



**Federal Democratic Republic of Ethiopia  
Federal Ministry of Health-Health Extension and Education Center**



**Report on the Assessment of Factors Contributing to  
and Affecting Performance of Health Extension Workers in  
Selected Woredas of  
Amhara National Regional State and  
Southern Nation, Nationalities and People's Region**

**September 2008  
Addis Ababa, Ethiopia**





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Given all the investments made in this assessment, the HEEC believes that this report and in particular, the findings and recommendations, remains a vital document contributing to the continued improvement and success of the Health Extension Program interventions in the future.

  
WONDWOSSEN TEMIESS  
GENERAL MANAGER

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### For further information, please contact:

Director, Extending Service Delivery Project  
1201 Connecticut Avenue, NW, Suite 700  
Washington, D.C. 20036  
Tel. 202-775-1977  
Fax 202-775-1988  
[ESDMail@ESDProj.org](mailto:ESDMail@ESDProj.org)

251-(0)11-5517031  
251-(0)11-5517032  
251-(0)11-5518031

Fax 251-(0)11-5519366  
251-(0)11-5512691  
251-(0)11-1552242

E-Mail: [moh@ethionet.et](mailto:moh@ethionet.et)  
Web site: [www.moh.gov.et](http://www.moh.gov.et)

1234  
Addis Ababa,  
Ethiopia

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## Acronyms

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AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
CBD	Community-based Distribution
CBRHAs	Community-based Reproductive Health Agents
CNHD-E	Center for National Health Development - Ethiopia
CPA	Civil and Public Agency
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
EC	Ethiopian Calendar Year
EFY	Ethiopian Fiscal Year
ESD	Extending Service Delivery (Project)
ESHE	Essential Services for Health in Ethiopia
FDRE	Federal Democratic Republic of Ethiopia
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FP	Family Planning
HEEC	Health Extension and Education Center
HEP	Health Extension Program
HEW	Health Extension Worker
HH	Household
HIV	Human Immune Virus
HP	Health Post
HSDP	Health Services Development Program
HTPs	Harmful Traditional Practices
IPO	Implementing Partner Organization
ITN	Insecticide-treated (bed) Net
NGO	Non-governmental Organization
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
RH	Reproductive Health
RHB	Regional Health Bureau
SNNPR	Southern Nation, Nationalities, and People's Region
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TTBA	Trained Traditional Birth Attendant
TT	Tetanus Toxoid
TVET	Technical and Vocational Education Training
VCHW	Voluntary Community Health Worker
VCT	Voluntary Counseling and Testing
WHO	Woreda Health Office
ZHD	Zonal Health Department

## **Glossary**

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<b>Colostrum</b>	The first secretion from the breast, occurring shortly after or sometimes before birth, prior to the secretion of true milk. It is a relatively clear fluid containing serum, white blood cells, and protective antibodies.
<b>Kebele</b>	The smallest governmental administrative unit with a population estimate of about 5000 people.
<b>Iddir</b>	A social organization established by community members, usually to help each other with modest amounts of money, labor and deeds during mourning, marriage, and/or other social occasions.
<b>Woreda</b>	Similar to a district.
<b>Injera</b>	A round, pebbled, soft type of bread about two millimeters thick, baked from a grain on a round clay surface of approximately a 40 centimeter diameter, and one of the most commonly eaten foods in Ethiopia.

## Executive Summary

### *An Innovative Approach to Meet Health Needs at the Community Level*

In 2005, the Federal Ministry of Health (FMOH) in Ethiopia realized that health services were not meeting the health needs at the community level. In response, the FMOH launched a new innovative program: the Health Extension Program (HEP). The HEP encourages community members to participate actively in planning and implementing health programs that improve the overall health status of their communities. The HEP works with community members to identify common health problems, discuss root causes and solutions, set priorities, develop plans of action, implement activities, and monitor and evaluate achievements. In particular, the HEP targets those most often underserved—mothers, neonates, children and rural communities—and places an emphasis on preventive health care practices. (Eighty-five percent of health problems in Ethiopia are preventable through changes in behavior, such as improved sanitation practices.)

A cadre of Health Extension Workers (HEWs) implements the HEP. The HEWs are women who are a minimum of 18 years old and have completed grade 10 or above. They also must complete a one-year training course on communicable disease prevention and health promotion, which prepares them to provide a package of 16 basic health services (see box). To date, the Health Extension and Education Center (HEEC) of the FMOH has trained nearly 24,600 of the planned 30,000 HEWs and assigned them to 11,000 health posts in rural *kebeles* (sub-districts), where they are estimated to reach a population of 4,757,000 people.

### *Assessing HEW Performance*

Thus far, assessments of the HEWs have not taken into account underlying factors that may affect worker performance. Pathfinder International-Ethiopia (PI-E) and the Extending Service Delivery (ESD) Project agreed to work with the FMOH/HEEC to conduct a performance assessment of HEWs to identify these factors and determine ways to improve HEW performance and ultimately the HEP.

The HEP covers a vast geographical area. However, there was an immediate need for identifying HEW performance factors and only limited financial resources available. Therefore, the HEEC decided to conduct a rapid assessment in four woredas of the Southern Nation, Nationalities, and People's Region (SNNPR) and the Amhara National Regional State. As PI-E is operational in these regions, it was able to provide

*The Health Extension Program is made up of 16 distinct packages of health care that have been carefully identified and developed by the Federal Ministry of Health to provide quality promotive, preventive and selected curative health care services in an accessible and equitable manner to reach all segments of the population, with special attention to mothers and children. Particular emphasis has been on establishing an effective and responsive health delivery system for those who live in rural areas, focusing on households at the community level. The program is the primary vehicle for bringing key maternal, neonatal and child health interventions to the community.*

*The packages include the following:*

#### **Family Health**

*Maternal and child health  
Family planning  
Immunization  
Nutrition  
Adolescent reproductive health*

#### **Disease Prevention & Control**

*HIV/AIDS, other STIs, TB  
prevention and control  
Malaria prevention & control  
First Aid*

#### **Hygiene & Environmental Health**

*Excreta disposal  
Solid and liquid waste management  
Water supply & safety measures  
Food hygiene & safety measures  
Healthy home environment  
Control of insects and rodents  
Personal hygiene*

#### **Health Education & Communication**

administrative and logistical support to facilitate the implementation of the assessment, which was conducted in March/April of 2008. The four woredas selected by the Regional Health Bureaus (RHB) were the first woredas to initiate the HEP in the country. Because they had more experience, their health posts generally reported better performance than those from other woredas.

