guyya belama nayaadachisuu 9. Dubartoota waan ta'aniif waliin mari'achun salphaa dha 10. Kan biro ibsi	
312	Kellaa fayyaa kanatti tajaajilli si hin gammachisnee maalii?	6. Yeroo hunda tajaajilaaf banaa miti 7. Tajaajili kenamu xiqqo waan ta'eef filanno kiyya hin arganne 8. Haali itti kessumessan natty hin tolle 9. kellaan fayyaa fagoo dha 10. Naannoon tajaajilli kun itti kennam namatti hintolu (icitiin hin egamul)	
313	Kellaa fayyaattii maalif hin fayyadamne?	5. Tajaajilli keenamu ga'umsa hin qabu 6. Hojatota eksteenshini kellaa fayyaa hin jaaladhu 7. Namonni naannoo Kenya jiran qusannaa maatii akka fayyadamu beku hin qaban. 8. Kellaan fayyaa osoo hin banamin bakka biraatti jalqabeef	
314	Kellaa fayyaa naannoo kanatti yoo hin fayyadamne essatti fayyadamtaa?	5. Kellaa fayyaa biraatti 6. Bufata fayyaatti 7. Hospitaala 8. Dhaabata fayyaa dhunfaatti	
315	Aradaa kanaratti namni odefanno qusanno maatii ilaalchisee siif kennu jiraa?	3. eyyen 4. lakkii	2 ⟶ gaafii 317

316	Yoo jira ta'e enyu inni?	6. Hojataa fayyaa hawaasaa 7. Hogantoota dubartoota 8. Hojatootaa misooma qonnaa 9. Barsiistota araddaa kessa jiran 10. Fira biroo	
318	Leenji fakki abbaa warraa leenjite bektaa?	3. eyyeen 4. lakkii	2 → Gaafii 323
319	Leenjii yoom xumurtee?	6. 1999 EC 7. 2000EC 8. 2001EC 9. 2002 EC 10. Amma leenji irra jira	
320	Leenjii xumuru kee waraqaa ragaa qabdaa?	3. eyyeen 4. lakkii	Eyyeen yoo jette waraqaa ragaa jiraachu isa mirkanessi
321	Mata dure hammataman maal fa'a?	14. Talaali ilaalchise 15. Fayyaa hadholii ilaalchise 16. Waa'ee qusannoo maatii 17. Haala nyaataa 18. Qulqulina naannoo 19. Qulqulina dhunfaa 20. Qulqulina bishaani 21. Ittisa ilbisotaa fi hantutaa 22. Dhukuba dadarbaa 23. Qulqulina manaa fi iddoo hoji 24. HIV/AIDS 25. Busaa ilaalchisee 26. Kan biro ibsii	
322	Yeroo hammamiif leenjii fudhatte?	5. Ji'a tokko 6. Ji'a lama 7. Ji'a sadii 8. Two weeks	
323	Abbaan warraa kee leenjii fakki abbaa warraa fudhate bekaa ?	4. eyyeen 5. lakkii 6. hin bekuu	Eyyen yoo jette waraqaa raga leenjich jiraachu mirkanessi
324	Odefanno leenjii irraa argatee siif himeeraa?	3. eyyeen 4. lakkii	2 → Gaafii 326
325	Waa'ee maal fa'a sitti himee?	14. Waa'ee talaalli 27. Talaali ilaalchise 28. Fayyaa hadholii ilaalchise 29. Waa'ee qusannoo maatii	

		30. Haala nyaataa 31. Qulqulina naannoo 32. Qulqulina dhunfaa 33. Qulqulina bishaani 34. Ittisa ilbisotaa fi hantutaa 35. Dhukuba dadarbaa 36. Qulqulina manaa fi iddoo hoji 37. HIV/AIDS 38. Busaa ilaalchisee 15. Kan biro ibsii	
326	Marii hawaasaa irratti hirmaatte beektaa?	3. eyyeen 4. lakkii	2 → gaafii 331
327	Yoom hirmaattee?	5. 1999 EC 6. 2000 EC 7. 2001 EC 8. 2002 EC	
328	Waa'ee maalii mari'atan?	1. Talaali ilaalchise 2. Fayyaa hadholii ilaalchise 3. Waa'ee qusannoo maatii 4. Haala nyaataa 5. Qulqulina naannoo 6. Qulqulina dhunfaa 7. Qulqulina bishaani 8. Ittisa ilbisotaa fi hantutaa 9. Dhukuba dadarbaa 10. Qulqulina manaa fi iddoo hoji 11. HIV/AIDS 12. Busaa ilaalchisee 13. Kan biro ibsii	
329	Yeeroo hammamif marii irra turtee?	-------- (ji'a)	
330	Yeeroo hammamin marii gotan	6. Ji'an yeeroo tokko 7. Ji'an yeeroo lama 8. Ji'an yeeroo sadii 9. Yeeroo tokko tokko 10. Kan biro ibsii----------	
331	Abbaan warraa kettii marii hawaasa ni hirmaataa	4. eyyeen 5. lakkii 6. hin beku	1ykn 2 gaafii xumurii
332	Waa'ee leenji'ee sitti himaa?	3. eyyeen 4. lakki	1or2 gaafii xumurii

