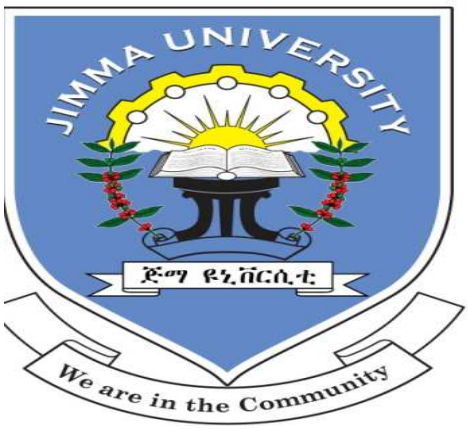

COMMUNITY SATISFACTION ON URBAN HEALTH EXTENSION PROGRAM AND ITS ASSOCIATED FACTORS IN HOSANNA TOWN, SOUTH ETHIOPIA

By

Ephrem Lejore (BSc)

A Thesis Submitted to Jimma University, College of Public Health and Medical Sciences, Department of Health Education and Behavioral Sciences in Partial Fulfillment of the Requirements for a Masters of Public Health in Health Education and Promotion

June 2013

Jimma, Ethiopia

JIMMA UNIVERSITY

COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES

DEPARTMENT OF HEALTH EDUCATION AND BEHAVIORAL SCIENCES

COMMUNITY SATISFACTION ON URBAN HEALTH EXTENSION PROGRAM AND ITS ASSOCIATED FACTORS IN HOSANNA TOWN, SOUTH ETHIOPIA

By

Ephrem Lejore (BSc)

Advisors:

1. Mr. Lakew Abebe (BSc, MPH in HE/HP, Assist. Prof)
2. Mr. Mamusha Aman (BSc, MPH in HE/HP)

June 2013

Jimma, Ethiopia

ABSTRACT

Background: Urban health extension program is an innovative government plan to ensure health equity by creating demand for essential health services through the provision of appropriate health information at a household level. It aimed at improving community's health status through their active participation and utilization of services, which depends on their satisfaction and acceptance of the program. However, there is no study done on community's satisfaction on the services provided by urban health extension program in Ethiopia.

Objective: To assess the level of community satisfaction on urban health extension program and factors associated with it in Hosanna town, South Ethiopia.

Methods: Community based cross sectional study, using both quantitative and qualitative methods were employed from March 1-30/2013. The quantitative data were collected by using interviewer administered structured questionnaire to sample size of 407 respondents. Data analysis was done by using SPSS. Descriptive statistics, bivariate analysis and multiple regressions were employed and the result was described in words and figures. P-value less than 0.05 and 95% confidence interval was used to declare association between independent and the dependent variables. Qualitative data were collected through FGD with Kebele health committee members and model families in Hossana town.

Results: 67.4% of the respondents were satisfied with services provided by urban health extension program. The study shows that communities' perception on technical competency (ß=0.425; 95% CI 0.084, 0.34), interpersonal relationship (ß=0.506; 95% CI 0.216, 0.797), and perceived accessibility of service (ß=0.752; 95% CI 0.064, 0.86) were independent predictors of satisfaction (P<0.05). In addition, marital status, knowledge and attitude of respondents were also associated with satisfaction of the community.

Conclusion and recommendation: The finding of this study showed that community's perception on health extension workers interaction had a significant influence on satisfaction of the community as well as on the implementation of urban health extension program. Therefore, urban health extension professionals and Hossana town health officials should give more emphasis on the improvement of their relationship with the community to enhance utilization of service.

Keywords: Urban health extension program, satisfaction

ACKNOWLEDGEMENT

First and for most I would like to thank the almighty God. I would like to extend my genuine thanks to my advisors Mr. Lakew A and Mr. Mamisha A. for their unreserved guidance, encouragement and support.

My special thanks also goes to my friends Mr. Yohannes, Mr. Belay, Mr. Zekarias and Mrs. Tangut for their constructive comments and constrictive suggestion.

I would also thank Jimma University College of Public health and Medical science for financing this study.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACRONYMS/ABBREVIATIONS

CHWs	Community Health Workers
CBHC	Community Based Health Care
CNHDE	Center for National Health Development in Ethiopia
EDHS	Ethiopian Demographic Health Survey
ETB	Ethiopian Birr
FGD	Focus Group Discussion
FMoH	Federal Ministry of Health
HSDP	Health sector Development Program
GOE	Government of Ethiopia
HEP	Health Extension Program
HEWs	Health Extension Workers
HH	Household
PHC	Primary Health Care
MDGs	Millennium Development Goals
SNNP	South Nations Nationalities and Peoples
UHEP	Urban Health Extension Program
UHE-Ps	Urban Health Extension Professionals
WHO	World Health Organization

CHAPTER ONE:

INTRODUCTION

1.1 BACKROUND

Health extension program is “a package of basic and essential promotive, preventive and curative health services targeting households in a community, based on the principle of Primary Health Care (PHC) to improve the families’ health”(1). It is initiated in 2003, as part of the health sector development program, by expanding physical health infrastructure (i.e., establishing a health posts) and training and deploying a cadre of female Health Extension Workers (HEWs)(2).

The main objective of HEP is improving access and equity to essential health interventions at the community levels by ensuring ownership and participation of the community; increasing health awareness and skills among community members; improving the utilization of PHC services; and promote life style conducive for good health(3,4). By so doing, it leads to the adoption of positive behavior and to create healthy environment (5). HEWs are trained and equipped with appropriate supplies to provide basic and essential promotive, preventive and selected curative services(6).

HEP has been implemented in three settings depending on the socioeconomic, cultural, and environmental conditions. These are the agrarian HEP; the pastoralist HEP; and the urban HEP(7). The urban HEP is started in 2009 by GOE at national level to ensure health equity by creating demand for essential health services through the provision of health information at a household level and access to services through referrals to health facilities, in order to address the health crisis and the HIV/AIDS epidemic in urban areas (8).

UHEP is expected to provide 15 health packages. The services were grouped into four main themes: hygiene and environmental sanitation, family health care, prevention and control of communicable and non-communicable diseases, and injury prevention, control, first aid, referral and linkages(11). Community utilization of the service is directly affected by their satisfaction

with the services they receive. Asking the community what they perceive about the service they have received is an important step towards improving the quality of care, and to ensuring that primary health care services are meeting communities needs (43).

UHEP in Hosanna town is commenced in 2002 E.C by deploying 32 urban health extension professionals, which received four months pre-service training course on urban health extension program. In general studies related to HEP in the past were mainly carried out in rural areas due to the elegantly program focused and implemented in rural areas. However, recently programs started in urban area to address urban health problems and there has been an increased need to understand satisfaction of the community towards the service provided by HEP.

1.2 STATEMENT OF THE PROBLEM

Even though different activities were conducted by government of Ethiopia to improve the health of the population, still there is a high rate of morbidity and mortality and also the health status is relatively poor(10). This is largely attributed to preventable infectious diseases and nutritional deficiencies associated with poor hygienic conditions, improper waste disposal practices, poor health service utilization and insufficient access to clean water. Infectious and communicable diseases account for about 60-80 % of the health problems in the country (12).

Ethiopia is one of the least urbanized countries in the world with only 16.7% of the populations are living in urban areas in 2010(13) and they are characterized as having a rich array of health and social services in comparison to rural areas(15). However, rapid migration from rural areas in search of job, education and for improved living; as well as natural population growth are putting further pressure on limited resources available in cities, especially in low-income countries which leads city dwellers to face health hazards and new health challenges have emerged(16).

UHEP has been adopted to address these health problems in urban areas by the GOE at national level to provide equitable disease prevention and health promotion services for urban population, which leads to the adoption of positive behavior, and ultimately, improved health outcomes(17).

For effective implementation of community based primary health care programs, the community has to trust and satisfied by the services provided by HEP(18). Therefore, understanding community's satisfaction on the services provided by urban health extension program is an important step to improve implementation strategies and approaches in community-based programs(1,19). In addition to this, it is clear that community satisfaction with the services provided by HEWs is critical for improved coverage and, hopefully, better delivery of services(20).

Satisfied people are more likely than dissatisfied ones to continue using services provided by HEWs and maintain their relationships with HEWs as well as they contribute to the effectiveness of the program (3, 4). A useful way of doing this is by carrying out community-based surveys who have used the health services (44).

Different studies were conducted in rural Ethiopia regarding health extension program by focusing on communities' satisfaction towards the program. However, since the inception of UHEP in Ethiopia, no other researches were conducted to assess satisfaction of the community. Therefore, this study, try to give an insight about the overall satisfaction of the community towards UHEP and the service provided by UHEPs in Hosanna town.

CHAPTER TWO

2.1 LITERATURE REVIEW

Satisfaction of the community towards primary health care services was derived from the sense that the program is addressing important health needs(27). Different studies conducted to assess community's satisfaction towards PHC services shows different level of satisfaction. 60.7% of the study participants in Kuwait(28) and 74.1% in India were satisfied with the overall services(29).

The study conducted in Kembata zone and Jimma Zone revealed that majority, 87.7% and 69.9% of the respondents respectively were satisfied by the services delivered by health extension workers (36, 41). Higher satisfaction of the community, 92%, is also reported among respondents from the study conducted in Wolayita zone (31).

There is a perceived risk that HEWs may not be equipped with the necessary skills and competence to properly implement the health extension packages with the training they received. According to CNHDEs evaluation report, communities satisfaction on the skill of the HEWs was relatively lower than the other measures of technical quality. About 82.5 to 91.2% of respondents stated that HEWs gave complete explanations, understood their problems, appeared to be skillful, made helpful suggestions, treated with respect, explained things in understandable way, made them free to ask questions, helped them to understand their illness, and discussed the treatment options(1).

According to the study conducted by CNHDE, the satisfaction of the community on the overall HEP services has improved over the years. The percent of respondents who rated the overall service as good or excellent has increased from 55.8% in 2007 to 84.2% in 2010. The increased satisfaction of the community on the overall HEP service was also indicated by the significant increase in the percent of respondents who would visit the health post again and who would recommend the service for other people – from 64.9% and 64.7%, respectively in 2007 to 85.6% and 86.9%, respectively in 2010. Satisfaction on family planning increased from 45.7% in 2007 to 59.6% in 2010(1,30).

Socio-demographic characteristics of the community are significant factors in evaluating their satisfaction with health care services in general have been researched in many studies. In a study conducted in Kuwait and Saudi Arabia shows that the overall satisfaction of respondents with Primary Health Care Services differs among males and females. In both studies, females are more satisfied than males with PHC services (28).

A cross sectional study conducted in Wolayita zone shows that, house hold respondents whose age group found between 20-24 are four times more likely satisfied by service provided by HEWs when compared to household respondents with age group 35years and above(31).

Educational level of peoples has also an impact in utilization of community based health services. A study conducted in India shows that, respondents' educational level have effect on the level of satisfaction; because of illiteracy and ignorance, the awareness and accessibility about other health facilities is limited among the respondents(32). In contrast to this, a study conducted in Egypt reported that the level of patient satisfaction with PHC services is not affected by gender and educational level(33).

In a community-based survey conducted among recipients of medical care who live at home, the predictors of being highly satisfied include increased education and income. In addition to this, a technical skill of health care providers is more important than interpersonal skills and the frequency of contact between health care providers and the community has increased the probability of being highly satisfied(34).

In a study conducted in china to assess residents' satisfaction with community health services shows that disadvantaged groups like the elderly, those only with an elementary level of education and those earning a lower level of income have lower satisfaction. In addition to this, the way of communication with health care providers can increase residents' satisfaction with health care services(35).

A study conducted in India, shows that respondents were highly satisfied with the immunization services provided by PHC, competency of the health care provider, and behavior of the health care provider(32).

A community satisfaction survey at national level indicated that 60% of the respondents rated all components of the HEP services as very satisfactory or satisfactory, with family planning receiving the highest score (76.5 %) (38). Respondents in the evaluation report of HEP expressed relatively high degree of satisfaction for services: family planning (76.5%), HIV education (76.2%), vector control (76%), Health education (75.6%) and immunization (74.9%) (1).

