The Role of Community health workers in improving uptake of institutional delivery service in Jimma zone

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The Role of Community health workers in improving uptake of institutional delivery service in Jimma zone

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ABSTRACT

Background; *- Many women lose their lives in the process of giving life. Reducing maternal morbidity and mortality is a global priority which is particularly relevant to developing countries.*

One of the key strategies for reducing maternal morbidity and mortality is increasing institutional delivery service utilization of mothers under the care of skilled birth attendants. The crucial role that Community Health Workers (CHWs) can play in delivering these interventions is not clearly understood.

Objectives; *- The aim of this study was to explore the role of community health workers in improving utilization of institutional delivery service in Jimma zone south west Ethiopia.*

Methods:-*A community based descriptive cross sectional study was conducted in Jimma zone Oromia regional state south west Ethiopia. The source population for this study was all women of reproductive age group, CHWs, other health workers, health managers and community members. Three woredas were selected using lottery method and two kebeles selected from each woredas then mothers of reproductive age groups, kebeles leaders, health extension supervisors, health extension workers and health managers were purposively selected. Qualitative data were collected using FGD (focus group discussion) and in-depth interview to get deep insight into the role of CHWs to institutional birth service utilization. Data were analyzed manually by thematic analysis and narration.*

Results: *The findings of the study showed that community health workers played a role of delivering key health education and information, referrals, and provision of services like immunization and acted as advocators (*speaking, acting, and writing with minimal conflict of interest on behalf *of the community). Their contribution to institiuonal delivery is affected by several factors like access to health facility, commitments and approaches of health workers, the skill of health careproviders, resource constraints, and factors related to the community, health facilities and healthcare providers.*

Conclusion: *CHWs contribution to the uptake of institiuonal delivery is changing positively in recent times but it is very slight. A continuous support from different stake holders to community health workers, with increased service quality and commitment of health workers will help to improve uptake of facility delivery services.*

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Contents

List of Abbreviations and acronyms

CHWS----------Community Health Workers

MDGS----------Millennium Development Goal

HIV----------Human Immune Deficiency Syndrome

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

WHO----------World health organization

NCD----------Non-communicable disease

STD----------Sexually transmitted disease

HEW----------Health extension workers

ANC----------Ante natal care

PNC----------Post natal care

HEP----------Health extension professional

CSA----------Central statistical agency

MD----------Medical doctor

TTBAS----------Trained traditional birth attendants

CBRHAS----------community based reproductive health agents

EDHS----------Ethiopian demographic and health survey

MMR----------Maternal Mortality Ratio

SBA----------Skilled Birth Attendance

EMOC----------Emergency Obstetric Care

HFs----------Health Facilities

CEMOC----------Comprehensive Emergency Obstetric Care

PPH----------Post-Partum Hemorrhage

GTP----------Growth and Transformation Plan

CHR----------Community Health Representative

HSDP----------Health Sector Development Program

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

UHC----------Universal Health Care

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

AHO----------African Health Observatory

SNNPR----------Southern Nation Nationalities and Peoples Region

PHFs----------Public Health Facility

FGD----------Focus Group Discussion

IDI----------In-Depth Interview

FANC----------Focused Antenatal Care

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Chapter one: Introduction

1.1 Background

Many women lose their lives in the process of giving life. Maternal mortality remains high in the developing world. The health of mothers and children is central to global and national concerns, [1]. Reducing maternal morbidity and mortality is a global priority which is particularly relevant to developing countries. One of the key strategies for reducing maternal morbidity and mortality is increasing institutional delivery service utilization of mothers under the care of skilled birth attendants [2].

From the early years of primary health care, community-based health workers (CHWs) have played a key role in satisfying the need and demand for essential health services. The Alma-Ata Declaration states that primary health care "relies, at local and referral levels, on health workers, including physicians, nurses, midwives, and community health workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community [3].

The 1978 Declaration of Alma-Ata described CHWs as a major vehicle for the advancement of primary health care in areas with limited resources, stating, "The people have the right and duty to participate individually and collectively in the planning and implementation of health care activities. The CHW Section of the American Public Health Association defines a CHW as a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community being served (4). This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

The crucial role that Community Health Workers (CHWs) can play in delivering these interventions is broadly recognized. CHWs are best positioned to deliver these services in communities engaged in the improvement of their own health, working in partnership with other frontline health workers and anchored in the primary health care system [5]. CHWs have a well-established history as agents and advocates for improving health in local communities. The implementation of health reform has increased interest in using CHWs to reduce health care

costs through coordination of primary care and community-based prevention services and activities, particularly in communities where health inequities are concentrated.

CHWs are trained to carry out one or more functions related to health care. CHWs may receive training that is recognized by the health services and national certification authority, but this training does not form part of a tertiary education certificate. While early programmes emphasized the role of CHWs as not only (and possibly not even primarily) health care providers, but also as advocates for the community and agents of social change, today's programmes emphasize their technical and community management function [5].

CHWs can be particularly effective in facilitating patient access to care services and navigation of the care system, coordinating care and providing referrals to locally available health and human services, and increasing patients' use of primary and preventive care services. As frontline workers with unique knowledge of the complex interactions among socio-cultural and physical environmental factors that influence health, CHWs provide the surveillance to inform the design of culturally appropriate, community-responsive care. Their knowledge also positions them well to advocate for actions to address issues at the community level that may negatively impact health, such as a lack of access to healthy foods, limited transportation links, few safe options for physical exercise, and violations of housing ordinances [6].

The use of community members to render certain basic health services to their communities is a concept that has existed for at least 50 years. There have been innumerable experiences throughout the world with programmes ranging from large-scale, national programmes to small-scale, community-based initiatives. We now know that CHWs can play a crucial role in broadening access and coverage of health services in remote areas and can undertake actions that lead to improved health outcomes, especially, but not exclusively, in the field of maternal health. The services offered by CHWs have helped in the decline of maternal and child mortality rates. However, the coverage by such programs and the overall progress towards achieving the targets was very slow. The growing consensus regarding this current pace of progress, especially in the low-income countries, is that it relates to fragile health and economic systems . HEWs are one of the community health workers currently [4].

In Ethiopia HEP (health extension program) was started in 2003 by the year 2010, a total of about 3 4,000 HEWs were trained and deployed throughout the country. In addition about 15,000 health posts were constructed in the country. CHWs are linked to the community through a network of community volunteers, who are members of the health development army (HDA). The HDA was introduced in 2012, officially replacing other community-based workers such as health promoters and traditional birth attendants (TBAs). It is based on gradual training of model families by CHWs. Model families become leaders of a group of five families known as the "one- to -five network", who in turn form a "development group" of 25 to 30 households within a village. "Graduation" to a model family occurs after training in all components of the HEP and proven implementation at the household level (7). CHWs are required to spend 75% of their time conducting outreach activities by going from house to house in their respective kebeles , while the rest of their time they are supposed to be at the health post. With the aim of reducing maternal mortality, CHWs are trained on how to provide care to pregnant mothers through pregnancy, birth and postnatal period. Since the implementation of the HEP, few studies have published findings on the effectiveness CHWs. However; none of them investigated the CHWs role in improving utilization of comprehensive maternal health services in general and institutional delivery service utilization in particular [8].

1.2. Statement of the problem

According to the World Health Organization (WHO), one in 20 African women die largely of preventable deaths, pregnancy and childbirth, compared to one in 4000 in Europe [9]. Maternal health remains one of the most prominent health challenges in the developing world. According to the World Health Organization, over 300 million women in the developing world experience significant maternal morbidity, and 99% of maternal deaths occur in developing countries [10].

In the developing world, the risk of death from complications relating to pregnancy and childbirth over the course of a woman's lifetime is one in 76, compared with one in 8 000 in the industrialized world. Globally, there are estimated 287, 000 maternal deaths in 2010. Developing countries account for 99% (284, 000) of the global maternal deaths. Out of this Ethiopia, accounts 9000 of the global maternal deaths reported in 2010 [1].

The minimum level of health workforce (MD, nurses and midwives and others) density required to achieve MDGs in Africa, for example, has been estimated at 2.5 per 1000 population. The current 0.2 per 1000 in Ethiopia clearly indicates the challenges ahead. Put simply, 'There is insufficient human capacity in many developing countries to absorb, apply and make efficient use of the interventions being offered" through the various initiatives related to, safe motherhood, child survival, HIV/AIDS, and malaria . Countries with such extreme shortages need to increase rapidly the number of health workers particularly at the (rural) community level where the needs are greatest [11].

In reaction to insufficient numbers of health personnel, many countries have focused on increasing production and distribution of health workforces. This occurred in 1980s particularly the community health workers although in the 1990s many such programmes weakened. Community health workers (CHWs) are widely used to provide care for a broad range of health issues. However, there is insufficient evidence about the role of their work in implementing comprehensive primary healthcare especially maternal health care and increasing institutional delivery. This lack of knowledge makes it difficult for policy makers to decide how CHWs can best improve the effectiveness of primary health care [10**,** 11]. Like in many resource constrained countries, Ethiopia has been training and deploying different categories of community health workers (CHWs) in the past decades. These CHWs include trained traditional birth attendants

(TTBAs), community based reproductive health agents (CBRHAs) and community health agents (CHAs). However, to accelerate the expansion of primary health care coverage and to ensure equitable access to health services, the government of Ethiopia started deploying specially trained new cadres of community based health workers named Health Extension Workers (HEWs). This initiative has been called the Health Extension Program (HEP). The HEP has been introduced in recognition of the failure of essential services to reach the people at the grass roots level in particular to underserved rural population. It was designed based on the concept and principles of comprehensive primary health care [10].

Giving birth in a medical institution under the care and supervision of trained health-care providers reduces the risk of maternal mortality and promotes child survival. According to Ethiopian Demographic and Health Survey 2014, the proportion of women utilizing safe delivery service in the country is very low. Delivery by skilled provider is (16%) and (13.1%) for Oromia region only 13 percent of women received postnatal care within the first two days of delivery (12). In Ethiopia, maternal mortality and morbidity levels are among the highest in the world. The maternal mortality ratio currently is 350 per 100, 000 live births [13].

There is currently a high level interest in community health worker (CHW) programs from the Secretary General of the United Nations to host-country governments to donor agencies and on down. Some countries have recently launched new cadres of CHWs as part of the primary health care system or are considering doing so. Other countries with mature CHW cadres in national programs are faced with decisions about possible changes in these programs, such as changing the selection criteria of CHWs, adding functions to existing CHW tasks, or modifying compensation arrangements. The majority of available published literature on CHW program effectiveness concerns CHW programs to improve population health. There is very little documentation on the planning and implementation of these programs. Also, there is a lack of empirical research on the overall effectiveness of CHW programs on community health and on the functioning of specific program components, such as institutional delivery.

CHWs have contributed substantially to the improvement in women's utilization of family planning, antenatal care and HIV testing. However, their contribution to advocating for skilled delivery and conducting postnatal check-up seems much lower and their knowledge and performance in maternal health -related tasks is poor and their role is not clear (12)

With the aim of reducing maternal mortality, HEWs are trained on how to provide care to pregnant mothers through pregnancy, birth and postnatal period. HEWs inform pregnant mothers on safe motherhood when they provide antenatal care (ANC), birth and post natal care (PNC). HEWs also provide family planning services and are trained on how to educate women. Since the implementation of the HEP, few studies have published findings on the effectiveness of HEWs and CHWs However; none of them investigated their role in improving utilization of comprehensive maternal health services particularly their role in increasing institutional deliveries service utilization [10].Therefore the aim of this study is to explore the role of community health workers in improving utilization of institutional delivery service in Jimma zone.

1.3. Significance of the study

First the study will benefit the community by making their problem known to concerned bodies; the results of this study will help policy makers and health managers to design appropriate strategies to increase institutional delivery service utilization. It help to decide how CHWs can best improve the effectiveness of primary health care by identifying the roles of CHWs. hence contribute in the effort to decrease MMR(maternal mortality rate). It also will be useful to jimma zone health department and other stake holders working on maternal and child health by exploring the role of CHWs to improve institutional birth service. It also helps the country at large to plan for increasing facility birth service utilization and will be a base for further similar researches.

Chapter 2 .Literature review

2.1. Maternal Health and Maternal Mortality.

According to the World Health Organization (WHO), maternal death is defined as the death of a woman whilst pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes [14].

Globally, 287,000 mothers die from complications of pregnancy and childbirth. Developing countries continue to account for 99% of the total maternal deaths. Of these estimated deaths, sub-Saharan Africa and South Asia accounted for 87% of the global maternal deaths. In sub-Saharan Africa, a woman's risk of dying from treatable or preventable complications of pregnancy and child birth over the course of her life time is 1 in 22, compared to 1 in 7,300 in the developed regions. The most common causes of maternal deaths are hemorrhaging, bleeding, sepsis, and prolonged or obstructed labor. However, current knowledge and technology can prevent these grave realities. The proportion of births attended by skilled birth attendants or skilled birth personnel is used as indicators to monitor the progress towards the target rate.

There are major technical interventions to improve the MMR. These include emergency obstetric care (EmOC), skilled birth attendance (SBA), management of unsafe abortions, focused ANC, and family planning. EmOC is a set of functions performed at HFs that can prevent the death of a woman experiencing an obstetric complication. According to the United Nations' (UN) recommendation, at least one comprehensive emergency obstetric care (CEmOC) and four basic EmOC facilities are required per 500,000 people. Increasing the provision of EmOC services does not necessarily require the construction of new HFs; many of the services can be delivered by upgrading the available HFs, improving staff skills and following pre-existing guidelines[14]. Ethiopia was one of the six countries which account more than 50% of all maternal deaths in 2008 . The proportion of deaths due to Post-Partum Hemorrhage (PPH) that occurred in facilities is most likely due to the fact that over 90% of births take place at home, and women with PPH may not be arriving at a health facility in time. Hence, an important component in the effort to reduce the health risks of mothers and children is to increase the proportion of babies delivered in a safe and clean environment and under

the supervision of health professionals. In Ethiopia, the proportion of births attended by skilled personnel in health institution is increased in a very slow fashion in the course of five years. The majority of Ethiopian women give birth at home without skilled attendants .Further, as reported in the 2005 Ethiopian Demographic and Health Survey (EDHS), the majority of births at home take place in poor hygienic conditions, while only 6 percent were in a health facility and are assisted by trained personnel. According to EDHS2014 About four in every ten Ethiopian women 41 percent did not receive any antenatal care for their last birth in the five years. maternal mortality and morbidity levels for Ethiopia are among the highest in the world [15]. Many researchers documented that more than three-fourths of maternal deaths are related to direct obstetric causes, such as hemorrhages, sepsis, abortion, ruptured uterus, and hypertensive diseases of pregnancy which are easily preventable and treatable, and 77% of deaths occur during or soon after childbirth (within 24 hours). Eighty-eight to ninety-eight percent of these problems are estimated to be avoidable, although over 99% of maternal deaths in Sub-Saharan Africa (SSA) could not be prevented. Maternal mortality in Ethiopia is the highest in the World with an estimated maternal mortality ratio of 676 deaths per 100,000 live births in 2011 which slightly increased from the 2005 maternal mortality ratio (MMR) level of 673 deaths per 100,000 live births [16].