The assessment used both quantitative and qualitative measures, including semi-structured key informant interviews, focus group discussions (FGDs), stakeholders' meetings, and observational visits to the health posts and nearby living quarters. These steps helped the evaluators obtain a better understanding of the work done by the HEWs, the environments where they worked, and their implementation of the HEP.

### ***Major Findings***

The assessment found that a number of factors contributed to the strong performance of HEWs. The most significant finding was the importance of a favorable and supportive national health policy. In addition, the assessment identified the following factors that positively affected HEW performance:

- The assignment of HEWs to communities with a common culture, tradition, and language.
- The availability of living quarters near the health post.
- A cadre of respected voluntary community health workers (VCHWs) who facilitated HEW entrée into the community and provided essential support.
- The establishment of “model families” to champion the HEP and promote positive health practices.
- The appointment of HEWs to kebele cabinets, to place health on the public agenda.
- The involvement of community members and groups, such as farmers' cooperatives.

Factors that were associated with gaps in HEW performance were numerous and varied from health post to health post. Some should be addressed immediately, while others can be implemented over a longer period. A summary of findings and recommendations are presented below. They are discussed in more detail in the full report.

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

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

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

This limited assessment suggests that the HEP and HEW approach is a cost-effective way of reaching underserved communities, with all stakeholders playing a critical role. With some modifications, the program can be significantly strengthened. We recommend that this information be shared at the regional, national and even global levels in order to facilitate the implementation of similar large-scale approaches to reach underserved populations with community-based health services.

## 1. Background

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The health challenges facing Ethiopia are substantial. According to the 2005 Demographic and Health Survey (DHS), maternal mortality in Ethiopia is 673/100,000; infant and under five mortality rates are estimated at 77/1000 and 123/1000, respectively. The total fertility rate is approximately 5.4 children per woman, which is among the highest rates in the world. The contraceptive prevalence rate (CPR) stands at 14.7%, and 34% of women report unmet need for family planning<sup>1</sup>. HIV/AIDS, malaria and tuberculosis are the major causes of adult morbidity and mortality in the country, while measles, malaria, acute respiratory infections and diarrheal diseases are major causes of death among children under five.<sup>2</sup> A large proportion of the country's health problems are preventable.<sup>3</sup>

Ethiopia adopted the Alma-Ata Declaration of Primary Health Care (PHC) in 1978. The health initiatives undertaken since 1978, however, have had little effect on the health status of people at the community level, in part because the old system of centralized planning did not encourage community participation and involvement. There was also little collaboration between the public and private sectors.<sup>4,5</sup>

In 2000/2001, the Federal Democratic Government of Ethiopia developed a new National Health Policy. The Policy emphasized the health needs of the underserved rural population, which makes up approximately 85% of the total population of Ethiopia<sup>6</sup>. Following the development of the Policy, the FMOH outlined the first phase of the Health Sector Development Program (HSDP), which complies with the country's Plan for Accelerated and Sustained Development to End Poverty, developed in response to the Millennium Development Goals.

The FMOH next introduced the Health Extension Program (HEP) as part of the 2002-2005 Health Sector Development Program II in an attempt to provide essential services to more communities. The HEP is an innovative, community-based health care delivery system designed to create a healthy environment and healthful living. The HEP empowers communities to collaborate with the government health sector at the kebele level (the lowest administrative level in a woreda [district]), to identify health problems and root causes, seek solutions, set priorities and formulate local plans of action. The HEP promotes healthy behavior and seeks to provide essential preventive care to underserved communities at the grassroots level.

The HEP consists of promotive and preventive health care services made accessible to all rural kebeles at a kebele health post, the lowest level of the FMOH's health system. The program includes a cadre of 30,000 HEWs, with each health post staffed by two female HEWs. Each health post serves a catchment area of approximately 5,000 people and refers clients to the health center (the next level facility up in the health system). As of August 2008, the FMOH had placed 82% of the planned 30,000 HEWs and staffed approximately 66% (9940) of rural kebele health posts.

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<sup>1</sup> CSA and ORC Macro, Demography and Health Survey, 2005

<sup>2</sup> WHO, Health Action Crisis, September 2007

<sup>3</sup> Federal Ministry of Health: HSDP III Health Sector Strategic Plan 2005/06. 2009/10, September 2005

<sup>4</sup> Annual Performance Report of HSDP III, 1997 EFY (2006/07), October 2007

<sup>5</sup> German Ethiopian Association: Health Service of Ethiopia [www.deutsch-aethiopischer-verein.de](http://www.deutsch-aethiopischer-verein.de) , November 2003

<sup>6</sup> Federal Democratic Republic of Ethiopia: The National Health Policy, 1993

## ***Health Extension Program Packages***

### **Family Health**

*Maternal and child health  
Family planning  
Immunization  
Nutrition  
Adolescent reproductive health*

### **Disease Prevention & Control**

*HIV/AIDS, other STIs, TB  
prevention and control  
Malaria prevention & control  
First Aid*

### **Hygiene & Environmental Health**

*Excreta disposal  
Solid and liquid waste management  
Water supply & safety measures  
Food hygiene & safety measures  
Healthy home environment  
Control of insects and rodents  
Personal hygiene*

### **Health Education & Communication**

The HEWs have completed schooling to grade 10 or higher and originally come from the communities in which they work. Recruiting HEWs from their community ensures a more rapid acceptance of the HEW: she speaks the local language, is respected by the community and in turn respects the local traditions and culture of the community. All HEWs receive training in the essential health promotion and preventive health care services that make up 16 health care packages identified in the HSDP (see box).

HEWs work closely with and supervise the efforts of volunteer community health workers (VCHWs), including Community-based Reproductive Health Agents (CBRHAs) and community health promoters. VCHWs conduct house-to-house visits to provide information on family planning, exclusive breastfeeding, nutrition and immunization, and refer individuals to the health post. This coordination between the HEWs and VCHWs maximizes the opportunity to obtain the desired outcomes of the HEP, as well as of the HSDP III and the Millennium Development Goals.<sup>7</sup>

## **2. An Assessment of the HEWs**

In June 2007, the FMOH sent a country team to participate in a sub-Saharan, multi-country workshop on “Community-based Reproductive Health and Family Planning Programs” held in Mali. This workshop was co-organized with support from the United States Agency for International Development/Washington, the Extending Service Delivery (ESD) Project/Washington, the World Health Organization,

and the UNFPA. The workshop’s goal was to identify best and promising practices, as well as gaps in scaling-up large, government-supported community-based reproductive health and family planning programs implemented in Cameroun, Ethiopia, Ghana, Madagascar, and Mali. Country teams were comprised of key government officials and NGO representatives; team members exchanged experiences and lessons learned, identified strengths and weaknesses of their programs, and developed a twelve-month follow-up action plan. Areas where additional technical assistance needs were also identified.

