ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTING HEALTH EXTENSION PROGRAMME IN ENSARO DESTRICT, NORTH-EAST ETHIOPIA

MSW DISSERTATION RESEARCH PROJECT REPORT

(MSWP-001)

By

MUSSIE SEWNET MELESSE

INDIRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

OCTOBER 2013

ADDIS ABABA, ETHIOPIA

ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTING HEALTH EXTENSION PROGRAMME IN ENSARO DISTRICT, NORTH-EAST ETHIOPIA

MSW DISSERTATION RESEARCH PROJECT REPORT

(MSWP-001)

By

MUSSIE SEWNET MELESSE

(Enrollment No: ID1114860)

PROJECT SUPERVISOR

SEBSIB BELAY (MR)

INDIRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

OCTOBER 2013

ADDIS ABABA, ETHIOPIA

DECLARATION

I hereby declare that the dissertation entitled "**ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTING HEALTH EXTENSION PROGRAMME IN ENSARO DISTRICT, NORTH-EAST ETHIOPIA"** submitted by me for the partial fulfillment of Master of Social Work (MSW) to Indira Gandhi National Open University (IGNOU), Addis Ababa is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirements for any other programme of study. I also declare that no chapter of this manuscript in whole or in part is lifted an incorporated in this report from any earlier work done by me or others.

Place: **Addis Ababa, Ethiopia**

Signature: _____

Date: **October 24, 2013**

Enrolment Number: **ID1114860**

Name: **Mussie Sewnet Melesse**

Address: **Addis Ababa, Ethiopia**

CERTIFICATE

This is to certify that **Mr. Mussie Sewnet Melesse** who is student of MSW from Indira Gandhi National Open University (IGNOU), Addis Ababa was working under my supervision and guidance for his project work for the course **MSWP-001**. His project work entitled **"ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTING HEALTH EXTENSION PROGRAMME IN ENSARO DESTRICT, NORTH-EAST ETHIOPIA"** which is submitting his genuine and original work.

Place: Addis Ababa, Ethiopia

Date: October 24, 2013

Signature _____

Name: Sebsib Belay (Mr)

Addresses:

Addis Ababa, Ethiopia.

Phone No.: +251-911-16-52-64

Table of Contents

Acknowledgments

Indeed thanks are never enough to the almighty God. Yet there is nothing I could say but always thanks for the benevolence and miraculous deeds he does in my life.

My earnest acknowledgment must goes to my project supervisor Mr. Sebsib Belay for his invaluable advice, patience and constructive criticisms on each and every step for my research work. He was always ready to answer to my queries in the entire process of researching and writing this dissertation. Without his meticulous and scholastic feedback, this dissertation would not have become a reality.

I would also like to extend my heartfelt gratitude to all the staffs of the Ensaro district Health Office and North Shewa Zone, Hiwot Ethiopia branch office staff members who have organized the community for the scheduled interview in offering me the information for the dissertation.

Finally my special thanks go to my wife Sr. Wudie Tilahun for her support and encouragements throughout the whole process of the dissertation work.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CSA	Central Statistics Agency
DOTS	Directly Observable Treatment-Short Course
EDHS	Ethiopian Demographic Health Survey
FMoH	Federal Ministry of Health
GTP	Growth and Transformation Plan
HEP	Health Extension Programme
HEWs	Health Extension Workers
HIV	Human Immunodeficiency Virus
HSDP	Health Service Development Programme
MDGs	Millennium Development Goals
MoFED	Ministry of Finance & Development
MOH	Ministry of Health
NGO	Non Governmental Organization
PHC	Primary Health Care
SNNPR	Southern Nations & Nationalities Peoples Region
TB	Tuberculosis
TGE	Transitional Government of Ethiopia
VCHWs	Voluntary Community Health Workers
WHO	World Health Organization

LIST OF TABLES AND FIGURES

List of Tables

List of Figures

Abstract

The purpose of this study was to assess the achievements and challenges of implementing Health Extension Program in Ensaro District of North-East Ethiopia. To this end, both quantitative and qualitative research methods were employed using structured interview schedules and interview guides, as well as observation schedule to collect data from 75 households and to generate data from the key informants and the settings of the study area. The quantitative data were analyzed using SPSS software, while the qualitative data were analyzed by using thematic as well as content analysis. The study found out that the targeted households benefitted from hygiene and environmental sanitation, and from disease prevention and control services, particularly the construction, usage and maintenance of sanitary latrine as well as family planning packages. The majority of the beneficiaries thought that achievement of the HEP's services provided were sufficient and satisfactory. However, there were mixed pictures regarding the factors challenging the implementation of HEP. The respondents didn't know any outstanding challenges, but the key informants expressed some challenges related to turnover of staffs, as well as from different stakeholders. Generally, the study concludes that the implementation of the HEP in Ensaro District can be rated as satisfactory, sufficient and it is to acceptable standards. Therefore it is suggested that stakeholders at different levels should work in close collaboration and shoulder to shoulder in order to effectively perform each responsibility to reach at the most satisfactory levels in providing all packages under the four components of the HEP in the intervention area(s).

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Ethiopia had no health policy until the early 1960s when a health policy initiated by the World Health Organization (WHO) was adopted. In the mid-1970s, during the 'Derg' regime, a health policy was formulated with emphasis on disease prevention and control. This policy gave priority to rural areas and advocated community involvement. The current health policy, promulgated by the Transitional Government of Ethiopia (TGE), takes into account broader issues, such as population dynamics, food availability, acceptable living conditions, and other essentials of better health. To realize the objectives of the Health Policy, the Government of Ethiopia established the Health Sector Development Programme (HSDP), which is a 20 year Health Development Strategy implemented through a series of four consecutive 5-year investment programmes. The HSDP prioritizes maternal and newborn care, and child health, and aims to halt and reverse the spread of major communicable disease, such as HIV/AIDS, TB, and malaria. The Health Extension Programme (HEP) serves as the primary vehicle for prevention, health promotion, behavioural change communication, and basic curative care. The HEP is an innovative health service delivery programme that aims at universal coverage of primary health care. The Programme is based on expanding physical health infrastructure and developing Health Extension Workers (HEWs) who provide basic preventive and curative health services in

the rural community (CSA, 2012, p. 5).

Following the new Health Policy of 1993, the health sector has undergone many reforms. The size of the Ministry of Health (MOH) has been reduced giving more tasks and power to regional health bureaus. The decentralization has further deepened to district level and health services delivery is now managed by districts. All the vertical programmes were integrated following the new policy of 1993. Reviews of the 1st HSDP (1997/98- 2001/02) indicated the challenges in achieving universal coverage of PHC and revealed that necessary basic health services have not reached the people at the grassroots level as envisaged and desired due to the nature of services being given by the health system. In response to this, the Ethiopian Government has introduced an innovative programme called Health Extension Programme (HEP). The HEP started its implementation during the 2nd HSDP (2002/03-2004/05). Accelerated Expansion of Primary Health Services strategy has also been planned as part of facilitating the achievement of universal coverage of PHC (FMoH, 2010, P. 3).

The Health Extension Programme (HEP) is an innovative community-based programme introduced started from 2003 during HSDP II. The HEP aims to create healthy environment and living by making available essential health services at the grassroots level. The objective of HEP is to improve equitable access to preventive essential health services through community (Kebele) based health services with strong focus on sustained preventive health actions and increased health awareness (FMoH, 2007, p. 25).

The HEP is a community level component of the Essential Health Services Package (EHSP) of the country. The objectives of EHSP is to reduce the morbidity, mortality and disability

resulting from the major health and health related problems affecting most of the population of Ethiopia. The HEP also makes the bottom level component of EHSP, and is primarily on preventive and promotive component, while essential curative care is introduced at Health Centre and District Hospital Level. The HEP is managed by the HEWs whose station is the Health Post (HP). The HC and five such HP surrounding the HC make a PHCU thereby making the services package and referral system linked to each other (Habtamu, 2007, p. 31). The core of HEP is to identify and provide a list of essential health services to households at the kebele level. As a preventive health programme, the HEP promotes four areas of care, namely, Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation, and Health Education and Communication (Pathfinder International, 2008, p. 3).

As Health Extension Programme is a newly introduced community-based approach and the fact that it has been in place in the study area for seven years and four months would make it possible to assess the achievements and challenges faced during implementation and come up with base line information to back up district and regional decision makers.

Ensaro District has been implementing HEP as per the national implementation guidelines prepared by the Federal Ministry of Health. Health Office of the District has billboard at it gate with vision and mission statements written on it. The Office has written the statement 'creating healthy and productive citizens' as its vision. In its mission statement, it includes major activities to be discharged in close collaboration with stakeholders in the due course of health services delivery process. The mission statement also includes principles of good governance in

provisions of health services to bring tangible improvements in the health status of their respective communities.

Ensaro District was selected for the research based on the personal observations while travelling to different local administration (kebele) areas and having personal talks with HEWs and the local community following the implementation of HEP. The researcher has observed that even if implementation of the program takes more than seven years, the occurrence of communicable diseases and awareness of the community is low. In addition, the quarterly and annual progress reports show that diarrhea and intestinal parasites (IPs) have been still among the 'Top Ten' reportable diseases in the last three years (Ensaro District Health Office report, 2012). This evokes the researcher to raise the question, 'What is the status of the HEP implementation?'

So far, a number of studies on Health Extension Programme in various contexts at different levels using public health perspective which result in and remain inconclusive, but not through social work perspective. Based on the researcher's observations, the local community didn't relay and accept HEWs as health agents. Even some of the HEWs are not satisfied with their daily professional tasks. Therefore, it seems imperative to assess the achievements and challenges of implementing HEP at district level in various contexts. Thus, the researcher decided to assess the achievements and challenges of implementing Health Extension Programme in Ensaro District of North-East Ethiopia using data generated in cross-sectional time period.

1.2 Statement of the Problem

During the period of HSDP II in 2003, the Government of Ethiopia has been mobilizing many resources for the development and implementation of health sector reform policies. Thus, the design and execution of health extension program aimed at improving the health conditions of the citizens especially those residing in rural areas has become a timely issue and been given priority in the health sector development agenda (FMoH, 2005, p. 11).

The main objective of HEP is to improve equitable access to preventive essential health intervention through community or kebele-based health services with strong focus on sustained preventive health actions and increased health awareness. This service is being provided as a package focusing on preventive health measures targeting at households, particularly women/mothers at the community or kebele level. Cognizant of the fact that HEP implementation throughout the country should be consistent; the Federal Ministry of Health has developed implementation guidelines (FMoH, 2005, p. 15). The guidelines is the best tool for the regional health bureaus, district health offices, and the health posts (HEWs) to implement community-based household focused health care services.

Although the HEP has been implemented by Health Office of Ensaro District for more than seven years, the members of the targeted local community do not exhibit a significant improvement in their health status and they are still suffering from different communicable diseases. Annual Report of the Fiscal Year of 2011/12 by the District's Health Office shows that, among the ten top reported illnesses, were those communicable diseases and infections

caused by poor hygiene. Moreover, there is a gap between the local HEWs and the local community in working together in collaboration for the same ends.

Health Extension Workers in the District are selected from the nearby local administrative sites, of which all of them are females, and this may decrease their acceptance and credibility resulting in poor acceptance to the implementation of the Programme. The educational background of most of those HEWs is 10^{th} grade completed, and trained on the Components of the Programme for only three months. The training period is too short to internalize the Programme and to apply to the local community in a context sensitive approach; and even no refreshment trainings are given to them. The Annual Report of the District's Health Office shows that some local administration sites were too remote to reach; there were problems in logistics and supplies, as well as shortage of skilled manpower due to turnover which were identified as challenges in the implementation of the HEP.

In spite of the above-stated problems and factors, no reliable and consistent research using social work principles and perspectives has been conducted in the District. Therefore, this study aims at assessing achievements and challenges of implementing Health Extension Programme are very important.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective of the study was to assess factors that have been contributing to those achievements and challenging the implementation of HEP in Ensaro District of North-East Ethiopia.

1.3.2 Specific Objectives

- To assess types of services provided to the local community during the implementation of HEP in the District;
- To examine the extent to which HEWs have been committed to assist the local community in the district;
- To identify factors that have contributed to achievements and challenges in the effective implementation of the HEP in the District; and
- To identify the strengths and constraints of the HEP implemented in the District.