Conceptual framework

(Developed after reviewing different literatures)

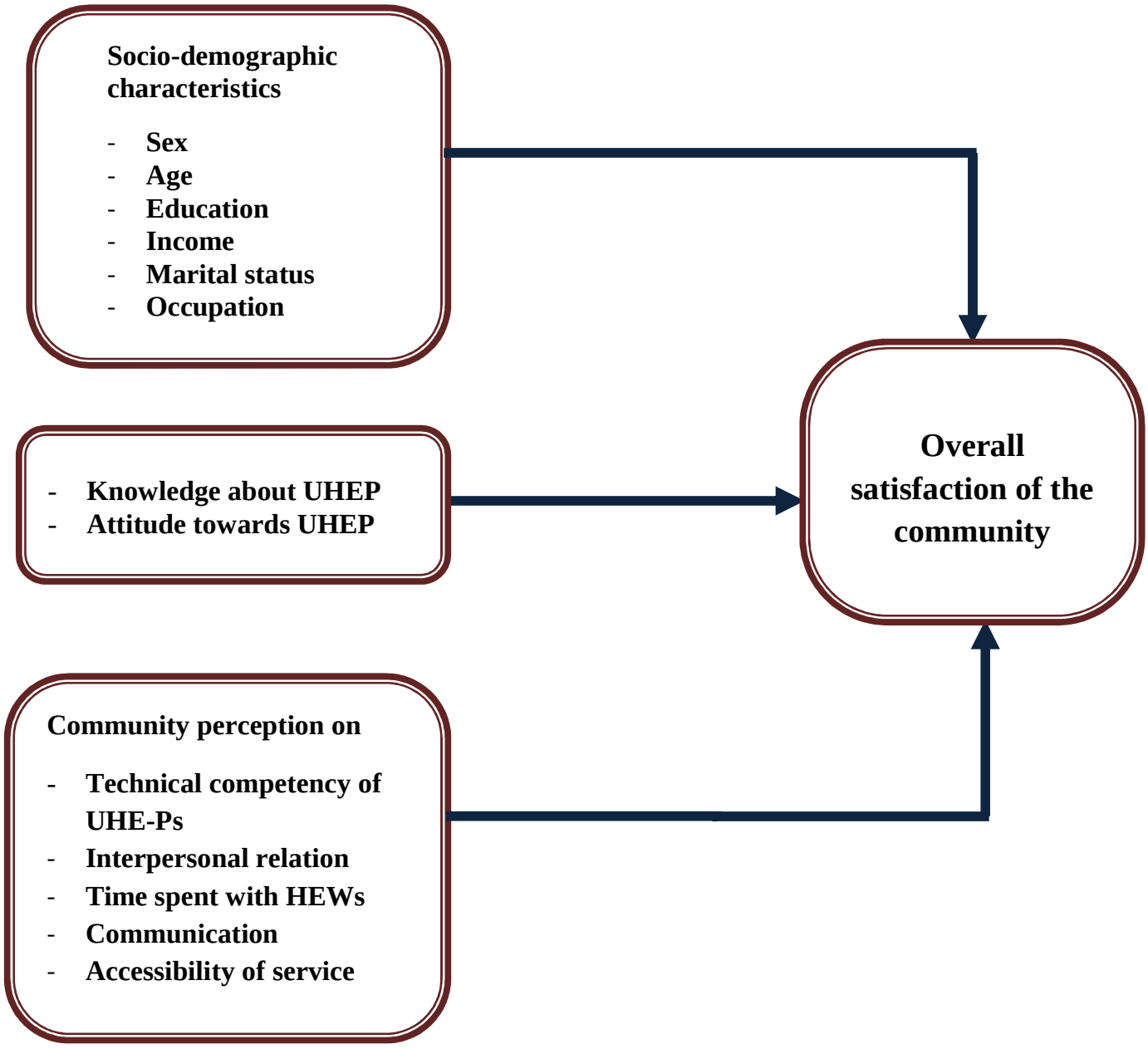

Figure 1: Conceptual framework of the study

2.2 SIGNIFICANCE OF THE STUDY

Urban health extension program is a newly introduced community based approach to address urban health problems. The program is believed that, it helps to achieve the millennium development goals (MDGs), if it is strictly implemented. Moreover, in the long term, it is hoped that the program may bring equity in health service provision in urban areas. The program has been operational since 2009 in the study area and it is possible to assess community's satisfaction on urban health extension program.

Studying satisfaction of the community on urban health extension program has an important role in improving the quality of health service. Where, satisfied patients are more likely to take an active role in their own health care. In addition to this, health professionals may also benefit from satisfaction surveys to identify areas for service improvement and it forwards best ways to empower the community to utilize community based health services.

Therefore, understanding community satisfaction on urban health extension program helps health professional and administrators to improve the services delivered by UHEP and address the major factors associated with their satisfaction. In addition to this, the data may also provide baseline information to program managers, researchers, non-government organizations and policy makers working on urban health extension program.

2.3 RESEARCH QUESTION

RQ1: What is the level of satisfaction of the community on urban health extension program in Hosanna town?

RQ2: What are the predictors of community satisfaction?

CHAPTER THREE

OBJECTIVE OF THE STUDY

General Objective

To assess satisfaction level of the community and the associated factors on urban health extension program in hosanna town, south Ethiopia.

Specific Objectives

- ✓ To assess the level of community satisfaction on urban health extension program in Hosanna town.
- ✓ To identify the factors associated with satisfaction of the community

CHAPTER FOUR

METHOD AND MATERIALS

4.1 STUDY AREA AND PERIOD

The study was conducted from March 1 to 30, 2013, in Hossana town.

Hossana town is the capital of Hadiya Zone, which is located 232 km from Addis Ababa, the capital of Ethiopia, and 194 km from regional city Hawassa. The town is administratively organized into 3-sub city and 8 kebeles.

According to the 2007 national census projected to 2011/2012, the total population of Hossana town is estimated to be 92,733, of this 45,875 (49.47%) are male and 46,858(50.53%) are female. The total households found in Hossana town 14,045.

According to the semi-annual report of Hossana city administration health office for 2005 FY, there is 1 Hospital, 3 health centers, and one pharmacy in the town. 1 private higher clinic, 17 middle level clinics, 7 lower level clinics, 3 pharmacies, 11 drug stores and 1 private diagnostic laboratory are available in Hossana town. The government health institutions provide service by assigning 127 health professionals of different categories, i.e, 12 Health Officers, 15 Mid-wives, 44 Nurses, 6 Environmental Health officers, 9 Laboratory technicians, 1 Pharmacy Technician, 8 Druggists and 32 Urban health extension workers/professionals.

Urban health extension program was started in 2009 in Hossana town by deploying 32 health extension workers in all kebeles with a ratio of one health extension worker to 440 households (39).

4.2 STUDY DESIGN

A community based cross sectional study using both qualitative and quantitative methods was employed.

4.3 POPULATION

4.3.1 SOURCE POPULATION

All households found in Hosanna town were used as a source population.

4.3.2 STUDY POPULATION

For quantitative study

- The sampled heads of households in hosanna town

For qualitative study

- Purposively selected Kebele health committee members and model families in Hossana town

4.3.3 STUDY UNIT

The study units were households.

4.4 ELIGIBILITY CRITERIA

4.4.1 INCLUSION CRITERIA

- Respondents aged above 18 years
- Respondents who live for more than 6 months in the study area

4.4.2 EXCLUSION CRITERIA

- Respondents who are unable to respond to questions due to illness

4.5 SAMPLE SIZE DETERMINATION AND SAMPLING PROCEDURE

4.5.1 SAMPLE SIZE

For quantitative study

The sample size was determined by using single population proportion formula considering the following parameters;

Since there is no similar studies on urban health extension program, sample size was calculated by assuming that 50% of the population are satisfied with UHEP.

P= 50%

$Z_{\left(1-\frac{\alpha}{2}\right)}$= Z-score at 95% confidence interval = 1.96

d= Acceptable margin of error = 5%

The Possible Non-response rate=10%

The formula for calculating the sample size (n) is:

$$n = \frac{\left(Z_{\left(\frac{\alpha}{2}\right)}\right)^2 P\,(1-P)}{d^2}$$

$$n = \frac{(1.96)^2 0.5\,(0.5)}{(0.5)^2}$$

$$n = 384$$

Final sample size by considering 10% possible non-response rate, it becomes **426** Households.

Qualitative data collection and sampling

Qualitative data were collected by conducting focus group discussion (FGD) among participants who were not included in the quantitative study. Four FGDs were conducted involving a total of 29, approximately 6-8 participants in each group, with in the age range of 24-60 years old and they were drawn from four Kebeles, two FGDs with model families and two FGDs with Kebele health committee members.

4.5.2 SAMPLING PROCEDURE

For Quantitative Study

All eight kebeles found in the town were considered in the sampling process for the selection of the study participants. The total sample size was distributed to all kebeles proportionate to their household size. The final respondents in each Kebele were selected by systematic random sampling method. Sampling interval was calculated for each kebeles to select sampled households. When more than one eligible respondent was found in a house, lottery method was used to select one respondent. When there is no eligible respondent in the selected house, it is considered as a non-response.

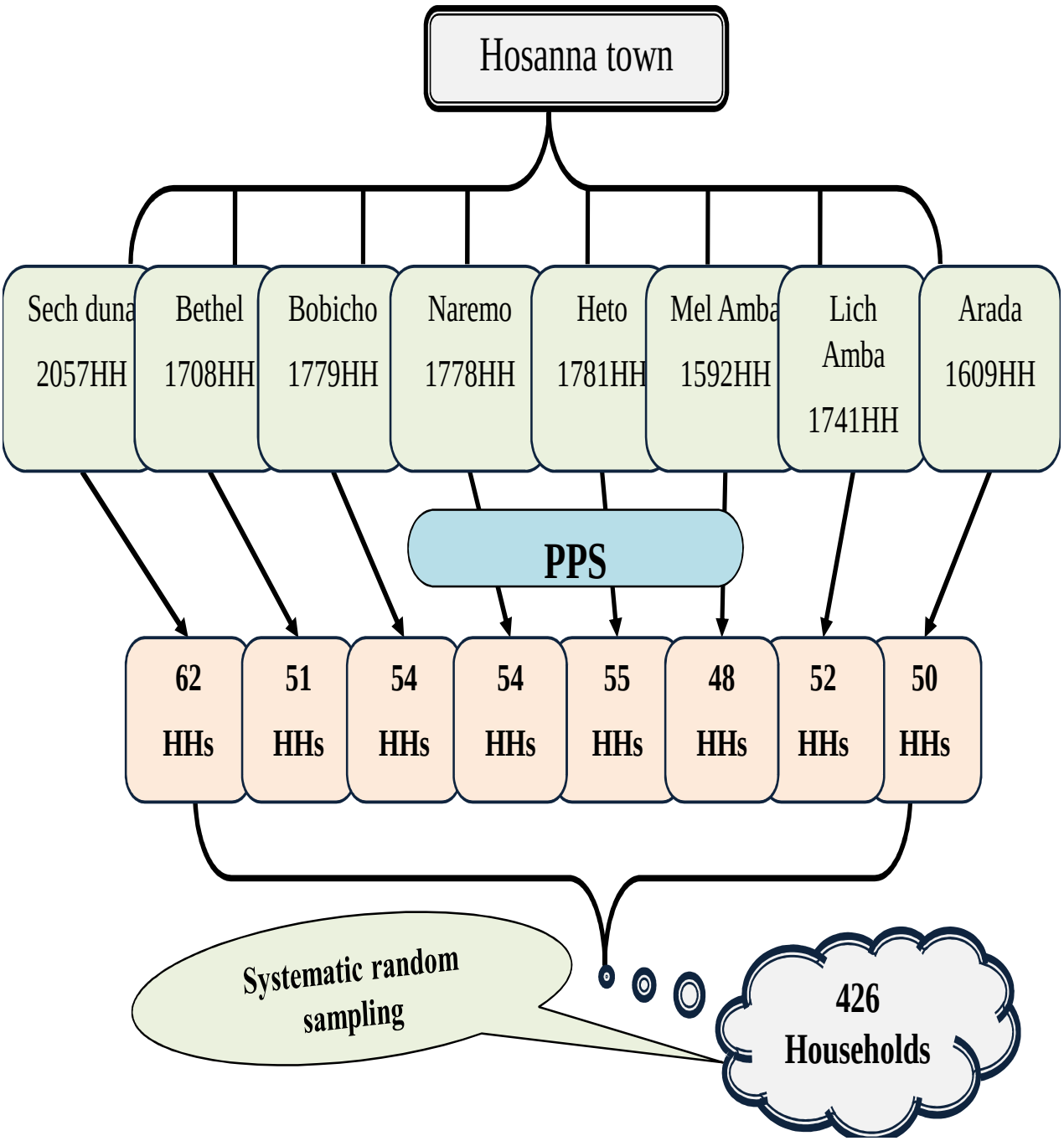

Figure 2. Schematic presentation of sampling procedure

For Qualitative Study

Purposive sampling method was used to select participants for focus group discussion from Kebele health committee members and model families in Hossana town to get in depth information about community satisfaction on urban health extension program.

4.6 DATA COLLECTION AND MEASUREMENT

4.6.1 INSTRUMENTS FOR QUANTITATIVE STUDY

Quantitative data were collected by using structured questionnaire. The questionnaire adapted from various previous studies (40, 41, 42, 47) conducted in rural areas, it was developed in English and translated into Amharic & Haddiyisa, then back translated to English by person blind to the original English version to facilitate reliable responses and to keep the original meaning of the instrument.

The questionnaire consists of the following parts;

Socio-demographic characteristics:-. Socio-demographic characteristics assessed include age, gender, ethnicity, religion, occupational status, marital status, educational status and income measured on different scales.

Knowledge: - Knowledge of respondents about UHEP was assessed with 7 items. Each item was rated by “yes or no” question. Each items response was summed to get knowledge score, which ranges from 0-7. A higher score indicated good level of knowledge.

Attitude: - Attitude of respondents on UHEP was addressed with four items. Each item was rated on a 5-point Likert scale ranging from (1) strongly disagree to (5) strongly agree which ranges from 4-20. These 4 items were based on the following questions: UHEP can bring health improvement in the community, The services provided by UHEP can addresses the needs of the community, The services provided by UHEP are appropriate to deal with urban health problems, and UHEP increases health awareness among community members. The scale has high internal consistency (Cronbach’s alpha=0.806). The score of all items was summed and higher score reflect favourable attitude.

Perception of the community: - perception of the respondents on UHEP was measured with five aspects of perception. These are:

- **Perceived technical competency**

  10 items measured perceived technical competency. Reliability coefficient showed that the scale has high internal consistency among items (Cronbach's alpha = 0.678). Each item was measured on a 5-point likert scale ranging from strongly disagree (1) to strongly agree (5) which yields a score of 10-50. Some of the questions were: UHEPs are competent to deliver services; I have some doubt about the ability of UHE-Ps, etc. The score of all items were summed after reversing negatively worded questions and higher score reflects higher perceived technical competency.

