Qualitative Assessment of Factors Affecting the Implementation of Urban Health Extension Program in Jimma Town, South West Ethiopia

By: Haileeysus Adamu (BSC)

Research Thesis Submitted to Jimma University, College of Public Health and Medical Sciences, Health Planning and Health Services Management, as Partial Fulfillment of the Requirements for the Degree of Master of Public Health in Health Services Management.

August, 2012
Jimma,
Ethiopia

Qualitative Assessment of Factors that Affecting the Implementation of Urban Health Extension Program in Jimma city, South-West Ethiopia

By: Haileeysus Adamu

Advisors:

1. **Waju Beyene (BSc, MPH)**
2. **Fikru Tafese (BSc, MPH)**

August, 2012
Jimma,
Ethiopia

ABSTRACT

***Background**: Ethiopia has made remarkable progress in health services coverage to improve the health status of the population. Despite the progresses that have been made, the populations still face a high rate of morbidity and mortality. In response to the country urban health problem, the Government has launched Urban Health Extension Program in 2009. The goal of the this program is to improve access and equity to basic health services and address major health problems and other issues in urban areas such as HIV, food security, and poor sanitation, among many other health and non-health issues. Since it has launched in urban settings, no or little is known about factors related with the implementation of this program in national or regional level. So this study may give baseline information on the current situation of the program.*

***Objective:** To assess factors that affects the implementation of urban health extension program in Jimma city.*

***Methods:** This assessment used cross-sectional design with qualitative methods. The study was conducted from August 5 to August 9, 2012. Purposive sampling technique was used to select 13 urban health extension workers, four health extension supervisors, and 13 kebele representative for in-depth interview, and 12 women representatives for focus-group discussion. The data collection methods were in-depth interview, focus-group discussion, and resource inventory. Qualitative data were analyzed thematically and resource inventory results were described.*

***Result:** All urban health extension workers were selected by woreda health offices and have taken 3months pre service training. All most all of urban health extension workers who were interviewed reported that pre service and in-service training on urban health extension program was sufficient. The program implemented through home to home visit, training of model families and front runner health collaborators. Currently the program stills not start the implementation in schools and youth centers. Most health extension professionals said there was community resistance to participate in urban health extension program. Most resources needed for the program available except material and drugs needed for emergency services.*

Conclusion and Recommendation: *there were encouraging efforts of urban health extension workers to implement the program based on the guideline. But the program still was not implemented in school and youth centers, and there was community resistance on the program. So the Jimma Woreda health office should be scaling up and benchmarking best practices such as selection and training of model family and front runner health collaborators. Urban health extension professionals and supervisors should start the implementation of the program in school and youth center settings. The kebele administrators should promote the program through available channels to increase awareness about the program among the community.*

ACKNOWLEDGRMENT

I extremely acknowledge and appreciate my advisors Mr. Waju Beyene and Mr. Fikru Tafese for their valuable comments and supports. I would like to give my heartfelt thanks to Health Services Management Department, Jimma University, for the supports throughout this thesis development. I would like to thank Dr.Beyene Wendafrash for his moral support, advice and help throughout the process. My thanks also go to Mr.Shimeles Ololo, head Health Services Management Department, for his support and cooperation. I would like to appreciate Health Education and Behavioral Sciences Department, Jimma University, especially the head of the department Mr.Lakew Abebe for providing tape recorders and Atlas.ti software. I would like to give my thanks to my best friends Mr.Abebe Mamo and Mr.Shiferaw Asefaw for conducting the in-depth interview and focus group discussion without any payment. I would like to thanks Jimma town health office, health extension supervisors, health extension workers and kebele administers for their cooperation and support during the data collection process.

TABLE OF CONTENT

Contents **page No**

List of tables

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CHW	Community Health Worker
FGD	Focus Group Discussion
HIV	Human Immune Virus
HEW	Health Extension Workers
HSDP	Health Services Development Program
HSEP	Health Service extension Programme
SNNPR	Southern Nation, Nationalities, and People's Region
UHEP	Urban Health Extension Program
UHES	Urban Health Extension Supervisors
UHEW	Urban Health Extension Workers
VCHW	Voluntary Community Health Worker
VHW	Village Health Worker

CHAPTER ONE

1. BACK GROUND

1.1 INTRODUCTION

Ethiopia is the second most populous sub-Saharan African country, with a highly diverse population of over 82 million people. The country has made remarkable progress in health coverage in the last five years. Despite the progress that have been made to improve the health status of the population in the last five years, the population still face a high rate of morbidity and mortality and the health status remains relatively poor (1).

In response to the country's health problem, in 2003 the Ethiopian Federal Ministry of Health launched a new health care plan, the "Accelerated Expansion of Primary Health Coverage," through a comprehensive Health Extension Program (HEP), which serves as effective mechanism for shifting health care resources from predominantly urban to rural areas, where majority of the country's population resides. Therefore, HSEP could be considered as the most important institutional framework for achieving the MDGs. Moreover, the government has focused on providing quality promotive, preventive, and selected curative health services in an accessible and equitable manner to reach all segments of population, with special attention to mothers and children (2).

The HEP is an innovative community based programme with the aim of creating healthy environment and healthful living by making available community (Kebele) based health essential health services at the grass roots level. By so doing it is envisaged to improve equitable access by focusing on sustained preventive health actions and increased health awareness (2).

The Government of Ethiopia (GoE) recognizes the fact that public health interventions in urban settings are less than optimal and has been working to develop an Urban Health Extension Program (GoE/UHEP) building on the success of the Rural Health Extension Program. The Program launched in 2009 (3).

The goal of the GoE/UHEP is to improve access and equity to basic health services and address major health problems and other issues in urban areas such as HIV, food security, and poor sanitation, among many other health and non-health issues. Central to the design of the GoE/UHEP is the need to improve access and equity of public health information and services to the urban population through the training and deploying of a cadre of Urban Health Extension (UHE) Professionals, and at the same time expand physical health infrastructure (2).

The organizing principle of the GoE/UHEP is the provision of "household-centered" promotive, preventive and limited curative services with strong referral linkages to public sector health facilities. UHE Professionals are placed in health centers, so as to bridge households, communities and these lower level health facilities. Each health center serves 40,000 people; therefore, one UHE Professional is assigned to 500 households, with 16 of these workers are placed in each health center, taking the average family size per household to be five. As frontline workers with close links to households and communities, these Urban Health Professionals have a unique opportunity to deliver integrated, tailored and targeted services. UHE Professionals also have a cadre of Supervisors with whom they work closely (3).

1.2 Statement of the problem

Study conducted in Oromia and North Gondar revealed that shortage of logistics, inadequate training and exposure time during field work and negative attitude of health professionals towards HEWs were found to be bottle necks that hinder the health extension program implementation in respective areas (4, 5).

A national level study conducted by federal ministry of health on assessment of health extension program on rural part of the country identified the following implementation factors (6).

Positive factors (in no particular order of priority) included the following:

- The existence of a HEP policy, which encouraged and supported the active participation of communities and community groups, such as farmers' cooperatives, in planning, implementing and monitoring the HEP;
- The placement of the health post within walking distance of most community members and the availability of living quarters for the HEWs within easy reach of the health post;
- The assignment of HEWs to communities where they share a common culture, tradition, and language;
- The appointment of the HEWs to kebele cabinets so that they could advocate for health in public meetings;
- The work of the VCHWs in facilitating the integration of the HEWs into the community, and providing HEP services in collaboration with the HEWs;
- The establishment of model families who provide concrete evidence of the benefits of the HEP.