1.4 Research Questions

The research was guided by the following research questions:

- What are the types of services provided to the local community during the implementation of HEP in the district?

- To what extent HEWs are committed to assist the local community in the district?
- What are the factors that have contributed and challenged the effective implementation of the HEP in the district?
- What are the strengths and constraints of the HEP implemented in the district?

1.5 Definition of Basic Concepts and Terms

The following working definitions were developed and adopted in the process of the study:

- **Assessment** is the process of data collection and evaluation of a programme towards the programme goal and objectives.
- **Challenges** are different issues which affect the proper implementation and achievement of a programme to bring about a significant change.
- **Health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- **Health Extension Programme (HEP)** is defined [as] package of basic and essential promotive, preventive and selected high impact curative health services targeting households.
- **Health extension worker** is a trained professional for one year predominantly about prevention and promotive health services to be assigned in health post at local administration level.

- **Family planning (FP)** is the use of various methods of fertility control that will help individuals or couples to have the number of children they desire at a planned time interval in order to ascertain the well being of the children, parents and communities at large.

- **Local administration** is the smallest and the lowest level of administration with at least 500 households in a district.

- **Kebele:** is the smallest political administrative unit in the Ethiopian current political system.

1.6 Limitations of the Study

In the due course of the study, in one way or another, multi faceted problems have been encountered. The problems have been presented as follows:

- Some households had low understanding to articulate what they experienced with the program implementation and this affects the quality and adequacy of the data given.
- It was found difficult to get the local community as per appointment schedule and some were also reluctant to cooperate. Thus, gathering data took much time than what was planned.
- It was also problematic to obtain sufficient recorded secondary data on the performance of the program in the study areas. However, all efforts and measures were taken to minimize the effects of these variables on the quality of the research.

1.7 Chapter Plan of the Dissertation

The dissertation will be logically arranged into five chapters. The First Chapter shall cover the introduction part which included background of the study, problem statement, objectives of the study, significance of the study, limitations of the study and chapter plan. The Second Chapter shall contain review of related literature in relation to the health extension program. The Third Chapter shall deal with research design and methodology. In Chapter Four, data analysis and interpretation on the achievements, performance and challenges of HEP in the study areas shall be made. In addition in Chapter Five major findings and discussions of the study will be clearly stated. Finally, in Chapter Six the thesis will present conclusions and recommendations for action and further studies.

CHAPTER TWO

REVIEW LITRATURE

2.1 Introduction

Health systems in Sub-Saharan African countries often suffer from weak infrastructure, lack of human resources, and poor supply chain management systems. Access to health services is particularly low in rural areas, where the majority of the population still lives. The few private outlets that are available usually favor urban or wealthy areas. Together with an uneven distribution of health workers, this pattern often results in little availability and poor quality of health services in rural areas (Bilal, 2012, p. 433).

The Ethiopian Government has been exerting too much effort to the health sector performance. To upgrade its citizens' health status, it has developed and is implementing a series of health sector development programmes (HSDPs). And it introduced health extension programme as a part of HSDP to ensure accelerated expansion of health care services which has focused on health promotion, preventive and curative health care services.

2.2 General Policy

High rates of disease and premature mortality in Sub Saharan Africa are costing the continent dearly. Poor health causes pain and suffering, reduces human energies, and makes millions of

Africans less able to cope with life. The economic consequences are immense. Poor health shackles human capital, reduce returns to learning, impedes entrepreneurial activities, and holds back growth of gross national product (World Bank, 1995, p. 40).

The policy includes the following broad areas: democratization and decentralization of health service system, development of the preventive and promotive components of health care, development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources, promoting and strengthening of intersectoral activities, assurance of accessibility of health care for all segments of the population, development of appropriate capacity building based on assessed needs, provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay, promotion of the participation of the private sector and nongovernmental organizations in health care (TGE, 1993). To combat the serious health problems the nation has been facing, the Ethiopian Government has given priorities for Information, Education and Communication (I.E.C.) to enhance health awareness and to propagate the important concepts and practices of self-responsibility in health, the control of communicable diseases, epidemics and diseases related to malnutrition and poor living conditions, provision of essential medicines, medical supplies and equipment shall be strengthened, and so forth (FMoH, 1993, 26-27).

2.3 Health Policy

Ethiopia had no health policy until the early 1960s, when a health policy initiated by the World

Health Organization (WHO) was adopted. In the mid-1970s, during the Derg regime, a health policy was formulated with emphasis on disease prevention and control. This policy gave priority to rural areas and advocated community involvement (FMoH, 1993, 30). The current health policy, promulgated by the Transitional Government, takes into account broader issues such as population dynamics, food availability, acceptable living conditions, and other essentials of better health, according to the same document.

To realize the objectives of the Health Policy, the Ethiopian Government established the Health Sector Development Programme (HSDP), which is a 20-year health development strategy implemented through a series of four consecutive 5-year investment programmes (FMoH, 2010). The first phase (HSDP I) was initiated in 1996/97. The core elements of the HSDP include: democratization and decentralization of the health care system; development of the preventive and curative components of health care; ensuring accessibility of health care for all segments of the population; and promotion of private sector and NGOs' participation in the health sector.

The HSDP prioritizes maternal and newborn care, and child health, and aims to halt and reverse the spread of major communicable diseases, such as HIV/AIDS, TB, and malaria. The Health Extension Programme (HEP) serves as the primary vehicle for prevention, health promotion, behavioural change communication, and basic curative care. The HEP is an innovative health service delivery program that aims at universal coverage of primary health care. The program is based on expanding physical health infrastructure and developing Health Extension Workers (HEWs) who provide basic preventive and curative health services in the rural community.

The first phase (HSDP I) was initiated in 1996/97.Thus far, the country has implemented the HSDP in three cycles and is currently extending it into the forth program, HSDP IV. Assessment of HSDP III shows remarkable achievements in the expansion and construction of health facilities, and improvement in the quality of health service provision. The assessment also shows that in the last five years the distribution of insecticide treated nets (ITN) were successful in reaching targeted areas of the country, including areas that were hard to reach, placing Ethiopia as the third largest distributor of ITNs in Sub Saharan Africa (FMoH, 2010, p. 18).

HSDP IV is designed to provide massive training of health workers to improve the provision of quality health services and the development of a community health insurance strategy for the country. In addition, HSDP IV will prioritize maternal and newborn care, and child health, and aim to halt and reverse the spread of major communicable disease such as HIV/AIDS, TB and Malaria. In line with the Ethiopian Government's current five-year national plan, the health sector continues to emphasize primary health care and preventive services; with focus on extending services to those who have not yet been reached and on improving the effectiveness of services, especially addressing difficulties in staffing and the flow of drugs (FMoH, 2011, p. 5).

2.4 National Health Profile

2.4.1 Health Status

Despite major strides to improve the health of the population in the last one and half decades, Ethiopia's population still faces a high rate of morbidity and mortality and the health status remains relatively poor. Vital health indicators from the DHS 2005 show a life expectancy of

54 years (53.4 years for males and 55.4 for females) and an IMR of 77/1000. Under-five mortality rate reduced to 101/1000 in 2010. Although the rates have declined in the past 15 years, these are still very high levels (FMoH, 2010, p. 3).

Generally, the major health problems of the country are largely preventable communicable diseases and nutritional disorders. More than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often as a combination of these conditions.

2.4.2 Strategic Initiatives of HSDP-IV

In the fourth HSDP, the health care service coverage are: Health Post for 1:5,000 population; Health Centre for 1:25,000 population; Primary Hospital for 1:100,000 population; General Hospital for 1:1,000,000 population; and Specialized Hospital for 1:5,000,000 population. Many of the listed initiatives and programmatic interventions were under implementation before HSDP-IV. The majority of these activities will continue to be implemented as per the agreed strategic directions. This section, however, outlines new strategic directions or focal areas that will attract more attention (FMoH, 2010, P. 50).

The Federal Ministry of Health (FMOH) of Ethiopia launched the Health Extension Programme (HEP) in 2003 and it became operational within the 2004–2005 which produced graduation of 7136 Health Extension Workers (HEWs), trained to work mainly in disease prevention and health promotion in rural villages. The Programme was expected to help accelerate the country's progress in meeting Millennium Development Goals (MDGs) 4, 5 and

6 (i.e. reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases by half). Now, it is the country's major health Program. In 2010, there were 30,578 HEWs serving almost all villages in rural areas of the country where sedentary farming practiced rather than nomadism is the norm (Hailom, 2011, p. 46).

2.5 Health Extension Programme

In Ethiopia, the HSDP III registered remarkable achievements in scaling up rural HEP coverage, particularly through putting in place the necessary infrastructure, i.e., HPs, equipment, and staff (like HEWs and Health Extension Supervisors). Hence, HSDP-IV will focus on the following aspects of HEP: scaling up urban and pastoralist HEP; maintaining coverage; and improving quality of HEP in rural areas (FMoH, 2010, p. 50).

The Health Extension Programme (HEP) is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of PHC, it is designed to improve the health status of families, with their full participation using the local technologies and the community's skills and wisdom. HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facility-based services (FMoH. 2007, p. 3).

HEP is a community-based health service delivery programme whose educational approach is based on the diffusion model, which holds that community behaviour is changed step by step:

training early adopter and then moving to the next group that is ready to change. Those resistant people should first change would then gradually be conditioned to change because of changes in their environment. HEP assumes that health behavior can be enhanced in communities by creating model families that others will admire and emulate (Hailom, 2011, p. 46).

The Programme is being implemented by deploying of two salaried female Health Extension Workers (HEWs) who are trained for a year at Technical and Vocational Training and Education Centers at each village (Kebele). The HEP makes the bottom level of Essential Health Services Package (EHSP) of the country and is primarily preventive and promotive service, while basic curative care starts at the health centre level. With this, it is designed to give services at local community level covering sixteen health extension packages categorized under three major areas, versus against disease prevention and control, family health service, hygiene and environmental sanitation; and health education and communication as a cross cutting approach (Habtamu, 2007, p. 2).

2.5.1 The objectives of the HEP

It includes;

- To improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas;
- To ensure ownership and participation by increasing health awareness, knowledge, and skills among community members;
- To promote gender equality in accessing health services;

- To improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through HEWs;
- To reduce maternal and child mortality; and
- To promote healthy life style (FMoH, 2007, p. 7).

2.5.2 Components of the Health Extension Package

HEWs are responsible for explaining and promoting the following preventive actions at community level:

1. Disease Prevention and Control: HIV/AIDS and other sexually transmitted infections (STIs) and TB prevention and control; Malaria prevention and control; First Aid emergency measures;
2. Family Health: Maternal and child health; Family Planning; Immunization; Nutrition; Adolescent Reproductive Health;
3. Hygiene and Environmental Sanitation: Excreta disposal; Solid and liquid waste disposal; Water supply and safety measures; Food hygiene and safety measures; Healthy home environment; Control of insects and rodents; and Personal hygiene; and
4. Health Education and Communication.

The major components of the Programme are summarized in the table presented below.

HEALTH EXTENSION PROGRAM - MAJOR TRAINING PACKAGES	
Hygiene and Environmental Sanitation	• Building and Maintaining Healthful House • Construction, Usage and Maintenance of Sanitary Latrines • Control of Insects, Rodents and other Biting Species • Food Hygiene and Safety Measures • Personal Hygiene • Solid and Liquid Waste Management • Water Supply Safety Measures
Family Health Service	• Maternal and Child Health • Adolescent Reproductive Health • Family Planning • Immunization Service • Nutrition
Disease Prevention and Control	• HIV/AIDS and Tuberculosis Prevention and Control • Malaria Prevention and Control • First Aid
Health Education and Communication	• Health Education and Communication Methods

Table 2.1 Major Health Extension Packages (Source: FMoH, 2007, p. 11)

2.6 Health Extension Approaches

HEWs are required to spend seventy-five percent (75%) of their time conducting outreach activities by going from house to house. During these visits, HEWs are expected to teach by example (e.g. by helping mothers care for newborns, cook nutritious meals, construction of latrines and disposal of pits). HEWs utilize the following three approaches: model families, community-based health packages and indicators of HEP (FMoH. 2007, p. 12).