- **Perceived interpersonal relationship**

  Perceived interpersonal relationship with health extension workers has 5 items. Each item was measured on a 5-point likert scale ranging from strongly disagree (1) to strongly agree (5) which yields a score of 5-25. The scale has high internal consistency among items (Cronbach's alpha =0.752). These 5 items were based on the following questions: UHE-Ps act too impersonal; UHE-Ps treats me in a very friendly manner; UHE-Ps should give me more respect; and UHE-Ps always do their best to keep me from worrying. The score of all items were summed and higher score reflects higher perceived interpersonal relationship.

- **Perceived time spent**

  It was measured with 2 items. The scale has high internal consistency among items (Cronbach's alpha =0.835). Each item was measured on a 5-point likert scale ranging from strongly disagree (1) to strongly agree (5). These 2 items were based on the following questions: UHE-Ps can give advice/service in a hurry way when they advice me; and UHE-Ps usually spend plenty of time with me. The score of all items were summed and higher score reflects higher perceived time spent with health extension workers.

- **Perceived way of communication**

  It was measured with 7 items. The scale has high internal consistency among items (Cronbach's alpha =0.834). Each item was measured on a 5-point likert scale ranging from strongly disagree (1) to strongly agree (5) yielding a total score of 7-35. Some of the items were: ability to communicate with the community, communication in health education session, discussing about private matters, and communication with UHE-Ps are very helpful for health. Each items were summed and higher score reflects perceived favourable communication.

- **Perceived accessibility**

  Perceived accessibility of service is measured with 5 items. Each item was measured on a 5-point likert scale ranging from strongly disagree (1) to strongly agree (5) yielding a total score of 5-25. Reliability check showed that high reliability coefficient (Cronbach's alpha =0.814). These 5 items were based on the following questions: I can easily find UHE-Ps; I can get service whenever I need it; the time that I can get service are convenient(good) for me; UHE-Ps office is conveniently located; and I don't get them in their office. Each items were summed after reversing negatively worded questions and higher score reflects perceived accessibility of the service.

Satisfaction with UHEP

Satisfaction of the community was measured with 5 items. Each item was measured on a 5-point likert scale ranging from strongly disagree (1) to strongly agree (5) which yields a total score of 5-25. The scale has high internal consistency among items (Cronbach's alpha =0.951). These 5 items were based on the following questions: I am totally satisfied with the services; not satisfied with the services; totally satisfied with UHE-Ps technical skills; I can use again services; and I will advise my friends or relatives to use services. Negatively worded questions were reverse scored to sum each items and higher score reflects higher satisfaction with UHEP.

Instruments for Qualitative Study

Interview guideline was used to guide the FGD. The main points that was addressed during discussion were attitude of the community on UHE-Ps and services provided by UHEP, perceived relationship with HEWs and satisfaction of the community on the services provided by UHEP.

4.6.2 PRE-TESTING OF THE QUESTIONNAIRE

A pre-test of the questionnaire was done using 5% (42 participants) of the sample size of the study in Wolayita Sodo town, to check for clarity of the questions and to eliminate ambiguity, difficult wordings or unacceptable questions.

4.7 STUDY VARIABLES

Dependent variables

- Satisfaction of the community on urban health extension program

Independent variables

- Socio demographic variables(age, sex, religion ,marital status, ethnicity, educational level, occupation and income)
- Knowledge of the community
- Attitude of the community

Intermediate variables

- Perceived Technical competency of UHE-Ps
- Perceived Interpersonal relationship
- Perceived Time spent with HEWs
- Perceived way of communication
- Perceived accessibility of service

4.8 DATA COLLECTION METHODS AND COLLECTORS

For Quantitative Study

The data was collected by face-to-face interview using structured questionnaire. Eight 10^{th} grade complete data collectors were recruited for data collection and four B.Sc health professionals for supervision of data collection process. One day training was given for data collectors and supervisors by the principal investigator on contents of the tool, relevant data collection principles and procedures before data collection.

For Qualitative Study

Interview guideline was used to guide the FGD. Principal investigator has moderated the FGD and it was conducted in Kebele offices. In addition, tape recorder was used to record the discussion.

4.9 DATA PROCESSING AND ANALYSIS

For Quantitative Data

First data was checked manually for completeness and it was coded, entered and analyzed with SPSS version 16.0. Descriptive statistics and mean score were used to summarize data and bivariate analysis was conducted to see the association of independent variables and satisfaction. All variables with p-value<0.05 during the bivariate analysis were entered to multivariate linear regression for further analysis. The final model was constructed using stepwise linear regression to identify independent predictors of satisfaction. P-value <0.05 was used to declare statistical significance.

For Qualitative Data

The data from FGD was transcribed verbatim from recorder and transcripts were checked for reliability. The data was analyzed manually by categorizing into different themes and triangulated with the quantitative study.

4.10 DATA QUALITY CONTROL

Questionnaire was prepared in English, translated in to Amharic and Hadiyisa, and back translated to English in order to check consistency of the two versions. The tools were also pre-tested by using 5% of the sample size.

A one-day intensive training was given to data collectors and supervisors. Frequent supervision by supervisors and principal investigators was also done during data collection. The filled questionnaires was checked for completeness, accuracy, and clarity. When error or incompleteness encountered, it was addressed on the following day before starting next day activities.

4.11 OPERATIONAL DEFINITION OF TERMS

Knowledge:- The knowledge score was summed and divided into two levels which are good knowledge and poor knowledge using the mean knowledge score as the cutoff point.

Attitude:- The attitude score was summed and divided into two levels which are favourable attitude and unfavorable attitude using the mean attitude score as the cutoff point.

Overall satisfaction on UHEP - The rating of the UHEP by the beneficiary community members, which is measured by 5 point likert scale ranging from 'strongly agree' to 'strongly disagree'. The score of all items was summed and the mean value was used as a cut point to label satisfaction.

Perceived Technical competency: - Community's opinion of technical competency of UHE-Ps in providing services. 10 items addressed it. A higher score indicates perceived high technical competence.

Perceived interpersonal relationship: – Communities opinion about the relationship with UHE-Ps. It was addressed by 5 items. A higher score reflects good relationship.

Perceived time spent: – community's opinion of time spent with HEWs. It was addressed by 2 questions and a higher score reflects perceived higher time spent.

Perceived way of communication: – Perceived community's opinion with their way of communication with urban health extension workers. It was addressed with 7 questions. A higher score indicates favourable communication.

Perceived accessibility: - communities opinion on the accessibility of the service. It was addressed by 5 items. A higher score indicates perceived accessibility of the service.

Model family:- Heads of household trained by urban health extension professionals for 96 hours (3 months) on the fifteen health extension packages.

Urban Health extension program – A program designed to a achieve equity in health care in urban areas in 15 different packages by targeting households.

Urban Health extension-Professionals - A diploma nurse trained for four months about preventive and promotive health services provided at community level

4.12 ETHICAL CONSIDERATION

The study was conducted after securing ethical approval from Jimma University postgraduate health research coordinating office. Permission was sought from SNNPR health Bureau, Hadiya zone Health department and Hossana city health office. Finally, after informing the participants about the purpose of study, benefit and risk associated with study, oral consent was asked from each study participants before conducting interview. The participants were also informed that their response will be kept confidential and their name will not be mentioned.

4.13 DISSEMINATION PLAN

The result of this thesis can be presented to Jimma university collage of Public Health and medical science. The study finding is also communicated to Hossana town, Zonal and Regional authorities who deserve the results. Finally, effort will be made for publication to disseminate internationally.

CHAPTER FIVE

RESULT

5.1 Socio-Demographic Characteristics

Four hundred seven respondents were interviewed, yielding a response rate of 95.5%. Out of the total respondents, 73.2% of them were females. 43.7% of the respondents are between 25-34 age category. The mean age of respondents was 33.5 ±11.5 years. Three hundred thirty five (82.3%) of the respondents were married. Regarding educational status, 32.2% of the respondents are college graduates and 29.5% of them had attended secondary school. Concerning religious affiliation, 65.8% of the respondents were protestant Christian. Occupationally, 34.2% of the respondents were government employees and 33.7% of them were housewife. By ethnic composition, majority of the respondents were Hadiya (69.8%) and the average monthly income of respondents was 1050 ETB.

Regarding family classification with regard to health extension achievements, only eighty-two (20.1%) of the respondents were recognized as model families. (*Table 1)*

Table 1: Socio demographic characteristics of the respondents in Hossana town, South Ethiopia, March 2013

Background characteristics		Frequency	Percentage
Sex	Female	298	73.2
	Male	109	26.8
Age	18-24	75	18.4
	25-34	178	43.8
	35-44	87	21.4
	45-54	36	8.8
	55+	31	7.6
Marital status	Married	335	82.3
	Single	48	11.8
	Divorced	16	3.9
	Widowed	8	2.0
Educational level	Illiterate	45	11.0
	Grade 1-8	111	27.3
	Grade 9.12	120	29.5
	College and above	131	32.2
Religion	Protestant	268	65.8
	Orthodox	88	21.6
	Muslim	27	6.6
	Catholic	24	5.9
Occupation	Gov't employee	139	34.2
	House wife	137	33.7
	Merchant	59	7.6
	Daily laborer	31	14.5
	Others*	41	10.1
Ethnicity	Hadiya	284	69.8
	Kembata	43	10.5
	Amhara	41	10.1
	Gurage	22	5.4
	Others**	17	4.2
Average monthly family income	≤500	169	41.5
	501-750	22	5.4
	751-1000	65	16.0
	>1000	151	37.1
Classified as model family	Yes	82	20.1
	No	326	79.9

*****Farmer, student ******Silte, Wolayita, Tigre

5.2 Respondent's Knowledge and Attitude towards UHEP

Community's knowledge about urban health extension program was assessed by seven questions. All the items were summed to get the respondents knowledge score. The mean score of community's knowledge about UHEP is 4.852 with SD ±1.156 and 278(68.3%) of them scored above or equal to the mean knowledge score. Thus, 68.3% of the respondents have good knowledge.

Table 2: Communities knowledge about UHEP in Hossana town, South Ethiopia, March 2013

Variables		Yes N (%)	No N (%)
Know about urban health extension program		369(90.7%)	38(9.3%)
Know the urban health extension Professional of your Kebele		350(86.0%)	57(14.0%)
Know the services provided by UHEP		346(85.0%)	61(15.0%)
UHEP focus only on mothers and children.		268(65.8%)	139(34.2%)
UHEP provides health education on important health problems		259(63.6%)	148(36.4%)
UHEP is aimed at providing curative health services for urban population		212(52.1%)	195(47.9%)
UHEP focused on providing disease prevention activities		317(72.9%)	90(22.1%)
Total Knowledge score	**Mean**	**4.852**	
	SD	**1.156**	

Similarly, attitude of the community towards urban health extension program was measured by five point likert scale measurement. Four items were used to measure respondent's attitude on the program and they were summed to get attitude score. Accordingly, the mean value of community attitude was 15.728 with SD $\pm$ 2.814. Two hundred fifty eight (70.1%) of the respondents rated their attitude above or equal to the mean value. Therefore, 70% of the respondents have had favourable attitude towards urban health extension program.

In the qualitative study, majority of the FGD participants have good attitude towards urban health extension program. Health problems like HIV/AIDS, improper utilization of latrine, child health problems, poor solid waste disposal mechanism of households, poor environmental sanitation etc were addressed by urban health extension program. For example, one of the discussant from Kebele health committee said:

> "*...Truly speaking since urban health extension professionals started working in our kebele, we are giving due emphasis for environmental sanitation activities. We have prepared separate solid and liquid waste disposal pit in our household. Which helped us to prevent ourselves and our family from different health problems"* (42 years old female participant)

Table 3: Communities attitude towards UHEP in Hossana town, South Ethiopia, March 2013

Items	Favorable attitude	Unfavorable attitude	Mean±SD
UHEP improves community health	187 (50.8%)	181 (49.2 %)	4.47±0.61
UHEP addresses community needs	93 (25.3%)	275 (74.7%)	4.07±0.81
UHEP is appropriate to deal with urban problems	295 (80.2%)	73 (19.9%)	3.76±0.89
UHEP increase health awareness of community	249 (67.7%)	119 (32.3%)	3.43±1.13
Overall attitude score	**258(70.1%)**	**110(29.9%)**	**15.728±2.814**

Community participation

Concerning community participation in the planning and implementation of the program, 250 (61.4%) of them did not participate in the planning process. In the qualitative study, majority of the respondents ascertained that their participation in the planning and implementation of the program helps to achieve the desired outcome. Even though they had good relationship with health extension workers during home visit, they do not involve the community in the planning of the program. One of the discussant said that:

> *"...I heard about the type of services provided by urban health extension program from health extension workers. I did not attend in any meetings for planning of the service provided by health extension program. If I can participate in the planning, I will contribute what is expected from me in the implementation of the program." (*A 46-years old male discussant)

Besides this, some of the FGD participants said that they are participating in the environmental sanitation activities organized by health extension workers.

*"...There was environmental sanitation campaign last month to clean the stagnant water in our area. Which is the main source of malaria in the Kebele and many people gets ill because of this. Then one day all the Kebele residents gathered and cleaned the area." (*A 42 years male discussant*)*

Relationship with health extension workers

Regarding the relationship of health extension workers with the community, 356 (96.7%) of the respondents have good relationship with urban health extension professionals. One of the FGD participants said that:

*"...She (HEW) acts like my child when she comes to my home. In addition, she discusses with me about my personal health problems with respect and in a friendly manner. She sees my problem as hers." (*A 48 years old female discussant*)*

Females' competency

One hundred eighty six (50.5%) of the respondents said that females are competent to deliver services. The participants in the qualitative study also supported this idea. They prefer to discuss frankly their personal health issues with females rather than males.