Building on the Mali workshop and the needs of the HEP in Ethiopia, the HEEC of the FMOH decided that it was important to explore factors affecting the performance of HEWs, who are key implementers of the HEP.

The Center for National Health Development Ethiopia (CNHD-E) assessed the effect of training on the first batch of HEWs, and has used the findings to strengthen the woreda health system and to identify ways to strengthen the HEWs’ efforts. The results of the assessment provided a number of insights into the challenges the HEWs faced in implementing the HEP.<sup>8,9,10</sup> A second assessment of HEWs and the

<sup>7</sup> Health Extension and Education Center, Federal Ministry of Health: Health Extension Program in Ethiopia, June 2007

<sup>8</sup> CNHD-E: Training of the Health Extension Workers: Assessment of the Training of the First Intake. Addis Ababa, 2004

<sup>9</sup> CNHD-E: Strengthening the Woreda Health System in Supporting the Health Extension Program. Addis Ababa, 2005

HEP was conducted in the Wolayita Zone of SNNPR and also identified factors that have affected implementation of the HEP, but the findings were limited.<sup>11</sup> To flesh out these preliminary findings, the HECC with the technical and financial assistance from PI-E and ESD,<sup>12</sup> decided to assess HEW performance in four select woredas of the SNNPR and Amhara Regional States. The purpose of the assessment was to better identify the underlying factors that contribute to and affect the performance of HEWs and their ability to implement the HEP successfully. The assessment had the following objectives:

- To identify issues and recommend actions requiring improvement in HEW performance and maximize results of the HEP.
- To document success stories of the HEWs in these sites.
- To draw lessons to improve program implementation in the future, contributing to global knowledge through information-sharing with national and international communities and other stakeholders.

## 2.1 Scope of Assessment

This assessment was conducted in 81 selected kebeles of four woredas—Kutaber and Banja in Amhara National Regional State and Arbaminch Zuria and Misha in SNNPR.

The two woredas of SNNPR, Arbaminch Zuria in Gamugofa Zone and Misha in Hadiya Zone, were selected because they were the first sites to initiate HEP in 2003, which helped lay the foundation for the development of the National HEP Strategy.<sup>13</sup>

The Regional Health Bureau (RHB) of Amhara Regional State selected the woredas of Kutaber in South Wollo Zone and Banja in Awi Zone because it believed that these sites had greater experience in implementing the HEP and could provide important evidence to the assessment.

Additional reasons for selecting these regions and woredas included:

- The HECC believed that there were better functioning health posts in these regions than in the other regions.
- These regions are two of the four major regions in the country with the largest population size and distribution of health facilities.
- These regions are two of the four major regions where PI-E is active.

### *Selected Woredas*

#### *Arbaminch Zuria woreda in SNNPR*

*Located in Gamugofa Zone*

*One of the first sites to initiate HEP in 2003*

*Estimated population: 164,705 (80,737 males and 83,968 females)*

#### *Misha woreda in SNNPR*

*Located in Hadiya Zone*

*One of the first sites to initiate HEP in 2003*

*Estimated population: 162,170 (79,463 males and 82,707 females)*

#### *Banja woreda in Amhara*

*Administrative seat of Awi Zone*

*Estimated population: 114,033 (56,836 males and 57,197 females)*

#### *Kutaber Woreda in Amhara*

*Located in South Wollo Zone in the eastern part of Amhara Regional State*

*Estimated population: 115,306 (56,962 males and 58,344 females)*

*Woreda Population Report, 2008*

<sup>10</sup> CNHD-E: Study of the Working Conditions of Health Extension Workers in Ethiopia. Addis Ababa, 2007

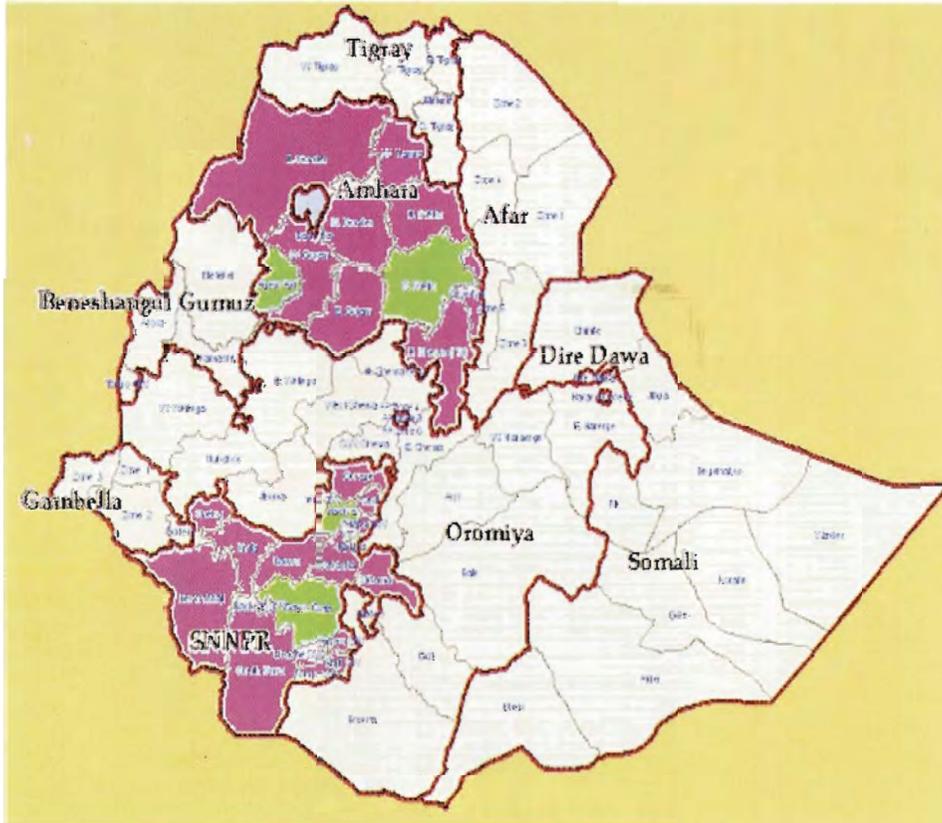
<sup>11</sup> Sefihun Bezabih: Assessment of Factors that Affect the Implementation of the Health Extension Program in Wolayita Zone, SNNPR, 2007

<sup>12</sup> ESD is a USAID-funded global reproductive health and family planning project based in Washington DC

<sup>13</sup> SNNPR Regional Health Bureau Report, 2005

Twenty-five kebele level health posts were selected in each woreda by the WHO, based on the percentage of achievements measured against yearly work plan targets by the HEWs. Work plans had to include activities for all 16 health service packages. The health posts/HEWs were then ranked on a scale ranging from first to 25<sup>th</sup> place.