2.6.1 Model Families

HEWs identify and train model families that have been involved in other development work and /or that have acceptance and credibility by the community, as early adopters of desirable health practices to become role models in line with heath extension packages. Model families help diffuse health messages leading to the adoption of the desired practices and behaviors by the community (FMoH. 2007, p. 12).

2.6.2 Community-Based Health Packages

HEWs communicate health messages by involving the community from the planning stage all the way through evaluation. HEWs also utilize Women and Youth Associations, Schools and Traditional Associations, such as idirrs, mahibers and ekubs to coordinate and organize events where the community participates by providing money, raw materials and labour (FMoH, 2007, p. 12).

2.6.3 Indicators of HEP

In order to monitor and evaluate the progress of the implementation of the Health Extension Programmme, the concerned professionals may use the following indicators:

- Immunization, breastfeeding, use of Oral Rehydration Salt (ORS), adolescent parenthood, antenatal care, assisted delivery, contraceptive use, and tetanus toxoid immunization;
- Use of Insecticide Treated Nets (ITNs), anti-malarial drugs, HIV and sexually transmitted

infections, TB follow-up and First Aid and self care;

- Facilities for liquid/solid waste disposal, safe drinking water, healthy home environment, sanitation and hygiene; and
- Access to and utilization of preventive and promotive health services, referrals, adequately-staffed and well-maintained health posts, participation in basic health/demographic data collection, and provision of financial support for Health Posts (FMoH, 2007, p. 18).

2.7 Roles and Responsibilities of Different Sectors for HEP

2.7.1 District Administration

It is responsible to allocate budget and other resources. It also co-ordinates activities implemented by governmental and non-governmental bodies, and monitoring and evaluation.

2.7.2 District Health Office

The Office provides technical, administrative and financial support to HEP; allocates budgets and supplies to Health Centers and Health Post; adapts communication materials; provides supportive supervision of HEWs and the overall management of Health Centers and Health Posts; plans and provides in service training to HEWs and District Health Office staff; obtains reports from Health Posts and Health Centers; and provides information to Regional Health Bureau/Zonal Health Department.

2.7.3 Health Extension Workers

HEWs' major task is increasing knowledge and skills of communities and households to deal with preventable diseases and be able to access services available at clinics and hospitals. HEP also considers maternal and child health tracer indicators of good health and HEWs give special attention to family health. In addition to conducting preventive family health education and sanitation, they can supervise intake of community Directly Observable Treatment-Short Course (DOTS) for TB and antiretroviral treatment for HIV/AIDS; conduct rapid diagnostic tests for malaria and administer malaria drugs; attend uncomplicated childbirth; refer patients to nearby health centers; and collect vital statistics. However, HEWs are not allowed to administer anti-biotics (Hailom, 2011, p. 46).

In addition, they manage operations of Health Posts, conduct home visits and outreach services to promote preventive actions, provide referral services to Health Centers and follow up on referrals, identify, train and collaborate with VCHWs, provide reports to District Health Offices (FMoH, 2007, p. 15).

2.8 Status of Health Extension Program in Ethiopia

Attribution of results to the programmes is always difficult because of the multiplicity of factors and actors in the social environment, but tangible improvements in key health indicators have been observed because HEP's implementation began supporting our conclusion that HEP is an effective approach to promoting good health in rural communities. It is now present in all rural

agrarian areas and is being expanded to include pastoralist and urban areas. Credit for these improvements (see Table 2.2) must be shared with global health initiatives that are major players in the implementation of the health sector development program. The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria; the President's Emergency Plan for AIDS Relief (PEPFAR); and the World Bank have been major players in health sector in the country for the last ten years. This has helped the work of the FMoH in HEP implementation (Hailom, 2011, p. 47).

Key health indicators	Year	
	2005 (%)	2010 (%)
Primary Health Care Coverage	76.9	90.0
Expanded Program of Immunization (EPI)	76.8	81.6
Contraceptive Acceptance Rate	37.9	56.2
Antenatal Coverage	50.4	67.7
HIV Prevalence	3.2	2.1

Table: 2.2. Progress in key health indicators in Ethiopia, 2005-2010 (Source: Hailom, 2011, p. 47)

Based on the Annual Progress Report for the F.Y. 2010/11, expansion of quality services is the main strategic theme of the health sector during the GTP. In line with this general direction, primary health prevention involving active participation of the community and supported by Health Extension Programme (HEP) focuses on expansion of quality services. The main targets of the Fiscal Year 2010/11 were set with the objective of strengthening the health system that ensure improving mother's health, reducing infant mortality and preventing the spread of HV/AIDS, malaria, TB and other communicable diseases (MoFED, 2012, p. 67).

2.8.1 Community Initiative/participation and Ownership

As part of the initiative to have two health extension workers (HEW) per rural kebele, a total of 34,382 health extension workers were deployed in rural areas. In addition, 1278 health extension workers were trained and deployed as gap fillers. Furthermore, 1322 prospective heath extension workers were undertaking a training programme. Initiatives were also taken to set up health extension program in urban areas based on the lesson learned from the rural health extension program. Moreover, awareness raising activities were performed for health workers in pastoral areas about the health extension program (MoFED, 2012, p. 68).

2.8.2 Health Infrastructure and Access to Health Services

In relation to improving health infrastructure, 903 new health posts (HP) were constructed in 2010/11. This increased the total number of HPs available in the country from 14,192 in 2009/10 to 15,095 at the end of the fiscal year. To realize full coverage of basic health services to Ethiopian people, it requires 3,299 health centers. Towards achieving full coverage, 518 new health facilities were constructed in 2010/11. This increased the number of health centers from 2,142 in 2009/10 to 2,660 at the end of 2010/11 (MoFED, 2012, p. 68).

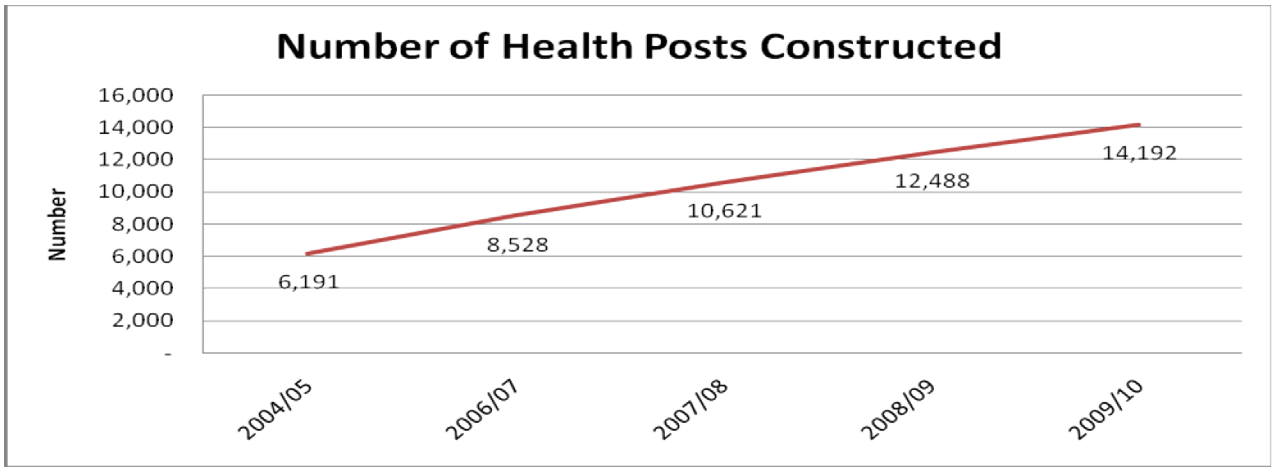


Figure 2.1 Trend of Health Posts constructed from 2004/05 to 2009/10 (SOURCE: Bilal, 2012, P. 439)

2.8.3 Family Planning Services

During 2010/11, contraceptive acceptance rate reached sixty-two percent, while the results of the Demographic and Health Survey (DHS) of 2011 reveal that the contraceptive prevalence rate reached twenty-nine percent. Training was provided to 27,744 health extension workers, and 2,336 health extension supervisors to strengthen the family planning services (MoFED, 2012, p. 69).

2.8.4 Antenatal and Postnatal Services

It was planned to increase antenatal service coverage to fifty-three percent and the service was provided to 2,404,279 mothers leading to an achievement 82.2%. Furthermore, postnatal service coverage increased from 36.2% in 2009/10 to 42.1% in 2010/11 by providing the services to 1,231,099 delivering mothers. The percentage of deliveries attended by skilled health personnel

increased from 15.7% in 2009/10 to 16.6% in 2010/11 (MoFED, 2012, p. 69).

2.8.5 Reducing Maternal and Child Mortality

According to the 2011 Ethiopian Demographic and Health Survey (EDHS) results, less than five child mortality rate dramatically declined from 123/1000 in 2005 to 88/1000 in 2010/11, while infant mortality rate per 1000 decreased from 77 to 59 in 2010/11 in the same period. Many interventions were undertaken to realize the aforementioned achievements. These include increasing full immunization coverage of infants to 74.5% in 2010/11. However, according to the result of the same survey, maternal mortality (i.e. MDG 5) did not show a decline and remained at 673 per 100,000 although other maternal health related indictors showed good progress. The result indicates that achieving MDG 5 will be a serious challenge and needs a serious attention (MoFED, 2012, p. 69).

2.8.6 Hygiene and Environmental Health Services

A Manual on Construction of Latrine and Usage of Latrine was prepared, and then a total of 299 health extension workers and supervisors were trained on WASH in collaboration with the Ethiopian Ministry of Water and Energy. In addition, awareness creation was made on methods to control domestic water pollution and food hygiene using public media, such as TV and FM radio programmes. Construction of latrines was also performed during the reporting fiscal year. Accordingly, the number of latrines increased from 12.7 million in 2009/10 to 14.7 million in 2010/11 which increased sanitation coverage from 75.0% to 86.0% in the respective years (MoFED, 2012, p. 70).

2.9 Status of Health Extension Program in Ensaro District

2.9.1 Training and Deployment of Health Extension Workers

The main purpose of the HEP implementation is to prevent the community from different communicable diseases and to improve the health status of the community at large. The total number of HEWs required for the District is 25. To date, twenty-four of HEWs have already completed their one-year training course and have been deployed to all local (kebele) administration areas. So far, one HEW has been assigned for Lemi town (sub-urban) that is a professional nurse and has got three weeks training for health extension programme. The total numbers of health extension workers deployed as of December 2012 are 25, which is 100.0% of the total required.

2.9.2 Construction of Health Posts

At the Health Post level, the HEWs provide antenatal care, delivery, immunization, growth monitoring, nutritional advice, and family planning and referral services to the general population of the Kebele administration (FMoH, 2007, p. 12).

The operational center of the HEP is the Health Post which functions under the supervision of the District Health Office, local (Kebele) administration office and with technical support from the nearest Health Center. Health Posts are located at local (Kebele) administration level to serve a population of 5000 people. Where possible, Health Posts are located near other public services and institutions (e.g. local (Kebele) administration offices) to foster enhanced coordination

among government service providers. In localities where Health Posts are not yet built, the services are provided in provisional posts (FMoH, 2007, p. 10).

In Ensaro District, there are 13 constructed Health Posts, one in each local (Kebele) administration area. The Health Post has three to four rooms to provide services for the community members (Ensaro District Health Office report, 2012).

Based on the reports collected from the Ensaro District Health Office prepared in 2010, 2011 and 2012, the Health Extension Programme has brought about the following results:

The Report on Annual Performance of the District health Office in those three years shows that there was minimal yearly increment in activities, like number of anti-natal care attendants and number of people tested for HIV. However, there is no continual increment in performance in other activities rather tends to decrease. The Annual Report collected from the Ensaro District Health Office shows the type of illnesses registered as the **'Top Ten Diseases'** are stated in Table 2.4 and the yearly achievements in table 2.3.

Figure 2.2 Photos of Health Posts constructed in Ensaro District

(SOURCE: Ensaro District Health Office report, 2012)

Table: 2.3. Three years health service performances in Ensaro District.