Negative factors (in no particular order of priority) included the following:

- Health posts lacking supplies and equipment and/or HEWs not knowing how to use them correctly;
- Frequently overburdened HEWs, especially when they work alone which was the case in 30.9% of the health posts assessed;
- Absence of supportive supervision; supervisory visits that were often didactic and focused on faultfinding instead of working with HEWs to propose solutions;
- HEW supervisors lacking adequate knowledge, skills, and management support to provide supportive supervision;

- Infrequent supervisory visits for hard-to-reach areas, with inadequate funds for transport and per diem;
- Inadequate facilities; in some cases, the health post had not yet been constructed and/or there were no residential quarters for HEWs;
- Many health posts still lacking hand-washing facilities after using the toilet, which directly contradicted one of the key HEP messages and limited the ability of HEWs to promote personal hygiene practices at the health post;
- A significant number of HEWs being assigned to kebeles other than from where they were recruited, which contributed to HEW dissatisfaction;
- Lack of feedback from the health center and hospital to the health post on cases referred by HEWs;
- Lack of transportation in areas with difficult terrain; over 30% of the health posts had no roads, particularly in Arbaminch Zuria (SNNPR) and Kutaber (Amhara), which affected the ability of theHEWs to provide services, of WHOs to provide supervisory support and of patients to travel if they were referred for care; and
- Lack of a management response to HEWs regarding requests for transfer, weekend leave, continued professional development, and promotion.

Since it has launched in 2009 in urban settings, no or little is known about factors related with the implementation of this program in national or regional level. So this study may give baseline information on the current situation of the program.

Chapter Two

2. Literature review

2.1 Health extension worker

The view of village health workers as advocates and agents of change and liberation for communities shifted as the focus on liberation, decolonization, democratization and self-reliance was replaced by World Bank driven policies of structural adjustment (7).

According to WHO, CHW programs have a role to play that can be fulfilled neither by formal health services nor by communities alone. Ideally, the CHW combines service function and developmental/promotional function that are also ideally, not just in the field of health, perhaps the most important developmental or promotional role of the CHW is to act as a bridge between the community and the formal health services in all aspects of health development, the bridging activities of CHWs may provide opportunities to increase both the effectiveness of curative and preventive services and, perhaps more importantly, community management and owner ship of health related program. CHWs may be the only feasible and acceptable link between the health sector and the community that can be developed to meet the goal of improved health in the near term (7).

In many Africa countries community health workers have fulfilled generalist health functions, specialist health roles, in such areas as nutrition, reproductive health, and malaria control, and wider roles as community advocates and change agents. Evidence suggests that these workers have increased coverage of a range of services over the last 30 years (8).

The Government of Ethiopia believed that universal health coverage could be achieved through implementation of health extension program and deployment of health extension workers. The capacity to mobilize and empower communities has dramatically increased through deployment of Over 30,100 health extension workers into rural kebeles and 5400 health extension workers into urban kebeles all over the country, who provide a package of health promotion and disease prevention services in the communities. Community-level capacity enhancement through

community conversations facilitated by health extension workers has resulted in increased demand for and utilization of health care services leading to social transformation (9).
As frontline workers with close links to households and communities, these Urban Health Professionals have a unique opportunity to deliver integrated, tailored and targeted services (3).

2.2 Profile of urban health extension workers and supervisors

Urban health extension workers are nurses who have diploma in nurse and they took one year training on urban health extension packages. Urban health extension supervisors are public health professionals who have at least Bachelor of Science in health education or environmental health or nursing or other public health fields with special training on urban health extension program.

2.3 Implementation of the program

In many Africa countries community health workers have fulfilled generalist health functions, specialist health roles, in such areas as nutrition, reproductive health, and malaria control, and wider roles as community advocates and change agents. Evidence suggests that these workers have increased coverage of a range of services over the last 30 years. Yet the effectiveness of community health worker programs on the continent has often been constrained by a lack of government support, the inattention to primary health care, and the reduced role of community health workers in national health care systems, particularly during political transition. And also the key to successful community-based programs may lie in the effective training and continuing education of its community health workers and their acceptance by the community. It is important for community health workers to gain knowledge and skills in presentation, leadership and community building (9).

A renewal of community health worker programs—better designed, managed, monitored, and evaluated, with greater support and supervision and more community participation and ownership—could help to meet the challenges of collapsing health systems, rising disease burdens, and departing professional (9).

The study conducted by Ethiopia federal ministry of health identified the following major area as a core for implementation of the program (6).

HEWs: Major factors that limited HEW performance include inadequate training on specific topics (especially for management of labor and safe delivery and the use of equipment), lack of supplies and equipment, inadequate supervision, health post not yet constructed, residential quarters not available within easy reach to the health post, and lack of transportation.

Community: The community is a key partner for the HEW and the HEP overall. The program must ensure that the community understands and supports the mission, vision, scope, and objectives of the HEP, as well as the limitations of what the HEW and the HEP can provide to avoid misleading expectations and maximize the effective involvement of the community.

Administrative Offices: Administrative institutions at the kebele, woreda, and zonal levels need to work together more closely to facilitate the efforts of the HEWs and the activities of the HEP. It is also important to ensure that the HEP activities reflect the needs of the community and that funds are appropriately allocated. There is also a need to better plan for and coordinate support to the HEWs and to better institutionalize their positions within the civil service structure.

An assessment (first intake assessment on the training of HEWs) done by the Center for national health development Ethiopia, indicated that the health extension program has the following problems:

1. The selection process was dominated by the Technical and Vocational Education (TVE) sector with minimal involvement of the health sector. Most trainees were selected from district towns. Another major weakness is that the health extension program seems to have attracted trainees with much lower grades compared, for example, to those in the regular TVES programs.
2. The trainers are too few in numbers and therefore are overloaded. They feel insecure about their status as they feel lost between the TVET and the health sectors.
3. The teaching/learning process suffers from a lack of textbooks, reference materials, inadequate practical/demonstration facilities and a compromised apprenticeship program inspite of last minute remedial efforts. The operational budget was clearly inadequate.
4. The first group of HEWs is being deployed but district health offices and health centers seem ill-prepared to receive and put them effectively to work. Most district health offices do not have adequate staff and budget to ensure proper supervision and support.

Similar assessment was carried out on working condition of first batch of health extension workers by the Center for National health development Ethiopia in 2006, indicated that shortage/ lack of equipments or supply, lack of regular reporting and feedback sharing mechanism, no assigned focal person at district level, lack of knowledge and skill in health education during training were the main problems that was observed (10, 11).

In other study conducted in Wolaita zone showed that All health extension workers reported working closely with the different types of community health workers such as community based reproductive health workers (CBRH) ,community health agent & community health promoters. Nearly one third of health extension workers raised the need for upgrading and the identified areas of health extension package which need additional refresher course such as managing delivery and services related to HIV/AIDS specifically VCT. All reported to have problems to travel to health center and district health offices and 19(20%) of them reported of having no job description and only 5 (5.2%) of HEWs complained of their salary not paid on time. Majority , 73, of the HEWs were supervised at least once in the last six months and 90 reported regularly their monthly activities to either the health center or district health offices and nearly half of HEWs complained that they usually do not get feedback for their report. Among the household respondents 646 (90.4%) prefer HEWs to be selected from their own village and 695 (88%) agree that the HEWs being female. HEWs had visited 494 (60%) households at least once within the last 3 months prior to investigation and the major issues discussed, based on their frequency, were about environmental sanitation including clean house & pit latrine, family planning, prevention of malaria, immunization, and HIV/AIDS prevention (12).

The available documents revealed that management support and supervision are the key element which “make or brake” of any community health program. It is recognized that many health personnel lack the back ground and orientation to provide supportive environment for HEWs. The health workers were socialized in to the hierarchical frame work of disease oriented medical care system and have poorly developed concept of primary health care, such paradigms are ill-suited to providing an environment supportive of true partnership and team work between deferent health workers, particularly if HEWs thought of as less important by misunderstanding their health promoting and enabling agent role within the community (7, 8)

Chapter Three

3. SIGNIFICANCE OF THE ASSESSMENT

Information on factors that affect the implementation status of UHEP in Jimma city will contributes to a better understanding of a country's UHEP situations and sheds light on the improvement of the program. Policy makers will be informed about the latest information on the status the program, as they plan to scale up the programs. So this study will be used as baseline information and it will be useful in identifying promising directions for the program and advancing the government efforts.

CHAPTER FOUR

4. OBJECTIVE OF THE STUDY

4.1 General objective

To assess factors that affects the implementation of urban health extension program in Jimma city.