**Map of Ethiopia with Assessment Regions and Woredas Highlighted.**



*The violet color indicates the two national administrative regional states while the green shows the four zones of the assessment.*

**2.2 Assessment Design, Methods of Data Collection and Sampling Strategy**

The cross-sectional assessment used both qualitative and quantitative data. In preparation for the assessment, the HEW training modules and the HEP Guide for Stakeholders were reviewed and used to develop the assessment instruments. Careful attention was paid to ensuring that the following areas were adequately evaluated:

- The level of involvement and participation of stakeholders in the HEP;
- The health knowledge of the HEWs;
- The commitment and performance levels of the HEWs;
- The health attitudes and practices of community members;
- The effect of external factors (both positive and negative) on HEW performance and ultimately the HEP.

Qualitative data collection methodology involved focus group discussions (FGDs), stakeholders' meetings, observations, and documentation of "success stories." These data were collected from male and female community members, VCHWs living in the catchment areas of the health posts, and the HEWs assigned to the health posts. Discussion guides and group exercises were developed for the qualitative data collection, while quantitative data were collected using semi-structured key informant interview questionnaires and checklists that assessed the functionality of health posts and the HEW residential quarters.

Individuals responsible for coordinating and leading program implementation in the kebeles, woredas and zones acted as key informants. These included representatives of the HSDP, staff responsible for coordinating and implementing the HEP (HEWs and VCHWs) and community members. Stakeholder meetings were held with representatives from the WHOs, health centers, kebele administrations, school directors, kebele women's affairs groups, youth associations, and religious institutions to assess their level of understanding, perceptions, involvement, and readiness to participate in the HEP.

For all data collection questionnaires and guidelines, see Annexes 2 – 12.

### ***2.3 Data Collection and Analysis***

Data collection activities were supervised by teams made up of staff from PI-E and the FMOH, as well as an evaluation consultant. The teams facilitated interviews and discussions among mid- and senior-level staff of the Rural Health Bureaus (RHBs), Zonal Health Departments (ZHDs) and the WHOs, while trained data collection assistants conducted in-depth interviews with the HEWs and assessed the health posts and residential quarters.

All data (both quantitative and qualitative) were transcribed, translated into English and compiled for analysis. The answers to open-ended questions were coded into thematic areas to facilitate analysis. The quantitative data were analyzed using SPSS to identify the significant variables that affected HEW performance.

### 3. Results

The assessment involved many different groups of participants to obtain a comprehensive picture of the HEP implementation. This section presents the major information gleaned from all data collected on HEW performance and the underlying factors that affected their abilities to do their jobs well.

**Table 1. Data collection methods and characteristics of respondents.**

Data Collection Methods	Frequency	Number of Participants	Responsibilities in HEP
Focus group discussions (FGD)	8 FGDs	76 HEWs	Implement the HEP at kebele level
	8 FGDs	75 male and female beneficiaries	Users of the HEP services
	4 FGDs	36 VHWs	Support the HEWs
In-depth interviews	4 sites	81 HEWs	Implement the HEP at kebele level
Key informant interviews	10 sites	10 HEP focal persons from the four woredas, four zones and two RHBs	Supervise, coordinate, and/or guide implementation of the HEP
Stakeholders' meetings	4 meetings	154 persons (WHO staff, health center staff, kebele administrators, school directors, women, youth, and opinion leaders)	Participate in planning, implementation, follow-up, and evaluation of the HEP
Review of health posts	81 sites	81 health posts	Provide primary health care at kebele level
Observations of homes	252 households	252 households living within 200 meters of the health posts	Provide residential quarters for the HEWs



*HEWs discuss their knowledge and skills from their pre-service training*

### 3.1 HEW Recruitment, Training, Deployment and Retention

The HEW is critical to the success of the HEP, and the assessment considered several factors that could influence HEW retention and turnover, including:

- location of the recruitment of the HEW versus the location of the posting;
- length of service as an HEW; and
- education of the HEW.

The HEP guidelines state that all HEWs should be assigned to health posts within their own communities. This provision is intended to enhance trust and acceptance of the HEWs in the community and to facilitate understanding and acceptance of the health information and services provided by the HEWs. As shown in Table 2 however, 53.1% of the HEWs reported that they were serving in kebeles different from where they were recruited. The WHOs explained this anomaly by claiming that when HEW recruitment was conducted, there were too few 10<sup>th</sup> grade candidates available to fit the guidelines, so HEWs were assigned to different communities.

HEWs themselves expressed dissatisfaction about working in kebeles that were not their original home communities and reported feeling homesick, socially insecure, and had difficulty adapting to the environment. The HEP focal persons in the kebele, woreda and zonal levels, (e.g., supervisors and coordinators) corroborated this perspective, and further remarked that these HEWs tended to have lower attendance rates and poorer performance.

**Table 2. HEWs by place of recruitment and assignment.**

Woredas	HEWs according to kebele of recruitment and assignment		
	From the community or nearby location (%)	From another community (%)	Number of HEWs
Arbaminch Zuria	47.4	52.6	19
Misha	85.0	15.0	20
Banja	48.0	52.0	25
Kutaber	0.0	100.0	17
Average	46.9	53.1	81

Those HEWs who were assigned to their home villages/kebele expressed a higher level of interest in extending their work assignment by one to two years, compared to those who were not assigned to their home villages/kebele (86.5% versus 68.3%). This suggests that assigning HEWs to different communities may lead to a higher rate of staff turnover (see Table 3).

**Table 3. HEWs by location of recruitment and intention to stay working on present site.**

HEWs' by residence	Length of time the HEWs intend to remain			Total number of HEWs
	6-12 months (%)	1-2 years (%)	2-4 years (%)	
Original resident or from nearby locality	13.5	86.5	0.0	37
Some other place	17.1	68.3	14.6	41
Average	15.4	76.9	7.7	78 (3 did not respond)

At the same time, however, while those HEWS who are serving in their own communities are more likely to stay one to two years longer than those who are not serving in their own communities, 14.6% of the HEWs who were from another community reported willingness to remain two to four years. None of the HEWs serving in their own community expressed interest in serving beyond two years.