2.2. Institutional delivery

Institutional delivery is when childbirth happens with skilled assistance in an institution which is built, equipped and managed in order to provide a delivery service as one of its functions. Ethiopia has a high MMR and constitutes 58 percent of global maternal deaths, making it a priority for the Ethiopian government to drop this rate. In order to do so, in 2011, the government prepared a five-year plan, known as the growth and transformation plan (GTP), with ambitious targets towards reducing HIV infection rates and maternal and child mortality rates while improving existing health systems. Deliveries assisted by skilled birth attendants, "an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new born was only 10 percent. With an overwhelming 90 percent taking place at home. As a result of the lack of medical

service usage by pregnant women [14]. The advantage of institutional delivery is that there is a greater certainty that the pregnant women will be able to access all the relevant services much easier than if she had received skilled assistance at home. In addition, identification of problems would be faster during an institutional delivery since it is carried out in an equipped healthcare setting .The majorities of births in sub-Saharan Africa still occur at home or in other non-healthcare settings [17].

2.3 Community health workers (CHWs)

According to WHO, "CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations"(WHO 1990).

Witmer et al (1995) define community health workers as community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care.

By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs. CHWs builds individual and community capacity to improve health outcomes by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, the provision of social support and advocacy [18,19]. CHWs, by virtue of their role as a bridge to the health care system, can help to disseminate widely efficacious interventions to populations that rarely benefit from health care advances.

CHWs are called by a variety of other names, including outreach workers, promoters, community health representatives (CHRs), and patient navigators. Regardless of title, CHWs are usually community members who assist in addressing social and health issues that affect the areas in which they live. They provide cultural mediation between communities and the health care system. Because of their ability to relate to patients, CHWs often can gain a high level of trust from patients and help improve health outcomes for vulnerable populations. They are

particularly effective because of their ability to connect with the community and their experience-based expertise. CHWs are "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community being served. A national study conducted in1998 identified seven core roles for CHWs-roles that remain the gold standard for defining the field (18).

1. Culturally mediating between communities and the health care system.
2. Providing culturally appropriate and accessible health education and information.
3. Ensuring that people get the services they need.
4. Providing informal counseling and social support.
5. Advocating for individuals and communities.
6. Providing direct services (such as basic first aid) and administering health screening tests.
7. Building individual and community capacity.

Additionally, CHWs can provide support to health care teams in the prevention and control of chronic disease by assuming a variety of roles that support both patients and providers: helping with the determination of eligibility for services and with enrollment, providing educational interventions, following up with patients to help with adherence to medications and treatment regimens and appointment keeping, coaching to assist in the management of chronic diseases (including goal setting and behavioral changes), helping patients navigate health care systems and planning for discharge from the hospital (patient navigation), and improving the engagement of patients with providers [19]. A clear understanding of the national health system—particularly its stakeholders, how health care is delivered, and its human resource needs—is needed to see where CHWs fit into the larger health system and to clearly define their roles and responsibilities. It is also necessary to understand what health services are valued by community members. Several study conducted on key informants showed that community members have a tendency to place greater value on curative treatments than on preventive messages. Understanding this tendency is needed to ensure CHWs are meeting some of these needs for them to gain credibility in the community [20]. CHWs commonly provide social support and informal counseling, health education, system navigation, patient self-management support and

follow-up, home visits, and perform outreach, administrative tasks such as scheduling and appointment reminders, and a host of communication -related duties, including translation, interpretation, and cultural mediation. Assign appropriate roles and duties to CHWs. CHWs may perform any number of duties in the health care setting. CHWs may be members of a care delivery team or act in various capacities as researchers. They can be vital in facilitating communication, through cultural mediation and translation. It is important to avoid role confusion by defining the CHW's scope of practice and clearly communicating the information to other health care staff working with the CHWs. Ensuring there is no confusion among staff about CHW roles and responsibilities will help promote successful integration of CHWs. When CHWs perform duties outside of their job description or focus too much on patients outside of the intended population, it may create problems which can potentially limit the success of the intervention. To decrease role confusion and promote well-coordinated service delivery, studies recommend that programs develop strictly enforced intervention protocols. Most CHWs perform activities across multiple roles. Regardless of the specific activities they perform, CHWs are always consumer advocates and cultural mediators (21).

CHWs act as a bridge between the [illegible] and the health system by playing different roles

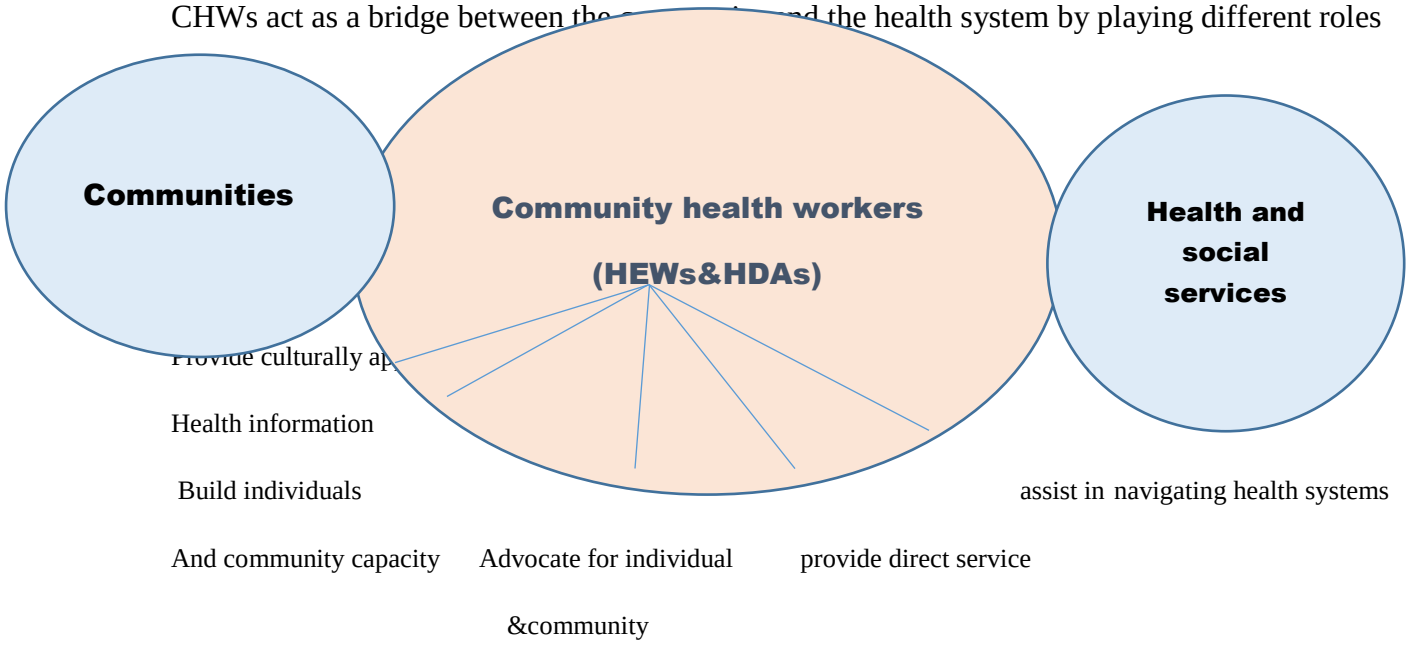

Fig.1. Community health workers act as a bridge between community and the health system adapted after literature review. (*Adapted from WHO,* Evidence and Information for Policy, *HRH, Geneva January 2007).*

Another way to define CHW roles is by target population. CHWs work primarily in underserved, vulnerable communities that may be defined racially or ethnically, geographically, or by disease. CHWs work is crucial in the elimination of health disparities and the promotion of health equity. Above all else, CHWs are reactive to community needs. Their roles and responsibilities are developed in response to a particular challenge faced by a community [22].

2.4. HEP and UHC

The aim of HEP (health extension program) is to expand universal health coverage (UHC) through strengthening primary health care (PHC). Guaranteeing access to health services for everyone while providing protection against financial risk are the main features of UHC. Therefore, services must be physically accessible, financially affordable and acceptable to patients if UHC is to be attained. As Ethiopia advances to middle income country status, its goal is to realize progress towards decreasing MMR and ultimately to achieve UHC for all Ethiopians. The last lap towards Millennium Development Goals was the performance of the health sector in EFY 2005", which gives an overview of the planned activities, main achievements and key challenges encountered in EFY 2005. It tries to address the critical question of how to speed the pace of change observed in the past into dramatically faster progress during the Health Sector Development Programme (HSDP) IV period, whose end in 2014/15 corresponds to the deadline of the quantitative, time-bound framework of accountability of the MDGs. Central to Ethiopia's health performance is the country's strategy to deliver more and better health care to women and children.[23,24] To this end, the HSDP has been successful in putting in place the Health Extension Program which has contributed in a major way to improved availability and accessibility of PHC services, and paved the way for the achievement of the MDGs. In this perspective, the implementation of the Health Development Army (HAD) is underway with the aim to drive behavioral change and expand safe health practices at community level, with a vision of considering the community as a potential producer of health, instead of as a mere consumer of medicines and curative services. A key strategy is to bridge the continuum of care from pregnancy, through childbirth and neonatal period, and beyond, and also between places of care giving (households and communities, outpatient and outreach services, and clinical-care settings). It is for this reason that different programs in place are focusing on ensuring continuum of care and strengthening the referral linkages across the levels of the health

system [29]. HSDP IV is aligned with the Millennium Development Goals (25), while Ethiopia has already met MDG 4 and most of the targets of MDG 6; further efforts are needed to achieve UHC (38). Ethiopian Fiscal Year (EFY) 2005 marks the third year of the fourth phase of the Health Sector Development Programme (HSDP) Concerning the Health Extension Programme, the organization of the Health Development Army has been expanded to all agrarian regions as well as in urban areas in EFY 2005 to promote safe health practices at the community level; whereas social mobilization has been under-taken in pastoralist regions. Concerning maternal and child health services, an increase was observed between EFY 2004 and EFY 2005 for antenatal and postnatal care coverage (from 89.1% to 97.4% and from 44.5% to 50.5%, respectively) as well as for the percentage of deliveries attended by skilled health personnel (from 20.4% to 23.1%), while the percentage of clean and safe deliveries (by health extension workers) declined from 13.2% to 11.6% in the same period [23, 24]. The Health extension package addresses 16 packages and has four components: 1). disease prevention and control, 2). family health, 3). hygiene and environmental sanitation, and 4). health education and communication (12).

Chapter 3 .Objectives

3.1 General objective

To assess the role of CHWs in improving utilization of institutional delivery service in Jimma zone from March 20/2016 – April 20/2016

3.2. Specific objectives

1. To explore the way CHWs get involved in improving uptake of institutional delivery service in jimma zone
2. To identify factors affecting performance of community health workers.
3. To assess the supervision and support arrangements to enable CHWs to get involved in the initiative to improve uptake of institutional delivery service.
4. To assess the challenges faced by the CHWs in fulfilling their role of improving uptake of institutional delivery service

Chapter 4 Methods and materials

4.1. Study area and period

The study was conducted in jimma zone Oromia regional state south west Ethiopia from March 20/2016 – April 20/2016.

Jimma zone is one of the zones in Oromia regional state. Based on the 2007 Census conducted by the CSA, Jimma Zone has a total population of 2,486,155, an increase of 26.76% over the 1994 census, of whom 1,250,527 are men and 1,235,628 women; with an area of 15,568.58 square kilometers.

4.2. Study design

Qualitative Cross sectional study design were employed

4.3. Source population

The source population for this study was health extension workers, health extension supervisors, health managers, traditional birth attendants, women of child bearing age, Kebele secretary, heads of health centers and community health agents in Jimma zone.

4.4. Study population

All selected mothers of reproductive age group, HEWs, health extension supervisors, health managers, and Kebele secretary and health development armies in the Kebeles.

4.5. Inclusion and exclusion criteria

4.5.1. Inclusion

Mothers, community members, health professionals, CHWs and other participant that stayed at least for six months in the Kebele were included.

4.5.2. Exclusion

Mothers, health managers, CHWs and community members who were very sick and those who cannot give the required information, were excluded.

4.6. Sampling and sampling techniques

4.6.1. Sample size

Two - FGD containing 6-12 members with mothers were done in each kebeles while ensuring homogeneity for free generation of idea. In-depth interview with key informants including *HEWs*, health managers (*zonal HEWs coordinator*), *elderly men, Kebele secretary, head of health center HE supervisors* were conducted. One HEW (Kebele cadre) in the selected Kebeles was included in the interview in each kebele.

4.6.2. Sampling method

Three woredas were randomly selected followed by purposive identification of 2 kebeles from each woredas. We belief that three woredas can represent jimma zone for getting rich information. The criteria to select the kebeles were reported relatively high and low institiuonal delivery and distance from the health center. The health extension workers and village (Gare) head communicated mothers to collect at one place, then after taking consent the FGD was conducted. With the help of HEWs and HE supervisors womens of reproductive age groups, were identified and listed the mothers were informed by the one to five link (takko- shanni) or Garee /village head about the presence of the discussion the mothers were made to gather at one place (meeting place) then after having consent to participate group discussion was conducted.

4.6.3. Sampling procedure

A total of six kebeles were included in this study form three woreda namely Gomma woreda, Omo Nada and Kersa woreda. Two health centers were selected from each woreda. Yachi and Gimbi health centers were selected from Gomma woreda health office this are those with low institiuonal delivery under yachi heath center catchment area there are three rural kebeles namely kilole, Dedo orache and yachi orache kebele (kilole and Dedo orache) kebeles were purposefully selected to be included because they are found to be the kebele with low institutional delivery relatively after having review of delivery register from the health center and the information we got from the health extension managers the other kebeles were selected using the same mechanisms. From Kersa woreda serbo health center was purpusfully selected under the catchments area of serbo health center Tikurbalto kebele and babo kebele were

included. From omo nada woreda nada health center was selected and under it bisogambo and nada sokote kebele were included in the study.