4.2 Specific objectives

- To determine availability of the needed resources to run the UHEP
- To assess factors that affects the implementation of urban health extension program

CHAPTER FIVE

5. METHODOLOGY

5.1 Study area and period

The study was conducted in Jimma city from August 5 to August 7, 2012. Jimma zone is one of the rural zones in Oromia Regional State and situated at about 356km away from Addis Ababa city, the capital of Ethiopia, in the Southwest direction. There are 456 health post, 52 health centers and 1 district hospital in the zone.

5.2 Study Design

This study was used cross-sectional design with qualitative methods.

5.3 Population

5.3.1 Source population

All Urban health extension workers/professionals (UHEW) and urban health extension supervisors (UHES), kebele administers, and women beneficiaries and all public health centers where urban health extension workers base.

5.3.2 Target population

All urban health extension workers/professionals (UHEW) and urban health extension supervisors (UHES), kebele administers, people representatives and all public health centers where urban health extension workers base.

5.3.3 Study population

Selected urban health extension workers/professionals (UHEW) and urban health extension supervisors (UHES).Selected kebele representatives, selected women representatives and all functional public health centers where urban health extension worker base.

5.4 sample size

A total of 13 UHEW were purposively selected for in-depth interview.

Four urban health extension supervisors (UHES) were purposively selected for expert interview. The compositions of these four UHES were

- 1 was from Zonal Health Department – Health Extension Program Supervisor who has direct program supervisory role and better work experience in the program; and
- The other 3 were from Woreda/city Health Offices – Health Extension Program Supervisors who have direct program supervisory role and better work experience in the program.

A total of 3 kebele administers were purposively selected for key informant interview. Two focus-group discussions involving 6 beneficiaries in each group were conducted

5.5 Sampling techniques

Purposive sampling technique was employed.

5.6 Inclusion and exclusion criteria

5.6.1 Inclusion criteria

Kebele representative, urban health extension workers (UHEW) and urban health extension supervisors (UHES) who work in the program/area for three months and a functional health center will included for this study.

5.6.1 Exclusion criteria

Those who not fulfill the inclusion criteria were excluded from the study.

5.7 Study Variables

- Availability of resources
- Factors that affect implementation of the program
    - Training of urban health extension professionals
    - Performance urban health extension professionals
    - Strategies used by urban health extension professionals

- ❖ Relationship among health extension professionals, supervisors, kebele administration, Woreda health offices and non-governmental organization.
- ❖ Community participation and perception

5.8 Data collection method

Key informant interviews were conducted for UHEW and UHES. Resource inventory also was used for availability of resources. Focus-group discussions were conducted for beneficiaries.

5.9 Data collection tools

Key informant interview guide was used to collect data from UHEW and UHES. Resource inventory checklists were used for availability of resources. Focus-group discussion guide was employed to conduct focus-group discussion. All tools were adopted from the national Ministry of Health study of rural health extension program (6).

5.10 Data collection procedures

Six health professionals who have experience in HEP were recruited as data collectors. Two health professionals who have experience in UHEP were recruited as supervisors. Two days training was conducted to train data collectors and supervisors.

5.11 Quality Assurance

Data collectors were trained on instruments and method of data collection before actual data collection. Completeness of the data was checked on daily basis.

5.12 Data entry

Data were categorized by main theme and coded in Atlas.ti software. The main themes are:

1. Urban health extension workers Recruitment, Training, Deployment and Retention
2. The UHEPs' assessment of pre-service and in-service training on the packages of urban health extension program
3. Strategies used by urban health extension professionals

4. The HEWs' assessment of their performance on the packages of urban health extension program
5. Community participation
6. Relationships with kebele administration, civil and nongovernmental organization
7. Observations of HEP Performance by Supervisors
8. Selection of model family
9. Referral linkage
10. Selection of front runner health collaborator
11. Community Perceptions about UHEWs and UHEP

5.13 Data analysis

The data were categorized, transcribed and presented by thematic area. Main quotes from interview were included to give more insight using quote manager command application of the Atlas.ti software.

5.14 Ethical Consideration

Ethical clearance was obtained from Jimma University Ethical Review Board.
Oral informed consent was obtained from study participants.

5.15 Dissemination plan

The result of this evaluation will be disseminating to:

- Policy makers and program owner of UHEP
- Governmental and non-governmental organizations that are interested to use it and interested to improve the implementation of UHEP.
- If possible, submitted to reputable Journal for publication.
- It will be presented for the university community.

5.16 Strength and Limitation of the study

Strengths

Providing the depth and detail through direct quotation and careful description of situations, events, interactions and observed behaviors.

Limitation

This qualitative study was conducted in Jimma Town. Each town has its unique physical, social and health characteristics, and the findings therefore cannot be generalized to urban health extension program of the country or other towns. Qualitative studies, however, have the potential for transferability of findings, in that similar contexts can be interrogated for the applicability of the findings to that context.

5.17 Operational definition

1. Health extension program: program designed to achieve significant health care coverage in Ethiopia targeting household.
2. Health extension professionals- diploma nurses who trained for three months about Prevention and promotive health services and assigned in kebele level.

CHAPTER SIX: Result

The assessment involved many different groups of participants to obtain a comprehensive picture of factors affecting UHEP implementation in Jimma town. Table 1 showed the methods and characteristics of the respondents.

Table 1: Data collection methods and characteristics of respondents, Jimma town, 2012

Data Collection Methods	Number of Participants	Responsibilities in HEP
Focus group discussions (FGD)	12 beneficiaries	Users of the HEP services
In-depth interviews	13health extension professionals	Implement the HEP at kebele level
Key informant interviews	3 health extension supervisors and 3 kebele administers	Supervise, coordinate, and/or guide implementation of the HEP
Observations of resources	13 kebeles	Resources needed to run the program

1. Urban health extension workers Recruitment, Training, Deployment and Retention

All urban health extension workers are nurses and have taken three months pre service training on urban health extension program.

The Woreda health extension coordinator describes: *standard curriculum developed by FMOH was used for the training and prior to the training we prepared in advance for all necessary materials.* The other supervisor explained that: *to ensure and maintain the quality of the trainers, trainers were oriented for three days. I think the orientation session played a paramount role in standardizing the topics the training scheduling and the overall organization and management of the training.*

Almost all urban health extension workers were selected by Woreda health offices. As expressed by one health extension professional: *we were recruited by Woreda health office on open notice.*

Most health extension workers intend to continue their job for more than one to two years.

One health extension professional explained: *I like this job b/c I saw the result of my effort in the peoples life. So I have intention to continue my work probably for two more years.*

The woreda health office supervisor said: *we have a plan to train and deploy more nurses in order to strengths the program.*

2. The UHEPs' assessment of pre-service and in-service training on the packages of urban health extension program

All most all of urban health extension workers who were interviewed reported that pre service and in-service training on urban health extension program was sufficient. One health extension professional elaborates the need for this training: *because you must upgrade yourself and have the necessary knowledge … new knowledge and to learn … you forget something on the way. So upgrading ourselves through training needed.*

3. Strategies used by UHEW

All health extension workers uses house to house visit ,training of model family and front runner health collaborator as implementation strategies. Health extension professionals elaborated their strategies:

I have 500 household under my zone so I go to home to home to deliver the packages to these households.

We use home visits, training of model family, and front runner health collaborators to deliver our services.

Currently we use one to five approaches to reach all segment of the population.