The HEP guidelines also state that an HEW should have completed the 10<sup>th</sup> grade. The assessment found that this criterion was easily met, and in some cases exceeded the minimum requirement, as a significant number of HEWs had some education beyond 10<sup>th</sup> grade. Thus, the data in Table 4 call into question the WHO's claim that they had difficulties recruiting women with a 10<sup>th</sup> grade education.

**Table 4. HEWs by woredas and educational levels.**

Woredas	Percent of HEWs by Educational Level				Total # HEWs
	10 <sup>th</sup> (%)	10 <sup>th</sup> + 1 (%)	10 <sup>th</sup> + 2 (%)	More than 12 <sup>th</sup> Grade (%)	
Arbaminch Zuria	42.1	5.3	52.6	0.0	19
Misha	50.0	15.0	25.0	10.0	20
Banja	92.0	8.0	0.0	0.0	25
Kutaber	88.2	11.8	0.0	0.0	17
Average	69.1	9.9	18.5	2.5	81

When looking at the HEWs preferred intention of how much longer they would like to continue working at their present sites, the findings suggest that most of the HEWs (81%), irrespective of recruitment site, site assignment or educational level completed, seem determined to leave their assigned health post after working there for two more years. Findings also show that for the HEWs with more than a 10<sup>th</sup> grade education, that they desire to give up working at their current health post after one or two more years as compared with those with only a 10<sup>th</sup> grade education (see Table 5 below).

**Table 5. HEWs by educational level and intention to remain working at present health post.**

Educational level	Duration the HEWs intend to stay at current health post			Total number of HEWs
	6-12 months (%)	1-2 years (%)	2-4 years (%)	
10 <sup>th</sup>	9.4	79.2	11.3	53
10 <sup>th</sup> + 1	0.0	100.0	-	8
10 <sup>th</sup> + 2	46.7	53.3	--	15
> 12 <sup>th</sup> grade	0.0	100.0	-	2
Average	15.8 (12/78)	76.9 (60/78)	6.6 (7/ 78)	78 (3 not responding)

### **3.2 Effectiveness of Pre-service Training on HEW Performance**

Nearly 73% of the HEWs reported that pre-service training increased their knowledge and skills and provided a good foundation for their efforts (see Table 6). A major area of concern, however, was their limited ability to attend to women in labor, as this area was not fully addressed in their initial training. (HEWs are supposed to refer these women to the health center or hospital.)

**Table 6. The HEWs' assessment of pre-service training.**

Adequacy of Training (n=81)	Percentage Agreed (%)
More than sufficient	4.9
Sufficient	67.9
Insufficient	27.2
<b>Total</b>	<b>100.0</b>

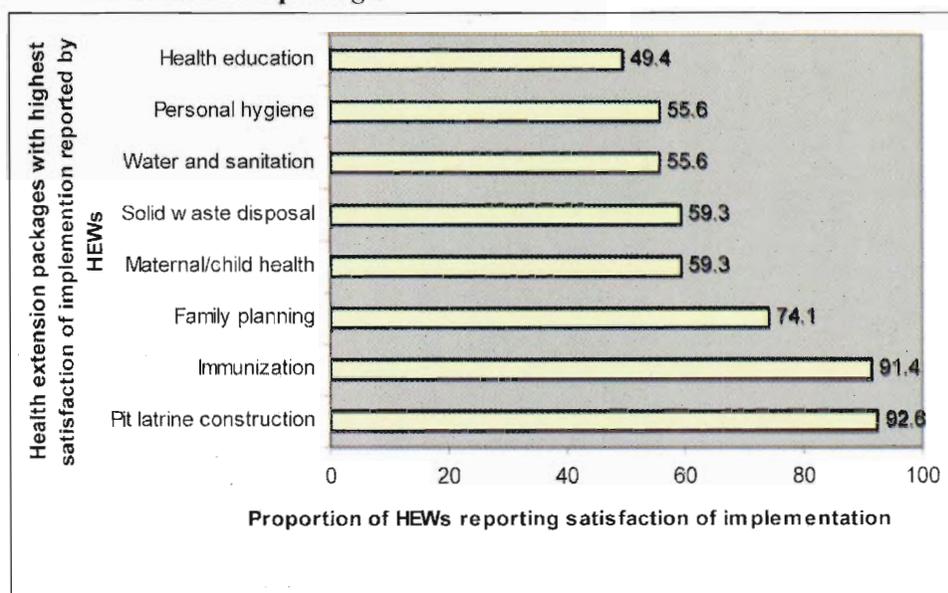
The assessment also examined the extent to which the HEWs could recall all 16 HEP packages. Observations of facilities and residential quarter reviews and findings from the FGDs and stakeholders' meetings found that the HEWs addressed almost all 16 packages. HEWs' initial responses to questions on which HEP packages they have provided, however, showed quite a range:

- Solid waste disposal 91.4%
- Immunization 88.9%
- Maternal and child health 87.7%
- Pit latrine construction 87.7%
- Malaria prevention and control 49.4%
- Nutrition and health 42.0%
- Adolescent reproductive health 32.1%
- Control of pests and rodents 32.1%

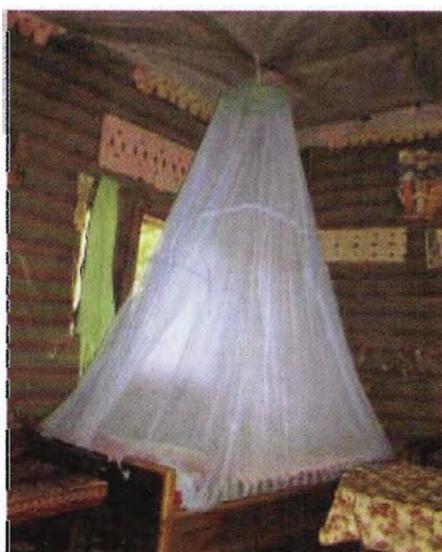
When probed, all HEWs were able to name the 16 packages. A HEW is likely to be more familiar with select packages based on her own knowledge and comfort level, as well as demand from the community. The variability in knowledge of the 16 packages raises questions and may be worth further inquiry.

The HEWs were very satisfied with their own performance in providing three of the HEP packages: pit latrine construction, immunizations, and family planning. Figure 1 highlights eight health extension packages which the HEWs reported as being the most satisfied with in terms of implementation in their communities. Annex 13 provides a more comprehensive list of the HEWs' satisfaction in providing the packages.