	Activities/Basic Indicators	Annual Performances		
		2010	2011	2012
1	**Immunization-** Pentavalent - 3	1658	1414	1635
	Measles	1479	1327	1630
	TT-2 Pregnant	1493	1495	1479
	Anti-Natal care	1515	1672	1926
	Assisted delivery	166	145	318
2	**HIV/AIDS -** Tested	6738	20804	14656
	HIV Positives	13	25	14
3	**Safe drinking water**	10173	10062	NA
	Latrine preparation	8425	8264	1798
4	**Constructed health posts**	13	0	0
5	**Trained HEWs**	25	Refreshment training was given for all	Refreshment training was given for all

(SOURCE: Ensaro District Health Office report, 2012)

Table: 2.4. Types of Top Ten Diseases in Ensaro District (2010 – 2012)

Level of Disease	Types of Ten-Top Diseases in each Year

Occurrence	2010	2011	2012
1st	Diarrhea	Pneumonia	Intestinal Parasites
2nd	Intestinal Parasites	Diarrhea	Pneumonia
3rd	Pneumonia	Intestinal Parasites	Acute Febrile Illnesses
4th	Acute Febrile Illnesses	Acute Febrile Illnesses	Diarrhea
5th	Dyspepsia	Acute Respiratory Tract Infections	Dyspepsia
6th	Acute Respiratory Tract Infections	Dyspepsia	Acute Respiratory Tract Infections
7th	Typhoid Fever	Typhoid Fever	Dysentery
8th	Skin Disease	Dysentery	Typhoid Fever
9th	Dysentery	Skin Disease	Injury
10th	Injury	Bronchial Asthma	Rheumatism

SOURCE: Ensaro District Health Office report, 2012

According to the Annual Reports collected for the 'TOP Ten Diseases' diseases, like diarrhea and Intestinal Parasites which are transmitted due to poor personal hygiene and poor environmental sanitation take the first rank in 2010, but in 2011 the frequency has decreased and in 2011 Intestinal Parasites become the first in rank; diarrhea decreased to the fourth rank. This shows that those diseases transmitted due to poor personal hygiene and poor environmental sanitation are still the major problems of the community in the Ensaro District.

CHAPTER THREE

RESEARCH DESIGN AND METHODS

3.1 Description of the Study Area

The study was conducted in Ensaro District located in North-East of the sovereign state of Ethiopia. It is situated at 130 kms away from the capital city Addis Ababa. Ensaro is one of the districts in the Amhara Region of Ethiopia. Part of the Semien Shewa Zone, the towns in Ensaro is Lemi. Based on the 2007 national census conducted by the Central Statistical Agency of Ethiopia (CSA), this district has a total population of 59,706, of whom 30,627 are men and 29,079 women; 3,164 or 5.44% are urban inhabitants. The majority of the inhabitants practiced Ethiopian Orthodox Christianity, with 99.89% reporting that as their religion. The two largest ethnic groups reported in Ensaro were the Amhara (70.27%), and the Oromo (29.58%); all other ethnic groups made up 0.15% of the population. Amharic was spoken as a first language by 68.97%, and Oromiffa was spoken by 30.98%; the remaining 0.05% spoke all other primary languages reported. The majorities of the inhabitants practiced Ethiopian Orthodox Christianity, with 99.87% reporting that as their religion (Ensaro District Finance & Economic Development Office Report, 2011/2012) and for the real location of the district see Appendix D.

3.2 Research Design and Methods

The research shall focus at assessing achievements and challenges of the health extension program encountered during the time of implementation in Ensaro district. Accordingly the researcher will employ mainly non-experimental study design and uses quantitative and qualitative approaches and descriptive sample survey methods.

3.3 Universe of the Study

Based on the Ensaro District Finance and Economic Development Office's Report for the socio-Economic data of 2011/2012 E.C, the total population of the District was 59,706 (29,079 females and 30,627males). In the District, there are 4 health centers and 13 health posts with 75 (44 females and 31 males) health professionals and 25 HEWs. The study population is taken from those residents of the local administrative site, named 'Lemi' where HEP implementation has been taken place for consecutive seven years and four months and the implementation started in December 2005. 'Lemi' is located at the center of the District the aggregation of elements from which the sample was actually selected. In this local administrative site, there were 3903 (1833 males and 2070 females) population. The study focused on the assessment of the achievements and challenges of implementing the HEP in the District since December 2005.

3.4 Sampling Methods and Sample Size

Sampling methods shall be developed based on the population size of the study. The method used for drawing a sample is significant to arrive at dependable results or conclusions. For the purpose of this study, purposive sampling method of the non-probability sampling methods was used based on the judgment of the researcher. The guiding factors in non-probability sampling methods include: the availability of the units, the personal experience of the researcher and /her convenience in carrying out a survey. The technique used was thus purposive sampling technique, because it would be more appropriate to select household cases that were judged to be typical of the population.

In order to assess the achievements and challenges of HEP implementation in Lemi area of the District, the total number of respondents was purposively determined. From the selected local administration site, a total of 75 residents from the local community were selected because of their important role in the implementation of HEP. In addition, the HEWs assigned in the site, as well as the HEP Supervisor at District level was interviewed.

3.5 Data Collection: Tools and Procedures

In order to gather the necessary data, the researcher employed both quantitative and qualitative data sources. The quantitative data were collected by using interview schedule filled and collected from the selected respondents from the local community members. Qualitative data were also collected through interview guide by holding semi-structured interviews with key

informants in relation to the Progamme under investigation. The primary data sources were respondents and informants identified and approached among the local community/residents, health extension workers, and health extension programme supervisors. Field observations were conducted as another important research method for obtaining primary qualitative data. The researcher went for field visits to observe some manifestations, such as hygiene of the dwellers, latrine availability, and clean water supply and so on. In so doing semi-structured interviews were conducted with health extension workers and HEP supervisors to get information to complement the data gathered accordingly. Secondary data were gathered from both published and unpublished materials, such as the District Annual Reports, charts, survey reports, magazines, journals, books, and web-based documents from the Internet.

3.6 Data Processing and Analysis

Based on the purpose of the research to assess the achievements, performances, and challenges of HEP; the researcher used descriptive statistical techniques of the SPSS to produce frequency distribution, charts, percentages, diagrams and tables and then extensively employed for appropriate interpretation.

3.7 Ethical Considerations

Health extension program was considered as a major health problem solving strategy and as an engine to fulfill the Millennium Development Goals (MDGs) in Ethiopia. The Ethiopian Government also works to the maximum by allocating the required budget for the

implementation of the programme. Therefore, the researcher first obtained relevant information for the study before starting the actual field work.

The study first began by briefing the purpose of the study to the Ensaro District Health Office programme supervisors. This was the first step to get the Office's willingness and permission. A supporting letter from IGNOU Coordination Office in Ethiopia was submitted to the Ensaro District Health Office. The researcher then got official permission from the Health Office to access the sampled population. After all this formal and ethical considerations had been undertaken, data collection process and contact with the sampled population and key informants began.

The sampled population was first requested for their willingness to participate in the study or not and they were also informed that the data obtained from them would be used only for the academic purpose of writing the thesis in partial fulfillment of the requirements of MSW. In addition, the participants were clearly informed that the provided data would be kept confidential and their names would not appear anywhere in the thesis and even they were not requested to tell and write their names to the researcher. In all cases, the study was held after the researcher had got verbal consent from each respondent in the study area.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

This chapter presents data on socio-demographic characteristics of respondents who are beneficiaries of the HEP, types of services delivered during the implementation of HEP, the First Component of the HEP, the Second Component of the HEP, the Third Component of the HEP, the Fourth Component of the HEP, the commitment of HEWs, the factors that have contributed to its achievements and challenged the effective implementation of HEP, and strengths and constraints of HEP implementation in the study area. In addition, qualitative data on these issues were collected from HEWs and HEP Supervisors at Ensaro District Health Office to triangulate the data generated from the respondents.

4.1 Socio-demographic Characteristic of Respondents

Based on the data obtained from 75 respondents who are living in the study area, it is possible to summarize and describe the different characteristic features of them as illustrated in Table 4.1. Three-fifth of the total respondents was found to be females. Table 4.1 shows that 61.3% of the beneficiaries were females, while 38.7% of them were males. In relation to their age distribution, about two-third (64.0%) of them were categorized in the age bracket of 25-64 years. Thus, the majority of the beneficiaries of the HEP are young and older adults. They were also found to achieve the second cycle of the primary education as thirty-two percent of the

respondents attended Grade 1 - 8 levels.

Concerning their marital status, among 75 respondents, sixty percent of them were in wedlock. Thus, significant majority of the beneficiaries are married ones. These respondents then gave birth to either 2 or 3 children as their perpetuators. About fifty-six percent of them had 2 to 3 children in their respective households. Therefore, they have acceptable numbers of children in the households. The respondents lived for 4 and more years in the area. Specifically, 44.0% of them lived 4-7 years. Generally, about thirty-five percent of their occupation was found to be trade, but there were farmers, government employees, house wives and students as beneficiaries of the Programme.

Table: 4.1. Socio-demographic Characteristics of Respondents

Sex of the respondents	Frequency	Percent (%)
Female	46	61.3
Male	29	38.7
Total	**75**	**100.0**
Age of respondents		
18-24	18	24.0
25-44	23	30.7
45-64	25	33.3
>=65	9	12.0
Total	**75**	**100.0**
Educational Status of respondents		
Informal education	26	34.7
1-8th grade	24	32.0
9-10th grade	14	18.7
11-12th grade	8	10.7
Certificate	2	2.7
Diploma	1	1.3
Total	**75**	**100.0**
Marital status of respondents		
Single	17	22.7
Married	45	60.0
Widowed	8	10.7
Divorced	5	6.7
Total	**75**	**100.0**
Number of children for respondents		
0	16	21.3
1	3	4.0
2	19	25.3
3	23	30.7
4	7	9.3
5	4	5.3
6	3	4.0
Total	**75**	**100.0**
Length of stay of the respondents		
1-3 years	12	16.0
4-7 years	33	44.0
More than seven years	30	40.0
Total	**75**	**100.0**
Job/Occupation of respondents		
Farmer	16	21.3
House wife	9	12.0
Trader	26	34.7
Student	9	12.0
Government employee	15	20.0
Total	**75**	**100.0**

4.2 Types of Service delivered during the Implementation of HEP

4.2.1 Knowledge of Services delivered

All of the respondents are knowledgeable about types of those services provided by health extension workers during the implementation of the Programme. They identified those services in the HEP as hygiene and environmental sanitation, family health services, and disease prevention and control. However, only 20.0% of them didn't know of the health education and communication services in their village. Regarding the benefits from these services, 100.0% of the respondents are benefited from the services like, hygiene and environmental sanitation, and disease prevention and control; where as 24.0% and 16.0% of the respondents were not benefited from health education and communication and family health services respectively. Based on data gathered from 75 respondents, the majority (93.3%) of the respondents thought that those services provided were sufficient and satisfactory. In relation to satisfaction of HEP services, 50.7% and 37.3% of respondents rated their satisfaction as agreed and strongly agreed in that given order as shown in Table 4.2.

4.2.2 The First Component of the HEP

The respondents were requested to rate their satisfaction regarding HEP Packaged services that have been implemented in their village. In the first component (i.e. hygiene and environmental sanitation), there are seven health extension packages. As depicted in Table 4.2, building and maintaining healthful house package was rated as satisfactory by sixty percent of the respondents; 65.4% of them rated the construction, usage and maintenance of sanitary latrine of

the first component of the HEP as very good. The control of insects, rodents and other biting species package of the Programme rated as satisfactory by 54.7% of the beneficiaries. About fifty-three percent of the clients of Programme viewed the food hygiene and safety measures package services as satisfactory. As to the personal hygiene package, 45.3% of the respondents in the study rated it as satisfactory; whereas the solid and liquid waste management package was rated as very good by forty percent of the sample target population. On the other hand, about fifty-one percent of the clients considered the water supply safety measures package as satisfactory. Generally, the First Component of the HEP services provided is rated as satisfactory.