*"...It is easier for me to discuss all my issues with females. If health extension workers are males, I cannot discuss my personal health problems freely. For example if I want to ask them about family planning, I can only talk freely with females." (*27 years female discussant)

Table 4: Respondents experience with urban health extension professionals in Hossana town, South Ethiopia, March 2013

Variables		Frequency	Percentage
Participated in planning and implementation of UHEP	Yes	118	32.1
	No	250	61.4
Relationship with UHE-Ps	Excellent	87	23.6
	Very good	145	39.4
	Good	124	33.7
	Poor	11	3.0
	Very poor	1	0.3
Females are competent to deliver service	Yes	186	50.5
	No	182	49.5

Exposure to health extension packages

Three hundred sixty eight (90.4%) of the respondents were visited or get advice/service from urban health extension professionals one year prior to the study period. Even though urban health extension program is designed to give services in 15 different packages, urban health extension professionals give more attention to some of the programs. For example, 91.8% and 89.7% of the respondents received service on environmental sanitation and latrine use, respectively. While programs like Malaria prevention, TB/Leprosy prevention, non-communicable disease prevention and accident prevention activities were given least attention even though they are serious health problems in urban area (*Figure3*).

The result of qualitative study also supports this idea.

> *"...Before the assignment of UHE-Ps nobody give due attention to personal hygiene & environmental sanitation. But, after their deployment, we have separate solid and liquid waste disposal pit and we also give more attention to our families' and environmental hygiene as well as we get the necessary advice from her at home." (*A 50 years female FGD participant)

Similarly, another FGD participant said that:

> *‘‘...We learnt from HEWs that by doing simple things at home we can protect ourselves from diseases. Keeping our houses and environment clean protects us from different diseases. These are simple things, that anybody can do. Since we started keeping our homes clean, our children and family members have a healthy life. As well as we can get family planning methods easily at home without going to health facilities. We are also feeding our children as per the training given by the HEWs.’’* (A 45 years old male discussant)

In addition to this, some of the respondents stressed the need of other programs like monitoring of blood pressure during home visits. One of the FGD discussant says:

> *“...For example, I have hypertension and I can’t go to health facility every time to check my blood pressure. If they check my blood pressure at home, I can take care of my health status accordingly without having medical cost. (A* 58 years old female participant*)*

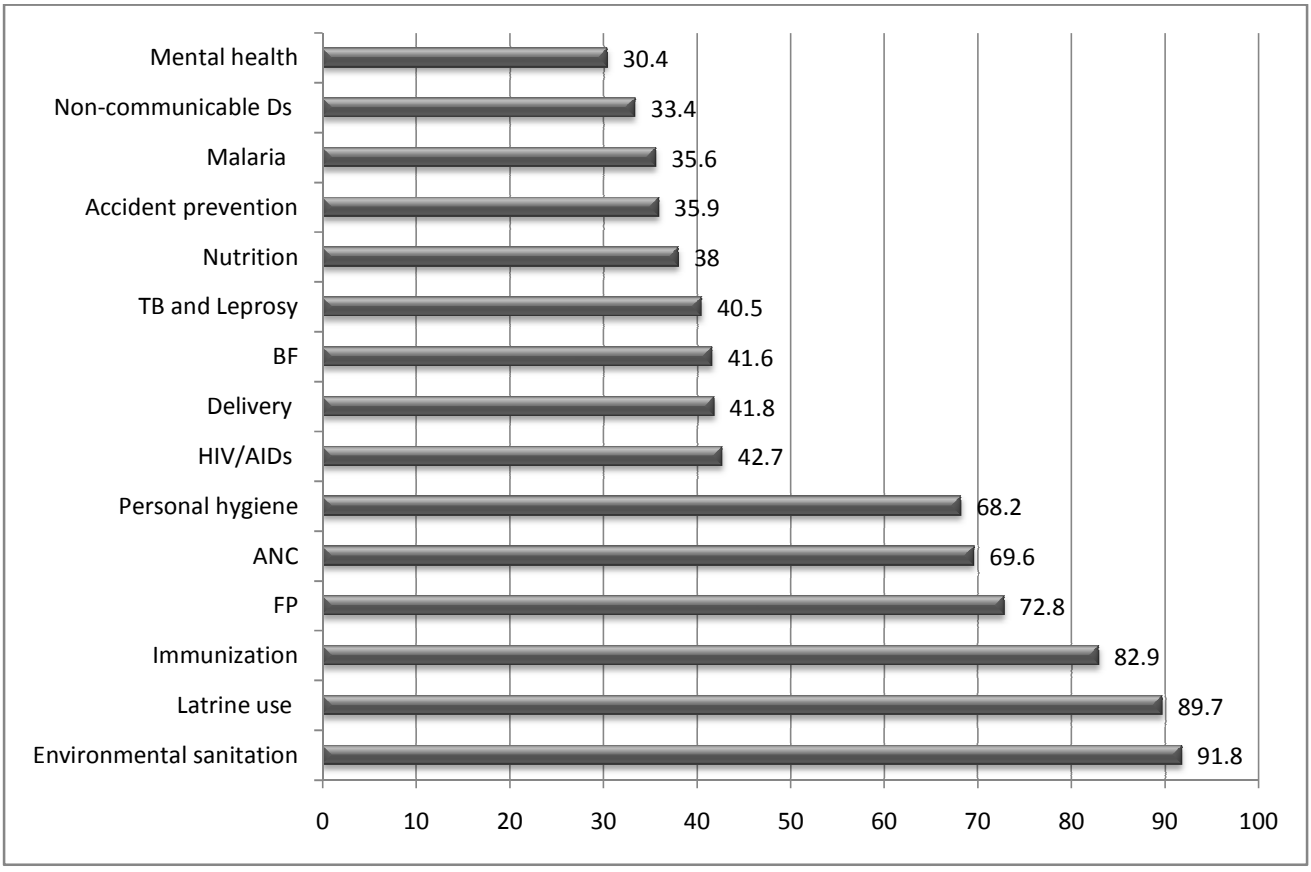

Figure 3: Community exposure to health extension packages in Hossana town, South Ethiopia, March 2013.

5.3 Perception of the Community on Satisfaction Sub-Scales

Community's perception on the services provided by urban health extension program was assessed in five key aspects of satisfaction. These are: perceived technical competency, perceived interpersonal relationship, perceived time spent, perceived communication with urban health extension professionals and perceived accessibility of the service, which were rated using five point likert scale from strongly disagree to strongly agree. The mean score is calculated for each sub-scales of satisfaction after they are summed up and converted into hundred percent for possible comparison.

The highest mean score was found for perceived HEWs communication with the community (81.59 ±7.83). The FGD discussants also give more attention to health extension workers communication during service provision. The way HEWs communicate with the community is important for improving utilization of the services of UHEP.

A relatively higher mean score was observed for perceived interpersonal relationship with HEWs (77.0±7.0). Result from the qualitative study shows similar finding. Majority of the discussants said that HEWs have good relationship with them during home visit and outreach services.

The mean score for perceived technical competency was 73.46±8.26. Majority of the FGD discussants also said that HEWs have good knowledge and experience with the service they deliver. For instance, one of the discussant said that:

> *"...when she come to my home she discusses about my families health. She knows everything about my issues and I get good response from her (HEW)." (*29 years old female discussant)

Higher mean score also observed for communities perception on accessibility of services (74.81±16.1). The findings of qualitative study also show consistent results. Majority of them said that they can get services of UHEP like family planning service near their home in kebele health offices and during outreach when they want them. One of the FGD discussant said that

> "*When I need to take family planning service, I can go to their office. And I can get any type of family planning method without any problem. In addition to this, she also brings different family planning methods during home visit."* (29 years old female discussant)

A relatively lower mean score was also observed for perceived time spent with health extension workers (60.76±6.84). Result from qualitative finding also supports this idea. Most discussants said HEWs come and visit our home in a hurry way and they spend shorter time with us.

Table 5: Perception of the community on interaction with health extension workers in Hossana town, South Ethiopia, March 2013

Variables	No of Items	Mean	SD	Range of possible score
Perceived technical competency	10	73.46	8.26	20-100
Perceived interpersonal r/n ship	5	77.00	7.00	20-100
Perceived time spent	2	60.76	6.84	20-100
Perceived way of communication	7	81.59	7.83	20-100
Perceived accessibility	5	74.81	16.10	20-100

5.4 The Overall Community Satisfaction

The overall patient satisfaction on UHEP was rated by five point likert scale ranging from strongly disagree to strongly agree. The study shows that the mean score of overall community satisfaction on UHEP was 72.82 with SD $\pm$22.09 (possible range of responses 20-100). 67.4% of the respondents rated overall satisfaction score above or equal to the mean value. Thus, 67.4% of the respondents are satisfied with the services provided by urban health extension program in Hossana town (*Table 6*).

In the qualitative study, majority of the FGD participants expressed as satisfied in general with the service received from urban health extension professionals. Majority of the FGD discussants said the type of service delivered by UHEP addresses urban health problems. For instance, one of the FGD attendants says:

> "*...In general, the service they provide for us is good because the service is important to address most of urban health problems and it reaches all segment of the population; whether poor or rich can get the service.* (38 years old male participant)

Other participants mainly concerned in interactions with health extension workers as base for satisfaction, expressed their relationship with them as caring, good communication skills, and based on respect. For example, 40 years old, women express this issue like this

> *"...When she came to my home, she discusses with me politely/ with respect and she gives me adequate time to discuss about my personal health problems, this makes me satisfied." (*A 40 years old female discussant)

Table 6: Overall satisfaction of respondents on UHEP in Hossana town, South Ethiopia, March 2013

Items	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Mean±SD
Satisfied with the services	17 (4.6%)	63 (17.1%)	-	132 (35.9%)	156 (42.4%)	3.94±1.23
Not satisfied with the services	111 (30.2%)	179 (48.6%)	-	57 (15.5%)	21 (5.7%)	3.82±1.18
Satisfied with UHE-Ps skills	12 (3.3%)	84 (22.8%)	2 (0.5%)	204 (55.4%)	66 (17.9%)	3.62±1.11
Use again services of UHEP	29 (7.9%)	86 (23.4%)	1 (0.3%)	193 (52.4%)	59 (16.0%)	3.45±1.23
Recommend others to use services of UHEP	39 (10.6%)	81 (22.0%)	7 (1.9%)	187 (50.8%)	54 (14.7%)	3.37 ±1.26
Total satisfaction score		**Mean**	**72.82**			
		SD	**22.09**			

5.5 Predictors of overall community satisfaction

5.6.1 Socio-Demographic Variables as Predictors of Satisfaction

Linear regression analysis was used to build the model in assessing the association between socio-demographic variables and satisfaction of the community. Marital status and ethnicity of the respondents were predictors of satisfaction, while age, sex, educational status, occupation, religion, and income were not associated with satisfaction of the community.

Accordingly, the satisfaction score of single respondents' is decreased by an average of 7.95 (ß; 95% CI: -15.45, -0.45) as compared to those who are married respondents. (*See table 7*)

Table 7: Socio-demographic predictors of community satisfaction in Hossana town, March 2013

Back ground characteristics		N (%)	Un standardized ß	95% CI for ß	P-value
Marital status	Married *	335(82.3%)			
	Single	48(11.8%)	-7.956	-15.45, -0.45	0.038
	Divorced	16(3.9%)	2.239	-10.00, 14.48	0.719
	Widowed	8(2.0%)	2.373	-14.20, 18.95	0.778
Ethnicity	Hadiya *	254(69.8%)			
	Kembata	43(10.6%)	3.712	-7.295, 7.305	0.999
	Amhara	41(10.1%)	3.889	1.704, 17.001	0.017
	Gurage	22(5.4%)	5.505	-13.73, 7.91	0.597
	Others	17(4.2%)	6.236	-6.494, 18.032	0.355

***Reference category (Category with highest frequency taken as reference category)**

5.6.2 Attitude and Knowledge as Predictors of Satisfaction

The association between respondents attitude and knowledge on the service provided by urban health extension program with satisfaction was analyzed by multiple linear regression though stepwise method. Bivariate analysis shows that respondents' knowledge and attitude towards UHEP were associated with satisfaction of the community.

Multivariate analysis also shows that both attitude and knowledge towards UHEP predicts community's satisfaction with UHEP. Accordingly, for a unit increase in the attitude score of respondents, the satisfaction score increases by an average of 3.002 (**ß**; 95%CI: 02.26, 3.74). Similarly, the satisfaction score of respondents' increase by an average of 2.302, as knowledge score increases by one unit. *(See table 8)*

Table 8: Knowledge and attitude of respondents on UHEP as a predictor of satisfaction in Hossana town, South Ethiopia March 2013

Variable	Un standardized ß	95% CI for ß	P- value
(Constant)	13.98	-1.302, 29.27	0.000
Attitude	3.002	2.26, 3.74	0.001
Knowledge	2.302	0.163, 4.44	0.035

5.6.3 Communities' Perception on UHEP as Predictors of Satisfaction

The association between satisfaction and perception of the community on the services delivered by urban health extension professionals was analyzed by multiple linear regression analysis through stepwise method to build the model. This model explained 49.7% of the variation in community satisfaction. In the model perceived technical competency, perceived interpersonal relationship, perceived way of communication, perceived time spent with health care workers and perceived accessibility of the services were included in the model as independent predictors of community satisfaction on urban health extension program.

Bivariate analysis shows that perceived technical competency, perceived interpersonal relationship and perceived accessibility of the services have significant association with satisfaction of the community, while perceived time spent with health care workers had not significantly associated.