333	Waa'ee maalii sittii himee?	1 Talaali ilaalchise 2 Fayyaa hadholii ilaalchise 3 Waa'ee qusannoo maatii 4 Haala nyaataa 5 Qulqulina naannoo 6 Qulqulina dhunfaa 7 Qulqulina bishaani 8 Ittisa ilbisotaa fi hantutaa 9 Dhukuba dadarbaa 10 Qulqulina manaa fi iddoo hoji 11 HIV/AIDS 12 Busaa ilaalchisee 13 Kan biro ibsii	

Gaafii hojatoota ekstenshini fayya

Maqaa Araddaa_____

Baayina ummataaa_____

Dubrtoota umrii da'msaa keessa jiran_____

Baayina hojatoota eksteenshinii fayyaa araddaa_____

Baayina goxii_____

Baayina Hojatoota fayyaa Hawaasaa_____

1. Tooftaa akkamit fayyadamtu?

a) Mana manarra demuu

b) Fakkii abbaaa warra

c) Marii hawaasaa

d) Dhaabbata fayyaa qofatti

2. Fakkii abbaa warraa leenjistee baktaa? A) eyyeen B)lakkii Yoo eyyen jette, wagga meqaaf?

a) Tokko b) lama c) sadii d) afur

3. Meshaale ittin lenjistu gaha ta'e qabdaa? A) eyyen B) lakkii Yoo eyyen jette , maalfaa qabdaa?

a) Qajeelfamaa

b) Barulle adda addaa FKN. Lifletii

c) Meshaalee odiyoovizhuwaalii

d) Postarii

e) Kan biro yoo jiraatee ibsii

4. Namoota leenjistu akkamin filattaa? Lakkofsa isaani hoo akkamin murtesita?

a) Ulaagalle ittin filadhu hin qabu Garuu goxiin filadhaa

b) Namoota adda duree ta'an fi jijirama kan fudhatan

c) Leenjidhaaf fedhii kan qaban

d) Fira kan ta'an

5. Tooftaa ittin leenjistu maalii? Ibsu dandessaa?

1) Kellaa fayya kessatti tiyooridhaan

2) Hawaasa kessatti hojii qabatamaan agarsiisun

3) Fakkidhaan agarsiisun

4) Kan biro yoo jiraate ibsi

6. Marsaa tokko xummuruf yeroo meqa fayadamtaa?_____

7. Paakejiin hundii leenjii kessatti hammatame jiraa?

a) Eyyen b) lakkii

8. Paakejiin hundii xiyeefannaa wal qixa ta'ee kennamafii? Yoo hin taanee maaliif?

a) Eyyen b) lakkii

9. Leenjii yoo xumurtuu leenjitotaf sartifikeetii ni kenitaa?

a) Eyyeen b) lakkii

10. Namoonni leenjii xumuran jiruu?

a) Eyyeen b) lakkii

11. Abbootiin warraa leenjii kana fudhatan odeeffanno argetan maatii isaanitiif nii dabasu jetanii yaaddu?

a) Eyyeen b) lakkii

12. Yoo eyyeen jettee, jijirama fakki abba warraatin hawaasa kessatii mul'atu akkamin

ibsitaa?

_____

_____

_____

13. Qaamni leenjii si gargaaru jiraa? gargaarsa isaani akkamiin ibsitaa?

a) Hogantoota amantii

b) Hojatoota fayya hawaasa

c) Hogantoota hawaasaa

d) Ogessota misoma qonnaa

e) Hogantoota dubartootaa

14. Marii hawaasaa gageesitee bektaa? A) eyyeen B) lakkii Yeroo hangamiif?_____

15. Hirmaatota akkamiin filatee?_____
_____
_____

16. Hawaasni marii hawaasaa irratti hirmaatee walumatii hamam ta'a?_____

17. Paakejiin qusanno maatii lenjii fakki abba warra irratii kenameraa?

a) Eyyeen b) lakkii

18. Waa'ee qusanno maatii yoo lenjiisti tooftaa akkamiin fayyadamtaa?_____
_____
_____
_____

19. Meeshaalee fakkii abba warraa waa'ee qusanno maatii ittin lenjistu qabdaa?

a) Eyyeen b) lakkii

20. Hordoffi mana mana irraa gotee bektaa? Eyyen____lakkii_____ yoo eyyen jette, guyaatti mana meqa illalta?_____ yeroo kanatii hojii qusanno maatii akkami hojatuu?

a) Gorsa

b) Namoota belama qaban yaadachisna

c) Pilsii fi koondomiinnama barbaaduf ni keninaa

d) Kan biro yoo jiraate ibsii

21. Fakki abba warra leenjii xumuran fi waa'ee qusanno maatii kan hin leenjinee akkamitti ibsitaa?_____
_____
_____
_____