Table: 4.2. Health Extension Packages under the First Component of HEP

Major HEP Components and Packages		5	4	3	2	1
		Excellent	Very Good	Satisfactory	Poor	Very Poor
Component-I	Packages	%	%	%	%	%
Hygiene and Environmental Sanitation	Building and Maintaining Healthful House	0.0	36.0	**60.0**	4.0	0.0
	Construction, Usage and Maintenance of Sanitary Latrine	29.3	**65.4**	5.3	0.0	0.0
	Control of Insects, Rodents and other Biting Species	2.7	17.3	**54.7**	22.7	2.6
	Food Hygiene and Safety Measures	1.3	8.0	**53.4**	37.3	0.0
	Personal Hygiene	0.0	24.0	**45.3**	30.7	0.0
	Solid and Liquid Waste Management	17.4	**40.0**	33.3	9.3	0.0
	Water Supply Safety Measures	0.0	21.3	**50.7**	28.0	0.0

4.2.3 The Second Component of the HEP

Table 4.3 indicates that the overall rating of the services provided under the second component of the Health Extension Programme was skewed towards satisfactory. As indicated in the table, there are five health extension packages. Among the total respondents in the study, only forty percent of them rated the maternal and child health package as satisfactory, 57.4% rated the adolescent reproductive health package as satisfactory, the family planning package services provided for the clients was considered as very good, 52.0% of them rated the services of the immunization service package as very good, and the nutrition serviced provided were rated as satisfactory by 57.4% of the beneficiaries in the village.

Table: 4.3. Health Extension Packages under the Second Component of HEP

Major HEP Components and Packages		5	4	3	2	1
		Excellent	Very Good	Satisfactory	Poor	Very Poor
Component-II	Packages	%	%	%	%	%
Family Health Service	Maternal and Child Health	20.0	34.7	**40.0**	5.3	0.0
	Adolescent Reproductive Health	0.0	4.0	34.7	**54.7**	6.6
	Family Planning	28.0	**44.0**	26.7	1.3	0.0
	Immunization Service	14.7	**52.0**	33.3	0.0	0.0
	Nutrition	0.0	0.0	**57.4**	37.3	5.3

4.2.4 The Third Component of the HEP

The third component of the HEP contains three packages. The data generated from 75 respondents show that the HIV/AIDS and tuberculosis prevention and control package, and the malaria prevention and control package was rated as satisfactory by 64.0% and 50.7% of them respectively. However, sixty percent of the clients viewed the first aid service as poor. Thus, one can deduce that the provisions of the services which are categorized under the Third Component of the HEP are rated as satisfactory.

Table: 4.4. Health Extension Packages under the Third Component of HEP

Major HEP Components and Packages		5	4	3	2	1
		Excellent	Very Good	Satisfactory	Poor	Very Poor
Component-III	Packages	%	%	%	%	%
Disease Prevention and Control	HIV/AIDS and Tuberculosis Prevention and Control	0.0	13.3	**64.0**	22.7	0.0
	Malaria Prevention and Control	0.0	0.0	**50.7**	49.3	0.0
	First Aid	0.0	0.0	40.0	**60.0**	0.0

4.2.5 The Fourth Component of the HEP

The Fourth Component of the HEP consists of health education and communication methods package. About forty-three percent (42.7%) of the respondents in the study rated their satisfaction with the services provided as satisfactory.

4.2.5.1 Commitment of HEWs

The HEP achievement is also determined on the commitment of the health extension workers. In order to know their level of commitment towards the implementation of the Programme, data was collected from 75 respondents. Thus, all of them (100.0%) expressed that the HEWs had high level of commitment in that they came and visited their family. About fifty-seven percent (57.3%) of the respondents indicated that the frequency of the visits was every two weeks.

During the visits, the type of health extension packages discussed with the family members was clearly seen percentages in Table 4.6. All (100.0%) of the respondents stated that they together with the HEWs held discussion about the construction, usage and maintenance of sanitary latrine and family planning packages during the visits. In addition, 86.7% and 84.0% of the respondents stated that their discussion issues were on immunization service and water supply safety measures packages respectively. Proportion of the respondents which range from 72.0% to 74.7% expressed that they discussed about building and maintaining healthful house, HIV/AIDS and tuberculosis prevention and control and personal hygiene packages. In addition, sixty-four percent of them discussed on first aid package.

Therefore, the HEWs in the study villages show high level of commitment to the achievement of the goal and objectives of the HEP because they usually visit each targeted household every two weeks and hold discussions with the members of the household about the construction, usage and maintenance of sanitary latrine and family planning packages; immunization service and water supply safety measures packages; building and maintaining healthful house; HIV/AIDS and tuberculosis prevention and control measures; personal hygiene packages; and about first aid package in decreasing magnitude of importance. Surprisingly, HIV/AIDS and TB which are deadly diseases are discussed as the fifth important issues.

Table: 4.5. Frequency of Visits by HEWs

Question	Frequency of visit	Frequency	Percent (%)
How frequent HEWs visited your family/home for the purpose of HEP?	Daily	0	0.0
	Every three days	0	0.0
	Weekly	13	17.4
	Every two weeks	43	**57.3**
	Every month	19	25.3
	Others	0	0.0
	Total	**75**	**100.0**

Table: 4.6. Proportion of Respondents covered under the Health Extension Packages

No	Health Extension Packages	No. of respondents in percentage (%)	
		Yes	No
1	Construction, Usage and Maintenance of Sanitary Latrine	**100.0**	0.0
2	Family Planning	**100.0**	0.0
3	Immunization Service	**86.7**	13.3
4	Water Supply Safety Measures	**84.0**	16.0
5	Solid and Liquid Waste Management	**78.7**	21.3
6	Maternal and Child Health	**78.7**	21.3
7	Building and Maintaining Healthful House	**74.7**	25.3
8	HIV/AIDS and Tuberculosis Prevention and Control	**73.3**	26.7
9	Personal Hygiene	**72.0**	28.0
10	First Aid	**64.0**	36.0
11	Malaria Prevention and Control	46.7	53.3
12	Food Hygiene and Safety Measures	42.7	57.3
13	Control of Insects, Rodents and other Biting Species	37.3	62.7
14	Nutrition	32.0	68.0
15	Adolescent Reproductive Health	28.0	72.0

In order to know the commitment and availability of health extension workers to provide services for the local community members, the researcher raised some questions. Eighty-four percent of the respondents ensured the availability of the HEWs when they wanted for services. Out of these respondents, 58.3% of them stated that their absence for the services was due to frequent meetings held, but 41.7% had no idea on the reason(s) for being not available in their duty station.

As shown in Table 4.7, 69.3% of the targeted sample beneficiaries agreed that the health extension workers gave them sufficient information about family planning methods. About fifty-seven percent (57.3%) of the respondents strongly agreed that they became knowledgeable about to whom family planning methods used and 76.0% of them also knew about the whereabouts of the family planning methods. Thus, the health extension workers are evaluated as effective and efficient in the services delivery of family planning.

Table: 4.7. Evaluation of the HEWs Commitment

No	Questions	5	4	3	2	1
		Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	Health extension workers give me sufficient information about family planning methods	0.0	0.0	0.0	**69.3**	30.7
2	I know family planning methods that women or men use to avoid pregnancy.	0.0	0.0	0.0	42.7	**57.3**
3	I know where I can get family planning method(s) I need.	0.0	0.0	0.0	24.0	**76.0**

In addition, questions on the community's level of awareness and level of understanding on the advantages of the family planning were posed to the respondents in the study. The findings of the study indicate that forty percent of them stated in terms of spacing between children, about thirty-five percent (34.7%) for spacing between children and to avoid early pregnancy and the rest, 25.3% to avoid early pregnancy. Therefore, there is low level of awareness of and understanding on the advantages of the family planning services provided.

4.3 Factors Challenging effective Implementation of HEP

The interview schedule was used to know factors challenging the effective implementation of the HEP at the targeted villages in the Ensaro District. The results of the study show that there were major factors which affected the implementation of the Programme. About eight-one percent (81.3%) of the respondents observed any problem during the implementation of the programme, while the rest 18.7% of them were neutral about the issue. About sixty-five of them believed that the services currently provided were sufficient. Moreover, 69.3% of the respondents agreed that the local community participated in the Programme implementation. Among the respondents, the majority (92.0%) confirmed that HEWs provided them with health education in the village. Moreover, 66.7% of the respondents participated in the Programme by implementing the information/education given by the HEWs.

4.4 Strengths of HEP Implementation

The Programme has strengths in the construction of sanitary latrine, personal hygiene, family planning, HIV/AIDS and TB. All of the respondents constructed sanitary latrine and used it, experienced in keeping their personal hygiene, knew the use of family planning methods, and understood how HIV/AIDS and TB transmitted.

As shown in Table 4.8, 89.3% of them strongly agreed that they knew family planning methods which help them to avoid pregnancy, but only 10.7% agreed for their uses. Moreover, 58.7% of

the respondents agreed for the availability of the family planning methods as per their preference.

Table: 4.8. Assessment of the Strengths of the HEP

No	Questions	5	4	3	2	1
		Strongly Disagree	Disagree	Neutral	Agree	Strongly agree
1	I know family planning methods that women or men use to avoid pregnancy.	0.0	0.0	0.0	10.7	**89.3**
2	Family planning methods are available at health post as one prefers.	0.0	0.0	24.0	**58.7**	17.3

In addition, 78.7% of the respondents' children got vaccinated their children, 85.3% of them confirmed that they could get referral services for those services not available in the health post. Thus, the HEP implementation in the villages is effective.

Generally, the qualitative data collected form key informants also substantiated the above-stated findings. In order to get data for the assessment of the HEP interview questions was administered to one HEW who is the agents of the program working in the study area.

The HEW assigned in the study area has been working for four years and three months long and has got six months of basic training about the health extension program before implementation of the program. The HEW has got refreshment training two times in her stay concerning the health extension packages. She has experience in preparing monthly reports and submits to the district health office. The district health office program officers support and supervise her in a monthly basis, but the supervisors didn't provide a feedback. The HEW pointed out that there is shortage of stationary materials like paper, pen, note book and report formats. In addition there

is shortage of medical equipments and family planning drugs, I used to submit the material and drug requests as soon as the remaining stock balance becomes one-third; there is problem in the process of distribution, most drugs were delivered after the stock balance becomes nil. In relation to the nature of the work the amount paid salary is not enough, I have requested salary increment so many times but no response from the district health office, so I am not satisfied with the payment, but I am very interested to work as a HEW in order to serve the community.

In order to get data for the assessment of the HEP, interview questions were administered for two Ensaro District Health Office HEP Supervisors who supervised and evaluated the Programme implemented in the study area.

Two of the HEP supervisors have been recruited before five years; they worked as a HEP for four years and seven months and three years as a program supervisor. They are experienced to provide support and supervision at monthly bases, but there are situations which hinder not to do at monthly basis. They also showed that HEWs deliver their report every month and timely.

In Ensaro district during the beginning of the HEP there were 25 HEWs trained and recruited; but in the last seven years of implementation ten HEWs has been resigned in different times. The cause of their resignation was not clearly known and registered. In addition within four to six months interval the district has trained and recruited other HEWs.

Those two HEP supervisors pointed out that the program was achieved its goal in relation to health extension packages, mainly in family planning package, immunization services package, maternal and child health package, and in construction, usage and maintenance of sanitary

latrine packages. But in the rest health extension packages there is a god progress but takes long time to bring about a radical change among the community.

In relation to the challenges of the HEP implementation, two of the HEP supervisors raised the following major challenges during the implementation of the program; such as turnover of HEWs and difficulty to replace the vacant position soon due several bureaucratic problems, less commitment in some HEWs, the communities low understanding and participation to the HEP, and lack of transportation access like car for monitoring and evaluation and to distribute the necessary materials and drugs to the health posts timely.

On the whole, the implementation of the Programme is effective and efficient. However, there are some challenges which have been affecting the commitment of HEWs and the actual implementation of all packages of the HEP Components in the targeted villages under the auspices of Ensaro District, North-East Ethiopia.