However, analysis with multivariate linear regression showed that only perceived technical competency, perceived interpersonal relationship and perceived accessibility of the service were significantly associated with satisfaction of the community.

Accordingly, as respondents perceived technical competency score increases by one unit, the level of satisfaction increases by an average 0.425 (**ß**; 95% CI 0.16, 0.68). Similarly, for a one unit increase in respondents perceived interpersonal relationship with health extension workers, level of satisfaction increases by an average 0.506(**ß**; 95% CI 0.216, 0.797). In addition, for a one unit increase of respondents perception on accessibility of service, the respondents satisfaction had an average increase of 0.752 (**ß**; 95% CI 0.64, 0.86). *(See Table 9)*

Table 9: Community perception as predictors of community satisfaction among respondents of Hossana town, South Ethiopia, March 2013

Explanatory variable	**Un standardized ß**	**95% CI for ß**	**P-value**
Constant	-53.67	-72.00, -35.33	0.000
Perceived technical competency	0.425	0.16, 0.68	0.001
Perceived interpersonal relation	0.506	0.21, 0.79	0.001
Perceived accessibility	0.752	0.64, 0.86	0.001

CHAPTER SIX

DISCUSSION

The study aimed to assess satisfaction of the community on urban health extension program. In the study, the mean score of community satisfaction on the services provided by urban health extension program for five items was 72.82 with SD ±22.09. The items covers I am totally satisfied with services of UHEP, I'm not satisfied with the services of UHEP, I'm satisfied with the skills of UHE-Ps, I will come again to UHE-Ps and I will advise my friends or relatives to see UHE-Ps. Generally, 67.4% of the respondents are satisfied with the services provided by urban health extension program in Hossana town. This is a lower from the study conducted in Jimma zone, in which 69.9% of the respondents were satisfied with the services provided by health extension workers (41). This might be because of difference in study area, status of HEWs and approaches of urban health extension professionals.

According to the urban health extension manual (11), all households were expected to be graduated as model families, however in this study only 20% of the respondents were recognized as model families. This is because of lack of clear implementation guide in urban areas, for instance, the USAID survey on urban health extension program implementation identified that Kebele administrators were also expected to approve on who will be model household, an additional criterion. In addition to this, the longer time (96 hours) required to train one group of model families and the number of packages expected from them to graduate were the main challenges (8).

Majority of the respondents said that they prefer females to receive services of urban health extension program. This result is consistent with other studies conducted in rural areas (36). This is because of their closeness to mothers because of the services of UHEP mainly addresses maternal and child health as well as during service provision mostly mothers are available at home.

The objectives of HEP can be achieved if the community should be involved in planning, implementing, and having a say about their own health and health care(23). In this study, majority (61.4%) the respondents were not participated in the planning and implementation of the program. This finding is consistent with summary of findings presented by Expert review

panel (18). This may be because of majority of the respondents are government employees and they have no time to participate in different meetings arranged by urban health extension professionals.

More than 90% of the respondents get advice/service from urban health extension professionals in the last one year prior to the study. This is much higher than that of studies conducted in rural health extension in Wolayita zone (36). The high number of households get information/advice because of the newly implemented strategy called, health development army /HDA/, a network of up to five people under the leadership of one that is recognized as a model family. The leader is expected to lead the group of households and gradually influence them with positive attitudes and skills towards healthy behaviour (8).

Respondents exposed better to some of the health extension packages like environmental sanitation and latrine use, and lower to malaria prevention, TB/Leprosy, non-communicable disease and accident prevention activities. This result is comparable with the study conducted in rural areas of Jimma zone (41). This is mainly because of their simplicity to implement these packages and the program is directly adapted from the rural program.

Among the socio-demographic variables, marital status of the respondents was the only socio-demographic predictor of community satisfaction. The satisfaction score of single respondents' is decreased by an average of 1.989 as compared to those of married respondents. This is consistent with the review conducted to assess the association of socio-demographic variables with satisfaction (45).

Concerning communities' relationship with health extension workers, majority of the respondents stated their relation as good, very good and excellent. This is consistent with the study conducted in Tigray region (46). This is mainly because most of the users of the service were women as well as the service is provided by female HEWs, which makes their relation easy.

Communities' knowledge and attitude towards urban health extension program is significantly associated with satisfaction of the community on the services provided by urban health extension program.

This study also shows that, perceived technical competency, perceived interpersonal relationship and perceived accessibility of the service were independent predictors of satisfaction of the community ($P<0.05$). Other studies conducted in rural health extension and PHC services showed that perceived way of communication, perceived respect, perceived technical skill and competency of health extension workers were predictors of satisfaction (32, 34, 35, 41, 45). Even though it is difficult to compare the perception of urban respondents with that of rural residents and with that of PHC services, but there are some factors which are common to both settings like perceived way of communication and perceived technical competency of health care providers.

Strength of the study

- Both qualitative and qualitative methods of data collection was used
- Reliability of the instrument was checked

Limitation of the study

- Social desirability bias by the respondents, they give positive responses about urban health extension professionals.
- Since the design of the study is cross-sectional, it does not permit for distinction between cause and effect relationships in the associations.
- Lack of adequate literatures to support this finding

CHAPTER SEVEN

CONCLUSION & RECOMMENDATION

7.1 CONCLUSION

Both the quantitative and qualitative components of the present study have clearly shown that majority of the respondents were satisfied with the services provided by urban health extension program. The study also shows that marital status of respondents is the socio-demographic predictor of community satisfaction.

Majority of the respondents prefer females to deliver service of urban health extension program because of their closeness with mothers to discuss their personal issues.

Respondents have favourable attitude and good knowledge towards urban health extension program and they were also associated with satisfaction of the community.

Community perception on technical competency and interpersonal relationship with urban health extension professionals as well as on the accessibility of service were identified as independent predictors of community satisfaction; implying that increased communities' perception on health extension workers relationship has a positive effect on community satisfaction.

7.2 RECOMMENDATION

Based on the results of the study the following recommendations forwarded

Health Extension workers:-

- ✓ Improve their interpersonal relationship and their way of communication with the community through frequent and ongoing interaction as a means to enhance community satisfaction with urban health extension program.

Town health officials:-

- ✓ Hossana town health officials should give additional trainings to urban health extension professionals to improve their knowledge and interaction/relation with the community.
- ✓ The town health officials should prepare different social mobilization activities to improve knowledge and attitude of the community towards urban health extension program, which enhances utilization of the service.

Researchers:-

- ✓ Further research should be done with wider scope in other settings of urban health extension program implementation like school and youth centers to assess satisfaction as well as to contribute to the effectiveness of the program.

REFERENCES

1. Center for National Health Development in Ethiopia, Columbia University. Ethiopia's Health Extension Program Evaluation Study 2007-2010; Health post and HEWs performance Survey. Volume-II..Addis Ababa, Ethiopia. 2011.

2. FMoH. HEP draft implementation guideline. Addis Abeba, Ethiopia. 2005.

3. FMOH. Health Extension Program in Ethiopia: Profile. Health Extension and Education Center. Addis Ababa, Ministry of Health, Ethiopia. 2007.

4. The Last ten Kilometers Project. Rapid Appraisal of Health Extension Program: Ethiopia Country Report; Addis Ababa, Ethiopia: Miz-Hasab Research Center; 2008.

5. Habtamu Argaw. The Health Extension Program of Ethiopia; Summary of Concepts, Progress, Axhievement and challenges. 2007.

6. Nejmudin Kedir Bilal, Christopher H. Herbst, Feng Zhao, Agnes Soucat, and Christophe Lemiere. Health Extension Workers in Ethiopia: Improved Access and Coverage for the Rural Poor. 2009.

7. Nejmudin Bilal. Health Extension Program: An Innovative Solution to Public Health Challenges of Ethiopia; A Case Study. 2012.

8. USAID/Ethiopia. End of project evaluation for the urban health extension program. Addis Abeba; 2012.

9. FMOH. Curriculum and facilitator's guide for urban health extension workers training. Addis Abeba, Ethiopia; 2009.

10. FMoH. Health Sector Development Programme (HSDP- IV), 2010/11 – 2014/15. 2010.

11. FMOH. Urban health extension program implementation manual. Addis Abeba; 2009.

12. FMoH. Health Sector Strategic Plan (HSDP-III) 2005/6-2009/10, Planning and Programming Departmen. Addis Abeba, Ethiopia; 2005.

13. CSA [Ethiopia] and ICF International. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International. 2012.

14. WHO. World Health report 2008: Primary Health care now more than ever. Geneva, Switzerland; 2008.

15. Mark R. Montgomery. Urban Poverty and Health in Developing Countries. Population Bulletin; 2009.

16. WHO. Why urban health matters: World health day 2010. 2010.

17. Teweldbrhan Hailu. Household Health Extension Package: Challenges and Implementation Issues; a Lesson from Field Practice. Mekelle, Ethiopia; 2005.

18. How Effective Is Community-Based Primary Health Care in Improving the Health of Children? Summary findings report to the Expert Review panel. 2009.

19. Binod Kumar Patro, Rakesh Kumar, Anil Goswami, Baridalyne Nongkynrih, Chandrakant S Pandav. Community Perception and Client Satisfaction about the Primary Health Care Services in an Urban Resettlement Colony of New Delhi. Indian J Community Med.; 2008.

20. WHO. Community participation in local health and sustainable development, Approaches and techniques, European sustainable development and health series 4. 2004.

21. FMoH. HEP draft implementation guideline. Addis Abeba, Ethiopia. 2005.

22. Hailom Banteyerga. Ethiopia's Health Extension Program: Improving Health through Community Involvement. MEDICC Review; 2011.

23. FMoH/HEEC. Report on the Assessment of Factors Contributing to and Affecting Performance of Health Extension Workers in Selected Woredas of Amhara National Regional State and Southern Nation, Nationalities and People's Region. Addis Ababa, Ethiopia; 2008.

24. Kilpatrick S. Multi-level rural community engagement in health. Australian Journal of Rural Health. 2009;17(1):39–44.

25. Center for National Health Development Ethiopia (CNHD-E). Working Conditions of the First Batch of Health Extension Workers. Addis Abeba; 2006.

26. Ambachew Teferi. Functioning Of Health Extension Program with Particular Focus on Client - Provider Interaction in Ghimbo Woreda of Kaffa Zone, SNNPR. 2011.

27. Alison Hernandez, Anna-Karin Hurtig, Kjerstin Dahlblom, and Miguel San Sebastian. Translating Community Connectedness to Practice: A Qualitative Study of Mid level Health Workers in Rural Guatemala. International Scholarly Research Network; 2012.

28. Sadika Bu-Alayyan, Abdelrahman Mostafa, Bader Al-Etaibi, Eman Sorkhou, Homood Al-Taher, Adnan Al-Weqayyan. Patient Satisfaction with Primary Health Care Services in Kuwait. Kuwait Medical Journal; 2008.

29. Shams et al. Patients' Satisfaction With Health Services Provided By Mobile Clinics In Rural Areas, Assiut Governorate . El-Minia Med. Bull; 2010.

30. Center for National Health Development in Ethiopia (CNHDE). Ethiopia Health Extension Program; Evaluation Study, 2005-2007; Household Health Survey; Amhara, Oromia and SNNP Regions. 2008.

31. Bezabih S. Assessment of factors that affect implementation of HEP in Wolayita zone, SNNPR. 2007.

32. Gadallah M, Zaki B, Rady M, Anwer W, Sallam I. Patient satisfaction with primary health care services in two districts of lower and upper Egypt. East Mediterr Health J; 2003.

33. Amare Yared. Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study. Addis Ababa, Ethiopia: The Last Ten Kilometers Project, JSI Research & Training Institute Inc; 2009.

34. Lee Y. & J.D.Kasper. Assessment of medical care in elderly people; General satisfaction and Health care provider quality. Health service research; 1998.

35. Zhijian Li, Jiale Hou, Lin Lu, Shenglan Tang, Jin Ma. On residents' satisfaction with community health services after health care system reform in Shanghai, China. BMC journal of Public Health. 2012.

36. Samuel korma. Assessment of the extent of implementation and affecting factors of environmental health extension packages at house hold level in Damboya Woreda, Kembata Zone, SNNPR. 2011.

37. Tigray Health Bureau 1999 EFY Profile. 2007.

38. FMoH. Health Extension Workers and Health Post Performance and Community Satisfaction and Perception Evaluation in Rural Ethiopia. Addis Ababa.; 2010.

39. Hossana city administration health office, town health office semiannual health service report of 2005 EFY. Hossana; 2013.

40. Tewodros Mekonnen. An Investigation into The Challenges of implementation of the Health Extension Program in Berek Wereda Of Oromiya Region. Addis Abeba; 2011.

41. Zewude B., Ameyu G., Yohannes K. and Mulusewu G. Mothers' experiences and satisfaction with health extension program in Jimma zone, Ethiopia. 2011.

42. A Wilson, G Hewitt, R Matthews, et al. Development and testing of a questionnaire to measure patient satisfaction with intermediate care. Qual Saf Health Care. 2006;15:314–9.

43. Health care Commission in North West London Hospitals. Outpatient survey report; 2004/2005.

44. Donabedian A. The quality of care. How can it be assessed? Journal of American Med Assoc; 1988; 260: 1743-1748.

45. Hall J. and Dornan, M. Patient Socio-demographic Characteristics as Predictors of Satisfaction with Medical Care: A Meta-Analysis. Social Science and Medicine; 1990; 30 (7):811-818.

46. Haile Negusse, Eilish McAuliffe, and Malcolm MacLachlan. Initial community perspectives on the Health Service Extension Programme in Welkait, Ethiopia. Human Resources for Health 2007, 5:21.