22. Tajaajila qusanno maatii kam keetu?

a) Gorsa

b) Kondomii

c) Pilsii

d) Kan limmen kenamuu

e) Kan biro yoo jiraate ibsii

23. Kusaan qusanno maatii qabdu gahaa dha? A) eyyen b) lakkii

24. Baatii sadan darban keessattii dawaa qusanno maatii dhumme kamii?

a) Kondomii

b) Pilsii

c) Kan limmen kenamu

d) Kan biro yoo jiraate ibsii

25. qusanno maatti hawaasni irra caalatti fayyadamu kamii?

a) Kondomii

b) Pillsi

c) Kan limmen kenamu

d) Kan bira yoo jiraate ibsii

26. Namoota kondomii fayadaman qusanno maatiif akka ta'e yookiin HIV/edsii ittisuf akka ta'e akkamiin adda
baasta?_____
_____
_____
_____

27. Namoota qusanno maatii keellaa fayaa isii keessa hin jiraannee filataniif maal gotu?
_____
_____
_____

28. Maamila/tajaajilamtoota keessaniif midhaan hin egamnee tooftaa qussanno maatii qabu itti himtu?

a) Eyyeen b) lakkii

29. Midhaan hin egamnee yoo isaan qunnamee maal gotuu?

a) Qusanno maatii toofta biraa jijiru

b) Gara dhaabata olaanaattii ergu

c) Midhaan yoo guddaa hin taanee akka itti fufan gochu

d) Kan bira yoo jiraatee ibsii

GARGAARSA KESSANIIF BAAYEE ISIIN GALATOMFADHAA!

Gaafii keellaa fayya illaachisee

Maqaa keellaa fayyaa _____

Gaafadhuu yookin ilaali

1. Guyaa keellaan fayyaa tajaajila ittii kenu _____ yeroo tajaajilli itti kenamu_____ yeroo itti cufamu_____

2. Postarii waa'ee qusanno maatii ibsuu keellaa fayyaa kessatii maxanfamee jira?

a) Eyyeen b) lakkii

3. Keella fayyaa keessatii tessumni maamiltonii irra ta'an jira?

a) Eyyeen b) lakkii

4. Manni fincaani tajaajila kennu jira? A) eyyeen B) no

5. Kutaan qusanno maatii itti kenamuu addan baayee jira? A) eyyen B) lakkii

6. Kutaan gorsii itti kennamu addatiti baayee jiraa? A) eyyen B) lakkii

7. Kan armaan gadii keessaa meshaaleen/dawaa keellaa fayyaa keessan keessatti kan argemu kamii?

Lakk.	Akaaku meeshaalee /dawaaNi	Argamaa	Hin argamu	Ibsa
	Meeshaalee			
	Termometri			
	Stetoskoppii			
	Lime ittin fayadamtee gattu			
	Meeshaa dhibba dhigaa ittin safaran			
	Fetoskooppii			
	Modeelii qaama hormaata dhiraa			
	Siree irra cisan dahan			
	Siree irratti dhukubsataa qoratan			
	Dawaa qusannoo maatii			
	pilsii			
	Pilsii projestronii qofa qabu			
	Koondomii dhira			
	Dawaa qusanno maati limmen			

	kenamu			
	Meshaalee barsiisuf gargaaran			
	Postarii			
	Flip chaartii			
	Brochure			
	Information sheet			
	Job aid			
	Counselling card			
	Other			

8. Dawaan qusanno maatii haala yeroon issani itti darbun tartibaan ka'amaniruu?

a) Eyyen b) lakkii

9. Dawaan yeroon isaa itti darbee jiraa? A) eyyeen B) lakkii

10. Tajaajila bara 1991 – 2002 ALH galmee irraa

Lakk.	hojii	1999		2000		2001		2002	
		Lakk.	%	Lakk.	%	Lakk.	%	Lakk.	%
1	Fakki abbaa warraa lenjii xumuuran								
2	Marii hawaasaa irrstti hirmaatan								
3	Baayina abba wara illaalamani								
4	Baayina maatii qusanoo maatii yeroo jalqabaatiif fudhatan								
5	Baayina maatii qusanno matii fudhacha turani fi kan fulduratti fudhatan								
6	Baayina maatii qusanno matii yeroo dherraa fudhachuf gara dhaabaa fayyaa olaanaatti ergaman								

11. Aleenjii fakki abbaa warraa fi marri hawaasa ilaalchisee

Gaaffille mata dureewwan leenjii fakkii abbaa warra fi marri hawaasa irraatii hamataman ilaalchise

Lakk.	Guyya mariin hawaasa itti gageefame	Mata duree irratti mari'atamee	hirmaatota		Yaada irratti walii galan	Guyya gabaasa
			dhi	du		
1						
2						

3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

12. Gaaf ilee lenjii fakki abbaa warraa ilaalchisee

Lakk	guyyaa	Mata dure leenjii	Himaatota leenjii		Tooftaa	ibsa
			dhi	du		