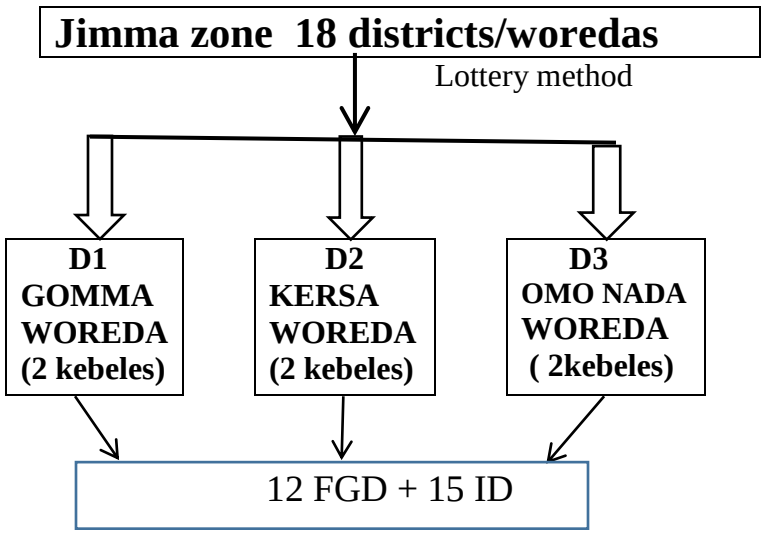

Fig .2. Sampling procedure

Table 1 Sample size for the study in depth interview Jimma zone May 2016

Study participants	**Gomma woreda**		**Kersa woreda**		**Omo nada woreda**	
	Kilole	Dedo orache	Tikur Balto	Babo	Nada sokote	Biso Gimbo
Health extension workers	1	1	1	1	1	1
HE SUPERVISOR	1		1			
HC HEAD	1		1		1	
KEBELE SECRETARY	1		1			1
ZONAL HEALTH EXTENSION MANAGER	1					
Total	15 participants					

Table 2 sample size for the study FGDs Jimma zone May 2016

FGD participant	**Women of reproductive Age group**											
Woredas	Gomma				Kersa				Omo Nada			
Kebeles	Kilole		Dedo orache		Tikur Balto		Babo		Nada sokote		Biso Gimbo	
No of FGD per kebele	FGD1	FGD2	FGD1	FGD 2	FGD 1	FGD 2	FGD 1	FGD 2	FGD 1	FGD 2	FGD 1	FGD 2
No of participants	11	12	8	12	9	10	6	11	10	11	12	8
Total	120 participants											

The total number of participants for FGD and IDI was (135) the Study participants were purposefully sampled to represent different ages, opinions, and job experiences and has been identified with the help of health center and woreda health office staff and HEWs.

4.8. Data collection instruments

The data were collected using interview guide for in-depth interview and focus group discussion guide (FGD guide). The interview tools were open ended inquiries adapted to address objectives and were prepared in English translated into Affan Oromo and back translated by different individuals to see its consistency.

4.9. Data collectors

Three HE (health education) experts who are fluent in the local language were recruited with one senior expert supervising them.

4.10. Data collection producers

Each FGD was run for 1- 1.5hrs and the modulator asked questions for discussion from the topic guide prepared in the local language. There were three types of questions engagement questions exploratory questions and exit questions. A maximum of 7-10 main questions were asked for one FGD group. During discussion the note taker inscribed notes, quotes and ideas.

The discussions were digitally recorded and the modulator modulated the generation of idea. In-depth interview guide was used for conducting the interview. During the interviews, follow-up questions using probes were asked in order to acquire a deeper understanding when an explanation was unclear. Data were recorded (transcribed ,Written, Field notes Supporting documents Audio and/ Visual Data was taken, focus groups consultation Photos was taken after informed consent from the participant was ensured),focus group notes, and notes of probing with facilitator and note taker was done. The FGDs were conducted near by the kebele office which is selected to be the suitable place for conducting the focus group discussion in each kebele.

4.11. Operational definition

- A role: - is the position or purpose that someone or something has in a situation or organization, it is a character or part played by a performer or the characteristic and expected social behavior of an individual.
- CHWs: - Health workers performing functions related to health care delivery; who have received a limited training focused on activities they need to carry out in the context of the interventions they implement. In this study community health worker refers to health extension workers, health development army, traditional birth attendants, and community health agents, community based reproductive health agents and all other community health workers with training and skill equal/less than HEWs.
- Advocacy;- Advocacy is speaking acting, writing with minimal conflict of interest on behalf of the sincerely perceived interests of a disadvantaged person or group to promote, protect and defend their welfare and justice. In this study Community advocacy; refers to community support, protection, encouragement, defending their welfare or backing of community.
- Institutional delivery;- is when childbirth happens with skilled assistance in an institution which is built, equipped and managed in order to provide a delivery service as one of its functions.
- WDA (womens Development army): -. These are community-level volunteers trained by the health extension workers to focus more intensively on sparking local behavior change. They make regular rounds to check on neighbors and encourage practices like latrine building and

setting-up separate cooking spaces. They are from "model families" and serve as living examples that the health extension workers' messages are being heard.

- TBA(Traditional birth attendants);- are a person (usually women) who assists a mother at child birth and who initially acquire her skills delivering babies by herself or by working with other TBAs. TBAs are more commonly found in rural than in urban.
- Community health agent;- are lay health workers who are not certified to practice medicine or nursing, but has the primary task of gathering information on the health status of a small community by means of a close relationship with it. In the initial design, the agent should be one of the residents of a neighborhood or surrounding region, and was to be selected on the basis of a good relationship with his neighbors.
- CBRHAs(Community based reproductive health agents);- are those lay health workers and only allowed to distribute oral contraceptives and condoms, for which they can receive a small commission, provide basic family planning services and referrals, although they have acquired more responsibilities in the community and often support the activities of the HEWs.

4.12. Ethical consideration

Letter for ethical clearance was taken from ethics review board and Jimma University. Letter was written from Jimma University to concerned bodies for their cooperation, written/oral consent was taken from study participants before data collection. To ensure confidentiality we have removed the names of the participants from all the recordings done by replacing the name of participants with codes. Records of the interviews and the FGDs were destroyed once the report for the findings of the study is approved by the appropriate bodies

4.13. Data quality assurance

Two days training for data collectors, note taker and facilitators on how to conduct FGD and in-depth interview was provided on how to probe question's, how to take notes and how to conduct free generation of idea . The tools were pre –tested on 11 participants 1 FGD and 3 IDI before the actual data collection. Each FGD data were analyzed. The main points of each FGD have been written down and useful quotes were noted. Memos were written down immediately not to miss important details. Idea keeping, bracketing, trustworthiness were kept to assure quality of

data and not to change meaning of the original data. The recorded data was represented to the groups to cheek if there is any correction for consistency of data.

Through the fundamental methodology of "**bracketing**" the researcher's own experiences, of the phenomena were not included in the analysis. Bracketing is deliberate putting aside one's own belief about the subject under investigation or what one already knows about the subject prior to and throughout the investigation. By bracketing the validity of the data collection and analysis process was demonstrated. The trustworthiness of the data was ensured by a procedure that helps the participants to ascertain if their answers to any questions is correct and has not been misinterpreted. The trustworthiness was ensured by Credibility (How congruent the findings were with reality? To ensure dependability, care was taken during the interview conversation, during transcription of the data, and most importantly, during constitution of the categories of description). Transferability (the extent to which the findings of the study can be applied to other situations), Confirmability (ensure that the findings were the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher). Analytic Memos were written to summaries major findings during data collection. Analytic memos are write-ups or mini-analyses about what the researchers think or are learning during the course of their evaluation. .

4.14. Data analysis

All interviews were audio-taped and were transcribed verbatim (word for word), translated, coded and has been thematically analyzed. Data was analyzed by content analysis and narration. Key categories and thematic frameworks were identified for the role of CHWS and the components affecting it. The findings were then narrated under the relevant theme to address the study objectives and highlight newly emerging issues in the data. Moreover, we have used direct quotes to substantiate opposing and supporting views pointed out in the study findings.

4.15. Dissemination plan

The results of the study will be presented to JU communities' feedback will be given to jimma zone health departments and other stake holders and an effort will be made to publish in peer reviewed scientific journals.

Chapter 5 Results

5.1. Description of study participants

Of the 15 participants of the in-depth interview six were females and their age ranges from 18-39 years. Most of the participants were educated at least to the level of secondary school and there were also participants who were 1st and second degree holders (Table 3). Twelve FGDs with women of reproductive age groups and 15 IDIs with different actors working in the program were conducted. Each FGD comprised of six to twelve participants the age of participants range from eighteen to forty-five. The educational status of the mother range from illiterate to secondary education complete. All participants engaged well with the topic and responded to the questions (Table 4). The research outcome resulted in a set of thematic categories that describe qualitatively different ways of experiencing the situation and that are logically related in structure and meaning. From the total participants 12(10 %) have not ever experienced pregnancy and 108(90%) has experienced one or more pregnancies in their life. And from the total mothers who has experienced delivery 28(26%) of them delivered in health facility and the rest 80(74%) at home.

(Table.3).Characteristics of participants Jimma zone may 2016

FGD Participant	Age	sex	Number of par	Educational level							Position in organization
				Illiterate	primary	2nd	10+1	diploma	1st degree	2nd degree	
	15-20	F	9	6	3						
	21-25	F	12	5	7	2					
	26-30	F	46	38	6	1					
	31-35	F	33	28	4						
	36-40	F	14	12	2						
	41-45		6	5	1						
Total			120((100%)	94(78.5%)	23(19%)						
In-depth interview	27	M							1		HEWs Supervisor
	38	M								1	Program coordinator
	26	M							1		HC head
	25	F					1				HEW
	22	F				1		1			HEW
	30	M						1			Kebele secretary
	27	M					1				HEWs Supervisor
	20	F					1				HEW
	18	F				1					HEW
	28	M							1		Kebele leader
	33	M							1		HC head
	35	M					1				HC head
	19	F					1				HEW
	23	F			1						HEW
	39	M									Kebele secretary

5.2. Means of transportation

Bisogambo one of the kebeles in Nada woreda it is to the southwest of omo nada and the road to the kebele and health post is not well constructed and is difficult for ambulance and other vehicles transportation. Peoples use traditional ambulance that is by carrying with bed made of twig till to the main road. The road to nada sokote is a little bit good but it is still not suitable for car transport because there are streams crossing the road with no bridge constructed. People from this kebele also use the same mechanism to reach the main road to transport mothers to the health center. Similarly, the road to yachi health center in Gomma woreda was not well

constructed although it is adjacent to the main road and the road was not suitable for ambulance and other vehicles transport. However, pregnenet mothers can be transported to the health center easily since it is close to the main road. Consequently the number of the mothers delivering in the health center currently has shown improvements

. A key informant said; "*Currently the health status is good waiting room is constructed in some health center awerness creation and health workers approach to client makes this change*" (head supervisor interview). However this is in contrast, Majority of the study participant discussed they have road problem "…….*another is we constructed a kind of road recent time by help of the community but it is not suitable it is simply a path*". In one of the FGD the participant talked over and said "*In our locality even we did not have any kind of road unlike my colleague said we transport delivering women as well as any emergency by carrying with locally available means of transportation to the main road especially around locally called "wajie" because vehicles cannot access it due to road problem, as I said you so that until we arrive the main road we face a lot of problems road is only around "kake" it did not touch "wajie*". Generally participant's reported that they have road problems so that they face challenges in transporting.

A participant in another FGD also added *"as I said earlier electric city is a great problem to us even the road is not well constructed but I don't know how to solve this problem at all. I think the road is the first in order to bring electric city if the road is nice and comfortable that electric city can come to us"*

5.3 .Uses of institiuonal delivery

Giving birth in health facilities with skilled birth attendants has many advantages. It shortens labor, and decrease complication that may result from bleeding. Despite this advantage still large number of mothers delivery not in health institution. A respondent explained this by saying "*sometimes the labor is hasty and at that time the network may be busy or absent and ambulance may not be found. Hence, lack of money for transportation compounded with other problems of access makes mother deliver on the road on their way to health institution or at home"* (HC sup interview). Recently the number of pregnant mothers who want to deliver at health facility has increased. A participant said "……..*My inner soul also tells me that I should stay at health institution up to delivery since it is good here and I get chance*".

Another participant added*" I am interested to deliver at health institution it is god and I who decide for me*" (FGD participants). It is evident that with the support of different actors' institiuonal delivery service utilization can be raised. This is explained by some mothers not wait even for ambulance to take them to health facility they did it by themselves. But the quality of service at the health facility matters to the mother one of the FGD participant explained this she said "*I gave birth at health center recently when I call for ambulance they said that ambulance is not ready. Now it goes other place and I looked for Bajaj and go health center after I reach the health center the health worker they did not helped me very well*".(FGD participants). Up surging institiuonal delivery service utilization needs a team work from different segments and professionals. Key informants replied to this "*all should help mothers starting from awerness creation there is transformation but the change is not only from the effort of health professionals"* (head of health center interview)

The major factors affecting utilization of institiuonal delivery service is poor management at the health office and other health center. The maternity waiting rooms are not adequate. Ahead of a health center said, "*There is shortage of supplies. For example there is no food supply at the waiting areas. Provision of food for mothers in the waiting room has already started but it is not adequate*". It seems the provision of food for mothers in the maternity waiting room has started. The health professionals at the health center collect money or food (maize) from the mother that is later to be converted to porridge for the mothers but that was said to be not adequate. Several participants mentioned lack of food supply at the waiting areas. A participant said "*I heard some mothers complaining about delivery service given at our health center. That is when mothers go health center for delivery and stay there is no support like food and porridge but they have collected from us some maize and other things."(FGD participants)*

On the other hand, participants suggested that some of the services related to child birth could be provided at the health post to facilitate uptake of the service. A participant noted, "*The Health center is somewhat far from us it is difficult for pregnant mother for follow up and delivery it's better if we get the services here at the health post"*. However, this view is contradictory to current policy which says all delivery should take place in health facility by skilled provider.