However nothing is being done on school and youth center health extension program. One health extension professional explained: *Nowadays we focus on home visit and training of model family. But we plan to reach the schools and youth centers in the near future.*

The supervisors also acknowledged these issue and they mentioned some reason: *this is because the numbers of health extension workers still not enough to cover all households and to reach other settings like school and youth centers.*

4. The HEWs' assessment of their performance on the packages of urban health extension program

All urban health extension workers say they satisfactorily performed on immunization, family planning and solid waste disposal in their assigned kebeles. One health extension workers said: *I performed well in all packages especially on immunization, family planning and solid waste*

disposal. The other claimed that*: I saw satisfactory accomplishment on the area of immunization and family planning.*

Community members during FGD also support this claim. One participant said: *they really performed well ….they were coming for immunizations and called us for sanitation campaigns frequently.* Another FGD participant explained: *they were giving health education on family planning and HIV/AIDS during home visits.*

Kebele administers also acknowledge the performance of health extension professionals. One kebele administer said: *they real work hard…they went home to home to provide immunization and family planning service.*

5. Community participation

Most health extension professionals said there was community resistance to participate in urban health extension program. One health extension professional explained: *the people are unaware of the program and its benefits. When we go to their home, they totally dispassionate on us and they were not volunteer for the service.* The other health extension professional also commented: *you know sometimes they released their dogs against me. Others closed their gardens and homes when I knocked their door. Some say we don't need you and other community members had attempted to chase us away from their home.*

The kebele representatives also acknowledge this issue*: I think there is the gap between the community and the health extension professionals. We tried our best to convince the community through meeting and other available channels.* Other kebele administers said: *when they assigned into our kebeles, we were introduced them to the member of the community through meeting. But all member of the community may not attend such meetings.*

6. Relationships with kebele administration, civil and nongovernmental organization

HEWs were asked about their relationships with key administrative and supervisory staff at the kebele, woreda and zonal levels. Most UHEP reported that they have good relationship with kebele administration and woreda health office. They reported good relationship with other civil and nongovernmental organization that works in their kebeles.

The kebele administration helps us in everything. They are the central part of our services.

The other went further*: the kebele administration assists me starting from my assignment in their kebele and still provides their help like calling the community for meeting and sanitation campaigns.*

We have good relationship with supervisors. They support us during the whole process especially during training and graduation of model families.

They are supportive and asked us what else we need from woreda health offices. But sometimes they came for supervision without prior notice.

I saw a lot of NGO that working in my kebeles and most of them try to coordinate their work with me. One NGO try to build the community latrine and they include me during the whole process of the construction of this latrine.

7. Observations of HEP Performance by Supervisors

Zonal and Woreda health extension supervisors affirmed that the majority of urban health extension workers are successfully implementing urban health extension packages. But they acknowledged some budget problem, management problems, and lack of commitment from city administrations as a gap during their supervision.

Both zonal and Woreda health extension supervisors provide frequent supportive supervisions.

One supervisor: *there was high turnover among health extension professional and many of them left the job and recruited by private clinic and other health institution after they start the job.*

Other supervisor reported: *I think the job needs commitments and most of them accomplish their task satisfactorily.*

8. Selection of model family

Model families were selected and some of them were graduated.

The Woreda health extension coordinator explained: *I think the model family approach is a key strategy for the implementation of urban health extension program and its successful implementation is crucial for the success of the whole program.*

In the town more than 2000 model families were graduated. One health extension worker elaborated: *Model families sacrifices their time and attend training sessions that we provide to them, and usually play an exemplary role by taking the lead in the implementation of the UHEP packages that they were taught to implement in their home and teach their neighborhoods.*

Other health extension workers explained: *we select models family using criteria such as family size, number of females/males in the family, ages, educational levels, health and well being of the family, occupation, living quarters separate from kitchen, availability and use of pit latrine, smokeless stove, safe water source personal and environmental hygiene, use of an ITN, shelves for keeping utensils and others.*

Another health extension workers also said: *I identified families in the community then I orient them to the 16 HEP packages and I send their list to Woreda health office to certify them as model family. The graduation ceremony attended by Woreda health office representatives, religious leaders, kebele administers and member of the community.*

One health extension professional explained what it mean model family: *Model families* ***model*** *healthy behaviors and practices to other member of community and provide evidence of the benefits of the UHEP*

9. Referral linkage

Lack of strong relationship between health extension workers and health centers were reported both by health extension workers and supervisors.

Health extension professional said: *we try our best for strong referral linkage.* The other explained: *most people directly go to health centers and most of them didn't trust us.*

The health extension supervisors explained: *in most cases people go to private clinics or health centers even for minor health complains and first aides…but they ignored these workers…I think this is due to lack of awareness about the program…*

10. Selection of front runner health collaborator

Front runner health collaborators were selected among model families. One of the kebele administer explained: *we organize the community in one to five approach for development and it includes health developments.*

One health extension workers explained: *currently one to five approaches implemented in all sectors including health sector. In our kebele we identified peoples among model families for one to five strategies. Each selected individual will be responsible for five member of the community.*

11. Availability of the needed resources

There are four functional health centers and 39 urban health extension workers. Table 2, 3, and 4 showed availability of needed resources for urban health extension program. Apart from Sphygmomanometer and fetoscope, all other generally needed materials were available. ORS, condom, implanon, depo-vera and GV were available while analgesics & antipyretics and ergometric maleattles were totally absent. Materials needed for emergency services like delivery kits, oxytocin, paracetamol were totally absent except first aid kits. The Woreda health office supervisor explained: *we already provide almost all important materials and drugs but we have some shortage of materials needed for emergency services. We will provide all material in enough amounts within the next 6 months.* One Health extension professional reported: *our main problem was transport and shortage of materials.*

Table2: Availability of materials needed for urban health extension program in Jimma town, 2012.

S.N	Item	Availability of the materials in the kebele office of UHEWs	
		Available	Not available
1	Sphygmomanometer		13 kebeles
2	Sthestescope	13 kebeles	
3	Thermometer(clinical)	13 kebeles	
4	Infant scale	13 kebeles	
5	Hand reflector/torch	13 kebeles	
6	Dressing instruments	13 kebeles	
7	Weighing scale	13 kebeles	
8	Bp apparatus	13 kebeles	
9	Fetoscope		13 kebeles
10	Rapid test kits for PMTCT	13 kebeles	

Table 3: Availability of drugs needed for urban health extension program in Jimma town, 2012.

S.N	Name of the Drugs	Availability of the drugs in the kebele office of UHEWs	
		Available	Not available
1	ORS(drugs used in diarrhea)	13 kebeles	
2	ASA&paracetamol (analgesics & antipyretics)		13 kebeles
3	-Condom, Implanon,&Depo provera(contraceptives)	13 kebeles	
4	Ergometric maleattles		13 kebeles
5	Gv	13 kebeles	

Table 4: Availability of materials needed for emergency services of urban health extension program in Jimma town, 2012.

S.N	Item	Availability of the drugs in the kebele office of UHEWs	
		Available	Not available
1	Delivery kits		13 kebeles
2	Oxytocin		13 kebeles
3	Paracetamol		13 kebeles
4	First aid kits -band aid -bandage -scissor/blade -alcohol or Gv -antiseptic	13 kebeles	

12. Community Perceptions about UHEWs and UHEP

During focus group discussion with the beneficiaries, participants share their perception about the program. Participants expressed their appreciation towards this program. One FGD participant explained: *prior to the introduction of this program we go to hospital a lot of times for immunizations and sometimes due to overload of the hospital we skip the scheduled immunization. But now the urban health extension professionals came to our home to deliver these services….really I am happy with them***.** Another FGD participant said: *this program is very important for us and it enabled us to know more about our health problem and how we can resolve these problems.*

Most FGD participants perceived urban health extension program positively. One participant elaborated: *I like the program because it provides basic health services without payment.* Other said: *they teach us how to use bed net and family planning.*

But others complain on them about their discipline especially on their clothes. One FGD participant explain: *if they are nurses why not wear their gowns …so we will treat them as health professional. But they are came in to my home wearing some disgusting and out of culture clothes.* This issue also raised by one kebele administer: *I think the people are ready to welcome them but what is expected from this nurses are to wear their gowns like other clinical health professionals in order to get the attention of the community.*

CHAPTER SEVEN DISCUSSON

This finding has aimed to provide latest information on factors that affecting the implementation of urban health extension program.

Almost all urban health extension workers were selected by woreda health offices. The national guideline also states that the selection of urban health extension worker should be done jointly by kebele administration and woredas council (2). Report from Burkina Faso revealed that failure in direct participation of community in selection and management of community health program decreases utilization of service provided by CHWs and emphasizes the centrality of community involvement in community health program (7).Study conducted in south Gondar, Ethiopia revealed that low community involvement in recruitment of community based reproductive health found to be the reason for less functionality of the program (5).