47. Grant N. Marshal and Ron D. Hays. Patient satisfaction questionnaire short form (PSQ-18).

ANNEX

QUESTIONNAIRE

JIMMA UNIVERSITY COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES
DEPARTMENT OF HEALTH EDUCATION AND BEHAVIOURAL SCIENCES

Questionnaire designed to assess community's satisfaction on urban health extension program in Hossana town, South Ethiopia 2013

Identification of the respondents

kebele_____ House number _____
Respondent ID_____

Consent Form for study participants

Greetings:
Hello, how are you?
My name is _____. I am working in the research team of postgraduate thesis of Jimma University. I would like to interview you a few questions about your experience and opinion of urban health extension program.
The objective of this study is to assess community satisfaction in Hossana town towards urban health extension program, which is important to improve services provided by urban health extension program so as to improve the health of urban residents. Your cooperation and willingness for the interview is helpful in identifying problems related to the program. Your name will not be written in this form. All information that you give will be kept strictly confidential. Your participation is voluntary and you are not obliged to answer any question which you do not wish to answer. You may refuse to answer any question and choose to stop the interview at any time. The information you provide us is extremely important and valuable, as it will help the Government and the health professionals involved in health extension package service provision to improve services delivery.

Do I have your permission to continue?
1- Yes 2 - No

If the answer is yes, thanks! Conduct the interview.
If the answer is no, Thanks! Proceed to the next eligible
Date of interview _____ Time started_____ Time finished_____
Supervisors name _____signature _____

I. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS				
S.No	**Questions**	**Response**		**Remark**
001	Age	.....years		
002	Sex	1. Male	2. Female	
003	Education status	1 Illiterate 2 Grade 1 – 8 3 Grade 9–12 4 College and above		
004	Occupation	1. Farmer 2. Governmental employee 3. Daily laborer 4. Merchant 5. House wife 6. Other(specify-------)		
005	Marital	1. Single 2. Married 3. Divorced 4. Widowed		
006	Religion	1. Orthodox 2. Protestant 3. Muslim 4. Catholic 5. Other(specify-------)		
007	Ethnicity	1. Hadiya 2. Kembata 3. Amhara 4. Gurage 5. Others(specify------)		
008	Average monthly family income(Birr)	------		

II. Knowledge about UHEP

S.No	Questions	Response	Remark
101	Do you know about urban health extension program?	1. Yes 2. No	
102	Do you know the urban health extension Professional of your Kebele?	1. Yes 2. No	
103	Do you know the services provided by UHEP?	1. Yes 2. No	
104	The services of UHEP focus only on mothers and children.	1. Yes 2. No	
105	UHEP provides health education and advice about important health problems for urban population.	1. Yes 2. No	
106	UHEP is aimed at providing curative health services for urban population	1. Yes 2. No	
107	UHEP focused on providing disease prevention activities	1. Yes 2. No	
108	During the last 12 months, did UHE-Ps visit your home?	1. Yes 2. No	
109	If yes, on what areas did you receive advice or health education from UHE-Ps?		

a) About nutrition	1. Yes	2. No
b) About family planning	1. Yes	2. No
c) About antenatal care	1. Yes	2. No
d) About immunization	1. Yes	2. No
e) About delivery	1. Yes	2. No
f) About breast feeding	1. Yes	2. No
g) About latrine use	1. Yes	2. No
h) About personal hygiene	1. Yes	2. No

	i) About environmental sanitation	1. Yes	2. No
	j) About HIV/AIDs prevention and control	1. Yes	2. No
	k) About TB and Leprosy prevention and control	1. Yes	2. No
	l) About Malaria prevention and control	1. Yes	2. No
	m) About non-communicable disease prevention & control	1. Yes	2. No
	n) About mental health	1. Yes	2. No
	o) About accident prevention	1. Yes	2. No
	p) Other (specify)_____		
110	What is your family status with regard to health extension achievements:	1. Model family 2. Not model family	
111	During the last 12 months, did you participate in planning and implementation activities of UHEP?	1. Yes 2. No	
112	How do you rate your relationship with health extension workers?	1. Excellent 2. Very good 3. Good 4. Poor 5. Very poor	
113	Do you think that females are competent to deliver services?	1. Yes 2. No	

III. Attitude of the community on UHEP

S.No	Statements	Strongly disagree	disagree	Undecided	agree	Strongly agree
201	UHEP can bring health improvement in the community	1	2	3	4	5
202	The services provided by UHEP can addresses the needs of the community	1	2	3	4	5
203	The services provided by UHEP are appropriate to deal with urban health problems	1	2	3	4	5
204	UHEP increases health awareness among community members	1	2	3	4	5

IV. Communities perception on UHEP

S.No	Statements	Strongly disagree	disagree	Undecided	agree	Strongly agree
	HEPs technical competency					
301	UHE-Ps are competent to deliver services	1	2	3	4	5
302	The service provided by UHE-Ps is good	1	2	3	4	5
303	I have some doubt about the ability of UHE-Ps who has been assigned in our kebele.	1	2	3	4	5
304	UHE-Ps are very knowledgeable on the service they deliver	1	2	3	4	5
305	UHE-Ps lack experience with the services they deliver	1	2	3	4	5
306	UHE-Ps are very well trained on the services they give	1	2	3	4	5
307	UHE-Ps lacks necessary skills to identify community problems	1	2	3	4	5
308	I am not comfortable with the service I have received from UHE-Ps	1	2	3	4	5
309	Females are more competent than males and they should continue their job	1	2	3	4	5
310	Health extension workers can correctly give injection for immunization	1	2	3	4	5
	Interpersonal manner					
401	UHE-Ps act too impersonal towards me when they treat me	1	2	3	4	5
402	The UHE-Ps treats me in a very friendly and courteous manner	1	2	3	4	5
403	UHE-Ps who treated me should give me more respect	1	2	3	4	5
404	UHE-Ps have a genuine interest in me as a person when they treat me	1	2	3	4	5
405	UHE-Ps always do their best to keep me from worrying	1	2	3	4	5

	Time spent with HEWs					
501	UHE-Ps can give advice/service in a hurry way during home visit	1	2	3	4	5
502	UHE-Ps usually spend plenty of time with me	1	2	3	4	5
	Communication					
601	UHE-Ps have the ability to convince the community about importance of UHEP	1	2	3	4	5
602	UHE-Ps sometimes ignore what I tell them	1	2	3	4	5
603	UHE-Ps can effectively communicate in health education session	1	2	3	4	5
604	During my contact with UHE-Ps, I can freely talk about private matters	1	2	3	4	5
605	UHE-Ps listen carefully to what I say	1	2	3	4	5
606	UHE-Ps have good relationship with the community	1	2	3	4	5
607	My relationship with UHE-Ps are very helpful for my health	1	2	3	4	5
	Items for accessibility and convenience					
701	I can easily find UHE-Ps when I need them	1	2	3	4	5
702	I can get service from UHE-Ps whenever I need it	1	2	3	4	5
703	The time that I can get service of HEP are convenient(good) for me	1	2	3	4	5
704	The office of UHE-Ps is conveniently located	1	2	3	4	5
705	When I go to UHE-Ps office, I don't get them in their office	1	2	3	4	5

V. Overall satisfaction of the community

	Overall satisfaction of the community					
801	I am totally satisfied with the services provided by UHEP	1	2	3	4	5
802	I am not totally satisfied with the services provided by UHEP	1	2	3	4	5
803	I am totally satisfied with UHE-Ps technical skills	1	2	3	4	5
804	I can visit again UHE-Ps	1	2	3	4	5
805	I will advise my friends or relatives to visit UHEPs	1	2	3	4	5

INDEPTH INTERVIEW GUIDE

1. What do you know about urban health extension programme?
2. How do you describe the importance of UHEP?
3. How do you describe the service provided by HEWs? (probe: which service people need but not provided by HEWs? Why?)
4. What is your recommendation on HEWs being female?
5. How do you describe the competency of HEWs? Why?
6. How do you describe the relationship of HEWs with the community?
7. What do you think is the importance of this relationship?
8. Do you participate in implementation of HEP at Kebele level?
9. How do you describe your satisfaction with the service provided by HEWs?
10. What are the major factors that you think contribute to the dissatisfaction of clients?
11. What is your suggestion to improve the services delivered by urban health extension program?
12. Any additional ideas_____

AMHARIC VERSION QUESTIONNAIRE

በጅማ ዩኒቨርሲቲ የህብረተሰብ እና የህክምና ሳይንስ ትምህርት ኮሌጅ፤ የጤና አጠባበቅና ስነ ባህሪይ ትምህርት ክፍል

በደቡብ ክልል በሆሳዕና ከተማ ህብረተሰቡ በከተማ ጤና ኤክስቴንሽን ፕሮገራም ላይ ያላቸውን እርካታ ለማወቅ የተዘጋጀ የመጠየቅያ ፎርም፡፡

ቀበሌ _____ የቤት ቁጥር _____

የመጠየቅያ መለያ ቁጥር _____

ከመጠይቁ በፊት የተዘጋጀ የፍቃድ መጠየቅያ ፎርም

ሰላምታ

ስሜ _____ ይባላል፡፡ እኔ ምሰራዉ በጅማ ዩኒቨርሲቲ የድህረ ምረቃ የጥናት ጽሁፍ ቡድን አባል ሆኜ ነው፡፡ በከተማ ጤና እክስቴንሽን ፕሮገራም ዙሪያ የተወሰኑ ጥያቄዎች ለመጠየቅ ነዉ፡፡

የዚህ ጥናት ዓላማ ጎብረተሰቡ በጤና ኤክስቴንሽን ፕሮገራም ላይ ያላቸዉን እርካታ ለማወቅ ነዉ፡፡ ይህ ጥናት የጤና ኤክስቴንሽን ፕሮገራም አገልግሎትን ለማሻሻል የሚሰጠው መረጃ ከፍተኛ ነው ፡፡ ስለዚህ በጤና ኤክስቴንሽን ፕሮገራም ዙሪያ እና በጤና ኤክስቴንሽን ባለሙያዋ ላይ ያሎትን አመለካከት ለማወቅ የእርሶ ትብብር አስተዋፅአዉ ከፍተኛ ነው፡፡ በመጠይቁ ላይ የእርስዎ ስም ወይም ማንነትዎን የሚገልፅ ማንኛውም ነገር አይጠቀስም እንዲሁም እርስዎ የሚሰጡኝን መረጃዎች ሚስጥራዊነት ለመጠበቅ ያመች ዘንድ መጠይቁ እኔና እርስዎ ባለንበት ቦታ ብቻ ይከናወናል፡፡ መጠይቁ የሚከናወነው በእርሶ ፍቃደኝነት ብቻ ሲሆን በመጠይቁ ወቅት መመለስ የማይፈልጉትን ማንኛውም አይነት ጥያቄ ማለፍ ይችላሉ ፡፡ በተጫማሪም በማንኛውም ሰአት ማቋረጥ ይችላሉ፡፡ ሆኖም እርስዎ የሚሰጡት ትክክለኛ መረጃዎች ለከተማ ጤና ኤክስቴንሽን ፕሮገራም አገልግሎት መስተካከል እና መሻሻል ስለሚረዳን ከፍተኛ ጥቅም አለው፡፡

በመጥይቁ ላይ ለመሳተፍ ፍቃደኛ ነዎትን?

መልሱ አዎ ከሆነ አመስግነህ/ሽ ወደሚቀጥለው ገፅ እለፍ/ፊ

አልፈልግም ከሆነ አመስግነህ/ሽ የሚቀጥለውን ተጠያቂ መጠበቅ

መጠይቁ የተደረገበት ቀን _____መጠይቁ የተጀመረበት ሰዓት _____ መጠይቁ የተጠናቀቀበት ሰዓት _____

የሱፐርቫይዘር ስም _____ ፊርማ _____

አጠቃላይ መረጃ			
ተ. ቁ	**ጥያቄ**	**ምላሽ**	**ምርመራ**
001	ዕድሜ	..... በዓመት	
002	ፆታ	1. ወንድ	
		2. ሴት	
003	የትምህርት ሁኔታ	1. ያልተማረ	
		2. ከ1-8 ክፍል	
		3. ከ9-12 ክፍል	
		4. ኮሌጅ እና ከዚያ በላይ	
004	የስራ ሁኔታ	1. አርሶአደር	
		2. የመንግስት ሰራተኛ	
		3. የቀን ሰራተኛ	
		4. ነጋዴ	
		5. የቤት እመቤት	
		6. ሌላ ከሆነ ይገለጽ	
005	የጋብቻ ሁኔታ	1. ያላገባ/ች	
		2. ያገባ/ች	
		3. የፈታ/ች	
		4. የሞተበት/ባት	
006	ሃይማኖት	1. ኦርቶዶክስ	
		2. ፕሮቴስታንት	
		3. ሙስሊም	
		4. ካቶሊክ	
		5. ሌላ ከሆነ ይጠቀስ	
007	ብሔር	1. ሃዲያ	
		2. ከምባታ	
		3. አማራ	
		4. ጉራጌ	
		5. ሌላ ከሆነ ይጠቀስ	
008	አማካይ ወርሃዊ ገቢ መጠን በብር	-------	