Some mothers not deliver at health institution due to lack of knowledge and the influence of cultural factors. A participant explained "*To add on this there are individuals who never came to*

*health institution for any other reason may fear injection due to this they give birth at home and faced placental detachment problem this is a scenario of my friend . Even I came here by fear of future consequences of delivering at home …" (*FGD participant).

There are different actors working on the initiative to improve utilization of maternal health service both governmental and non-governmental organization included. There are some non-governmental organization working to improve maternal health service utilization like the engine and carter. For example engine is stakeholder working on maternal health in Gomma woreda. It is supporting by providing on job training, support and supervision to maternal health services. Similarly carter provides technical and material support in Kersa woreda it provides training to professionals. But it needs the joint effort of more many stakeholders to be effective in the program. Despite remarkable effort by government the maternal mortality is unacceptably high and facility delivery is so. This study showed that there is lack of other sufficient NGOs working on this program in the zone. Our respondents told us that previously there are stakeholders like ***carter*** working on maternal health but it has phased out. Those actors who worked on maternal health have contributed to the system by providing on job training updating professional skills. A key informant said "…..*The NGOS working on maternal health provide us training and technical support" (kebele secretary)'.*

Another FGD participant discussed *"There is no organization other than government working in our area. I don't know if there is any*" (FGD participants). This contradictor view showed that there is an insufficient stakeholder for the service. Another participant explained "*previously there are NGOs who work on maternal health but currently we don't have any working on the issue because they stopped their work but I don't know the reason for that.*

There is lack of sufficient supervision to the works of health extension workers. Majority of the participants said *"With regard to supportive supervision health extension workers come to visit our home and sometimes when there are immunization others come"*. A participant also added about actors supporting maternal health "*with regard to organization helping pregnant mothers I don't know anybody working to improve health in our kebele other than the health professionals but I have heard one organization constructed water previously the health extension workers are the one who always come to our home for many reasons".*

5.4. Supervision arrangements

The findings of this study revealed that there is support and supervision to health extension workers from the health center. There are health professionals who are assigned to each kebele on regular basis. They support and follow the kebele to which they are assigned but this support is not only with regard to maternal health issues. It is comprehensive it even includes the works of others sectors. The support given to health extension worker at the kebele level is virtuous but the support to individual in the kebele at the household level by health extension workers is weak. Key informants stated out saying this "*we are told to clean our latrine and environment when visitors are to come from either from the zonal health office or woreda health office or elsewhere. Otherwise except health extension workers no one visit us or supervises us what we do*". Hence, health extension workers perform a role of home visit .The support from zonal health department is uneven and not as strong as from the woreda health office. A participant from the health center explained that "zonal health office visit us not on regular basis sometimes they come quarterly other times yearly and so on. They come if there is any unusual alarm from the region that makes them come for supervision. Key informant stated that " *There is supportive supervision from woreda health office to health centers and health post every month the zonal health department comes once per year for review not for supportive supervision*"(HC interview).

The zonal health office comes for evaluative purpose. When they came they are not focused on single issue". Generally the support and supervision activity to CHWs regarding institiuonal delivery service utilization is weak and irregular. The unevenness of the supervision from the zonal health office may be due to work overload for them since they are responsible not only for maternal health and perform activities in the health system. The community health worker supervises and visits the mothers' home but this also uneven. Several participants discussed and said "*The health extension workers supervise what we are doing. They follow us wither we construct toilet or not wither our child is immunized. They are usually following us. They teach us about bleeding if there is bleeding during pregnancy they teach that we should go to health center immediately" (FGD participants)*.

5.5. Challenges for community health workers

Health extension workers face challenges from fully applying their role the challenges are multifaceted. When conducting home visit the health extension worker go long distance on foot. A respondent added "*we go very long distance on foot there are hard to reach area this challenges me*". The other challenge is from the community perception. One respondent explained this "*we cannot say every people can have the same knowledge and the same understanding some people easily accept changes but others are unaffected so we are working without becoming fed up to bring changes*" (HEW interview). Other respondents said "*urban health extension workers faced a challenge of acceptance because urban mothers are near to health facility and have access also the urban health extension professional's has no health post or office"* . other participant added "*I don't know but they come to our home to visit our home ,environment and teach about hygiene even the toilet but no one give attention to them. People supposed that they have money even if I become ill I will go to advanced treatment area like Jimma and get treatment there.* To improve that health extension worker should not be tired of repeatedly visiting and educating such kind of people. So that people develop knowledge if health extension workers not stop visiting them due to the reason they ignored. *If they ignored today they will return back tomorrow (health extension workers) but it should not be*". Therefore they not give attention to health extension workers because they think that they will easily go to health facility when they face any problems. The other challenge for the community health worker is the wide range nature of their activities since they are cadres of the kebele they are expected to perform many more tasks by the kebele. As the participant discussed community perception and cultural factors are a major challenge for community health workers. A participant said" *I think the problem for health extension worker is the community perception. Peoples are not willing to do what the health extension worker discusses. This is due to lack of knowledg*e". Another participant also said *"…….because this is due to negligence or lack of knowledge but we regret after the problem occurred. I know one mother that has bleeding and she stayed at home.* This is very bad situation I think this is due to lack of knowledge*" (FGD participant).* Cultural factors created challenge for the community health workers. The FGD participant discussed "……. *there is also pressure from family that hinder her from giving birth at the health center. This is why she is not free did not seek institiuonal deliveries*". The other

challenge for community health worker is that peoples are not willing to come to meeting place where she can delivery key health messages.

A key informant explained“ *the health extension workers face a challenge for example when there is meeting peoples are not volunteer to come and hear the information given there therefore they miss the information this created challenge because those people who has no information are difficult to accept changes(*sup interview*).*

We have more than ten villages but only one or two villages participate on meeting. We don't know there reason but most of them are not willing to come to meeting place". Community health workers are facing a challenge from applying their role fully because there are different influencers from different dimensions like their acceptance, problem of access, distance, lack of knowledge, community expectation, motivation and commitments of health professionals and cultural factors. There were more problematic views in regard to service utilization. A respondent explained that some people in the community say that "*GOD will control what happens" and it does not matter whether or not a pregnant women goes to a health institution for delivery"*.(sup interview).

From the findings of this study community health workers are principally health extension workers and womens health development army. Previously there were TBAs (traditional birth attendants) called by local name "*dessistu adda*". On the other hand, currently they are not functioning due to the health education given by health extension workers to them not to attend delivery. If mothers come to a TBA she will refer them to health center. The other community health workers are womens health development army who play an important role in identifying and notifying pregnant mothers to health extension workers and health centers. A participant in one of the FGD said "*we have only health extension workers and village head who came and visit our home we don't know others* "(FGD participants). Previously there are different community health workers beside TBAs and health extension workers like community health agents those people that help health extension workers by propagating information to the community from the health extension workers and other health professionals. A participant group in one of the FGD said" *There is no other community health worker other than health extension worker who teaches us on maternal health and help us on maternal health and there are no traditional birth attendants here in our community.*"(FGD participant)

The community health workers identified to have role in the effort to improve uptake of institutional delivery service in this study are health extension workers and health development armies.

5.6. Involvements of community health workers in institiuonal delivery service

The community health worker that means the health extension workers and womens development army get involved in the initiative of helping mothers to facility delivery by a system of networking. There is one to five (takko-shanee) networking in each village (Gare) the mothers in the link distinguishes each other's very well because they meet and discuss their health issue in a group of five. Therefore, a pregnant mother in the link is known to all in the group.

The head of the Gare (dursitu gare) is also informed about the presence of pregnant mother by the members. The village head notifies the mother to attend ANC follow up. The HEWs in the kebele is aware of who is pregnant in her kebele through the information she got from the one to five bond. Since community members live and share the same culture and life style therefore they knew each other's this helps them get involved. A respondent added "*The health development armies have relation with the health extension workers and the Gare head dursitu gare*" (sup interview.) They identify and know the pregnant mother therefor be involved in the helping of pregnant mothers because they know who is pregnant". Also the mother herself informs the community health works in case they may not recognize that she is pregnant because they are told to do so. Several FGD participants discussed and said "*The health extension herself knows who is pregnant mother in the kebele because she usually visits our home even when she doesn't know that we our self tells them that we are pregnant we tell them because they help us many things during emergency time they call ambulance for us and follow us*". (FGD participants).

The participants discussed that they discuss with health development army head saying "*We have one to five networking using that network we discuss our health issues and other things in cell the leader facilitates it and health extension worker also helps us (*FGD participants).

Other group added to this said "*we discuss together our health issues and take it to the government and then solving it. We have a leader her name is Shito we all talk to her all matters*

that affects our health and with health extension workers they search for the solutions" (FGD participants).

The role of community health workers to uptake of institiuonal delivery is verified in several ways the findings of this assessment revealed that community health workers plays a decisive role of referral ,home visit ,advocacy for the mothers health ,provide health education about ANC, family planning ,institiuonal delivery , HIV counseling and generally act as a bridge between the community and the health system.

One of the respondents explained about this saying "The CHWs play even other roles than health issue they even teach mother about income generating activities" (sup interview).

The HEWs played roles with respect to institiuonal delivery they offer health education and information, and advocate for the community. A key informant said 'Even the health extension workers are required to bring mothers to health center unless the delivery is short-lived" (head of health center interview). Health extension worker played a number of Roles like Referrals, health education, advocacy, and provision of services.

5.6.1. Referrals

Starting from the one to five links the referral system starts if a pregnant mother is observed in the one to five relations. The members encourage one another to go to health institution due to the information and education they got from the health extension workers and women's development army leader. The pregnant mothers will be identified and registered by CHWs (health extension worker) after four months referred from health post (kella fayya) HEW refers the mother to health center.

They will follow the ANC. At 8 months they are alarmed by HEWs to waiting rooms till delivery. Our participant discussed "*The health extension workers tell us to go to waiting room when we approach to terms" (FGD participants). They send us to health institution for delivery*". But they discussed the referral system lack formats for referring from health post it is through oral communication or using pieces of paper. During referral the mothers face lack of ambulance and other transportation problem. Participants stated by saying" *There are mother who deliver at home due to transportation problem we have no road problem the road is good but we have a*

*transportation problem sometimes the ambulance is busy and other time there may be no network …" (*FGD participant).

Sometimes the referral is due to lack of services this decreased the satisfaction of the mother. Participant discussed and said" *We are not satisfied because we cannot find drug as we want from the health center but after the waiting room construction they help us up to their capacity if it is beyond their capacity they refer us to higher institution for better services*". Sometimes the referral system is difficult especially in emergency situation due to problems related to road, ambulance and the networking services. The FGD participants said "*regarding transportation as I told you earlier there is enough ambulance that can access us when we need if the road were properly constructed ……we will call ambulance by searching network on hill place but if we miss ambulance there is no way to get other transportation means rather than traditional carrying one" (*FGD participants*).*

5.6.2. Health education

The health extension workers distribute key health information and education to mothers. From the findings of this study we see that health extension workers contributed to uptake of maternal health service and also other health issues by distributing key messages. Several participants explained that they have got the information that delivery should be in health facility. Due to this they went to health facility for ANC follow up and also in an effort to get waiting room when the approach term. A participant in one of the FGD explained "*if we follow ANC we have a chance to get the waiting room later*". One of the participants said, "*The health extension workers teach us about the danger signs of pregnancy, bleeding about immunization, fistula, and the benefits of institiuonal delivery" therefore they are our day to day teachers* (FGD participants). Another participant said "*the health extension worker teaches about danger signs of pregnancy and the importance of facility delivery using (delivery in health facility mother health and baby good) catchphrase they teaches about problems of early marriage and fistula, about bleeding ,and shortening of labour in health facility" (FGD participant).*

Even the mothers who have the information disseminate the information to other mother. A participant said" *I knew what pregnant mothers should take before delivery they should take ante natal care, tetanus vaccination, iron and others the health extension workers teach us about this*

well. We ourselves transmits the messages we have got from the health extension workers to those who have no the information" (FGD participant) and other mother said "*The health extension workers told us about food they teach us what to feed our child and what to eat during pregnancy they teach about balanced diet".*

5.6.3. Advocacy

Advocacy is speaking acting, writing with minimal conflict of interest on behalf of the sincerely perceived interests of a disadvantaged person or group to promote, protect and defend their welfare and justice by being on their side and no-one else's being primarily concerned with their fundamental needs remaining loyal and accountable to them in a way which is emphatic and vigorous and which is, or is likely to be, costly to the advocate or advocacy group. The community health workers acts as advocates of the community health they are struggling to improve the health status of the people in the kebele where they are working. One FGD participant stated by saying "community health workers are our advocates. *They fight for us they care for our health we thanks them. They talk to any concerned body to discuss our health problems and situation that can affect our health. They represent us and work for us*" (FGD participant). The advocacy role starts from their existence in the kebele because as they are working and promoting the health of community ultimately they are advocating for them. Therefore this showed that community health workers are advocates for the community even though the level of advocacy is affected by many factors. Regardless of their activities health extension workers are usually consumer advocates and cultural mediators. Their advocacy role emanates from the nature of their work and the cultural intimacy they have with their community.

5.6.4 Provision of services

Community health workers principally health extension workers provide some uncomplicated services like first aid at a time of emergences , provision of immunization and medicine as well as attend clean delivery community health workers provide a role of direct service provision our participant explained this saying "*the health extension workers give us immunization and attend deliveries in emergency situation*" FGD participants.

Health extension workers and womens health development army Role to institiuonal delivery is a very important issue in the effort to increase uptake of institiuonal delivery the influencers can be grouped as those from the community ,from the health professional and those from the governments or the health system related part. The research outcome resulted in a set of thematic categories that describe qualitatively different ways of experiencing the situation and those logically related in structure and meaning. It is affected by several factors categories of the factors are acceptance *by the community*, *motivation of HEWs*, *resource constraints*, *accessibility of facilities*, *health professional approach* and *delay at health facility***.** Quotations are used to create these thematic groupings. All themes captured the discussion from FGD and response from the interviews. The finding shows that there is interaction of factors between each other when affecting the role of health extension worker and development agents.