CHAPTER FIVE

MAJOR FINDINGS AND DISCUSSIONS

The study was intended to assess the achievements and challenges of the implementation of the HEP in Ensaro district of North-west Ethiopia. In the study quantitative data was used in the form of questionnaire administered to the randomly selected local community members living in Ensaro district local administration and qualitative data was collected from the Ensaro health office two HEP supervisors and one HEW working in the local administration. Assessment of the health extension program (HEP) was made primarily based on the indicators of progress; basic requirements need to be satisfied to efficiently and effectively implement the program. As a result of collection of the relevant data major findings have been summarized and discussed as follows.

During the implementation of HEP it has its own program guide line which states clearly the type of services and packages to be delivered to the local community. These services and packages should be easily understood and accepted by the people, it ensures the participation of the local communities in the implementation of HEP. So, in relation to this the local community has been effectively communicated to be part of the program. The community was familiar with the HEP packages and services; in addition the services are at satisfactory level in most of the

health extension packages, but there are still poor service deliveries in first aid, adolescent reproductive health, food hygiene and safety measures, and in personal hygiene packages.

The most front desk health service providers in the implementation of HEP are HEWs. These individuals have a very close contact than any other body with communities and they are primary agents of HEP implementation. One could deduce from this fact that HEWs have to be competent enough to serve communities as well they have to advance ethical behaviors in service rendering process.

HEWs' are responsible to educate and promote people so that communities would develop healthy behavior to improve their health status and living standards, more over those HEW's should be committed for their duty in order to serve the local community. Therefore due to the findings of the study health extension workers have been visited each community member every two weeks and they have discussed on major health extension packages like about family planning, about immunization services, about water supply and safety measures and about HIV/AIDS and tuberculosis prevention and control packages extensively; they work to the maximum to increase awareness of the local community about family planning methods and how to use it, and they expensed majority of their time with the community an on duty which show the commitment of the HEW's. But there are some health extension packages which are not frequently discussed with the local community like nutrition, adolescent reproductive health, control of insects, and rodents and food hygiene and safety measures. In addition frequent meetings out of the working area tends them not to fully discharge the duty of HEP execution

and decreases their effectiveness and commitment in order to provide better services. The findings of study showed that the implementation of HEP addressing the needs of various segments of the communities and some health extension packages could not adequately be undertaken by health extension workers.

HEP is aimed at providing health services and to protect the community from easily communicable diseases and due unhygienic living styles. Therefore the implementation of the program should be under close follow-up and due consideration. The study shows during implementation of the program there were no significant problem observed and they are satisfied with the services. The services presently provided are almost sufficient but there are some challenges which affect the effective implementation of the program lack of community support and participation and lack of adequate materials and drugs. For health posts or HEWs to serve the communities in their full capacity, they have to be provided with necessary facilities such as equipments, medicine and any other vital kits. Regarding, the findings of the study shows the under supply of HEWs or health posts with required equipment materials to provide services. Additionally, logistic problems, shortage of stationary materials and report formats have been observed predominantly at furnishing the health post.

Working being HEW is an awkward profession that a person who does not have other alternative joins it as phrased by HEW. The finding in the study has shown that due to very low payments they tend to loss the interest to work, which increases the rate of turnover, long stay in the profession, they are working till the opportunity of better job.

It is stated in implementation guide that sound supervision is an essential input in the execution

of HEP. Provision of appropriate and timely feedback for the reports made help HEWs to keep track of their progress and make corrective measures as fast as possible. Unfortunately, findings of the research reflected the weak support and supervision in the execution of HEP. However, in the study areas due attention has not been given to the supervision aspect of HEP. It was reported that the supervision is done monthly, and district health office has not ever provided written feedback to HEWs.

HEP was implemented with a great effort and commitment to bring about a better health for the community. For the achievement of the program health posts has been constructed at each local administration site, basic training was given for the HEWs and the appropriate budget has been allocated.

In relation to this the study shows there is a greater effort to change the traditional way of life in to a modernization by using and preparing a sanitary latrine, keeping hygiene's of the family, vaccinating children, and using family planning methods.

Finally, the findings of the study reflected that there have been some achievements in some health extension packages and there is a significant change in the life style of the local community by decreasing family size and protecting himself from different communicable diseases. In addition it has some challenges which affect the implementation of the program, to be focused on for better achievements.

CHATER SIX

CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusion

Different data collection methods were employed to gather data from the local community members, district health office supervisors and HEWs involved in the implementation of HEP. Appropriate analysis instruments were put in place to look into the patterns of data collected which have been summarized.

To begin with the awareness activities the community is well informed and understood the importance of the HEP; satisfied with the services provided and even participated in the program implementation activities. The data shows there is a good acceptance of the program among the local community and indicates that HEWs have been providing primary health services at village level to improve the health standards of the local communities. Among the achievements registered, increased utilization of family planning services, construction and usage of sanitary latrines, increased number of immunized children, increased maternal and child health services and provision of health education by HEWs at each family level have been identified as major achievements of the execution of HEP.

On the other hand, the findings of the study showed many poor performance areas in the execution of the health extension packages; like in the adolescent reproductive health package,

first aid package, nutrition package, food hygiene and safety measures package and personal hygiene packages.

It also highlighted that there have been challenges in high rate of turnover ad difficulty to recruit soon, lack of transportation facilities, and shortage of provisions of stationary materials. Moreover, the result of the study has proven that HEWs has complained for lower salary payments and lack of appropriate and frequent supervisory activities.

Nonetheless, the findings showed up that there is a significant shortage of basic necessary stationary materials, medical equipments and drugs for HEWs to serve communities as intended.

Supervision is an important management tool to ensure effective and efficient management of HEP. In the study areas, the findings reflected that generally there have been weak and lack frequent supervision. In addition, there was no transportation facility for supervisors to smoothly coordinate and supervise the performance of HEWs.

6.2 Recommendations

Based on the findings of the study, recommendations having options for further practical interventions and corrective measures in order to improve health service delivery performance and to achieve the goal of the HEP; the following recommendations have been forwarded.

- Materials and essential drugs needed for the provision of quality health services should be delivered soon before the stock balance becomes nil. It is important to fulfill health service delivery kits, gloves, and supply of family planning drugs should be improved to

ensure sustainable provision of health services.

- As presented in this thesis, adequate positive changes in the knowledge /understanding/ about the program is encouraging, Thus, health education and communication should be reinforced and continued to inculcate receptive spirit among the local community so that their full participation would be realized that could be a potential assurance for the success of the program.
- The support and supervision activities should be immediately improved. The present support and supervision system is very weak that it induces changes in terms of improving the managerial and technical skills of supervisors. In addition immediate feedback should be given to the HEWs. In addition further study should be conducted to solicit feasible and sustainable transportation facilities for supervisors and HEWs such as motor cycle should be used to smooth support and supervision activity.
- As of any other sector staff, arrangements have to be made to address the increasing needs of HEWs like salary increment. There should be a system to handle them to decrease turnover, and if not immediate recruitment and training should be given.
- HEWs are expected to provide primary health services and referral arrangements for patients with chronic illness those cannot be treated at health posts to higher health institutions i.e. health centre or hospital. But evidences have shown that there have been problems in performing the service as needed, in doing timely referrals, so HEWs should be capacitated and supported for this basic service.
- Heath education and communication should be given priority in HEP by government. Despite this fact, the result of the study showed that it has not been considered as it is very important method of community mobilization so as to address the local community.

The study indicates that health education was not given due attention as a result, it was noticed that HEWs could not impart the basic information and knowledge to the local community to bring positive behavioral changes among them to be self reliant in keeping their health.

- Finally, further study should be conducted to improve the implementation of the HEP in order to achieve the intended goals.

References

Bilal, N.K., et al. (2012). Health extension workers in Ethiopia: Improved access & coverage for rural poor. Retrieved March 1, 2013, from http://siteresources.worldbank.org/AFRICAEXT /Resources/258643-1271798012256/Ethiopia-health.pdf.

Central Statistical Authority [CSA], (2012). Ethiopian demographic and health survey. *Addis Ababa:* Author

Ensaro district Finance & Economic Development Office report, (2011/2012). Socio-economic data report: Ensaro district. Unpublished.

Ensaro District Health Office Report, (2012). Annual health service report, Unpublished.

Federal Ministry of Health [FMoH], (2005). Health service development program-III, 2005/06-2009/10. *Addis Ababa:* Planning and Programming Department.

FMoH, (1993). Health Policy of the Transitional Government of Ethiopia. *Addis Ababa*.

FMoH, (2005). Health service extension implementation guideline. *Addis Ababa:* Ethio Tikur Abay Printing Press.

FMoH, (2007). Health extension program in Ethiopia: Profile. Addis Ababa: Health Extension and Education Center Press.

FMoH, (2010). Health service development program-IV, (2010/11-2014/15): Addis Ababa. Planning and Programming Department.

FMoH, (2011). Health and health related indicator, planning and programming department. Addis Ababa. Retrieved March 1, 2013, from http://cnhde.ei.columbia.edu/.pdf.

Habtamu, A. (2007). The health extension program in Ethiopia: Summary of concepts, progress, achievements and challenges. Unpublished master's thesis, Addis Ababa University, Addis Ababa.

Hailom, B. (2011). Ethiopia's health extension program: Improving health through community involvement: *MEDICC Review*, Vol 13, No 3, Addis Ababa.

Ministry of Finance and Economic Development [MoFED], (2012). Growth and transformation plan: Annual progress report for fiscal year 2010/11, Addis Ababa.

Pathfinder International, (2008). The Ethiopian health extension program: Pathfinder international support, Addis Ababa, Ethiopia

Transitional Government of Ethiopia [TGE], (1993). National population policy of Ethiopia. Addis Ababa, Ethiopia: Transitional Government of Ethiopia.

World Bank, (1995). Better health in Africa, A World Bank Publication.

Appendices

Appendix A: Interview Schedule for Respondents in the Study Area

:

INDRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

Dear respondent,

I am a student at School of Social Work of the Indira Gandhi National Open University,. I came to collect information from you to undertake a research entitled **'Assessment of Achievements and Challenges of Implementing Health Extension Program'**. The information is collected for academic purpose and to suggest actions to improve the program. Moreover, the information gathered is kept confidential and never affects your personal life. You are also not required to write and to tell me your name. Therefore, you are kindly requested to give your genuine answers to the questions raised in accordance with the instructions.

Thank you very much for your cooperation!

Questionnaire developed for direct beneficiaries of the HEP in the local administration.

Instruction: Please tick or encircle the appropriate answer for these questions.

No	Questions	Responses
	Part One: Socio-demographic Information	
1.1	Your Sex	1. Female 2. Male
1.2	Your age group	1. 18-24 2. 25-44 3. 45-64 4. >65
1.3	Educational Level	1. Informal education 2. 1 – 8th grade 3. 9 – 10th grade 4. 11 – 12th grade 5. Certificate 6. BA/BSC Degree 7. Post Graduate Degree 8. Other Please Specify; .....
1.4	Marital Status:	1. Single 2. Married 3. Widowed

		4. Divorced
1.5	Number of children;	.....
1.6	How many years do you live in this local administrative site?	1. Below one year 2. 1 – 3 years 3. 4 – 7 years 4. More than seven years
1.7	What is your job (work) currently?	1. Farmer 2. House wife 3. Trader 4. Student 5. Government employee 6. Others, specify: .....

Part Two

Questionnaire concerning types of services delivered during the implementation of HEP

2.1.	Do you know those services provided during the implementation of the HEP?	1. Yes 2. No
2.2	What are the types of services that are delivered in your village by the HEP? Please thick more than one.	
	2.2.1 Hygiene and environmental sanitation	1. Yes 2. No
	2.2.2 Family health services	1. Yes 2. No
	2.2.3 Disease prevention and control	1. Yes 2. No

	2.2.4	Health education and communication	1. Yes 2. No
	2.2.5	Others; please specify:	

2.3	What are the services that you are benefited from the HEP? Please thick more than one.		
	2.3.1	Hygiene and environmental sanitation	1. Yes 2. No
	2.3.2	Family health services	1. Yes 2. No
	2.3.3	Disease prevention and control	1. Yes 2. No
	2.3.4	Health education and communication	1. Yes 2. No
	2.3.5	Others; please specify:	
2.4	Do you think services provided are sufficient and satisfactory?		1. Yes 2. No
2.5	What is your recommendation to be done to get better services?		
2.6	Are you satisfied with those services?		1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree

2.7	Currently, how Major HEP Components and Packages are implemented and carried out in your village, please rate your satisfaction in the services you have been provided by HEWs?