Majority of health extension professionals reported that they live in their assigned kebeles. The national urban health extension guideline states that all urban health extension workers should reside in their assigned village (2).

Most health extension workers intend to continue their job for more one to two years. The study conducted in selected woredas of Amhara National Regional State and Southern Nation, Nationalities and People's Region showed that 81% of health extension workers intend to work for two more years (6).

All most all of urban health extension workers who interviewed reported that pre-service and in-service training on urban health extension packages was sufficient. It is important for community health workers to gain knowledge and skills in presentation, leadership and community building (7).Study conducted in Somalia showed that the community health workers refresher training included extensive use of role plays, dramas and song and that can capture the attention of audience during actual practice in the community (8).

All health extension workers uses house to house visit ,training of model family and front runner health collaborator as implementation strategies. However nothing done concerning about school and youth center health extension program. The national implementation guideline of urban health extension program stated that school and youth center health extension programs are the main part of the program (2).

HEW reported that they have good relationship with kebele administration, woreda health office and nongovernmental organizations. The study conducted by Ethiopia federal ministry of health insisted that administrative institutions at the kebele, woreda, zonal levels and at nongovernmental institutions need to work together more closely to facilitate the efforts of the HEWs and the activities of the HEP (6).

HEWs and supervisors mentioned transport problem and shortage of equipments their main problems. The assessment that was carried out on working condition of first batch of health extension workers by the Center for National health development Ethiopia in 2006, indicated that shortage/ lack of equipments or supply, lack of regular reporting and feedback sharing mechanism, no assigned focal person at district level, lack of knowledge and skill in health education during training were the main problems that was observed (10, 11).

The physical presence of health centers not meeting the national goal of 100%. There are only 4 functional health centers in the zone. The numbers of urban health extension workers in the zone were less than 50 which were below the recommended one. The national urban health extension implementation guideline proposes 1 urban health extension workers for 500 households or 2500 peoples. The national survey showed that a total population of 159,009 lives in the town which means it needs 64 urban health extension workers (1, 2).

Most health extension workers, kebele administers and supervisors say there is community resistance to participate on the program. But the community reported that the urban health extension workers need to respect the values and religion of the community. The national guideline states that the community is a key partner for the HEW and the HEP overall. The

program must ensure that the community understands and supports the mission, vision, scope, and objectives of the HEP, as well as the limitations of what the HEW and the HEP can provide to avoid misleading expectations and maximize the effective involvement of the community (2).

CHAPTER EIGHT CONCLUSION AND RECOMMENDATION

8.1 Conclusion

- Encouraging effort of urban health extension workers to implement the program based on the guideline. It includes training of model family and front runner health collaborators
- Strong relationship among urban health extension professionals, kebele administration, Woreda health office and nongovernmental organization for successful implementation of the program.
- The program still not implemented in school and youth centers.
- Shortage of necessary equipments and drugs needed for emergency service.
- Community resistance on the program.

8.2 Recommendation

Based on the findings of this study, the following are recommended for:

District and zonal health offices

- Scaling up and benchmarking best practices such as selection and training of model family and front runner health collaborators to sustain it.
- Providing necessary equipments specifically materials and drugs needed for emergency service.

Urban health extension professionals and supervisors

- Strengthen their encouraging effort on selection and training of model family and front runner health collaborators
- Starting the implementation of the program in school and youth center settings

Kebele administrators

- Promotion of the program through available channels to increase awareness about the program among member of the community.

References

1. Central Statistical Agency (Ethiopia) and ORC Macro (2006).Children's Health and Nutritional Status: A new look at data from the 2005 Ethiopia Demographic and Health Survey (EDHS).
2. MOH (2007).Guidelines for Health Extension Program.
3. USAID/UHEP (2009). http://www.uhep.jsi.com/Work/work.htm.
4. Fasil Tsegaye(2006).Assessment of Knowledge and Attitude of North Gondar Health Professionals towards Health Extension programme (HEP) and the Millennium Development Goals(MDGs),Ethiopia,Msc Thesis.
5. Daniel Argaw(2002): Sustainability and factors affecting the success of community based reproductive health programs in rural North West Ethiopia.
6. Ministry of Health-Health Extension and Education Center (2008). Report on the Assessment of Factors Contributing to and Affecting Performance of Health Extension Workers in Selected Woredas of Amhara National Regional State and Southern Nation, Nationalities and People's Region.
7. Human Resources for development (2004).A Joint Learning Initiative: Review of the Utilization and Effectiveness Community-Based health Worker in Africa.
8. National Center for Primary Health Care (2006).Community Voices, Health Care for the Underserved, Morehouse School of Medicine, Atlanta.
9. Federal Ministry of Health/HIV/AIDS Prevention and Control Office (2009). The Strategic Plan for Intensifying Multisectoral HIV Response, SPM II (2009-2014); in Ethiopia.
10. Center for National Health Development in Ethiopia (2006). Assessment of working condition of the first batch of health extension worker, A.A, Ethiopia.
11. Asedu Yeshewalul (2006).: Evaluation of health service extension program in Ethiopia, Research presented to center for global health, Trinity collage, Dublin University, Ireland.
12. Sefihun bezabih (2007).Assessment of factors that affect the implementation health extension program in Wolayita zone,Ethiopia,Msc Thesis.

Resource inventory checklist

Resource inventory checklist tool to assess availability of resources for implementation of urban health extension program.

Availability of Materials Needed

S.N	Item	Availability of the materials in the kebele office of UHEWs	
		Available	Not available
1	Sphygmomanometer		
2	Sthestescope		
3	Thermometer(clinical)		
4	Infant scale		
5	Hand reflector/torch		
6	Dressing instruments		
7	Weighing scale		
8	Bp apparatus		
9	Fetoscope		
10	Rapid test kits for PMTCT		

Availability of Drugs

S.N	Name of the Drugs	Availability of the drugs in the kebele office of UHEWs	
		Available	Not available
1	ORS(drugs used in diarrhea)		
2	ASA&paracetamol (analgesics & antipyretics)		
3	-Condom, Implanon,&Depo provera(contraceptives)		
4	Ergometric maleattles		
5	Gv		

Availability of materials needed for emergency services

S.N	Item	Availability of the drugs in the kebele office of UHEWs	
		Available	Not available
1	Delivery kits		
2	Oxytocin		
3	Paracetamol		
4	First aid kits -band aid -bandage -scissor/blade -alcohol -Gv -antiseptic -furacin		

Key Informant Interview for Health Extension Workers (HEWs)

Individual Questionnaire for: Health Extension Workers (HEWs)

Informed consent:

Greetings,

Allow me to introduce myself. My name is _____. I am here to gather information from responsible sources like yourself and the people that you serve, regarding the services that your health post (HP) is providing; the strengths that you have exhibited; the weaknesses that you need to deal with; the challenges that you faced and how you overcome them, etc., while you perform your day to day activities. Such information is very crucial in that it enables the creation of a common understanding among all stakeholders regarding the real issues on the ground, which will be very helpful to further strengthen the strong aspects, deal with weaknesses in a timely manner, understand the nature of the challenges, and foresee possible threats that may endanger the effectiveness of the entire health services provision endeavor.

The information that is obtained from HEWs, like yourself, is believed to be vital in reflecting the quality of the health service provision at the kebele level which will in turn be instrumental to improve the health service provision as a whole. I hope that you are willing to share with us your experiences by participating in the interview. I would like to assure you at this point that the information that you give me is confidential and it will only be compiled and organized along with that of your fellow HEWs. No personal details will ever be released.

Even though this data collection is being done with the knowledge and permission of the Regional and Woreda Health Offices, we would also like to get your prior consent as to whether or not you are willing to participate in the interview. Are you, thus, willing to participate in the interview?

Interviewer:

If the HEW identified for the interview is willing to participate in the interview, proceed with the interview. If she is not willing to participate in the interview, stop it here.