5.7. Factors at the community level

5.7.1. Acceptance by the community

Acceptance of the community is the recognition getting socialization or reception of health extension workers by the community members. for any program to be effective and successful it should be accepted and has to be practiced at the grass root level by the community .the findings of this study showed that health extension workers are accepted and loved by the community because they are part of community and advocates of the mothers or living in the kebele. They live with the people they serve but this acceptance will be less if they are not from the kebele or lives in other place. Our respondents stated that "*some health extension workers lives in the city they come and go we don't know what they do we don't know them*". Other respondent added "*it is evident the health extension worker respect us and they support us (visit us) they teach us and they are serving us very well. They approach to us as if they are our children and they serve us friendly and I do not have comment to be corrected for maternal health being given in our kebeles as I think individually*"(FGD participant).

Rural health extension workers are more accepted by the community than urban health extension professional this is due to the condition that urban dwellers have easy access to health education and others because of infrastructure this makes them not to relay on health extension workers most of urban mothers are educated and has health information because of this factors there is less acceptance.

The other thing is that urban health extension currently has no health post on which they treat and counsel mothers they are conducting home visit and other activities but the community considers them as useless and ignore them. Our respondent spoke saying " *urban extension are less accepted by the community because the urban community consider themselves as more educated and want to go directly going to health facility than listening and accepting the extension workers*" (HC head interview).

5.8. Factors at the healthcare provider level

5.8.1. Motivation of heath extension workers

Motivation is the inner stimulus to accomplish something the findings of this study disclosed that most of the health extension workers are motivated at their work because they have got training and education , they know that delivering at health facility is a very important in saving the life of mothers this motivated them one of A respondent said "*I am very happy and motivated in my job I have faced no problem in my work I have got the chance of education and salary increments all three of us working in this Keble are happy with our work"* (HEW interview). But still there are health extension worker that are less motivated at their work due to absence of incentives like education and training our interview respondents specified that "*I am happy with my work but what demotivates me is the policy of the government that is health extension will remain health extension for the rest of her life whatever they increase their educational level this is the thing that always I think over it should be corrected"* (HEW interview). The other thing that affects the inspiration of health extension worker is from the community part, ignorance and problem of putting in to practice what the health extension worker had educated them. One key informant said "sometimes *after we teach mothers and them fail to take what we have taught them it demoralizes us*" (health extension worker interview). Lack of incentives in terms of continuous professional development and lack of knowledge from the community are the major factors that affect health extension workers motivation as the informants distinguished.

5.8.2. Health professionals approach

Our finding exposed that the approach of health professional play an important part in utilizing maternal health services, but most of the health professional don't consider that this is affecting it

and it affects the community health workers from fully applying their role because the mothers sent by the community health workers are not getting service as needed in the health facility one mother said " *The health professionals did not respect us they disrespect and shout at us they didn't treat us appropriately. That makes me deliver at home because I am annoyed and decide to deliver at home the next time"* (FGD participants). This shows that ethically acting health professional can contribute a great deal to mothers facility delivery by treating them politely and respectfully and in a friendlily manner. Those unprofessionally acting health workers results decreased mother trust on health professionals. One participant discussed this saying "*Concerning maternal health especially on family planning we did not have right to choose what we want. They enforce us to take the implant and now we became pregnant in fear of taking this family planning. Generally I have no trust in getting maternal health service at our health center. Because the health workers are not giving service as we need. They did not respect us they did not give standardized services so that it is better to have birth at home or other health center*" (FGD participant). Other participant added "*When mothers go there for delivery some health professionals did not follow her very well. They leave her alone and when there is problem with her they did not refer her quickly. They say every pregnant mother when her time of delivery reaches she should have to go health center and stay there but they did not help and serve them.*"(FGD participant). The study participant commented that a commitment of health professional is crucial in order to increase acceptance of institiuonal delivery service. The approach of the health professional plays important role. They should be motivated by onjob training and educational oppournity, by availing supplies in a timely manner.

5.9. Factors at the health system level

5.9.1. Resource constraints

Dearth of resource is the other factor that affects the utilization of institutional delivery this constraints are especially in the form of materials and human resource and several respondents explain this as "*we have shortage of materials especially food for the mothers in the waiting room we are providing from our capital we cannot afford as the number of mother in the waiting room increases, the workers who care for the mothers in the waiting room are also recruited. The waiting room itself is not enough to accommodate the mothers and their relatives the health center cannot construct rooms. It has no enough budget there is shortage of money to do this the*

government and the community should work together to solve this problem" (head of health center interview). Resource problems are not only this there are also shortage of health professionals and other human resource for the service to be real for example there are no adequate number of midwifes in some health center the mothers may not get basic service they need or it create a delay. Resources are also needed to provide on job training and education for the health workforces with regard to maternal health and institutional delivery utilization.. Other factor for reduced utilization of maternal health services from this study is that there is nonexistence of the service the mothers want. One FGD participant explained availability of drugs saying "*when we go to health center examined and drug was prescribed usually there is no drug at the health center. We are told to buy outside from private pharmacy this put us into difficulty like cost problems because the cost is much higher at the private clinic and pharmacy than the government" (*FGD participant*).*

5.9.2. Accessibility of health facilities

Even though the dimension of access are defined in many ways Our participants discussed that most common access issues that hamper them from using institiuonal deliveries are explained in terms of road, transportation and distance. The road was not constructed so they cannot use vehicles to reach to health facility on time. When the labor starts in such a case they are forced to use traditional ambulance that is carrying by human using bed made of stick locally called (siren) to bring mothers to the main road. Despite this it also takes time to mobilize and to collect for carrying mothers this created a delay and the mother give birth at home or on the road on her way to heath facility. A participant discussed "*There is road problem in our area and there is home delivery. Deliveries at our health center are seldom due to this road problem especially during summer time it is impossible to have ambulance because of road problem*" (FGD participant). There are also mothers that discussed accessibility in terms of costs even though most of the maternal health services are exempted. An informant noted by saying" *The main issue or reason why this few in number mother gave birth at home is that labor are too accidentally and they give birth at home. They fear that the service given at the health facility is not free but everything including ambulance service is free. There is also fear of costs of transportation costs after giving birth*" (key informant). Another participant explained "*we can*

use Bajaj if the road is well constructed in addition to this sometimes the labor is fast that we cannot reach to health center as we expected".

In addition to the road there is also problem of the transportation itself even though the road is good this is because we are far from health center so that we must wait till car comes or may be the network is not functional to call the ambulance this thing delay institution delivery even the woman wants to deliver at health facility. The respondents also discussed the issue of distance in terms of accessing health facilities. A long distance and road problem compounded with absence of transportation affected mothers from using institiuonal delivery service utilization.

5.9.3. Delay at health facility (The third Delay)

This is characterized the third delay this delay is the most unsafe delay because there are other delays earlier in the sequence like the first delay which is the delay in deciding to seek medical care in our case facility deliver ,the second delay which is the delay in reaching to health facility after deciding to deliver at health institution which is mostly caused by road and transportation problem and the third delay this delay occur in the health facility after the mother reached to health facility. The Health professionals didn't act urgently one participant explained that " *after I reached to health center no one helped me and I delivered on the floor after that the health workers run and come to me*". The third delay is unnecessary delay that is usually caused by shortage of health professionals at the health facility, lack of commitment of health workers, negligence or work overload. Because of the other delays the mother is now exhausted and weak this annoys the mother, decrease the satisfaction she get from delivery service and the mother decide to go to other facility for the next delivery or prefer home delivery. A participant in one of the FGD said "*they teach that a mother should go to health facility as her time approaches she should stay there and should give birth there but they do not give the service as we need they don't help us urgently*". In line with this Mothers who come to health facility for maternal health service pose distrust on the skill of health workers as well one participant said "*I went to health center for labor and told to health workers that labour has started but the health workers replied me that the labor has not yet started they said I will give birth in the coming week they told me I returned back to my home immediately as I reached to my home labor started and I give birth at home so how can I trust them*". Other participant said "*the health professionals don't tell us the exact date of delivery due to this we give birth at home because we don't know*

the exact date''. Therefore negligence of the health workers results in unnecessary delay affecting mother's utilization of institiuonal delivery.

Table 5. Factors affecting uptake of institutional delivery in the study communities may 2016

	Health care provider related factors	Health system related factors	Factors at the community level
1	Lack of commitment	Lack of required resource /failure to allocate resources e.g. for waiting room construction and feeding of the mothers in the waiting areas.	Lack of knowledge and resistance to change, due to social and other cultural factors.
2	Poor approaches of health workers to client.	Lack of training and educational opportunity to health extension workers.	Low level of acceptability by the community.
3	Inadequate knowledge and skills of the health professionals(a skilled professional provide quality care)	Difficulty to access facilities in terms of distance and lack of transportation.	Uncertainty about the skill of professional's (the community question the skill of some health professionals with regard to the service they give)
4		Motivation of CHWS with regard to incentives, education and continuous professional development	Community supporters (community health workers need the support of the community members e.g. kebele leaders, religious leaders and chiefs.
5		Inadequate number of health professional's	

5.10. Discussion

The study was undertaken with the aim of exploring the roles played by community health workers for increasing institiuonal delivery. This is believed to contribute for uptake of institiuonal delivery and decrease maternal mortality. The community health workers found to have role in maternal health were health extension workers and health development armies. Even though the utilization has increased as compared to previous time it has not brought significant changes with respect to institiuonal delivery. We compared the findings with research done in similar or related topics.

Different factors are found to affect the roles of community health workers. Transportation problem are the cause for some mothers to deliver at home. However in areas where there was no

transportation peoples use other options. They are organized for such and other social issues; they collect together for carrying mothers when there is certainly no transportation. But this was difficulty due to road. The presence of waiting room for mothers has slightly increased the number of mother's utilization of institiuonal delivery to some extent. However this is only for remote mothers because the waiting room cannot accommodate all pregnant mothers. Therefore priority is given for those mothers from remote area. But also the road problem was not solved by the waiting room since all pregnant mothers living far from the facility can't be accommodated in the rooms. A study conducted in Ethiopia six regions, 23 zones and 27 woredas by Awash et al (17) showed that health extension worker played a role for improvements of antenatal care, family planning, immunization but not for institiuonal delivery.. This low performance might be due to the factors listed above that hinder community health workers from fully applying their roles. It is also affected by motivation of community health workers and other cultural factors like fear of delivering at health facilities and hiding of labors. Study conducted by Medhanyie et al showed the similar findings Women's preference for having birth at home is a deeply embedded cultural belief. Women may believe that it is appropriate to go to a health facility for birth assistance and checkup only if there are visible complications during birth. Socioeconomic problems like fear of transportation cost and the cost of drugs caused mothers from not utilizing services. Even though most of the maternal services are free they don't know what services are free and not. They lack knowledge on maternal health service provision.

Quick referral using referral formats is believed to save the lives of mothers by making them get the service on time. The Community health workers are expected to play this role by the community and the health system. Mothers face problems in reaching to health facility on time by referral problems. The absence of referral formats worsen by creating untimeliness for the mothers at health facilities even after the mother has reach the health facility birth. The referral systems are also delayed by watching for ambulance and searching network to call the driver. Mothers fail to use facility birth care because of long distance travel and costs of travelling to health facilities. However, however, most mothers want to deliver at higher level health facilities seeking for quality care. This finding is in line with the study conducted in different regions of Ethiopia (28). Where mother seek care at health center than health post.

Health education is the main channel through which the community health workers transfer and transmit important health messages to their community. To identify what role do community health worker play towards transmitting health information and education for uptake of institiuonal delivery we asked whether health education was given or not by the community health workers to them. The participants stated that they have got health education like the importance of antenatal car, family planning and institiuonal delivery. . However, some of the participants discussed that mother's give home delivery due to not attending health education given by community health workers. The participants were asked if there were other community based health workers that involved in delivering health education and discussed but they said that health extension workers are their "day to day teachers and educators." The facilitation of health education is done by health development armies and village head to mobilize and collect for meeting. This finding is consistent with the finding of study done on mother's satisfaction on health extension program 2014 in Jimma zone (29).where heath extension worker were their local teachers.

Approaches of the health professionals significantly affected maternal utilization of institiuonal delivery. Study participants claimed that there is usually insulting and shouting at in the health facilities. Some professional made the mother to go back home without getting the service. Some health professionals are even not willing to provide services especially family planning. Mothers were enforced to use contraceptives that were not their choice and once they took it they face problems. When they suffer from the side effects and want to removal it, for example, implanon the health workers do not agree to remove it. This has forced some mother to get pregnant by fear of taking the contraceptives which was not their choice. Moreover, the freedoms of choosing family planning of their choice and debate over uses of long term family planning are quite common. The other factor related to health care provider was lack of commitment this may advance due to decreased motivation because of absence of incentives. Lack of commitment, poor approaches of health workers to client, and professional skills are the major challenges reported by the study participants.

On the other hand, shortage of health professional and the skills of health workers were also discussed by the participants. Majority of the mothers question the skill of health workers by saying "*they don't know the exact date of delivery how can I get ready they can't tell us our*

exact date of delivery" (FGD participant). This may be the expectation the workers have to tell them. However more education has to be given that the onset of labor is not perfectly predictable and can start at any time after term.

We asked participants what services are provided by community health workers to know the direct services that community health workers are providing. They community health workers are providing services like immunizations (TT vaccinations) and attend antenatal care they attend delivery in an emergency situation when labor is fast and the mother cannot reach health facility. However deliveries should be attended by skilled providers in health facilities that are equipped with materials and skilled personnel. If the mothers were from very remote area and cant access facility delivery the community health workers send her to waiting room. Till she give delivery. Health extension workers are also providing immunization for the new born babies. Nevertheless these services are usually interrupted due to shortage of logistics supply like vaccine. Another factor at the community level that which was found to affect utilization of institiuonal delivery and the role of community health workers was lack of knowledge. They fear the costs of delivery service but the service is exempted.

Currently the plan of government is to have all deliveries take place in health institution with skilled birth attendants. This study found out community health workers (health extension workers and womens health development army) has contributed slightly to improvement in the utilization of maternal health services. Even though the contribution not bring changes as needed with regard to institiuonal delivery service utilization as it is for ANC and FP.

Some other Cultural factors hamper mothers from utilizing maternal services. There are some factors like husbands' preference and requirements of the presence of grandmother and others during delivery that makes them stay at home and deliver at home. This might be due to hoping help they might get from their family during labor. The individual difference in knowledge and attitude is also a serious factor that affects mother's utilization of services. Majority of the study participants who delivered at home 80(74%) discussed that the labor was so fast that they give birth at home. This might be sometimes labors are fast and the mother may not reach to health facility even though she is urging to reach. This is not to mean labor is fast when it takes place at home. These problems will be solved by keeping the mothers to waiting room. The finding of this study is in line with the findings of other studies conducted in different regions of Ethiopia

and the EDHS 2005(30) findings where fast labor are the cause for home delivery. Similarity of finding might be due to the relatively similarity in natural process or stages of labor. Keeping every mother in waiting room is not an easy task it requires the construction of waiting room and other resources. However, comments of gives the impression that delivery has slightly increased because of the waiting room.