Major HEP Components and Packages		5	4	3	2	1
Components	Packages	Excellent	Very Good	Satisfactory	Poor	Very Poor
2.7.1. Hygiene and Environmental Sanitation	2.7.1.1. Building and Maintaining Healthful House					
	2.7.1.2. Construction, Usage and Maintenance of Sanitary Latrine					
	2.7.1.3. Control of Insects, Rodents and other Biting Species					
	2.7.1.4. Food Hygiene and Safety Measures					
	2.7.1.5. Personal Hygiene					
	2.7.1.6. Solid and Liquid Waste Management					
	2.7.1.7. Water Supply Safety Measures					
2.7.2. Family Health Service	2.7.2.1. Maternal and Child Health					
	2.7.2.2. Adolescent Reproductive Health					
	2.7.2.3. Family Planning					
	2.7.2.4. Immunization Service					
	2.7.2.5. Nutrition					
2.7.3. Disease Prevention and Control	2.7.3.1. HIV/AIDS and Tuberculosis Prevention and Control					
	2.7.3.2. Malaria Prevention and Control					
	2.7.3.3. First Aid					
2.7.4. Health Education &Communication	2.7.4.1. Health Education and Communication Methods					

Part Three			
Questionnaire concerning the commitment of HEWs			
3.1	Does HEWs came and visited you/your family?		1. Yes 2. No
3.2	How frequently HEWs visited you/your family?		1. Daily 2. Every three days 3. Weekly 4. Every two weeks 5. Every month 6. Others, specify: .....
3.3	What type of health issue do you discuss with health extension workers?		
		3.3.1. About building and maintaining healthful house	1. Yes 2. No
		3.3.2. About construction, usage and maintenance of sanitary latrine	1. Yes 2. No
		3.3.3. About control of insects, rodents and other biting species	1. Yes 2. No

		3.3.4. About food hygiene and safety measures	1. Yes 2. No
		3.3.5. About personal hygiene	1. Yes 2. No
		3.3.6. About solid and liquid waste management	1. Yes 2. No
		3.3.7. About water supply safety measures	1. Yes 2. No
		3.3.8. About maternal and child health	1. Yes 2. No
		3.3.9. About adolescent reproductive health	1. Yes 2. No
		3.3.10. About family planning	1. Yes 2. No
		3.3.11. About immunization service	1. Yes 2. No

		3.3.12. About nutrition	1. Yes 2. No
		3.3.13. About HIV/AIDS and tuberculosis prevention and control	1. Yes 2. No
		3.3.14. About malaria prevention and control	1. Yes 2. No
		3.3.15. About first aid	1. Yes 2. No

3.4	Does HEWs are available when you want to get services?		1. Yes 2. No 3. Not always
		3.4.1. If 'No' or 'Not always', why?	
		3.4.1. Due to frequent meetings	1. Yes 2. No
		3.4.2. She gone to town	1. Yes 2. No
		3.4.3. She didn't come to office	1. Yes 2. No
		3.4.4. I don't know the reason	1. Yes 2. No
		3.4.5. Others;	
3.5	Health extension workers give me sufficient information about family planning methods		1. Strongly disagree 2. Disagree 3. Neutral 4. Agree

		5. Strongly agree
3.6	I know family planning methods that women or men use to avoid pregnancy.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree
3.7	I know where I can get family planning method/s I need.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree
3.8	What are the advantages of family planning? Please mention at least three of such advantages.	

Part Four		
Questionnaire concerning the factors that have influenced and challenged the effective implementation of HEP		
4.1	Is there any problem that you have observed during the implementation of the HEP?	1. Yes 2. No 3. Neutral
	4.1.1 If 'Yes', what are those problems you have observed?	
4.2	Do you think services currently provided are sufficient in the areas of HEP implementation?	1. Yes 2. No 3. Neutral
4.3	What improvements need to be made to get better the services?	
4.4	Does the local community participate in the HEP implementation? How do you evaluate?	1. Strongly disagree 2. Disagree 3. Neutral

		4. Agree 5. Strongly agree
	4.4.1. If 'Disagree' mention your reasons.	
4.5	Does HEWs provide health education in your village?	1. Yes 2. No
4.6	How often you have participated in health education program/sessions?	1. Very often 2. Sometimes 3. I have no ever participated
4.7	Do you think there are problems during implementation for health extension workers being female?	1. Yes 2. No
4.8	What problems exist with health extension workers being female? Please write it down.	
4.9	What was your participation in your village during the implementation of HEP?	1. Only attending the health education session 2. Implementing the information/education given by the HEWs 3. I don't have any participation

Part Five			
Questionnaire concerning strengths and constraints of HEP implementation			
5.1	Do you have constructed sanitary latrine?		1. Yes 2. No
5.2	Do you use sanitary latrine?		1. Yes 2. No 3. Sometimes
		5.2.1. If 'No', why?	
		5.2.2. If 'Yes', who advise you to construct sanitary latrine?	1. My friend 2. HEWs 3. No one, because I know the advantage 4. Others specify; .....
5.3	Do you keep your & your family personal hygiene?		1. Yes 2. No
		5.3.1. If 'No', why?	
5.4	Do you know about ways of HIV/AIDS transmission?		1. Yes 2. No

5.5	Do you know how Tuberculosis is transmitted?	1. Yes 2. No
5.6	Do you know about the use of family planning?	1. Yes 2. No
	5.4.1. If 'No', why?	
5.7	I know family planning methods that women or men use to avoid pregnancy.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree
5.8	Family planning methods are available at health post as one prefers.	1. Strongly disagree 2. Disagree 3. Neutral 4. Agree 5. Strongly agree
5.9	Do you have vaccinated your children?	1. Yes

		2. No 3. I have no child
5.10	Do you get referral system on time for those services not given in the health post?	1. Yes 2. No
5.11	What measures do you suggest to be taken to improve the services given by HEWs?	

Appendix B: INTERVIEW GUIDE

INDRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

INTERVIEW GUIDE

Dear interviewee;

I am a student at Indra Gandhi National Open University, School of Social Work. I came to collect information from you to undertake a research entitled **'Assessment of achievements and challenges of Implementing Health Extension Program'**. The information is collected for academic purpose and to suggest actions to improve the program. Moreover, the information gathered is kept confidential and never affects your personal life. You are also not required to tell me your name. Therefore, you are kindly requested to give your genuine answers to the questions raised in accordance with the interview guide.

Thank you very much for your cooperation.

A. Interview Questions for HEWs

1. For how long do you have been working as a HEW?
2. Do you have got training for HEP?
3. Do you have refreshment training about the program?
4. Do you prepare a monthly report and report to the health office?
5. Does the health office support and supervise you frequently?
6. Do you have enough stationary materials?
7. Do you get medical equipments and medicine timely?
8. Do you think the salary is enough?
9. Are you satisfied with the salary paid?
10. Are you interested to work as a HEW?

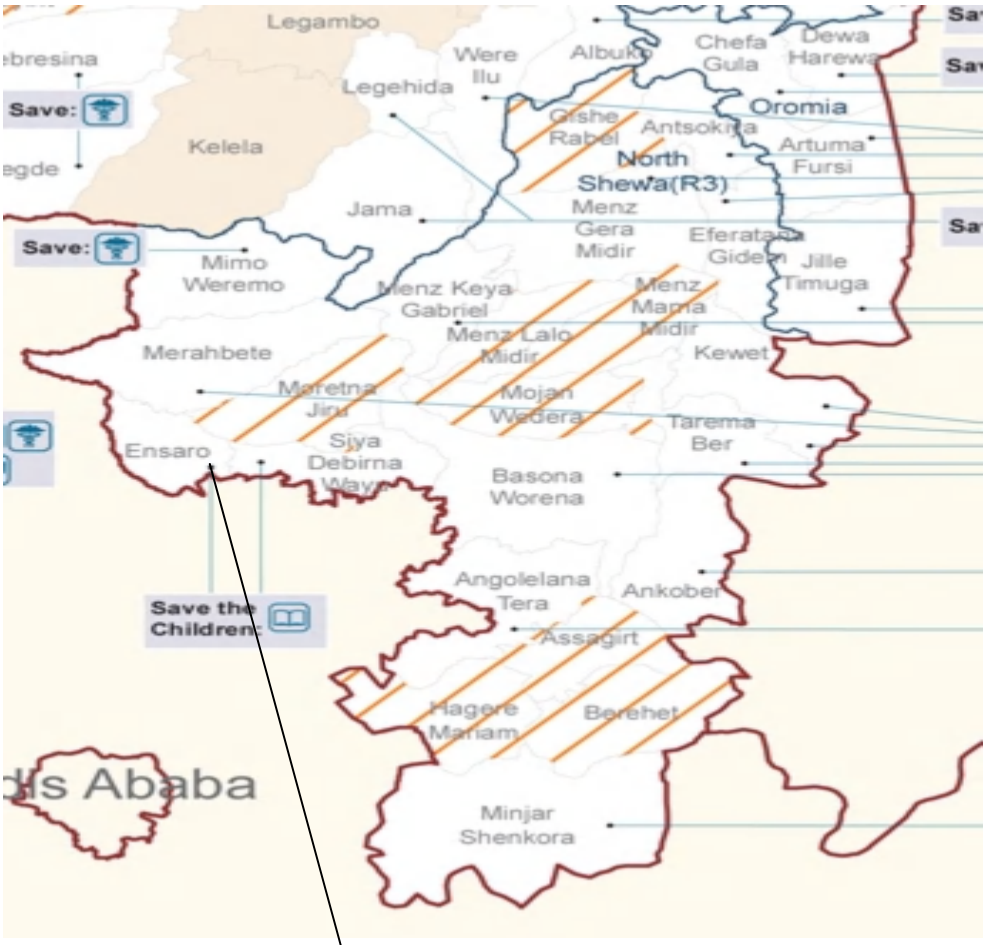
B. Interview Questions for health office HEP supervisor

1. For how long do you have been working as a HEW?
2. How often you provide support and supervision to HEWs?
3. Do you have get reports from HEWs timely?
4. Is there turnover for HEWs? How many of them resigned in the last six months?
5. What is the cause for their resignation?
6. Do you have recruited instead of them soon?
7. What are the major achievements during the implementation of the program?
8. What are the major challenges during the implementation of the program?

C. Observation Checklist in Ensaro District

1. What are the services provided in the district by HEWs?
2. What are the services that the local community more benefitted from the HEP implementation?
3. Does the community have constructed sanitary latrines?
4. Does the community use the constructed sanitary latrines?
5. How is HEWs work closely with the local community?
6. How the local community accepts the HEWs during their visit?
7. What are the achievements of the HEP in the local community?
8. What are the challenges encountered during the implementation of the HEP?
9. What are the supports, initiatives and follow-ups given to HEWs by the District Health Office?

Appendix- C: Location of Ensaro District



Location of Ensaro District-North East Ethiopia

PROFORMA FOR SUBMISSION OF MSW DISSERTATION PROJECT PROPOSAL FOR APPROVAL FROM ACADEMIC COUNSELLOR AT STUDY CENTER

Enrollment No: **ID1114860**

Date of Submission: _____

Name of the Study Center: **St. Mary University College, School of Graduate Studies**

Name of the Guide: **Sebsib Belay (Mr.)**

Title of the Project: **"ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTING HEALTH EXTENSION PROGRAMME IN ENSARO DESTRICT, NORTH-EAST ETHIOPIA"**

Signature of the Student: _____

Approved / Not Approved

Signature: _____

Name and Address of the Guide:

_____

_____

_____

_____

_____

Name and Address of the Student:

Mussie Sewnet Melesse

P.O.Box: 101198; Addis Ababa, Ethiopia.