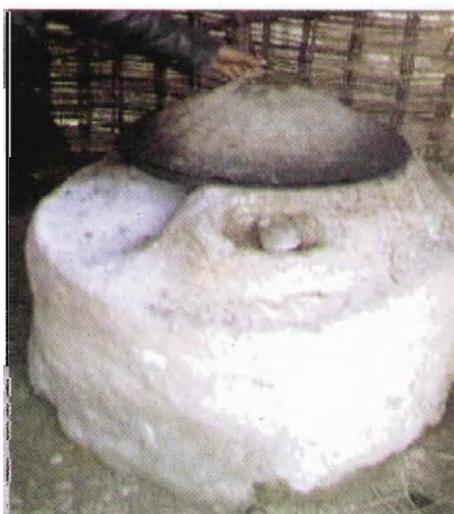
**Figure 1. HEWs reporting highest satisfactory performance with implementation of the specific health extension packages**



A large proportion of HEW efforts is devoted to awareness creation through “community conversations” to increase the practices of immunization, pit latrine construction, family planning, and personal hygiene. HEWs used teaching aids such as posters and demonstrated skills as part of community conversations. The HEWs also emphasized the identification and training of model families to champion the HEP as instrumental to promoting healthy practices. Model families visibly show communities how to construct and properly use pit latrines and how to practice other preventive health measures and behaviors.



*Demonstration of ITN in a model family's residence*



*A smokeless stove (for baking injera) in a model family's living quarters.*

### **Model Families**

*“Model families volunteer their time and attend training sessions that we provide them, and usually play an exemplary role by taking the lead in the implementation of the HEP packages that they were taught to implement...”*

*—Health Extension Worker*

As part of HEP, certain families in the community are identified and designated as “model families.” Model families are selected using criteria\* established by the WHO. Once identified as a model family, HEWs then orient the family to the 16 HEP packages and certify the family’s competence. Model families “model” healthy behaviors and practices to the community and provide concrete evidence of the benefits of the HEP.

A review of health post records found that all HEWs identified, trained, and certified select community members as “model families.” Evidence of the accomplishments of the “model family” approach included:

- Improved sanitation in the community through the use of pit latrines and solid waste disposal.
- Increased use of smokeless and energy-efficient stoves.
- Increased evidence of the construction of kitchens and mangers separate from living quarters.
- Decreased evidence of standing water.
- Increased use of ITNs.

*\*Criteria include family size, number of females/males in the family, ages, educational levels, health and well being of the family, occupation, living quarters separate from kitchen, availability of radio, manger separate from kitchen, provision for hand washing, availability and use of pit latrine, smokeless stove, safe water source and/or protected well water, protected spring or river water pool or dam, proper drinking water storage and use, personal and environmental hygiene, use of an ITN, shelves for keeping utensils.*

The HEWs believe that the communities have recognized improvements in the health of their children and the greater community, since the HEWs started providing services. Communities increasingly accept and trust HEWs. Most HEWs, however, are concerned that they are unable to help women in labor. While they were exposed to lectures on labor and delivery during pre-service training, most have never participated in or seen a normal delivery, even during their practical sessions with other health care providers at the health centers. Although a few claimed to have gained some knowledge and skills through their practicum, they agreed that they have forgotten how to manage labor and safe delivery, due to lack of practice. In addition to lack of practice, they lack equipment and other related supplies for delivery at the health post. Still others reported that the WHO staff told them that theoretical knowledge about labor was sufficient, as they were expected to refer mothers in labor to the health center.

HEWs also mentioned that they lacked training on antenatal care, postpartum care, giving injections (with the exception of injectable contraceptives), first aid (c.g., minor suturing), and how to operate refrigerators. Further, the follow-up of tuberculosis patients is one of their responsibilities, but they are unable to provide this service because there is no functional referral system for this health issue between the health post and the health center.

### ***3.3 Relationships Among HEWs and Other Staff***

HEWs were asked about their relationships with key administrative and supervisory staff at the kebele, woreda and zonal levels. HEWs reported that supervision was irregular and focused more on “fault-finding” than in supporting the HEW to improve her performance. Supportive supervision should engage the HEW in problem-solving and create an enabling work environment. HEWs found that the current form of supervision was demoralizing and did not improve their work performance. Another issue was that the supervisor’s time with the HEW was insufficient. Nearly 60% of the HEWs reported that the duration of the visit did not allow them the opportunity to discuss issues, concerns and receive supportive technical assistance from supervisors that could have helped them improve their performance. Overall, 66.7% of the HEWs were dissatisfied with their WHO supervisors and lacked clarity on their expected roles and performance objectives.



*A model family keeps livestock inside the manger, separate from the family living area.*

### ***3.4 Other Factors***

The difficult terrain in Kutaber and some parts of Arbaminch Zuria woredas was an additional challenge for HEWs, and affected their ability to make follow-up home visits on a regular basis.

### ***3.5 Observations of HEW Performance by Supervisors and Administrative Staff***

Key informants at the WHO, RHB, and ZHD acknowledged the gaps in the HEW training. They were, however, quite positive about HEW performance overall and attributed the following changes in the community to the HEWs’ efforts:

- reduced incidence of vaccine preventable diseases;
- reduced morbidity and mortality from malaria;
- increased number of family planning acceptors;
- increased number of water wells; and
- improved environmental sanitation.

They also affirmed that the majority of the HEWs address all 16 HEP packages.

The respondents felt, however, that some problems experienced by the HEWs were related to the fact that the HEP did not receive the adequate attention from the different administrative levels involved until mid-2006, when the FMOH finally allocated dedicated funds to employ a zonal HEP coordinator. The hiring of the HEP coordinator was a huge step forward in improving successful program implementation. Under the direction of the zonal coordinators, the following activities were implemented in support of HEP and the HEWs:

- training of VCHWs in the HEP packages;
- training of HEWs to facilitate community conversations; and
- developing job aids, such as supervisor checklists.

In addition, focal persons from the health center staff were assigned to support the HEWs by strengthening their practical skills in service delivery through a month-long rotation at the health center which oversees the health post. Each focal person was also to conduct monthly supervisory support visits to the HEW at the health post and was to function as the link between the health post and referral health center.