Community health Workers are located between the health system and the community. The intermediary position between the community and the health system makes the community health workers to play their role like advocacy and acting as channel between the community and the health system. The relationship that CHWs share with the community in which they work has long identified them as a natural bridge to the health care system this is reinforced by the support they get from the kebele administrator and other managerial bodies. Since they are part of the kebele cadre activity in the kebele affects their function. Therefore, they need support from the kebele leaders since some role confusion about their functions are not uncommon. A strong backing from the kebele leaders with regard to their purpose will enable them to fully practice their role. The cross-cutting aspects that affect womens utilization of maternal health are grouped as those from the community, from the health care provider and those from the health system part. Health extension workers play a role of referral to health facilities in institiuonal delivery service utilizations. Starting from one to five networking. This finding is in agreement with study conducted in Tigray (31).

But there are people that reflect that the health extension worker should attend delivery. The referral system is weak and there is no referral formats referred mothers uses either oral referral or is using a cut of paper. Less attention given to referral systems or might are the referrals are urgent or is from the mother's own home. The finding of this study is in line with the findings of other study conducted in Ethiopia (32).

In order to increase the service utilization particularly institiuonal delivery needs continuous health education to mothers on birth preparation and readiness. Continuous supply of drug, supply and equipment's since absence of drug annoy mothers and decrease future use.

Generally the reason given for low achievement in institiuonal delivery and the factors affecting it are deep rooted and diverse. The supervision at all levels are taking place but they are not equally strong findings showed the support and supervision to health extension worker at the

health post level from the health center staff was stronger than the support from zonal health office to woreda health office. Absence of skilled personnel and equipment at the primary care centers like the health posts makes them not utilized for delivery. Institiuonal delivery is low compared to other maternal services utilization as several key informants noted. The health extension workers and health development army's part with regard to delivery is facilitating and sending mothers to higher institution for skilled delivery and supporting the health extension workers, a study conducted in sidama zone (33) showed that most Mothers go to health center than going to health post for seeking high quality services especially delivery service. This finding is also in agreement with the study conducted in six regions of Ethiopia (29) in which most mothers seek high quality care and went to health center than health post.

HEWs are required to spend 80% of their time outside of the health post conducting outreach activities like health education and home visit. There is a perception that the health extension workers attend skill delivery. This community expectation is a challenge for them. Administrative problems are also creating problems for mothers from using services. There is also problem of water and electricity at health center that decrease the quality of services. The 2014 MEDHS finding shows that the coverage of institiuonal delivery at national level was only 16% and 13.1% for Oromia region(30) which is very low and the multifaceted factors that hamper CHWs from applying their role fully calls for all to act as priority problem . Generally the cross cutting factors which affects utilization of institiuonal delivery are summarized in (table.5 below).

5.11. Limitations of the study

The study is subject to social desirability bias (but we minimized it by conducting the interview and discussion in neutral environment, and deep probing). The findings cannot be easily generalized for external setting but we believe it can represent the districts in Jimma zone.

5.12. Conclusions

- From the findings of this study we can conclude that the primary community health workers are health extension workers and women health development army.

- We found that community health workers are causal to up take of institiuonal delivery service by diverse mechanisms. They teach advice, visit household homes, and support the community and in generally acting as advocates of the community.
- The support and supervision arrangement specifically targeting use of institutional birth service is weak.
- There are only few actors engaging to improve uptake of institutional delivery service utilization.
- Community health workers are facing a challenge from applying their role fully because there are different influencers from different direction like their acceptance, problem of access, distance, lack of knowledge, community expectation, motivation and commitments of health professionals and cultural factors. Generally, the factors are related to the healthcare system, the community and healthcare provider.
- We founded the closeness of the community health workers to the community makes them get involved in helping mothers. They know their community by a system of networking but if they are from other place it negatively affects their role.

5.13. Recommendations

- ✓ Since lack of adequate waiting room hinders mothers utilization of institutional delivery. Jimma zone health office should consider construction of adequate maternity waiting room and provision of resources for them till the mothers give birth.
- ✓ Timely stock inspection and making the necessary logistics and supply easily available raise maternal health service utilization and ultimately institiuonal delivery. Therefore Jimma zone health office with other stakeholders should work intimately on this.
- ✓ A continuous support and supervision to community health worker specifically targeting improving uptake of institutional birth care is recommended.
- ✓ A collaboration of the different actors in the field is needed to mobilize and use resource for health. To this end the health Jimma zone health office should attract different stakeholders to the program.
- ✓ The community health workers should be supported by different stakeholders and actors.
- ✓ Kebele leaders and managers should support and work very intimately with CHWs.
- ✓ Community health workers should be motivated by incentives.

References

1. A.Wolelie *Open Journal of Epidemiology* 4 (201 4) 30 -35.
2. Understanding the factors associated with institutional delivery service utilization in Ethiopia (MHF)
3. Community health workers for universal health-care coverage: from fragmentation to synergy WHO 2013.
4. Chang, Christina M *BMC Pregnancy and Childbirth* 2008.
5. Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goal.
6. WHO Evidence and Information for Policy, Department of *Human Resources for Health Geneva, January 2007.*
7. Campbell & Graham, *BMC Health Services Research* 2006.
8. WHO Evidence and Information for Policy, Department of Human Resources for Health Geneva, January 2007.
9. WHO fact sheet on maternal health.
10. Bewket Abebe et al (Ethiopia: Health Development Army - Decisive Factor for Sector Enhancement.
11. The World health report 2006.
12. Campbell & Graham, *BMC Health Services Research* 2006.
13. Armies and Model Families: Ethiopia's vision for better health John Donnelly) April 11, 2011.
14. Developing and Strengthening Community Health Worker Programs at Scale A Reference Guide for Program Managers and Policy Makers.
15. The Effect of Community Maternal and Newborn Health Family Meetings on Type of Birth Attendant and Completeness of Maternal and Newborn Care Received During Birth and the postpartum
16. Early Postnatal Period in Rural Ethiopia Danika Barry, MPH, Aynalem Hailemichael Frews, RN, RM, MPH, Hajira Mohammed, MSc, Binyam Fekadu Desta, MPH, Lelisse Tadesse, BSc, Yeshiwork Aklilu, RN, MPH, Abera Biadgo, MPH, Sandra Tebben Buington, CNM, PNP, MPH, Lynn M. Sibley, CNM, PhD, RN).
17. Causes of Low-skilled Birth Attendance Coverage in Selected Woredas of Amhara, Oromia and SNNP Regions Formative Assessment, World Vision Ethiopia.
18. *Biomed international* volume 2015(2015) Article ID43938 http//dx.doi.org/10.1155/2015/436938.
19. (Electronic Thesis and Dissertation Repository May 2015.
20. D. Bogale and D. Markos, Ethiopia. Journal of Gynecology and Obstetrics. Vol. 2, No. 4, 2014, pp. 63-70.
21. Hailemichael F, Woldie M, Tafese F. Predictors of institutional delivery in Sodo town, Southern Ethiopia. *Afr J Prm Health Care Fam Med. 2013*;

22. Best Practice Guidelines for Implementing and Evaluating Community Health Worker Programs in Health Care Settings Sinai Urban Health Institute January 2014).
23. CSA 2005 National Statistics.
24. Dechassa Lemessa, ("Prosperity Fades: Jimma and Illubabor Zones of Oromia Region",) UN-OCHA report November 1999 (accessed 3 April 2009).
25. The CHW Section of the American Public Health Association.2010.
26. Developing and Strengthening Community Health Worker Programs at Scale A Reference Guide for Program Managers and Policy Makers.
27. World Health Organization, author. Primary health care and the Millennium Development Goals: issues for discussion. Switzerland, Geneva: 2003.
28. Study of the Working Conditions of Health Extension Workers in Ethiopia). Ethiop.J.Health Dev.
29. International j of sociology and anthropology (bisrat tesfa and nega jibat)14 August 2014.
30. EMDHS 2014.
31. Medhanyie et al. *BMC Health Services Research* 2012, 12:352.
32. *Ethiop.J.Health Dev 2007*; 21(3) Studies of the working conditions of health extension workers in Ethiopia.
33. Kok et al. Human Resources for Health (2015) 13:80.
34. 1 MCW technical task force report.2010.
35. CSA 2005 National Statistics.
36. COMMUNITY HEALTH WORKERS IN CALIFORNIA: Sharpening Our Focus on Strategies to Expand Engagement JANUARY 2015.
37. WHO Report 2010
38. Census 2007 Tables: Oromia Region, Tables World Bank, Four Ethiopians: A Regional Characterization).
39. FMOH Report 2o13.
40. Community Health Workers Discussion Paper *Consumer Health Foundation* Natalie Erb July 2012).

Annex I IDI GUIDE and FGD GUIDE (ENGLISH)

Consent to participate in in-depth interview

I want to thank you for taking the time to meet with me today.

My name is _____ and I would like to talk to you about The Role of community health workers. Specifically, to institutional delivery we are assessing their roles to uptake of institutional delivery service the information obtained from this can be used in future interventions.

The interview should take less than half an hour. I will be taping the session because I don't want to miss any of your comments'

Although I will be taking some notes during the session, I can't possibly write fast enough to get it all down. Because we're on tape, please be sure to speak up so that we don't miss your comments.

All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Yes_____signature _____ date_____

I. In-depth interview guiding questions for key informants (zonal HEW coordinator)

1.1) Time of interview _____ 1.3) Date _____
1.2) Interviewer name _____ 1.4) Note taker _____

I. Personal information

1.1. Age? …… sex……

1.2. How many years have you been working in this zone? .....

II Information about maternal health service

2. How do you see maternal health in this zone(Where do majority of mother give birth?) (Why?)

---

3. Did you provide supportive supervision to woreda HEWs supervisors using checklist? (How many times, what does the supervision activities include?

III information about utilization of institutional delivery service

4. What do you think is the major reason behind that most mothers are not delivering at health facilities?

.---

5. What do you think are the major factors affecting institutional delivery?

.---

V Information related to role of HEWs

6. What role do you /CHW/ played/what did they do/ to increase institutional delivery?

.---

7. How and when CHWs refer mothers?

. ---

8. Is there any organization personnel health professional or others facilitating improvement in uptake of institutional birth service in your zone?

. ---

9. Is there any supervision /support from regional, zonal or any other stake holders to you with regard to institiuonal delivery /who are they /at what frequency?

---

10. What is the main problem facing CHWs and other CHWs from fully applying their roles?

---

11. Have you any general idea or comment about the situation? ----------

II.In-depth interview guiding questions for key informants (woreda HEW supervisor)

1.1) Time of interview _____ 1.3) Date_____
1.2) Interviewer name _____ 1.4) Note taker _____

II. Personal information

1.1. Age? …… sex……

1.2. How many years have you been working in this woreda? .....
1.3. What is your responsibility in the office? ----------

II Information about maternal health service

2. How do you see maternal health in this woreda (Where do majority of mother give birth? (Why?)

1----------
2----------

3. Did you provide supportive supervision to HEWs using checklist? (How many times, what does the supervision activities include?

1. ----------

III information about utilization of institutional delivery service

4. What do you think is the major reason behind that most mothers are not delivering at health facilities?

.1----------

5. Whom do you think is responsible for helping mother to deliver at health facility?

.1----------

6. What do you think are the major factors affecting institutional delivery?

.1----------
.2----------

7. How can institutional delivery can be increased/ solved?

.1----------
.2----------

V Information related to role of HEWs

8. What role do you /CHW/ played/what did they do/ to increase institutional delivery?

.1----------
.2----------

9. How and when CHWs refer mothers?

1. ----------
2. ----------

10. How did HEWs, TBAs, CHA, CBRHA, and others help or be involved in maternal health or institutional birth services?

1. ----------
2. ----------

11. Who are the different CHWs and how the help mothers?

1. ----------
2. ----------

12. Is there any supervision /support from regional, zonal or any other stake holders to you with regard to institiuonal delivery /who are they /at what frequency?

1. ----------
2. ----------

13. What is the main problem facing CHWs and other CHWs from fully applying their roles?

1. ----------
2. ----------

14. Have you any general idea or comment about the situation?

III .In-depth interview guiding questions for key informants (health extension workers,)

1.1) Kebele: _____

1.2) Time of interview _____ 1.4) Date_____

1.3) Interviewer name _____ 1.5) Note taker _____

II. Personal information

2.1. Age? ……

2.2. How many years have you been working as HEWs in this Kebele? .....

III. Information about maternal health service

1. Tell me about maternal health in your Kebele?. (Where do majority of mother in this Kebele) give birth?

1. ----------

2. Did you give monthly report to health center about maternal health services you offer? What does the report include? ----------

1. educational sessions provided in the community
2. visited households
3. the number of pregnant women
4. number of deliveries in their respective villages

IV information about utilization of institutional delivery service

3. What do you think is the major reason behind that most mothers are not delivering at health facilities?

4.1----------
4.2----------

4. Whom do you think is responsible for helping mother to deliver at health facility?

5.1----------

5. What do you think are the major factors affecting maternal health in this Kebele?

6.1----------
6.2----------

6. What do you think are the factors affecting institutional delivery in your kebeles?

7.1----------
7.2----------

8. How can institutional delivery can be increased/ solved?

8.1----------
8.2----------

V <u>Information related to role of HEWs</u>

9. What role do you /CHW/ played/what did you do/ to increase institutional delivery in this Kebele?

9.1----------
9.2----------

10. How and when you refer mothers?

11.1. ----------
12. 1----------

11. Is there any supervision /support from regional,zonal,woreda health office or any other stake holders to you with regarding to institiuonal delivery /who are they /at what frequency?

1. ----------
2. ----------

12. What is the main problem facing you and other CHWs from fully applying their roles?

1. ----------
2. ----------

13. What are the things that motivate /demotivate you at your work?

1. ----------

IV .In-depth interview guiding questions for key informants (health center HEW supervisors)

1.2) Time of interview _____ 1.4) Date_____
1.3) Interviewer name _____ 1.5) Note taker _____

III. Personal information

1.1. Age? …… sex……

1.2. How many years have you been working in this HC? .....
1.3. What is your responsibility in HEEWs supervision? ----------

II Information about maternal health service

2. How do you see maternal health in your catchment area?(Where do majority of mother give birth?) Why?

1----------
2----------

3.Did you provide supportive supervision to HEWs using checklist? (How many times, what does the supervision activities include?