Part I: Area Identification:

Region _____Zone _____Woreda _____Kebele _____

Part II: Detailed Questions:

1. What is the performance category of the health extension worker?

1) Strong 2) Weak

2. Sex of the HEW?

1) Female 2) Male

3. Age of the HEW in completed years: _____ Years

4. What was your educational level when you were recruited for the post?

1) 10th grade_____ 2) 10th +1_____3) 10th +2_____ 4) 12th and above_____

5. How many health extension workers are there in your kebele? ____

5.1 What is your job description?

_____

_____

_____

6. Who recruited you (the HEW) for the post?

1) The kebele administration_____ 2) The community I live with_____

3) The community and the kebele administration_____ 4) My School_____

5) Other (Specify) _____

7. Where were you living before you were recruited for training to be a HEW?

1) Same with this place 2) Different from this place

Interviewer:

If the answer for the above question is '2,' i.e., different from this place, then ask the next question.

8. How long does it take to get to the HP on foot from here (your home where you were recruited from) ?

1) Half an hour_____ 2) An hour_____ 3) Two hours_____ 4) Three hours_____

5) Half a day_____ 6) Too far to be reached on foot _____

9. How do you see the sufficiency of the knowledge and skills that you acquired during training as a HEW for performing your duties?

1) More than enough_____ 2) Just enough_____ 3) Not enough_____

4) Don't know_____

Interviewer:

If the answer for the above question is '1' or '3', then ask either question 10 or 11 accordingly.

10. If the answer for question 9 is '1,' then what are your reasons to say that the training given for the HEWs is more than enough?

11. If the answer for question 9 is '3,' then what are your reasons to say that the training given for the HEWs is not enough?

Interviewer:

When the next question is asked, code 1 (yes without probing) should be circled if the specific categories given spontaneously by the respondent, matching this with the corresponding category listed below accordingly. For the others, where the respondent did not mention categories spontaneously, the interviewer needs to probe one by one and in doing so, see if the respondent acknowledges that the probed package is being performed in their HP--- then you can circle code 2 (yes with probing). If there is any category not mentioned at all, circle code 3.

12. Does HIV/AIDS and tuberculosis prevention program are performed in your kebele?

1) **Yes 2**)No

Interviewer:

If the answer for the above questin is '2' then ask question 13

13. if the answer for question 12 is '2' , then what are your reasons to say that the program for not being performed

_____

_____

_____

_____

13. For how long have been serving in this kebele?

1) Less than a year_____ 2) One year_____3) Two years_____4) Three years_____

14. For how many more years are do you plan to work in this kebele?

1) ____ # Months 2) _____# Years _____3) _____Not decided 4) _____No more years

Interviewer:

If the answer in the previous question is code 4 (No more years), then you should ask the respondent why she/he is not ready to work for more years in that HP.

15. Reason for saying not ready to work anymore in the kebele.

_____

_____

16. Out of the HIV prevention care and support related activities, how many of them do you think that you have performed satisfactorily?

1) All of them_____ 2) More than half_____ 3) Half of them____ 4) A quarter of them _____ 5) Non of them_____

Interviewer:

- *If codes 1, 2 or 3 are circled in question 19, then question 20 should be asked.*
- *If codes 4 or 5 are circled in question 19, then question 21 should be asked.*

17. How did you exhibit such a satisfactory performance?

_____

_____

_____

18. Why didn't you exhibit a satisfactory performance?

_____

_____

_____

19. What were the strategies used while performing the program?

_____

_____

_____

_____

_____

20. What are your working relationships with the kebele administration?

_____

_____

_____

_____

_____

21. What are your working relationships with the civil and nongovernmental organization (NGOs) who work in your kebele?

_____

_____

_____

_____

_____

22. How do you describe the participation of the community in the program so far?

_____

_____

_____

_____

_____

23. Are there voluntary community workers (TBAs, CBRHAs, etc.) in the areas of your operation?

1) Yes there are _____ 2) No there are not_____ 3) Don't know_____

Interviewer:

If the answer for the last question is '1' (Yes there are), then record the respective number in questions 23.1 - 23.6. Put '0' if they are not available there.

23.1 Traditional birth attendants (TBAs) _____

23.2 Community-based Reproductive Health Agents (CBRHAs)_____

23.3 Voluntary community promoters _____

23.4 Voluntary community counselors _____

23.5 Peer educators _____

23.6 Home-based care and support providers _____

24. How do you describe the working relationship that you have with these community volunteers?

1) _____

_____

_____

2) We don't have any working relationship._____

25. What problems did you face while implementing the health extension?

1) _____

_____

_____

2) We did not face any problem. _____

Interviewer:

If she/he reports in the above question that she/he has faced problems, then proceed with the next question

26. Whose help did you seek to overcome those problems that you faced?

_____

_____

_____

27. To what extent were you able to solve the problem?

1) To some extent_____ 2) Everything _____ 3) Not at all _____

28. How frequently do you meet with the Woreda's Health Extension Desk?

1) Once in two weeks_____ 2) Once a month_____3) Once in three months_____ 4) Once in six months_____ 5) As required_____

29. Do you think the frequency that you met with the Woreda HEP Supervisor is enough?

1) More than enough_____2) Quite enough_____3) Not enough_____4) Don't know_____

30. To what extent do you think has the Woreda Health Office carried out its responsibility with regard to the activities of the UHEP?

1) Very well_____ 2) Not as much as expected_____ 3) Don't know_____

Interviewer:

If the answer to question 33 is '2' (Not as much as expected), then skip question 31 and ask question 32.

31. You said that the Woreda Health Office has carried out its responsibility very well. What are the things that the Woreda Health Office did and what and how did they carry out this responsibility?

_____

_____

_____

_____

_____

32. You said that the Woreda Health Office did not carry out its responsibility as much as expected. What do you think are the reasons for this?

_____

_____

_____

_____

33. What do you think should be done so that the Woreda Health Office can carry out its responsibility better in the future?

_____

_____

_____

_____

_____

34. Do you have anything you want to tell me about the UHEP and related issues in your region that were not discussed above?

_____

_____

_____

_____

_____

I really appreciate your very interactive participation and to thank you for your time on behalf of the beneficiary community and myself.

Key Informant Interview for Woreda Health Office

Individuals Questionnaire for: Woreda Health Office (WHO), Health Extension Program (HEP)

Supervisor

Informed consent:

Greetings,

Allow me to introduce myself. My name is _____. I am here to gather information from responsible sources like yourself and the people that you serve, regarding the services that your health post (HP) is providing; the strengths that you have exhibited; the weaknesses that you need to deal with; the challenges that you face and how you overcome them, etc., while you perform your day-to-dayactivities. Such information is very crucial one in that it enables the creation of a common understanding

among all the parties involved regarding the real issues on the ground, which will be quite helpful to further strengthen aspects, deal in a timely manner with weaknesses, understand the nature of challenges and foresee possible threats that may endanger the effectiveness of the entire service provision of the HEP.

The information that is obtained from the WHO is believed to be vital in reflecting the quality of the service provision at the woreda level which will in turn be instrumental to improve the health service provision as a whole. I hope that you are willing to share with us your experiences by participating in the interview. I would like to assure you at the information that you give me will be confidential, and it will only be compiled and organized along with that of your fellow HEWs. No personal details will ever be released.

Even though this data collection is being done with the knowledge and permission of the Regional and Zonal Health Department (ZHD), we would also like to get your prior consent as to whether or not you are willing to participate in the interview. Are you willing to participate in the interview?

Interviewer:

If the WHO HEP supervisor identified for the interview is willing to participate in the interview, proceed with the interview. If she/he is not willing to participate in the interview, stop here.