II. ግንዛቤን በተመለከተ

ሕብረተሰቡ በጤና ኤክስቴንሽን ፕሮገራም ዙሪያ ያለዉን ግንዛቤ ለማወቅ የተዘጋጀ መጠይቅ			
ተ.ቁ	**መጠይቅ**	**መልስ**	**አስተያየት**
101	ስለ ከተማ ጤና ኤክስቴንሽን ፕሮግራም ያዉቃሉ?	1. አዎ 2. አላዉቅም	
102	የቀበሌያችሁን የጤና ኤክስቴንሽን ባለሙያ ያዉቋታል?	1. አዎ 2. አላዉቅም	
103	በከተማ ጤና ኤክስቴንሽን ፕሮግራም የሚሰጡ አገልግሎቶችን ያዉቃሉ?	1. አዎ 2. አይደለም	
104	የከተማ ጤና ኤክስቴንሽን ፕሮግራም የእናቶችና ህፃናትን ብቻ ጤንነት ለመጠበቅ ይጠቅማል?	ነ. አዎ 2. አይደለም	
105	የከተማ ጤና ኤክስቴንሽን ፕሮግራም ከጤና ኤክስቴንሽን ባለሙያዎች የጤና ትምህርት ለማግኘት ይጠቅማል	1. አዎ 2. አይደለም	
106	የከተማ ጤና ኤክስቴንሽን ፕሮግራም አላማዉ የህክምና አገልግሎት መስጠት ነዉ?	ነ. አዎ 2. አይደለም	
107	የከተማ ጤና ኤክስቴንሽን ፕሮግራም በሽታን መከላከል ላይ ያተኮረ ነዉ	ነ. አዎ 2. አይደለም	
108	ባለፉት አስራ ሁለት ወራት ዉስጥ የጤና ኤክስቴንሽን ባለሙያዋ ወደ ቤትዎ መጥታ ታዉቃለች?	1. አዎ 2. አታዉቅም	
109	መልስዎ አዎን ከሆነ በምን በምን ዙሪያ ከጤና ኤክስቴንሽን ባለሙያዋ አገልግሎት አገኙ?		
	1. ስለ ስነ-ምግብ	አዎ	አይደለም
	2. ስለ ቤተሰብ ምጣኔ አገልግሎት	አዎ	አይደለም
	3. ስለ ቅድመ - ወሊድ አገልግሎት	አዎ	አይደለም
	4. ስለ ክትባት አገልግሎት	አዎ	አይደለም
	5. ስለ ወሊድ አገልግሎት	አዎ	አይደለም
	6. ጡት ማጥባትን በተመለከተ	አዎ	አይደለም
	7. ስለ መፀዳጃ ቤት አጠቃቀም	አዎ	አይደለም
	8. ስለ ግል-ንፅህና አጠባበቅ	አዎ	አይደለም
	9. ስለ አካባቢ ንፅህና አጠባበቅ	አዎ	አይደለም
	10. ኤች አይ ቪ/ኤድስ መከላከልና መቆጠጠርን በተመለከተ	አዎ	አይደለም
	11. ስለ ሳንባ ነቀርሳ እና የስጋ ደዌ በሽታ መከላከልና መቆጠጠር	አዎ	አይደለም
	12. ስለ ወባ በሽታ መከላከልና መቆጠጠር	አዎ	አይደለም
	13. ተላላፊ ያልሆኑ በሽታዎች መከላከልና መቆጠጠር	አዎ	አይደለም
	14. ስለ ስነ አዕምሮ ጤና አጠባበቅ	አዎ	አይደለም
	15. የጉዳትና የግጭት መከላከልና የመጀመሪያ እርዳታን በተመለከተ	አዎ	አይደለም
	16. ሌሎች ይጠቀሱ		
110	ከጤና ኤክስቴንሽን ስራ ጋር በተያያዘ በየትኛዉ ይመደባሉ?	1. ሞዴል ቤተሰብ 2. ሞዴል ቤተሰብ አይደለንም	

111	ባለፉት አስራ ሁለት ወራት ዉስጥ የጤና ኤክስቴንሽን ባለሙያዋ በምታዘጋጃቸዉ በጤና ነክ ጉዳዮች ላይ ተሳትፈዉ ያዉቃሉ?	1. አዎ 2. አላዉቅም	
112	ከጤና ኤክስቴንሽን ባለሙያዋ ጋር ያሎት ግንኙነት ምን ይመስላል?	1. እጅግ በጣም ጥሩ 2. በጣም ጥሩ 3. ጥሩ ነዉ 4. ጥሩ አይደለም 5. እጅግ በጣም ጥሩ አይደለም	
113	ሴቶች የከተማ ጤና ኤክስቴንሽን ለመስጠት ብቁ ናቸዉ ይላሉ?	1. አዎን 2. የለም	

III. አመለካከትን በተመለከተ

ሕብረተሰቡ በጤና ኤክስቴንሽን ፕሮግራም ዙሪያ ያላቸዉን አመለካከት ለማወቅ የተዘጋጀ መጠይቅ						
ተ.ቁ	ዝርዝር	በጣም አልስማማሁም	አልስማማሁ	አስተያት የለኝም	እስማማለሁ	በጣም እስማማለሁ
201	የከተማ ጤና ኤክስቴንሽን ፕሮግራም የሕብረተሰቡን ጤና ለማሻሻል ይረዳል	1	2	3	4	5
202	በከተማ ጤና ኤክስቴንሽን ፕሮግራም የሚሰጡ የጤና አገልግሎቶች የህብተሰቡን የጤና ችግሮች ይቀርፋሉ	1	2	3	4	5
203	በከተማ ጤና ኤክስቴንሽን ፕሮግራም የሚሰጡ የጤና አገልግሎቶች የከተማ ጤና ችግሮች በትክክል ይዳስሳሉ	1	2	3	4	5
204	የከተማ ጤና ኤክስቴንሽን ፕሮግራም የህዝቡን የጤና ግንዛቤ ለማሳደግ ይጠቅማል	1	2	3	4	5

IV. **የሕብረተሰቡን እይታ በተመለከተ**

ሕብረተሰቡ በጤና ኤክስቴንሽን ፕሮገራም ዙሪያ ያላቸዉን አርካታ ለማወቅ የተዘጋጀ መጠይቅ						
ተ.ቁ	**ዝርዝር**	በጣም አልስማማም	አልስማማ	አስተያየት የለኝም	እስማማለሁ	በጣም እስማማለሁ
የጤና ኤክስቴንሽን ባለሙዎች ቴክኒካል ብቃት እሳቤ						
301	የከተማ ጤና ኤክስቴንሽን ባለሙያዎች አገልግሎት ለመስጠት ብቁ ናቸዉ	1	2	3	4	5
302	በከተማ ጤና ኤክስቴንሽን ባለሙያዎች የሚሰጡ አገልግሎቶች ጥሩ ናቸዉ	1	2	3	4	5
303	በአካባቢያችን የሚሰሩ የጤና ባለሙያዎች ስላላቸዉ ዕዉቀት ጥርጣሬ አለኝ	1	2	3	4	5
304	የከተማ ጤና ኤክስቴንሽን ባለሙያዎች ስለሚሰጡት አገልግሎት በቂ እዉቀት አላቸዉ	1	2	3	4	5
305	የከተማ ጤና ኤክስቴንሽን ባለሙያዎች በሚሰጡት አገልግሎት ዙሪያ በቂ ልምድ አላቸዉ	1	2	3	4	5
306	የከተማ ጤና ኤክስቴንሽን ባለሙያዎች በሚሰጡት አገልግሎት ዙሪያ በቂ ስልጠና ወስደዋል	1	2	3	4	5
307	የከተማ ጤና ኤክስቴንሽን ባለሙያዎች የህብረተሰቡን የጤና ችግሮች ለመለየት ብቃት ያንሳቸዋል	1	2	3	4	5
308	የከተማ ጤና ኤክስቴንሽን ባለሙያዎች የሚሰጡት አገልግሎት ብዙም አይመቸኝም	1	2	3	4	5
309	ሴቶች ከወንዶች የተሸሉ ስለሆኑ አገልግሎቱን እነሱ ብቻ ሊሰጡ ይገባል	1	2	3	4	5
310	የጤና ኤክስቴንሽን ባለሙያዎች ክትባት በትክክል መስጠት ይችላሉ	1	2	3	4	5
ከጤና ኤክስቴንሽን ባለሙያዎች ጋር ያላቸዉን ግንኙነት በተመለከተ						
401	የጤና ኤክስቴንሽን ባለሙያዎች ለተገልጋዮች ጥሩ አክብሮት የላቸዉም	1	2	3	4	5
402	የጤና ኤክስቴንሽን ባለሙያዋ በጥሩ ሁኔታ ትንከባከበኛለች	1	2	3	4	5
403	የጤና ኤክስቴንሽን ባለሙያዎች አገልግሎት ሲሰጡን አሁን ካለዉ የበለጠ ሊያከብሩን ይገባል	1	2	3	4	5
404	የጤና ኤክስቴንሽን ባለሙዎች ምክር ሲሰጡን እንደራሳቸዉ ችግር አይተዉ ይረዱናል	1	2	3	4	5
405	የጤና ኤክስቴንሽን ባለሙያዎች የሚቻላቸዉን ሁሉ ያደርጉልናል	1	2	3	4	5

ከጤና ኤክስቴንሽን ባለሙያዎች ጋር የሚቆዩበት ሰዓት						
501	የጤና ኤክስቴንሽን ባለሙያዋ አንድ አንድ ጊዜ ምክር ስትሰጠኝ በጣም ትቸኩላለች	1	2	3	4	5
502	ከጤና ኤክስቴንሽን ባለሙያዋ በቂ ጊዜ ሰጥታኝ ታወራኛለች	1	2	3	4	5
ተግባቢነት						
601	የጤና ኤክስቴንሽን ባለሙያዎች በጤና ኤክስቴንሽን ፕሮግራም ዙሪያ ህብረተሰቡን የማሳመን ብቃት አላቸዉ	1	2	3	4	5
602	የጤና ኤክስቴንሽን ባለሙያዎች አንዳንድ ጊዜ የምንነግራቸዉን ነገር ችላ ይላሉ	1	2	3	4	5
603	በጤና ትምህርት መስጫ ጊዜ የጤና ኤክስቴንሽን ባለሙያዎች ከህብረተሰቡ ጋር በደንብ ይግባባሉ	1	2	3	4	5
604	ከጤና ኤክስቴንሽን ባለሙያዎች ጋር በምገናኝበት ወቅት የግል ጉዳዮቼን በነፃነት ማዉራት እችላለሁ	1	2	3	4	5
605	የጤና ኤክስቴንሽን ባለሙያዎች የምነግራቸዉን በትክክል ይሰማሉ	1	2	3	4	5
606	የጤና ኤክስቴንሽን ባለሙያዎች ከህብረተሰቡ ጋር ጥሩ ግንኙነት አላቸዉ	1	2	3	4	5
607	ከጤና ኤክስቴንሽን ባለሙያዎች ጋር ያለኝ ግኑኝነት ጤንነቴን ለመጠበቅ በጣም ይጠቅመኛል	1	2	3	4	5
ምቹ እና አገልግሎቱን በቅርበት የማግኘት እሳቤ						
701	የጤና ኤክስቴንሽን ባለሙያዎችን በምፈልግበት ሰዓት አገኛቸዋለሁ	1	2	3	4	5
702	ከጤና ኤክስቴንሽን ባለሙያዎች አገልግሎት ማግኘት በፈለግኩበት ሰዓት አገኛለሁ	1	2	3	4	5
703	የጤና ኤክስቴንሽን አገልግሎት የማገኝበት ሰዓት በጣም ምቹ ነዉ	1	2	3	4	5
704	የጤና ኤክስቴንሽን አገልግሎት የማገኝበት ቦታ በቅርበት ይገኛል	1	2	3	4	5
705	ወደ ጤና ኤክስቴንሽን ባለሙያዎች ቢሮ በምሄድበት ሰዓት በቢሮ አላገኛቸዉም	1	2	3	4	5

V. **እርካታ**

ሕብረተሰቡ በጤና ኤክስቴንሽን ፕሮግራም ላይ ያላቸዉ እርካታ						
801	በጤና ኤክስቴንሽን ፕሮግራም በሚሰጡ አገልግሎቶች ሁሉ እረክቻለሁ	1	2	3	4	5
802	በጤና ኤክስቴንሽን ፕሮግራም በሚሰጡ አገልግሎቶች አልረካሁም	1	2	3	4	5
803	በጤና ኤክስቴንሽን ባለሙያዎች ብቃት እረክቻለሁ	1	2	3	4	5
804	ወደ ጤና ኤክስቴንሽን ባለሙዎች በድጋሚ እሄዳለሁ	1	2	3	4	5
805	ጓደኛዩን፤ዘመድ ወይም ቤተሰብ በጤና ኤክስቴንሽን ፕሮግራም የሚሰጡ አገልግሎቶችን እንዲጠቀሙ እመክራቸዋለሁ	1	2	3	4	5

የዉይይት ጥቄዎች

1. ስለ ጤና አክስቴንሽን ፕሮግራም ምን ያዉቃሉ?
2. የጤና ኤክስቴንሽን ፕሮግራም ጠቀሜታን እንዴት ይገልፁታል?
3. በጤና ኤክስቴንሽን ፕሮግራም የሚሰጡ ፕሮግራሞችን ጠቀሜታን እንዴት ይገልጻሉ?
4. የጤና ኤክስቴንሽን ባለሙያዋ ሴት መሆንዋን እንዴት ይመለከቱታል?
5. የጤና ኤክስቴንሽን ባለሙያዋን ብቃት እንዴት ይመለከቱታል?
6. የጤና ኤክስቴንሽን ባለሙያዋ ጋር ያለዎትን ግንኙነት እንዴት ይገልፁታል?
7. የጤና ኤክስቴንሽን ባለሙያዋ ጋር ያለዎት ግንኙነት እንዴት ያዩታል?
8. በጤና ኤክስቴንሽን ፕሮገራም ትግበራ ላይ ተሳትፈዉ ያዉቃሉ?
9. በጤና ኤክስቴንሽን ፕሮግራም ላይ ያሎት እርካታ ምን ይመስላል?
10. ህብረተሰቡ በጤና ኤክስቴንሽን ላይ እርካታ እንዳይኖረዉ ያደረገዉ ምኑድነዉ ብለዉ ያስባሉ?
11. የጤና ኤክስቴንሽን ፕሮግራምን ለማሻሻል የእርስዎ አስተያየት ምንድነዉ?