III information about utilization of institutional delivery service

4. What do you think is the major reason behind that most mothers are not delivering at health facilities?

.1----------
.2----------

V Information related to role of HEWs

5. What role do you /CHW/ played/what did they do/ to increase institutional delivery?

.1----------
.2----------

6. How and when CHWs refer mothers?

1. ----------
2. ----------

7. How did HEWs, TBAs, CHA, CBRHA, and others help or be involved in maternal health or institutional birth services?

1. ----------
2. ----------

8. Is there any organization personnel health professional or others facilitating improvement in uptake of institutional birth service in your woreda?

1. ----------
2. ----------

9. Is there any supervision /support from regional, zonal or any other stake holders to you with regard to institiuonal delivery /who are they /at what frequency?

1. ----------
2. ----------

10. What is the main problem facing CHWs and other CHWs from fully applying their roles?

1. ----------
2. ----------

V .In-depth interview guiding questions for key informants (health extension workers,)

1.1) Kebele: _____

1.2) Time of interview _____ 1.4) Date_____

1.3) Interviewer name _____ 1.5) Note taker _____

2. Personal information

2.1. Age? ……

2.2. How many years have you been working as HEWs in this Kebele? .....

3. Information about maternal health service

1. Tell me about maternal health in your Kebele?

1----------

2. Where do majority of mother in this Kebele give birth?

1. ----------
2. ----------

3. Did you give monthly report to health center about maternal health services you offer? What does the report include? ----------

1. Educational sessions provided in the community

2. Visited households

3. The number of pregnant women

IV information about utilization of institutional delivery service

4. What do you think is the major reason behind that most mothers are not delivering at health facilities?

4.1----------
4.2----------

5. Whom do you think is responsible for helping mother to deliver at health facility?

5.1----------
5.2----------

6. What do you think are the factors affecting institutional delivery in your kebeles?

7.1----------
7.2----------

7. How can institutional delivery can be increased/ solved?

8.1----------
8.2----------

V <u>Information related to role of HEWs</u>

8. What role do you /CHW/ played/what did you do/ to increase institutional delivery in this Kebele?

9.1----------
9.2----------

9. How and when you refer mothers?

11.1----------
11.2----------

10. Who are the different CHWs in this Kebele and how the help mothers?

1. ----------
2. ----------

11. Is there any organization personnel health professional or others facilitating improvement in uptake of institutional birth service in this Kebele?

1. ----------
2. ----------

12. Is there any supervision /support from regional,zonal,woreda health office or any other stake holders to you with regarding to institiuonal delivery /who are they /at what frequency?

1. ----------
2. ----------

13. What is the main problem facing you and other CHWs from fully applying your roles?

1. ----------
2. ----------

VI .In-depth interview guiding questions for community members (Kebele secretary)

A.1) Kebele: _____

A.2) Time of interview _____ A.4) Date_____

A.3) Interviewer name _____ A.5) Note taker _____

I. Personal information

1.1. Age? …… sex……

1.2. How many years have you been living in this Kebele? .....

1.3. What is your responsibility in the Kebele? ----------

1. What is the main reason that makes mothers not deliver at health facility?

1. ----------
2. ----------

2. Why mothers prefer delivering at home?

1. ----------
2. ----------

3. Is there any organization/personnel helping mothers to deliver at health facility other than HEWs? (Who are they?)

1. ----------
2. ----------

4. Is there any cultural practice that promotes home/HF delivery? (What is it explain for me)

1. ----------
2. ----------

5. What are the religious factors that can affect utilization of maternal health services?

1. ----------

6. Have you any idea or comment on how to increase institutional delivery?

1. ----------

II .Information related to roles of CHWs

7. Did the HEWs/CHWs visit your home? (When and for what reason?)

1. ----------

8. What did the health extension worker teach you about during home visit?

1. ----------

2. ----------

9. How and when does CHWs refer you/mothers?

1. ----------

2. ----------

10. Who is the decision maker in selecting place of delivery? Why?

1. ----------

2. ----------

11. What is the insight of the community about the competence of HEWs in providing maternal health service?

1----------

4. ----------

ANNEX II FGD GUIDE (English)

Consent to Participate in Focus Group

You are asked to participate in a focus group. The purpose of the group is to understand what roles CHWs

Play to uptake of institutional delivery service in Jimma zone. The information learned in the focus groups

will be used to design public health messages and programmes intended to encourage uptake of Institutional delivery service.

You can choose whether or not to participate in the focus group and stop at any time. Although the focus group will be tape recorded, your responses will remain anonymous and no names will be mentioned in the report.

There is no right or wrong answers to the focus group questions. We want to hear many different viewpoints and would like to hear from everyone. We hope you can be honest even when your responses

may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

I understand this information and agree to participate fully under the conditions stated above:

Signed: _____ Date: _____

FGD GUIDE

Guiding questions for FGD on the role of CHWs to institutional delivery in ----- Kebele

FGD no._____

Site._____

Moderator (facilitator) _____

Note taker_____

Start time _____

End time_____

KEY
I - INTERVIEWER
R1-Respondent number 1
R2- Respondent number 2
R3- Respondent number 3
R4- Respondent number 4
R5- Respondent number 5
R6-Respondent number 6

Socio demographics of FGD participants

Sno	Age	Education	pregnancy		Place of delivery		religion
			yes	no	home	HF	
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Introduction:

1. Welcome
2. Explanation of the process
3. Ground Rules
4. Turn on Tape Recorder

   I: Welcome to our discussion, my name is ____ and I am from Jimma University and today we are going to talk about maternal health institutional delivery and the role of community health workers to institutional delivery in this Kebele. Now here I will have list of questions for discussion and we are going to discuss together, as I told you that when I ask a question the one who has understood will answer and we will continue like that up to the end of our discussion.

Maternal health services questions

1. How do you see maternal health services in your Kebele?
   1. ----------
   2. ----------
2. What can you say about institutional delivery?
   1. ----------
   2. ----------
3. What roles does CHWs play to institutional delivery?
   1. ----------
   2. ----------

4. What are the major problems related to maternal health's? ----------

5. How can the above problems will be solved?
   1. ----------

2. ----------

6. What is the reason behind for most mothers not giving birth at health facility despite much effort by government?

This question is asked to find out the reason for not delivering in health facility

1. ----------
2. ----------

7. What can be done to solve the problems?

1. ----------
2. ----------

8 Does CHWS play any role to intuitional delivery? What role do they play to increase institutional delivery?

1. ----------
2. ----------

11. Are there traditional birth attendants in here in this Kebele? Who are they?

1. ----------
2. ----------

12. Are there community based reproductive health agents in here in this Kebele? Who are they?

1. ----------
2. ----------

13. What is the role of HEWs to improve utilization of institutional birth service?

This question is asked to know the contribution of HEWs

1 ----------

2. ----------

14. Who among the community members other than health workers are helping mothers to deliver at health facility in this Kebele and how can you explain it?

1. ----------

2. ----------

15. How do you see the support/supervision from regional, zonal, woreda health office and any other to CHWs to increase institutional birth service utilization in this Kebele?

1. ----------

2. ----------

16. Who is the decision maker in selecting place of delivery? Why? ----------

ANNEX II IDI GUIDE AND FGD GUIDE (AFFAN OROMO)

IDI consent (Affan Oromo) Fedlii hirmaanna (Affan Oromo).

Fedlii hirmaanna Gaffii'f deebin gad fageeryaan

Yeroo keesan aarsaa gochuun asitti argamuu keessanif isinin galateeffadha.
Maqyaan koo _____jedhama har'a kan nuti wojjin mariiannu ga'ee hojjetoota fayyyaa hawaasaa ta 'a, keessumattuu ga 'ee isaan tajajila dhahumsadhaebbilee fayyaa keessatti godhamu irratti qaban ilaalla. odeeffanno nuti as irra argannus tarkaanfii gara fuuldura tajajila dhahumsa dhaebbilee fayyaa keessatti godhamu,olkaasuf fudhannu keessatti nu gargaara.
Gaaffif deebiin keenyas wallakka sa'atii ol nutti hin fudhatu marin keenyas waraabbi sagaleen kan deggerameedha, sababiin saas yaada isin kennitan guutumma guutuutti akka fudhanuufi.
Maarii keenya kassatti yaadannoo yoon qabadheyyuu, saffisaan yaada hundumaa keessani al tokka qabachuun waan narakkisuuf sagalee keessan waraabuun dirqama natti ta'a, kanaaf isinis sagalee kessan ol-kaasuun akka dubbattan isin qaafadha.
Deebiin keessan dhoksaan saa ni eegama kana jechhuun deebin keessan dhuunfaadhaan kan eenyuu akka ta'ee hin beekamu,kan beeku nuwarra amma isin bira jiru qofa akka ta'e akka isin beektan barbanana, yaadadha waan dubbachuu hin barbaanne dubbachuu dhiisuu dandeessu,yeroo barbaaddanitti addaan kutuus ni dandeessu.

Waanan isinii ibserratti gaaffiii yoo qabaattan?

Gaaffif deebin kana keessatti hirmaachuuf fedhii qabdu ?
Eeyyee_____ Mallatto_____ Guuyyaa_____

Zonal HEW coordinator interview

1.1. Ganda---------- 1.4. Guyyaa----------
1.2. Yeroo Gaiffif deebii---------- 1.5. Yaadanno kanfudhatu----------
1.3. Maqaa Gafata----------
2.1. Umri----------
2 Fayya haadholii aanaa kana kessaa akkamin illaalta?
1. ----------
2. ----------
3. Haadholin bay'inaan eessatti dahu? Maaliif?
1. ----------
2. ----------
4. Hojijettota extenshini fayyaaf tajajila degersaaf hordoffii cheeklisti fayyadamuun ni goota?
1. ----------
2. ----------
5. Sababni cimaan haadholin dhaabbilee fayyatti akka hin deenya tassisu maal jettee yaadda?
1. ----------
2. ----------
7. Wanntonni fayya hadholii miidhuu danda'an maal fa'i jettee yaadda?
1. ----------
2. ----------

8. Wanntonni haadholin ulffa dhaebbile fayyaatti akka hindeenye godhan maal fa'i jettee yaadda?

1. ----------
2. ----------

9. Dahumsa dhaabbilee fayyaatti godhamu akkamiin dabaluun, dannda'ama?

1. ----------
2. ----------

V. Odeeffanno ga'ee hojjettota extenshinii fayya wajijin wal qebate

10. Dahumsa dhaabbilee fayyaa dabaluuf ga'een kee maanni?

1. ----------
2. ----------

11. Hojiile (Barumsa fayya, Hawasa kakasu, gorsa miti ideilee)hojjetoota fayyya hawasan hojjetaman maal fa'i

1. ----------
2. ----------

12. Hojijettooni fayya hawasa yeroo akami fi akamitti tejajila ol-ergu haadholif kennu?

1. ----------

13. Hojjettonni fayya hawasa eenyu fa'i? Akkamin haadho lii gargararu?

1. ----------
2. ----------

14. Dhaabbileen, tajajilli dhabbilee fayyatti dahuu akka dabaluuf, dhaabbilee motumma ykn miti mootummaa isinii wajjin hojjetan godina kessan kessa jiru?

1. ----------
2. ----------

II woreda HEW supervisor

1.1. Ganda---------- 1.4. Guyyaa----------
1.2. Yeroo Gaiffif deebii---------- 1.5. Yaadanno kanfudhatu----------
1.3. Maqaa Gafata---------- 1.6.Umri ----------
1.7. Saala----------
1.8 Wagga meqaaf supervisorii hojjettota extenshinii fayyaa taate hojjette? ----------

III. Odeeffannoo waa'ee tajajile fayya hawasa

2 fayya haadholii aanaa kana kessaa akkamin illaalta?

1. ----------
2. ----------

3. Haadholin bay'inaan eessatti dahu? Maaliif?

1. ----------
2. ----------

4. Hojijettota extenshinii fayyaaf tajajila degersaaf hordoffii cheeklisti fayyadamuuni goota?

1. ----------
2. ----------

5. Sababni cimaan haadholin dhaabbilee fayyatti akka hin deenye tasisu maal jettee yaadda?

1. ----------
2. ----------

6. Hadholin dhaaabbilee fayyatti aka dahanif qaamni gargaaru eenyu jettee yaaddaa?

1. ----------

2. ----------

7. Wanntonni fayya hadholii miidhuu danda ‘an maal fa’i jettee yaadda?
   1. ----------
   2. ----------

8. Wanntonni haadholin ulfaa dhabbilee fayyaatti akka hin deenye godhan maal fa’i jettee yaadda?
   1. ----------
   2. ----------

9. Dahumsa dhaabbilee fayyaatti godhamu akkamiin dabaluun danda’ama?
   1. ----------
   2. ----------

V.<u>Odeeffanno ga’ee hojjettota extenshiniii fayya wajijin wal qebate</u>

10. Dahumsa dhaabbilee fayyaa dabaluuf ga’een kee maanni?
    1. ----------
    2. ----------

11. Hojille (Barumsa fayya, Hawasa kakasu, gorsa miti ideilee) hojjetoota fayyya hawasa hojjetaman maal fa’i?
    1. ----------
    2. ----------

12. Hojijettooni fayya hawasa yeroo akami fi akamitti tajajila ol-ergu haadholif kennu?
    1. ----------
    2. ---------- ---

13. Hojijettooni fayya hawasa (dessistu Aadaa (TBA,), wamamaa fayya (CHA)) fayya haadholi ‘ykn dahumsa dhaabbilee fayya kessatti hirmaannaan isaani maal fa’i?
    1. ----------
    2. ----------

14. Hojjettonni fayya hawasa eenyu fa’i? Akkamiin haadholii gargararu?
    1. ----------
    2. ----------

15. Dhaabbileen tajajillii dhabbilee fayyatti dahuu akka dabaluuf dhaabbilee motumma ykn miti mootummaa isinii wajjin hojjetan godina kessan kessa jiru?
    1. ----------
    2. ----------

16. Qaamin deggersa ykn hordoffi dhahumsa dhaabbilee fayya ilaalchise isini kennu jira? eenyu fa’i? yom, yom?
    1. ----------
    2. ----------

For HEW

1.1. Ganda---------- 1.4. Guyyaa----------

1.2. Yeroo Gaiffif deebii---------- 1.5. Yaadanno kanfudhatu----------

1.3. Maqaa Gafata----------

2.1. Umri----------

2.2 wagga meeqaaf hojjiettu extenshinii taate hojjette ganda kana keessatti?