Part I: Area Identification:

Region _____ Zone _____ Woreda _____

Part II: Detailed Questions:

1. What is the population size of the woreda?

Male _____ Female _____ Total _____

2. How long have you served in your current assignment?

1) Less than a year

2) A year

3) A year and half

4) Two years

5) Two years and half

6) Three years

7) Other, specify _____

3. How many kebeles are there in your woreda?

_____# kebeles

4. How many HCs are there in your woreda?

_____ # HPs

5. How many HEP supervisors are there in your Health Office?

_____ # HEP supervisors

6. How frequently do you visit each HC?

1) Once a month

2) Once in two months

3) Once in three months

4) Once in six months

5) Other, specify _____

7. What do you use as the basis for your plan before going to the HCs to undertake supervision?

1) My monthly working plan

2) My bi-annual working plan

3) When the timing is convenient to undertake the supervision

4) The working plan of the HEW (daily, weekly, monthly, etc.)

8. What are the major activities that you do during supervision visits?

_____

_____

_____

_____

_____

9. How many health extension workers are there in your woreda?

_____ # HEWs

10. How many of the kebeles in your woreda are successfully implementing the HEP?

_____ # kebeles

11. What are the reasons for the success of these kebeles?

_____

_____

12. What are the reasons for the rest of the kebeles not being successful?

_____

_____

_____

13. What possible solutions do you suggest to improve the situation?

_____

_____

_____

14. Does the UHEP are performed in kebeles of your woreda?

1) **Yes 2**) No

15. if the answer for question 13 is '2' , then what are your reasons to say that the program for not being performed

_____

_____

_____

_____

16. Out of UHEP packages, how many of them do you think that accomplished by HEWs in your woreda?

16.1 All

16.2 About 50%

16.3 About one third (33%)

16.4 About a quarter (25%)

Interviewer:

If responses to question number 16 were number 16.1 or All, or About 50%, continue asking questions 16 through 18.

17. How many or what proportion of the HEWs in the woreda do you think have such an accomplishment?

_____ # HEWs or _____% of the HEWs

18. What strategies did the HEWs use for the woreda to achieve the above mentioned results?

_____

_____

_____

19. What did the WHO contribute to the achievements of the HEWs?

_____

_____

_____**Interviewer:**

If responses to question number 16 were number 16.3 or 'About 33%', or number 16.4 or 'About 15%', ask questions 20 and 21.

20. In your opinion, what were the factors that may have affected the achievements of the HEWs?

_____

_____

_____

21. What did you or the WHO do to try to improve the performances of those HEWs?

_____

_____

_____

22. What training did you have that enabled you undertake supervisory responsibilities?

22.1_____

_____

_____

22.2. I never had training in this area.

23. How sufficient was your knowledge and skills to supervisee HEWs?

23.1 Sufficient 23.2 Insufficient

24. If the answer for the above question is insufficient, what are your reasons?

_____

_____

25.Do you have anything you want to tell me about the UHEP and related issues in your region that were not discussed above?

_____

_____

_____

I appreciate your participation very much and want to thank you for your time on behalf of the beneficiary community and myself.

Key Informant Interview for Zonal Health Department

Key Informant Interview Guide: Zonal Health Department (ZHD)

Informed consent:

Greetings,

Allow me to introduce myself. My name is _____. I am here to gather information from responsible sources like you about the Health Extension Program (HEP). Such information is very crucial to establish a common understanding among all parties involved in the HEP. It is also helpful to further strengthen aspects, deal in a timely manner with weaknesses, understand the nature of challenges and foresee possible threats that may endanger the effectiveness of the HEP.

The information that is obtained from ZHD is believed to be vital in reflecting the challenges and related solutions. I hope that you are willing to share with us your experiences by participating in the interview. I would like to assure you that the information that you provide will be confidential and will only be compiled and organized along with that of your fellow colleagues from various levels. No personal details will ever be released.

Even though this data collection is being done with the knowledge and permission of the FMOH-HEP, we would also like to get your prior consent as to whether or not you are willing to participate in the interview. Are you, thus, willing to participate in the interview?

Interviewer:

If the interviewee is willing to participate in the interview, proceed with the interview. If she/he is not willing to participate in the interview, stop it here.

Part I: Area Identification:

Region: _____ Zone _____

Responsibility of the respondent: _____

Part II: Detailed Questions:

1. What is the population size of the zone?

Male _____ Female _____ Total _____

2. How long have you served in your current assignment?

1) More than three years

2) Three years

3) More than two years

4) Two years

5) Others specify _____

3. How many woredas are there in your zone?

_____ # woredas

4. How many urban health extension workers (UHEWs) are there in the zone? _____

5. How many of the kebeles in the zone have HEWs? _____

Urban kebeles #_____

Rural kebeles #_____

6. How many UHEP supervisors are there in the ZHD?

_____ # HEP supervisors

6.1 What program sections are represented in the supervisory team?

_____

_____

_____

_____

7. How frequently does the ZHD supervisory team make supportive site visits to the woredas?

1) Once a month

2) Once in two months

3) Once in three months

4) Once in six months

5) Other, specify _____

8. What do you use as the basis of your plan for supportive site supervision?

8.1 Monthly activity plan

8.2 Bi-annually activity plan

8.3 As deemed necessary

8.4 On the basis of the HEW's routine/ weekly/ monthly plan (underline any of the indicated)

9. What are the major activities that you do during supervision visits?

_____

_____

_____

10. How many health centers are there in the zone?

Developed _____

Developing _____

10.1 What are the strong points in the relationship between the HEWs with the health centers?

_____

_____

_____

10.2 What are the problem areas in the relationship between the HEWs and the health centers?

a._____

_____

_____

b. No problem areas _____

Interviewer:

If the answer for question 10.2 explains a problem, ask the following question.

10.3 What efforts did the ZHD undertake to solve the problems mentioned and what were the outcomes?

_____

_____

_____

11. How many of the woredas in the zone do you think have accomplished extraordinarily well in the HEP implementation?

_____# Woredas (__ %)

12. What do you think are the factors that contributed to the success of the woredas?

_____

_____

_____

_____

13. What do you suggest to improve the weaknesses observed in the other woredas ?

_____

_____

_____

_____

14. what percent of the UHEP accomplished by HEWs in your zone?

14.1 All

14.2 50%

14.3 30%

14.4 25%

Interviewer:

If the answer to question 14 is 14.1 (All) or 14.2 (50%), ask question 14.5, 14.6 and 14.7.

14.5 What is the number or proportion of the woredas that have so performed?

_____(number) or ____%

14.6 What were the factors that helped the woredas so to perform?

_____

_____

_____

14.7 What did the ZHD contribute to the performance of the woredas that you mentioned?

_____

_____

_____

Interviewer:

If the answer to question 14 is 15.3 (30%) or 14.4 (‘25%) ask questions 14.8 and 14.9.

14.8 What do you think were the factors that affected the performance of the woredas?

_____

_____

_____

14.9 What efforts did the ZHD or the RHB make to improve the weak performance of the woredas?

_____

_____

_____

15.Do you have anything you want to tell me about the UHEP and related issues in your region that were not discussed above?

_____

_____

_____

I appreciate your very interactive participation and want to thank you for your time on behalf of the beneficiary community and myself.

Focus Group Discussion with Female Beneficiaries

Questionnaire Designed for Focus Group Discussion to be addressed to: Female Beneficiaries

Informed consent:

Informed consent:

A note to the Moderator:

Start first by greeting the participants, giving your name, and telling them from where you came. Then explain why you are here as is stated in the following paragraphs to get their consent. We are here today, to discuss with you and gather information about factors that are associated with the service delivery of your respective health posts (HPs). It is believed that being residents of the locality and beneficiaries of the services that the HP gives, you are believed to have a lot experiences to share regarding the issues associated with ground level implementation of the Health Extension Program

(HEP). The information that we get from you will be merged with others like you in and outside of this region. Then it will be documented, analyzed, and interpreted by experts to reflect what the service looks like and generate recommendations on what still needs to be done to improve HEP implementation in general. We value each and every bit of information that everyone of you can give us. Therefore, all of you are kindly requested to actively participate in the discussion. We would also like you to note that our discussions will be tape-recorded to help us recall what was stated and to rightly recall the views provided when we get back to our posts and document them in writing. I would also like to assure you that whatever you cite will remain confidential, and in no way will the write up associate the findings with individuals here. I hope that each one of you is now aware of the purpose of the discussion session. Even though this focus group discussion (FGD) is being held with the knowledge and permission of the Woreda Health Office (WHO) and the kebele administration, we would also like to confirm whether or not you are willing to participate in the discussion. Therefore, we would like to know if you are willing to participate in this discussion.