Mobile: +251-911-41-46-89

E-mail: se.mussie@yahoo.com

Date: _____

ASSESSMENT OF ACHIEVEMENTS AND CHALLENGES OF IMPLEMENTING HEALTH EXTENSION PROGRAM IN ENSARO DESTRICT, NORTH-EAST ETHIOPIA

MSW DISSERTATION RESEARCH PROPOSAL

(MSWP-001)

By

MUSSIE SEWNET

(Enrollment No: ID1114860)

PROJECT SUPERVISOR:

SEBSIB BELAY (MR.)

INDIRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

MARCH 2013

ADDIS ABABA, ETHIOPIA

Table of Contents

1. Introduction

Ethiopia had no health policy until the early 1960s, when a health policy initiated by the World Health Organization (WHO) was adopted. In the mid-1970s, during the 'Derg' regime, a health policy was formulated with emphasis on disease prevention and control. This policy gave priority to rural areas and advocated community involvement. The current health policy, promulgated by the Transitional Government of Ethiopia, takes into account broader issues, such as population dynamics, food availability, acceptable living conditions, and other essentials of better health. To realize the objectives of the Health Policy, the Government of Ethiopia established the Health Sector Development Program (HSDP), which is a 20 year Health Development Strategy implemented through a series of four consecutive 5-year investment programs. The HSDP prioritizes maternal and newborn care, and child health, and aims to halt and reverse the spread of major communicable disease such as HIV/AIDS, TB, and malaria. The Health Extension Program (HEP) serves as the primary vehicle for prevention, health promotion, behavioral change communication, and basic curative care. The HEP is an innovative health service delivery program that aims at universal coverage of primary health care. The program is based on expanding physical health infrastructure and developing Health Extension Workers (HEWs) who provide basic preventive and curative health services in the rural community (CSA;

2012, p. 5).

Following the new Health Policy of 1993, the health sector has undergone many reforms. The size of Ministry of Health (MOH) has been reduced giving more tasks and power to regional health bureaus. The decentralization has further deepened to district level and health services delivery is now managed by districts. All the vertical programs were integrated following the new policy of 1993. Reviews of the 1st HSDP (1997/98- 2001/02) indicated the challenges in achieving universal coverage of PHC and revealed that necessary basic health services have not reached the people at the grass roots level as envisaged and desired, due to the nature of services being given by the health system. In response to this the government has introduced an innovative program called Health Extension Program (HEP) and this started implementation during the 2nd HSDP (2002/03-2004/05). Accelerated Expansion of Primary Health Services strategy has also been planned as part of facilitating the achievement of universal coverage of PHC (FMoH; 2010, P. 3).

The Health Extension Program (HEP) is an innovative community based program introduced started in 2003 during HSDP II. The HEP aims at creating healthy environment and living by making available essential health services at the grass root level. The objective of HEP is to improve equitable access to preventive essential health services through community (Kebele) based health services with strong focus on sustained preventive health actions and increased health awareness (FMoH, 2007, p. 25).

The HEP is a community level component of the Essential Health Services Package (EHSP) of the country. The objectives of EHSP is to reduce the morbidity, mortality and disability resulting from the major health and health related problems affecting most of the population of Ethiopia. The HEP makes the bottom level component of EHSP, and is primarily on preventive and promotive component, while essential curative care is introduced at Health Centre and District Hospital Level. The HEP is managed by the HEW whose station is the Health Post (HP). The HC and five such HP surrounding the HC make a PHCU thereby making the services package and referral system linked to each other (Habtamu . 2007, p. 31). The core of HEP is to identify and provide a list of essential health services to households at the kebele level. As a preventive health program, the HEP promotes four areas of care: Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation, and Health Education and Communication (Pathfinder International, 2008, p. 3).

Since health extension program is a newly introduced community based approach and the fact that it has been in place in the study area for seven years and four months would make it possible to assess the achievements and challenges faced during implementation and come up with base line information to back up district and regional decision makers.

Ensaro district has been implementing HEP as per the national implementation guideline prepared by ministry of health. Health office of the district has bill board at their gate with vision and mission written on it. The office has written the statement ***'creating healthy and productive citizens'*** as their vision. In the mission statement it has included major activities to be discharged being collaboration with stakeholders or not in the due course of health service delivery process.

The mission statement has also included principles of good governance in provision of health services to bring tangible improvements in the health status of their respective communities.

Ensaro district had been selected for the research based on the personal observations during moving to different local administration (kebele) and having personal talks with HEWs and the local community following the implementation of HEP. The researcher observed that even if implementation of the program takes more than seven years the occurrence of communicable diseases and awareness of the community is low, the reports shows that in the last three years diarrhea and intestinal parasites (IP) are still among the 'Top Ten' reportable diseases (Ensaro Health Office report, 2012). This evokes the researcher 'where is the result of the HEP implementation?' Based on the researcher's observation the local community didn't relay and accept HEWs as a health agent. Even some of the HEWs are not satisfied with their daily job. There for the researcher decided to assess the achievements and challenges of implementation of the HEP in the district.

2. Statement of the Problem

During the period of HSDP II/2003 Government has been mobilizing many resources for the development and implementation of health sector reform policies. Thus, the design and execution of health extension program aimed at improving the health conditions of the citizens especially those residing in rural areas has become a timely issue and been given priority in the health sector development agenda (MOH, 2005, p. 11).

The main objective of HEP is to improve equitable access to preventive essential health

intervention through community/kebele based health services with strong focus on sustained preventive health actions and increased health awareness. This service is being provided as a package focusing on preventive health measures targeting households particularly women/mothers at the kebele level. Cognizant of the fact that HEP implementation throughout the country should be consistent; the Federal Ministry of Health has developed an implementation guideline (MOH, 2005, p. 15). The guideline is the best tool for the regional health bureaus, district health offices, and the health posts (HEWs) to implement community based household focused health care services.

Although the HEP has been implemented by Ensaro district health office for more than seven years the targeted local community do not exhibit a significant health improvement and still they are suffering from different communicable diseases, 2011/12 annual report of the health office shows that among the ten top reported illnesses are those communicable diseases and infections caused by poor hygiene; more over there is a gap between HEWs and the local community in order to work together in collaboration.

Health Extension Workers in the district are selected from the nearby local administrative sites, all of them are females, and this may decrease their acceptance and credibility resulting poor acceptance to the program implementation. Most of those HEWs educational background is 10^{th} grade completed, and trained about the program for three months; the training period is too short to internalize the program and to apply to the local community; even no refreshment trainings are given.

The annual report of the district health office shows that some local administration sites are too

remote to reach, logistic and supplies problems and shortage of skilled manpower due to turnover were identified as challenges in the implementation of HEP.

In spite of the above problems and factors, no reliable and consistent research has been conducted in the district. Therefore, assessing achievements and challenges of the status of health extension program is very important.

3. Objectives of the Study

3.1. General Objectives:

The general objective of the study is to assess factors that have been affecting the implementation of HEP and to suggest possible courses of action to be taken to improve the performance of the program in the study district.

3.2. Specific Objectives:

- To assess types of services provided to the local community during the implementation of HEP in the district;
- To determine the extent to which HEWs have been committed to assist the local community in the district;
- To identify factors that have challenged the effective implementation of the HEP in the district; and

- To identify the strengths of the HEP implemented in the district.

4. Research Questions

The research will be guided by the following research questions:

- What are the types of services provided to the local community during the implementation of HEP in the district?
- To what extent HEWs are committed to assist the local community in the district?
- What are the factors that have challenged the effective implementation of the HEP in the district?
- What are the strengths of the HEP implemented in the district?

5. Study Design and Methods

The research shall focus at assessing achievements and challenges of the health extension program encountered during the time of implementation in Ensaro district. Accordingly the researcher will employ mainly non-experimental study design and uses quantitative and qualitative approaches and descriptive sample survey methods.

6. Universe of the Study

Based on the Ensaro district Finance & Economic Development Office report for the socio-Economic data of 2011/2012 E.C total population of the district is 59,706 (F-29,079 & M-

30,627). In the district there are 4 health centers and 13 health posts with 75 (F-44 & M-31) health professionals and 25 HEWs. The Study population is taken from those residents of the local administrative site named 'Lemi' where HEP implementation takes place for seven years and four months and the implementation starts in December 2005. 'Lemi' is located at the center of the district the aggregation of elements from which the sample is actually selected. In this local administrative site there are 3903 (Male= 1833, & Female= 2070) populations. The study focuses in the assessment of the achievements of the HEP in the district.

7. Sampling Methods and Sample Size

Sampling methods shall be developed based on the population size of the study. The method used for drawing a sample is significant to arrive at dependable results or conclusions. For the purpose of this study Non-probability sampling shall be deployed based on the judgment of the researcher. The guiding factors in non-probability sampling include the availability of the units, the personal experience of the researcher and his/her convenience in carrying out a survey. The technique to be used is purposive sampling technique, because it will be more appropriate to select cases that are judged to be typical of the population.

In order to assess the achievements and challenges of HEP implementation in the district the total number of interviewees shall be determined one local administrative site will be selected purposively. From the selected local administration site 70 residents from the local community shall be selected because of their important role in the implementation of HEP. In addition the HEW assigned in the site and the HEP supervisor at district level will be interviewed.

8. Data Collection: Tools and Procedures

In order to gather the necessary data both qualitative and quantitative data sources will be employed. The quantitative data shall be collected by using structured questionnaire to be filled and collected from the selected sample population. The participants shall be from the local community members. Qualitative data shall be collected through interview guide and from open ended questionnaires. For the purpose of the study both primary and secondary data sources will be employed. The primary data sources are those sources that provide the researcher with first hand data. Those sources shall be the local community/ residents, health extension workers, and health extension program supervisors. Field observation will be another important instrument used for obtaining primary data. The researcher will do field visits to observe some manifestations such as hygiene of the dwellers, latrine availability, clean water supply and so on. Structured and non structured interview will be conducted with health office administrators and HEP supervisors to get information to complement the data gathered accordingly. Secondary data sources will be gathered from both published and unpublished sources the district annual reports, charts, survey report, magazines, journals, books have been reviewed.

9. Data Processing and Analysis

Based on the purpose of the research to assess the achievements, performances, and challenges of HEP SPSS, descriptive statistical techniques, such as frequency distribution, charts, percentages, diagrams and tables shall be extensively employed for appropriate interpretation and to reach in conclusion.

10. Chapter Plan of the Dissertation

The dissertation will be logically arranged into five chapters. The First Chapter shall cover the introduction part which included background of the study, problem statement, objectives of the study, research methodology, data analysis, etc. The Second Chapter shall contain literature review in relation to the health extension program. The Third Chapter shall deal with research design and methodology. In Chapter Four, data analysis and interpretation on the achievements, performance and challenges of HEP in the study areas shall be made. In Chapter Five major findings and discussions will be stated. Finally, in Chapter Six the thesis will present conclusions and recommendations and tries to draw conclusions and to forward suggestions for action and further studies.

References

Central Statistical Authority [CSA], (2012). Ethiopian demographic and health survey. *Addis Ababa:* Author

Ensaro district Finance & Economic Development Office report, (2011/2012). Socio-economic data report: Ensaro district. Unpublished.

Ensaro District Health Office Report, (2012). Annual health service report, Unpublished.

Federal Ministry of Health [FMoH], (2005). Health service development program-III, 2005/06-2009/10. *Addis Ababa:* Planning and Programming Department.

FMoH, (2005). Health service extension implementation guideline. *Addis Ababa:* Ethio Tikur Abay Printing Press.

FMoH, (2007). Health extension program in Ethiopia: Profile. Addis Ababa: Health Extension and Education Center Press.

FMoH, (2010). Health service development program-IV, (2010/11-2014/15): Addis Ababa. Planning and Programming Department.

FMoH, (2011). Health and health related indicator, planning and programming department. Addis Ababa. Retrieved March 1, 2013, from http://cnhde.ei.columbia.edu/.pdf.

Habtamu, A. (2007). The health extension program in Ethiopia: Summary of concepts, progress, achievements and challenges. Unpublished master's thesis, Addis Ababa University, Addis Ababa.

Pathfinder International, (2008). The Ethiopian health extension program: Pathfinder international support, Addis Ababa, Ethiopia

Transitional Government of Ethiopia [TGE], (1993). National population policy of Ethiopia. Addis Ababa, Ethiopia: Transitional Government of Ethiopia.