1. ----------

III. Odeeffannoo waa'ee tajajila fayya hawasa

1. Waa'ee fayyaa hadholi ganda hojjechaa jirtuu natti himi?
    1. ----------
    2. ----------
2. Haadholiin Ganda kanaa baay'inaan eessatti dahu?
    1. ----------
    2. ----------
3. Tajajila fayya hadholiif keennitu buufata fayyaaf gabaasa ji'aa ni ergita? Gabasi ati ergitu maalfaa of keessa qaba? ----------
    A. .Barumsa fayya marasan hawaasaaf kennamu
    B. .Daawwanna mana mana
    C. Baay'ina dubartoota ulfaa
    D. Baa'na haadholii dahnii gandicha keessa jirani.
    E. Gabaasa waa'ee qusannoo maatii.

IV. Odeeffannoo waa'ee itti fayyadama tajaajila dhaebbilee fayyatti da'uu

4. Sababni cimaan haadholin dhaabbilee fayyatti akka hin deenya tassisu maal jettee yaadda?
    1. ----------
    2. ----------
5. Hadholiin dhaaabbilee fayyatti akka dahaniif qaamni gargaaru eenyu jettee yaaddaa?
    1. ----------
    2. ----------
6. Wantonni ganda kana keessatti fayyaa haadholi miidhuu danda'an maal fa'i jettee yadda?
    1. ----------
    2. ----------
7. Wantonni ganda kana kessatti dahumsa dhaabbilee fayyaatti godhamu hir'isuu danda 'an maal fa'ii,?
    1. ----------
    2. ----------
8. Dahumsa dhaabbilee fayyaatti godhamu akkamiin dabaluun, danda'ama?
    1. ----------
    2. ----------

V.Odeeffanno ga'ee hojjettota extenshinii fayya wajijin wal qebate

9. Ganda kana kessattii Dahumsa dhaabbilee fayyaa dabaluuf ga'een kee maanni?
    1. ----------
    2. ----------
10. Hojille,(Barumsa fayya, Hawasa kakasu, gorsa miti idilee) hojjetoota fayyya hawasaan hojjetaman maal fa'i?
    1. ----------
    2. ----------

11. Yeroo akkamiifi akkammitti tajaajila ol-erguu haadholiif kennitu?

1. ----------
2. ----------

12. Hojjetoonni fayya hawasa garaagaraa ganda kana kessa jiran eenyu fa'i? akkamiin haadholi gargaaru?

1. ----------
2. ----------

13. Atiif hojjettoonni fayya haawsaa kanneen biroo, fayyaa haadholii ykn dahumsa dhaabbilee fayya keessatti hirmaannaan keessan maalii?

1. ----------
2. ----------

14. Hariiroon isin hojirratti, waali keessan, biiroo fayya aanaa fi hawaasa waliin qabdan maalii?

1. ----------
2. ----------

15. Dhaabbileen tajajillii dhabbilee fayyatti dahuu akka dabaluuf dhaabbilee motumma ykn miti mootummaa isinii wajjin hojjetan godina kessan kessa jiru?

1. ----------
2. ----------

16. Qaamni deggersa ykn hordoffi dhahumsa dhaabbilee fayya ilalchisee isini kennu jira? eenyu fa'i? yom, yom?

1. ----------
2. ----------

17. Rakko cimaan isinii fi hejjettota fayya haawsaa kanneen biroo ga'ee kessan akka hin baane godhu maalii?

1. ----------
2. ----------

18. Wantonni hojirratti si kakaasan ykn humaan si buusan jiruu?

1. ----------
2. ----------

19. Yaada waliigalaa tajajilla dahumsa ilaalchisee qabdan?

For HC HEW supervisor

1.1. Ganda---------- 1.4. Guyyaa----------
1.2. Yeroo Gaiffif deebii---------- 1.5. Yaadanno kan fudhatu----------
1.3. Maqaa Gafata----------
1.6. Umri----------
1.7 wagga meeqaaf hojjiettu buufata fayya tate hojjette ganda kana keessat?
1. ----------
2. Qabanno keessan keessatti fayya hadholii akkamin ilaata?
1. ----------
2. ----------
3. Haadholiin bay'inaan eessatti dahu? Maaliif?
1. ----------
2. ----------
4. Hojijettota extenshinii fayyaf tajajila degersaaf hordoffii cheeklisti fayyadamuuni goota?
1. ----------
2. ----------

III. <u>Odeeffannoo waa'ee itti fayyadama tajaajila dhaebbilee fayyatti da'uu</u>

5. Sababni climaan haadholiin dhaabbilee fayyatti akka hin deenye tassisu maal jettee yaadda?
1. ----------
2. ----------
6. Hadholiin dhaaabbilee fayyatti aka dahanif qaamni gargaaru eenyu jettee yaaddaa?
1. ----------
2. ----------
7. Wantonni fayyaa haadholii miidhuu danda'an maal fa'i jettee yaaddaa?
1. ----------
2. ----------

8. Wantonni haadholiin ulfaa dhaabbilee fayyaatti akka hin deenye godhan maal fa'i jettee yaadda?
1. ----------
2. ----------
9. Dahumsa dhaabbilee fayyaatti godhamu akkamiin dabaluun, danda'ama?
1. ----------
2. ----------
10. Dahumsa dhaabbilee fayyaatti godhamu dabaluuf ga'een kee maanni?
1. ----------
2. ----------
11. Hojille,(Barumsa fayya, Hawasa kakasu, gorsa miti idilee) hojjetoota fayyya hawasan hojjetaman maal fa'i?
1. ----------
2. ----------
12. Hojjetoonni fayya hawasa garaagaraa ganda kana kessa jiran eeyyu fa'i? akkamiin haadholi gargaaru?
1. ----------
2. ----------

13. Hojijettooni fayya hawasa (dessistu Aadda (TBA), wamamaa fayya (CHA)) fayya haadholi ykn dahumsa dhaabbilee fayya kessatti hirmaannaan isaani maal fa'ii?

1. ----------
2. ----------

14. Hojjettonni fayya hawasa eenyu fa'ii? Akkamiin haadholii gargararu?

1. ----------
2. ----------

15. Dhaabbileen, tajajillii dhabbilee fayyatti dahuu akka dabaluuf dhaabbileen motumma ykn miti-mootummaa isinii wajjin hojjetan godina kessan keessa jiru?

1. ----------

16. Rakko cimaan isinii fi hejjettota fayya haawsaa kanneen biroo, g'ee kessan akka hin baane godhu maalii?

1. ----------
2. ----------

Kebele secretary interview

1.1. Ganda---------- 1.4. Guyyaa----------
1.2. Yeroo Gaiffif deebii---------- 1.5. Yaadanno Kan fudhatu----------
1.3. Maqaa Gafata---------- 1.6. Umri----------
1.7 wagga meeqaaf ganda kana keessa jiraata jirtu?

1. Rakko cimaan haadholiin dhaabbilee fayyatti akka hin deenye godhu maalii?

1. ----------
2. ----------

2.Haadholiin manatti dahuu maalif filatu?

1. ----------
2. ----------

3. Dhaabbaleen /namoonni haadholin dhaabbilee fayyaatti akka dahaniif gargarsa godhan jiru? hojjetota extenshinii fayyaan alatti? eenyu fa'ii?

1. ----------
2. ----------

4. Dliibbaa Aadaa Kan haadholin manatti ykn dhaabbilee fayyatti akka da'an kakaasan jiru? (maalfa'ii,naaf ibsi)?

1s. ----------
2. ----------

5. Dhiibbaan amantiii itti fayyadama fayya haadholii irratti qaban maal fa'ii?

1. ----------
2. ----------

6. Yaada waligalaa tajajilla dhaabbilee fayyatti dahuu dabaluu irratti qabdan?

1. ----------
2. ----------

<u>Odeeffanno ga 'ee hojjettota extenshinii fayya wajjin wal qabate</u>

7. Hojjettonni extenshinii fayya mana kessan ni daawwatuu? (Yoom, sababa maliif?)

1. ----------
2. ----------

8. Ogeessonni extenshini fayya yeroo mana keessaan daawwatan waa'ee maalii faa isin barsiisu?

1. ----------

2. ----------

9. Hojjettonni extenshini yoomif akkamitti tajaajila ol-erguu haadholiif kennu?
   1. ----------
   2. ----------

10. Bakka dahumsaa Kan murteessu eenyu ? Maalif
   1. ----------
   2. ----------

11. Gahumsa Hojjeetoota extenshini fayya tajaajila fayya haadholi kennu irratti qaban uummatni akkamiin ilaala?
   1. ----------
   2. ----------

FGD Consent (Affan Oromo) FGD Fedhii Hirmaanna(Affan Oromo)

Fedhii hirmaanna: xiyyeeffanno marii garee

Xiyyeeffannoo marii garee kessatti akka hirmaattaniif gaafatamtanittu, Fayidaan garee kanaas ga'ee hojjettota fayyaa hawasaa dahumsa dhaebbilee fayyaa keessatti godhamu olkaasuuf raawwatan Kan Godina Jimma hubachuuf ta'a .odeeffannoon xiyyeeffannoo Mari garee kana keessatti godhamu irraa angamu kunis Ergaa Mari haawaasaafi sagantaalee fayyaa dahumsa dhaebbilee fayyaa kessatti godhamu olkaasuuf (foyyeessuuf) nu gargaara.

Marii garee kanaa keessatti hirmaachuus dhisuus ni dandeessu.Sagaleen keessan yoo waraabame iyyuu, deebin isin laattan dhoksaan Kan eegamu fi maqaan keessan gabaasa keessatis Kan hin ibsamne ta'uusa isin beekisna.

Dirqama deebiin keessan sirri ykn sirri tal'u dhiisuu ni danda'a,nuti yaada isin qabdan isinirraa dhagahuu feena, isinis kana beekuudhaaan waan isinitti dhagahame akka nuuf ibsitan.

Yaada walii keessanni kabajuuf ykn wal dhaggeeffachuuf dabaree dabareeedhaan deebii keessan akka laattan, deebiin miseensonni garee hundi kannes dhoksaadhaan ni eegama.

Odeeffannoo armaan olitti eerame habachuun fedhii kootiin itti hirmaachuukoo niin ibsa.

Mallattoo: _____ Guyyaa: _____

FGD GUIDE (Affan Oromo)

Lakkofsa xiyyeeffanno mari garee----------
Bakka ----------
Haala mijeessa----------
Yaadanno kanfuudhu (qabu) ----------
Yeroo itti jalqabamu----------
Yeroo itti xumummu----------
FURTUU
I –GAAFATA
R1 –DEEBISA LAKKA .1
R2 - DEEBISA LAKKA .2
R3 - DEEBISA LAKKA .3
R4 - DEEBISA LAKKA .4
R5 - DEEBISA LAKKA .5
R6 - DEEBISA LAKKA .6
Seensa

1. Baga nagaan dhuftan
2. Ibsa adeemsaa
3. Seera ittin bulmaata

Gara mari keenyaa baga nagaan dhuftan isiniin jechaa maqaan koo---------- jedhama kanan dhufee Jimma yuniverssitti irra yoo ta'u guyyaa har'aa kan nuti irratti mari'annu mata duree waa'ee fayya haadholi ,dahumsa dhaabbilee fayyaattii godhamu fi ga'ee hojjettoota fayya hawaasaa dahumsa dhaabbilee fayya ganda kana keessatti qaban irratti ta'a.An amma qaffilee irratti mar'annu of harkaa qabaa, waliin ta'uun ni mari'anna akkuman

isinniin jedhe an gaaffilee isinin qaafadha isin keessa yaada gaaffichaa kan hubate naaf deebisa haala kanan marii itti fufna jechuudha.

Gaaffii 1ffa Tajaaila fayya haadholii

1. Tajaajila fayya haadholii ganda kessani akkamiin ilaattu?
    1. ----------
    2. ----------
2. Tajaajila daahumsaa dhaabbilee fayyaatti godhamu iratti maal jettu?
    1. ----------
    2. ----------
3. Tajaajila daahumsaa dhaabbilee fayyaatti godhamu keessatti ga'een hojjettota fayya hawaasaa taphatan mali?
    1. ----------
    2. ----------

4. Rakkoolee armaan olii akkamiin furuu danda'ama?

    1. ----------
    2. ----------

5. Osoo mootummaan tumsa godhuu sababiin haadhliin ulfaa dhaabbilee fayyaattii hin dleenye maalif?
    1. ----------
    2. ----------

6. Rakkoo kana furuuf maal gochuutu ta'a?
    1. ----------
7. Hojjiettonni fayya hawaasaa dahumsa dhaabbilee fayyaa kessatti ga'ee taphatan qabuu? Ga'een isaanii dahumsa dhaabbilee fayyaa dabaluu keessatti maali?

    1. ----------
8. Yoo ta'uu baate sababni isahoo maali?
    1. ----------
    2. ----------
9. Walumaagalatti dahumsa dhaabbilee fayyaatti gadhamu dabaluuf maal gochuutu ta'a?
    1. ----------
    2. ----------
10. Waamamaan hormaata fayyaa hawassaa ganda kana kessa jiruu? Eenyu fa'ii?
    1. ----------
    2. ----------
    1. ----------
11. Ga'een Hijjettota extenshinii fayyaa dahumsa dhaabbilee fayyaa fooyyessuuf qaban maalii?
    1. ----------
    2. ----------
12.Hawassaa keessa, ogeessota fayyaatin alatti dhaabbilee fayyaattii akka isin deessaniif kan isin gargaran ganda kana kessa jiru? akkaamin ibsitu?

1. ----------
2. ----------

13.Waa'ee Namoota ykn dhaebbilee tajaajila daahumsa dhaebbilee fayyatti godhamu ol-kaasuuf (fooyyessuf) ganada kana keessatti hojjetani maal jettuu? Isan eenyu fa'ii?

1. ----------
1. ----------

14. Bakka dahumsa Kan murteessu eenyu ? Maalif? ----------

Name of the student: ISRAEL DEREKIYAB SHENAB

Date._____ Signature _____

APPROVAL OF THE INTERNAL EXAMINER

NAME OF INTERNAL EXAMINER:

Date._____ Signature _____