Zonal HEW supervisors concurred with the HEWs observation that the practicum and supervision were weak, and cited the following concerns:

- Since services at health posts are free, community members expected the same situation when referred to the health center, which charges a fee-for-service. When HEWs referred clients to the health center, they did not always alert their clients that there would be a charge for services, which led to some problems for the clients and the health facility staff.
- Some health posts did not provide key services such as delivery and immunizations because the HEWs lacked the skills to provide the service. Further, in some cases, delivery beds had not been unpacked, and refrigerators for storing vaccines were unused because HEWs did not know how to assemble or operate them.
- The amount of vaccines distributed to the health posts was often insufficient, and HEWs had to travel on foot to distant health centers to obtain vaccines.
- Supportive supervision visits were limited by budget constraints, despite the obvious need to motivate and support staff.
- HEW supervisors were often overburdened with multiple responsibilities, which significantly affected their abilities to visit health posts.
- Though HEWs were employed at the kebele level, they did not receive adequate support from the kebele administration.

*“Community members use to reprimand us saying, ‘we contributed in labor and kind to build the health posts, not for being told to dig pit latrines or to wash hands, and if that is why you are here, we do not need you anymore. So you can pack your goods and go back to where you came from.’ Even worse, some community members had attempted to chase us away. Others hid themselves so that they would not be available to talk to us during our home visits.”*

*—Health Extension Worker*

On a positive note, the respondents reported that they are planning to provide the HEWs with a one-month refresher training on safe delivery, which will include a skill practicum component, so that they can attend a normal delivery.

### ***3.6 HEWs' Observations of Community Expectation and Reactions to their Efforts***

Both the HEWs and VCHWs observed that many of the communities where they were assigned expected that the health post and HEWs would provide care similar to services provided at the health center and hospital, especially curative care. The HEP however, focuses on preventive care through awareness creation, motivation, and behavior change. As HEWs began their efforts to implement the HEP, the communities were often resistant to preventive health care interventions. They continued to seek curative treatment at the health posts, a challenge that required the HEWs to be patient, tactful and respectful in their responses to the needs of the community, until they gained the community's understanding and confidence.

To overcome the lack of community understanding of the HEP objectives and the role of the HEWs, the HEWs worked closely with established VCHWs to win community confidence during home visits and other activities.

The HEWs have clearly made headway in building trust and confidence in their services in many communities. One HEW commented that, "... *these days, regarding immunization services, it is the community that looks for the HEW to get their children vaccinated and not the HEW who seeks out the community to bring their children to the services.*" Another HEW stated that, *"The community members attend health education and community conversation sessions and get actively engaged in community-based health activities, such as developing spring water sources and digging wells for water."*

While the HEWs still face many challenges on the job, most remain committed to the objectives of the HEP and are pleased to see that community members are more knowledgeable about the root causes of their common health problems and have come to support the HEP.

### ***3.7 Community Perceptions about Change Due to Efforts of the HEWs and HEP***

#### *Active Involvement and Changing Attitudes.*

Community members understand that they play a pivotal role in their own health and the health of their community. They have been actively involved in choosing the sites for the health post, negotiating the purchase of land, assisting in construction of the health post (including fencing), providing locally available materials (e.g., sand, stones and wood), transporting equipment to the health post, and providing security services for both the health post and the HEWs.

The communities also recognized change within themselves. One major change that they reported was their attitude toward HIV/AIDS and persons living with HIV/AIDS (PLWHAs). They reported that before the HEP, they discriminated against PLWHAs for fear of catching the disease. As community members participated in the HEW's awareness creation sessions, they learned more about the causes of HIV/AIDS and how this is transmitted. With greater understanding, people began to develop more positive attitudes towards PLWHAs, and now they interact more freely with them. They are supportive of changes in social norms, especially around greater use of voluntary counseling and testing (VCT) services.

The VCHWs believe that communities' positive attitudes and commitment to the HEP can be attributed to collaboration between HEWs, VCHWs, kebele administration staff, and other local stakeholders. Further, the communities can see the benefits of the HEP through use of the HEP services provided by the HEW, especially:

- family planning;
- immunizations;
- rapid diagnosis and treatment of malaria; and
- outreach to mothers on maternal child health.

#### *Improved Access to Services.*

Almost all community members and stakeholders reported that prior to the establishment of the HEP, very sick people or pregnant women had to be carried in hammocks by people to the health center or hospital. Travel often took many hours and sometimes days, and all too frequently, women died or experienced a stillbirth before reaching the health facility. Among those who reached the health facilities alive, many still suffered complications or died because they sought health services too late. Respondents believed that the HEP has had a positive effect in reducing maternal and newborn deaths, because pregnant women are now followed up with and referred to the health center by the HEWs. It is rare to hear about the death of a pregnant woman because of delayed care, or of children dying from vaccine preventable diseases.

Men observed that before the HEP, many women did not know about the services offered at the health center or hospital and had no interest in using the available services, even when faced with serious health issues that required treatment. They believe that the HEP has had a positive effect in the community, since now almost all community members know about the health post in their area and are supportive of the HEW's efforts to involve the community to promote healthy practices. In particular, they appreciate that the HEP has provided antenatal care services, early referral to the health center for women in labor, and family planning for birth spacing. They themselves know how to prevent tetanus, measles and whooping cough, and believe that illness and death among children have been reduced. (Their one reservation about the HEP and the HEWs is that the services seem to be skewed in favor of women.)

Both men and women expressed their appreciation in having a health post within walking distance. For those living in malaria endemic zones, they can obtain diagnosis and treatment of malaria within two hours of the onset of fever. These days, they are less likely to get sick with malaria and do not have to miss time away from important livelihood activities, even during malaria's peak season.

#### *Better Knowledge of Reproductive Health and Family Planning.*

Knowledge about family planning and the benefits of appropriate birth spacing have increased significantly. Almost all women respondents knew at least one method of contraception, mentioning pills, injectables, the intrauterine contraceptive device, implants and exclusive breastfeeding. They reported that many satisfied clients of the HEW often tell others about the benefits of family planning. Women also related some positive changes in common practices related to childbirth and breastfeeding.

Prior to the introduction of the HEP, women discarded the colostrum and refrained from feeding newborns because they feared it would cause health problems. Mothers commonly fed their babies water and other food, believing that breast milk did not meet the nutritional needs of the newborn. They now nurse their newborns immediately beginning with the colostrum, and practice exclusive breastfeeding until the babies are six months old. Many attribute these positive health changes to the efforts of the HEWs and VCHWs. In addition, because of the common practice of partial breastfeeding, many women became pregnant before their babies reached six months of age. Women now better understand that not

only is breast milk the best nutrition for their babies, but early and exclusive breastfeeding will prevent pregnancy in the first six months postpartum.

*Commitment to Hygiene.*

Community members recognize that the HEWs have shown how poor hygiene and environmental sanitation contribute to common health problems such as malaria, eye infections and diarrhea; they now know which actions they can take to minimize or eliminate the threat of these health problems.