Moderator:

If the discussants react positively, continue the FGD with those who volunteered to participate in the discussion and allow the rest to leave. Continue the FGD with those who volunteered to participate in the discussion after having allowed those who did not agree to leave.

Part I: Area Identification:

Performance category of the Health post: 1) Strong 2) Weak

Discussants number: _____

1. Region _____ Zone _____Woreda _____ Kebele _____

2. For how long have you lived in this kebele?

2.1 One year

2.2 Two years

2.3 Three years

2.4 More than three years

2.5 Any other---------- (explain)

Focus Group Discussion with Female Beneficiaries

2

3. Will you please tell me your age or date of birth? (Start from one corner and tally them in the age

groups provided here below.)

3.1 15---19 ----------

3.2 20---24 ----------

3.3 25---29 ----------

3.4 30---34 ----------

3.5 35---39 ----------

3.6 40---44 ----------

3.7 45---49 ----------

3.8 50 and above ----------

4. How many of you have been to school? (Tally their numbers by asking them to raise their hands.)

4.1----------been to school 4.2---------never been to school

4.3 How many of you have been to primary school (grades 1-4)? ----------

4.4 How many of you been to grades 5 to 8? ----------

4.5 How many of you been to senior secondary school (9-12)? ----------

4.6 How many of you been to tertiary/college level? (12+2, 12+4,etc.) ----------

5. How many of you have ever been married?

5.1 Never been married _____

5.2 Widowed _____

5.3 Divorced _____

5.4 Separated _____

5.5 Still married _____

6. How many of you have ever given birth? (Tally their numbers by asking them to raise their hands.)

6.1 ----------ever given birth

6.2 ---------- never given birth

7. How many of you are breast-feeding? (Tally their numbers by asking them to raise their hands.)

7.1 ----------breast-feeding

7.2 ----------not breast-feeding

Moderator:

For question 8 below, go through 8.1 through 8.4 and provide answers according to instructions below and once you ask and clarify the question: Keep on circling code number '1' when they cite the type of the HEP (service) that the HP delivers without probing. They may not cite them sequentially as was put in the questionnaire.

Therefore, read through the HEP packages to recall their locations when discussants/respondents cite them. Give them time to recall until they tell you that they have nothing more to mention. Look at the type of health extension package that you have not circled (meaning that they have not cited it, starting from 8.1). Then read/cite for them each health extension package. Every time you finish reading/citing the particular health package whose number '1' answer code was not marked, ask them if they have anything more to tell you about it. If they tell you anything, then circle number '2', if not, circle number '3'.

8. What are the health services that the health extension in your kebele is providing?

	Yes without Probing	Yes with probing	No

8.1 Hygiene & Environmental Health	1	2	3
8.1.1 Excreta disposal	1	2	3
8.1.2 Solid & liquid waste disposal	1	2	3
8.1.3 Water supply and safety measures	1	2	3
8.1.4 Food hygiene and safety measures	1	2	3
8.1.5 Healthy home environment	1	2	3
8.1.6 Control of insects and rodents	1	2	3
8.1.7 Personal hygiene	1	2	3
8.2 Health Education and Communication			
8.3 Family Health	1	2	3
8.3.1 Maternal and child health	1	2	3
8.3.2 Family planning	1	2	3
8.3.3 Immunization	1	2	3
8.3.4 Nutrition	1	2	3
8.3.5 Adolescent reproductive health	1	2	3
8.3.6 Reproductive health related harmful traditional practices	1	2	3
8.4 Disease Prevention and Control			
8.4.1 HIV/AIDS & other sexually transmitted	1	2	3
infections (STIs) & TB prevention & control	1	2	3
8.4.2 Malaria prevention and control	1	2	3
8.4.3 First aid emergency measures	1	2	3

Moderator:

When you someone tells how she knew about it, ask the rest to raise their hands if they had the same response and tally the similar responses together.

9. How did you come to know about the aforementioned health services? *(When one person responds, do not stop, but keep on encouraging more to speak up, until they stop citing).*

9.1 HEWs that came to our homes told us _____

9.2 We heard about it when we went to the HCs seeking for services_____

9.3 Friends who heard about it told us _____

9.4 Community members who heard about it told us_____

9.5 HEWs told us at the meetings we held_____

9.6 If the discussants cited some other ways heard, write them in the spaces provided below.

_____

_____

_____

10. What has been done by the HEWs to keep the water that you use clean?

_____

_____

11. What were you trying to do when getting sick before the HEWs in your locality started working?

_____

_____

Moderator:

If the discussants mention that they were going to a HP or a hospital, ask them how long it took them to walk there. (__hrs or _____day/s walk-in) or travel by car (____hrs or____-day/s driving).

12. Which of the health problems that were the most prevailing in the days before the HEWs started service, were now reduced?

_____

_____

_____

_____

13. What were the similarities and differences between your expectations before the HEP started providing services and after you observed the types of services?

_____

_____

_____

_____

14. In your opinion, how helpful was the service by the HEW in reducing the burden of health problems in your community?

_____

_____

_____

_____

15. What health services are given for mothers and children by the HEW? What changes were observed ever since?

_____

_____

_____

_____

16. What would you suggest to improve the current health service of the HEW?

_____

_____

_____

_____

In the name of my team, the beneficiaries of the HEP and on my own behalf, I whole heartedly thank you very much for taking your time to come here and share with us your observations regarding the HEP.

Key-informant interview with the kebele health representative

1. For how long you served in the kebele?
2. What was your involvement in the establishment of the HPs?
2.1 _____
2.2 We were not involved _____
3. What were the issues that you discussed with the HEW?
3.1 _____
3.2 We never had discussed such issues. _____
Moderator:
If the group members express views stated in 3.2 or said, "We never discussed such issues," ask 3.3.
3.3 Why were you not motivated to discuss issues about the health service that the HEW was giving?
_____
4. What community health differences did you observe between the days before and after the HEP was launched in your localities?
4.1 _____
4.2 No changes were observed in the health of the community _____
Moderator:
If the view that the stakeholders expressed was 4.2, 'No changes were observed in the health of the community,' skip number 5 and ask number 6.
5. What differences did you observe in environmental sanitation in the days before and after the HEP was launched in your localities?
5.1 _____
5.2 No changes were observed in the environmental sanitation _____
6. Which of the health services did you observe as better or best performed among all others?
6.1 _____
6.2 What was your involvement and contributions in the areas that you explained as having been performed well or best?
_____
6.3 Nothing was performed satisfactorily. _____
Moderator:
If the view that the stakeholders expressed was 5.3, 'Nothing was performed satisfactorily,' then go to 6.4

6.4 What do you think are the reasons for not seeing any commendable performance in the health service delivery of the HP?
_____
7. What would you suggest to do differently to enable the health posts perform better than the current?
_____
8. What contributions do you think could you make to improve the current health service status?
_____
9. Which of the existing health problems in your area affect the public most?
_____

10. In which of the health intervention do you think you would find yourself fit to contribute?

_____

11. What conditions do you think facilitates your efforts in enable you discharge your share in the HEP?

_____

12. Please if you have issues that were not raised in our discussion, speak them out and let's discuss on them?

DECLARATION

I, the undersigned declare that this thesis is my original work, has not been presented for a degree in this or any other university and sources of materials used for the thesis have been fully acknowledged

Name: Haileeysus Adamu

Signature: _____

Name of institution: Jimma University, College of Public Health and Medical Sciences, Department of Health Service Planning and Management

Date of submission: _____/_____/_____

This proposal has been submitted after examination, with my approval as University advisor

Name and Signature of the first advisor: _____

Date: _____/_____/_____

Name and Signature of the second advisor: _____

Date: _____/_____/_____

Name and Signature of internal examiner: _____

Date: _____/_____/_____