    ተጨማሪ ሃሳብ ካለዎት

HADIYISA VERSION QUESTIONNAIRE

Jimm universtei minadaphphi fayya'omm sayins losa'n kollagr fayya'ooma egerimmi haalaxx losa'n baxxancha

Hadiyyi Zonane hossa'n minadaphph fayya'om programanne yoo qoodo'o la'mmina guduk xa'mmich forma

Qabale'e _____ mi'n xigo _____

Xa'mmicha annannisoo xigo_____

Xammich illage gudukki eyyenxxxa'mmich forma xummato

Isummi_____yamamookko. Ani baxommoki jimmy unerste'I mastert digree'I sarayyakam kitaaph mateyyo'mmi tuutich hanatette . beero'I fayya'oommi hegeegonne xa'mmicha hincaaimi'ate. Ka saryyi horoor woshi minadab fayyaomanne yoo lirancha laimminate. Ku sarayy minadaph fayyomina hasano shooto'I isaako awwaado uwwodlia caakkisohane. Ebkkina fayya'oomina hassiso dhaannee fayyomanne baxoo baxaan ogora laimmina ki'n harammat hasisooko xa'mmichanne ayyedae ikkako'isaa summa kurimm hasisooyyo. Xa'mmichchina dabachcha uwwimm xale'I ihookko.

Dabachcha uwwimm xanamokkok ki'n eyyitinet ihubikkina dabarimmina hasamoobee'I xa'mmichchi hee'ulas urimmi teim higimmi xanamookko.

Xa'mmicha dabarimmina eyyite issitakka'a?

Dabachchi eyya yoohane ihulas galaxoomo.

Awwona yoo idone higghe.

Hasomoyyo yitakamane ihulas awwonaa yoo xammamancho egerimma.

Xa'mmich hunchuk balli _____

Xa'mmich asheeramu soat _____

Xa'mmich beedukk soat _____

Alansaanch summi _____ furma'a _____

Lulei naqasha

xigo	Xa’mmicha	dabachcha	saaraya
001	umura		
002	Albachcha	1.goona 2.meentoo	
003	Losa’n duha’a	1.losubee’ane 2. 1-8 baxxancha 3. 9-12 baxxancha 4.12 baxxanchi hanaan	
004	Marcho baxoh?	1.abuulaancho 2.gassi baxxancho 3.balli baxxancho 4.dadaraancho 5.mi’n amma 6.mullek yoolas caakkisstee	
005	Idooxx duha’a	1.mine issubee’ane 2.mine issitobee’ane 3.meentichchoonse teim manchiinse ann-ann ikkoo’kotane 4.menticho teim manch lehaakkohane	
006	Amanaxx duha’a	1.ortodoksa 2.protestaanta 3.musiliima 4.kaatolika 5.mullan ihulasi naqasshe	
007	Giira	1.hadiyya 2.kambaata 3.amhara 4.guraage 5.mullan ihulasi naqasshe	
008	Mat aganan hinka’in siido		

Manadaph fayya'oom takki progra'm hegeegonne yoo qossimma la'mmina gudu xa'mmichcha			
xigo	**Xa'mmichcha**	**Dabachcha**	**sawwite**
101	Kta'm fayyoo'im takk program ki'n qabalenne awwaadukuya yoo'isa lqakkamo?	1.eyya 2.laomoyyo	
102	Ki'n qabalei fayya'oomina losisamota laqakamonehe?	1.eyya 2.laomoyyo	
103	Kta'm fayyoo'im takk program kata'm manina lobakat awadoko	1.eyya 2.laomoyyo	
104	Kta'm fayyoo'im takk program minadab fayaoma egeriman hasisoko	1.eyya 2.laomoyyo	
105	Kta'm fayyoo'im takk program faya'oma losisaninse fayaoma lossan sidimina denamoo	1.eyya 2.laomoyyo	
106	Kta'm fayyoo'im takk program hasisokoki minadab fayaoma hech losisimina awadoko	1.eyya 2.laomoyyo	
107	Kta'm fayyoo'im takk program minadab fayaoma bikina yoo qossimma la'imina awadoko	1.eyya 2.laomoyyo	
108	Highu tomonne lohe aga'n woronne fayyoo'm losisaancho ki'n mine wataha?	1.eyya 2.laomoyyo	
109	Dabach eyyaa yoohan ihulas mabikkina lossakko'o?		
1.hrbaxxibkkina		1. eyya	2. eisayyo
2.abaroosa qoodmbkina		1. eyya	2. eisayyo
3.qarmilage yoo awwadbkina		1. eyya	2. eisayyo
4.ktibaax awwdbkina		1. eyya	2. eisayyo
5.qarimm awwdbkina		1. eyya	2. eisayyo
6.shoo'm mi'n awwdbkina		1. eyya	2. eisayyo
7.gaqmccurooma egerimbkina		1. eyya	2. eisayyo
8.hegeeqmccurooma egerimabkina		1. eyya	2. eisayyo
9.ach ayv ads hoormina egermbkina		1. eyya	2. eisayyo
10.qodafa'l jaboo shishira egermbkina		1. eyyo	2. eiyayyo
11.kachis jaboo egermbkina		1. eyya	2. eiyayyo
12.matimatonne higobe'I jaboo egermbkina		1.eyya	2. eiyayyo
13.horoo'l woro ambadaxissoo jabbkina		1. eyya	2. eiyayyo
14.mulkeenom naqasssehe		1. eyya	2. eiyayyo
110	Beero'I fayyoo'm baxonne hokanone ikekemmo?	1.Denam aberossanne 2. la'ommoyo	
111	Mat hinchonne fayaoom bexannine wixittekea laqakamonhe?	1.eyya 2.laomoyyo	
112	Fayyoo'm taklosisaanchone yoo edanchi maha laboo?	1.horyyem danaamo 2. danaamo 3.eraneme 4.mham ihooyoo	
113	Fayyoo'm tak losisaancho meentichote ihimm uwwitam awwadonne hawo qoochooko yitka'a swwitakamo?	1.eyya 2.aocooyo	

Mindaph fayyoo'm tak program hegeegonne yoo sawwite la'mmina gudakoo xa'mmichcha						
xigo	Finto'o	Horem shinatam	shinatam oyyo	Uwwom sawwit	shinatam oomo	Herem shinatam oomo
201	Beero'I fayyoo'm ekisteenshin program minadaph fayyoom danoo'isaa hramookko	1	2	3	4	5
202	Programa uwwoo fayyoo'm awwaduuwi minadaph hawwo shollisookko	1	2	3	4	5
203	Programa uwwoo fayyoo'm awwaduuwi minadaph hawwo shollisookko	1	2	3	4	5
204	Ciiluwi dishulese extenshin betan bey mesommo	1	2	3	4	5

Minadaph fayyoo'm progra'm kululetanne yoo woda'n usheexato laimmina gudakoo xa'mmichcha						
Xigo	Finto'o	Horem shinatam	shinatam oyyo	Uwwom sawwit	shinatam oomo	Herem shinatam
Fayyoo'm taklosisaa'n lachch qooroommi qoossimma						
301	Beeroi fayyoo'm qaanqa losisaan danamisa awwaado uwwo keeno	1	2	3	4	5
302	beero'I fayyoo'm qaanqa losisaan uwwo awwaad erane	1	2	3	4	5
303	Ni hegeegonne yoo fayyoo'm heechch qanq losisaa'n amma'nn eena xanommyyo.	1	2	3	4	5
304	Beeroi fayyao'm qanqi losisaan uwwamoo awwax kululetanne danam lachch yookko	1	2	3	4	5
305	Beero'I fayyoo'm qanqa losisaan jor hawwo afisama lamooyyo.	1	2	3	4	5
306	Beero'I fayyoo'm qanqa losisaan uwwamo awwadonne danaam losan yooko.	1	2	3	4	5
307	Beer'I fayyoo'm ekisteenshin losisaan uwwamoo awwaado mishaam isso losano massamaakko	1	2	3	4	5
308	Beero'I fayyoo'm ekisteenshin losisaan fayyoo'm hawwo annaaissimina xanamooyyo	1	2	3	4	5
309	Beero'I fayyo'm losisaan uwwo awwaad lobakata makooyyo	1	2	3	4	5
310	Beero'I fayyoo'm ekisteenshin losisaan kitibat uwim xanamoko	1	2	3	4	5

401	Fayyo’m ekisteenshin losisaancho danamisa aboyyitamo	1	2	3	4	5
402	Fayyo’m ekisteenshin losisaancho danamisa aboyyitamo	1	2	3	4	5
403	Fayyo’m eksteenshin losisaa’n awwaado uwwimmina hayydmm hasisookko.	1	2	3	4	5
404	Fayyo’m ekisteenshin losisaancho danamisa aboyyitamo	1	2	3	4	5
405	Fayyo’m eksteenshin losisaan malayy xanoo hundam issamohane	1	2	3	4	5
Fayyo’m ekisteenshin losisaan maqire higisakkam soat						
501	Fayyo’m ekisteenshin losisancho sogitano uwwitamok gagabatette	1	2	3	4	5
502	Fayyo’m ekisteenshin losisaancho danamisa hincala’a atorssitamo	1	2	3	4	5
601	Fayyo’m ekisteenshin progra’m kluleesanne mnadab xanamoo keeno	1	2	3	4	5
602	Fayyo’m ekisteenshin losisaan mat mat ammane kurakam woshsha. macceesameen hasamooyo.	1	2	3	4	5
603	Fayyo’m losano uwwakam ammane fayyo’m ekisteenshin losisaan minadabinne shinnatamamookko.	1	2	3	4	5
604	Fayyo’m ekisteenshin losisaan maqire edammoom ammane hasoomm quuxo muccuroomine kureena xanoommo.	1	2	3	4	5
605	Fayyo’m ekisteenshin losisaan kurakkam woshsha danamisa macceesamokko.	1	2	3	4	5
606	Fayyo’m ekisteenshin losisaanina minadabinne danaam edanch yookko	1	2	3	4	5
607	Fayyo’m ekisteenshin losisaaninne yoo edanch fayyoma egerimmina awwaadhane.	1	2	3	4	5
Makkoo awwaado abbis beyyonne siidimm sawwite						
701	Fayyo’m ekisteenshin losisaan hasamu saatanne siidamoommo.	1	2	3	4	5
702	Fayyo’m ekisteenshin losisaan awwaado siideena hasumm saatanne sidaommo	1	2	3	4	5
703	Fayyo’m ekisteenshin losisaan awwaado siidoom soat erane	1	2	3	4	5
704	Fayyo’m ekisteenshin losisaan awwaado siidoom beyyi abbiso.	1	2	3	4	5
705	Fayyo’m ekisteenshin losisaan biiro’o maromm ammane hee’amooyyo.	1	2	3	4	5

..

Minadaph fayyo'm ekisteensh programanne yoo woda'n usheexato						
801	Fayyo'm ekisteenshin program uwwoo awwadonne liramammo	1	2	3	4	5
802	Fayyo'm ekisteenshin programinne uwwamoo awwadonne liramumoyyo	1	2	3	4	5
803	Fayyo'm ekisteenshin losisaa'n danaam baxonne liramammo	1	2	3	4	5
804	Fayyo'm ekisteenshin losisaa'n beyyo odim maroommo.	1	2	3	4	5
805	Ibeshichcho, qarmancho teim abaroosa fayyo'm ekisteenshin program awwaado awwaxamona sogoommo.	1	2	3	4	5

Saga'l Xammichi awwonsa

1. Beero'I fayyoo'm ekisteenshin program bikkina laqoo luchch yoohonehe?
2. Beero'I fayyoo'm ekisteenshin program bikkina caakkiseena xanto'o?
3. Fayyoo'm ekisteeshin losisaa'n awwado hinkid caakkiseena xanto?
4. Fayyoo'm ekisteenshin losisaa'n meent ihubkina maha sawwite uwwitoo?
5. Fayyoo'm ekisteenshin losisaa'n awwaado danam lachcha yohannhe?
6. Fayyoo'm ekisteenshin baxaa'n awwaado mindabine yoo hinict hinkidette?
7. Fayyoo'm ekisteenshin baxaa'n lambennee minaddaph lambee'nne yoo hincit mahina hasisoo?
8. Qabalenne yoo fayyoo'm ekisteenshin programanne sidantoo?
9. Fayyoo'm ekisteenshin baxaa'n awwaado hinkid moo'llooto?
10. Fayyoo'm awwaado sidomanni uwwakam awwaadonne liramoobee'isa issookkok marucho?
11. Beero'I fayyoo'm ekisteenshin awwaado minadabina afimmane elloo'isa baxakkona hinkido'I sawwite uwwitoo?
12. Mull sawwit yoo lase naqasehe

DECLARATION

DECLARATION

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

Name: **Ephrem Lejore**

Name of the institution: **Jimma University**

Date of submission: **25/06/2013**

Signature:

This thesis will be submitted for examination with my approval as University advisor

Name and Signature of the first advisor _____

_____

Name and Signature of the second advisor _____

_____