*Room for Improvement.*

Nevertheless, both the VCHWs and community members say that there is still a need for curative care, and the communities request that additional services (beyond those provided for malaria) be included in the health post's services, particularly, the management of labor and delivery.

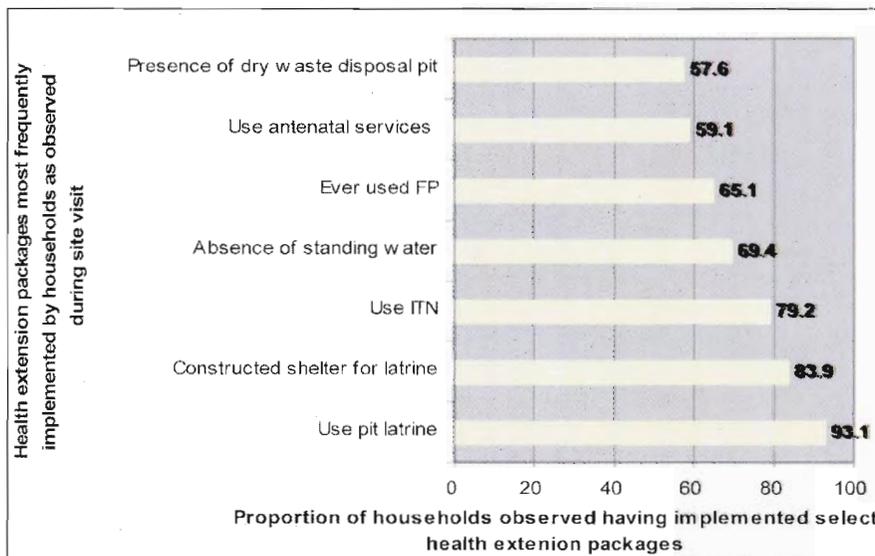


*Community members discuss differences between their health knowledge, attitudes and practices before and after the HEWs started working at the health posts. They are pleased that the HEWs respect the local social norms, traditions and culture of their community.*

*Confirming Observations.*

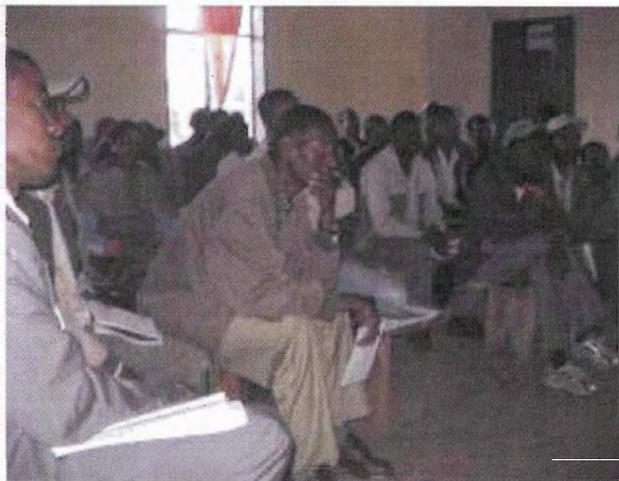
To confirm community members' observations about positive changes in several key health practices, the assessment team visited and visually observed 252 homes and the immediate surroundings, which were located relatively close to the health post. The following figure shows which packages the households practiced the most frequently around their homes, as observed during the assessment visit: A comprehensive list can be found in Annex 14.

**Figure 2. Health extension packages implemented by households as observed during site visits.\***



*\*Residential quarters located within 200 meter radius of a health post (n=252), SNNPR and Amhara National Regional States, 2008.*

It is important to note that non-observation of a particular practice does not necessarily mean its absence. It is likely that these particular health practices are simply implemented less frequently.



*Stakeholders meetings served as fora to disseminate information about the objectives of the HEP; practices of the HEWs, VCHWs, and model families; who the actors are; and future directions of the HEP.*

In summary, all respondents emphasized that the following points and recommendations are critical to ensuring that the HEP becomes routine practice in the community:

- A supportive policy environment that encourages community participation.
- Participation of the kebele administrations in coordinating activities.
- Support to model families to demonstrate healthy practices.
- Participation of VCHWs to serve the hard-to-reach through home visits.
- Commitment of the HEWs.
- Documentation and dissemination of the personal experiences of satisfied community members who can advocate for HEP.
- A focus on results.



*The HEWs acknowledged the key role that the VCHWs play in establishing harmonious working relationships between the HEWs and their community. The VCHWs also expressed their appreciation for the work of the HEWs in equipping communities with health knowledge and initiating positive attitudinal and behavioral changes in a short time.*

### 3.8 Relationships between the HEWs and VCHWs

HEWs reported that the VCHWs were instrumental in their efforts to bring services to the community. HEWs felt that they had greatly benefited from working with the VCHWs to monitor the HEP implementation and community-planned activities. The VCHWs:

- Significantly contribute to the promotion of family planning through door-to-door distribution of contraceptive pills.
- Actively provide communities with health information and education and mobilize communities for public health campaigns, including immunizations and environmental sanitation activities.
- Follow up with pregnant women to complete tetanus toxoid vaccinations.
- Document vital events including births and deaths.
- Convince families to become early adopters of the HEP and to demonstrate the benefits of the HEP as a “model family.”

Administrative staff, community members and other stakeholders validated these observations of VCHW performance.

In turn, the VCHWs appreciated the commitment of the HEWs to partnership, especially their efforts to help them understand the HEP. They valued the opportunity to plan their activities and evaluate their achievements in collaboration with the HEWs.

Both the HEWs and VCHWs were confident that the communities where they worked have developed positive health seeking behaviors, which were confirmed by the increased use of services at the health post. They have also observed an increase in community participation and contribution to the health education and community conversation sessions organized by the HEWs. Two areas most often mentioned by the communities were the development of spring and well water systems and an increased interest in becoming a model family, which includes a significant commitment of time to train other families in the HEP practices.

*“We very much appreciate the stamina and commitment of the VCHWs who vigilantly work in their community, withstanding all sorts of socio-cultural and traditional challenges beyond sacrificing their energy and free time to improve the health knowledge, attitudes and practices of their communities and cultivate the fertile ground to make our work acceptable.”*

— Health Extension Worker

### 3.9 Major Achievements to Date

Overall, the assessment team was pleased with the findings and responses from administrative staff, health providers and community members. In general, the HEP has increased community members’ access to health information and basic services at the health post/kebele level and through the efforts of HEWs and VCHWs. Major achievements include:

- *Improved Community Participation in Health.*  
The involvement of communities in identifying health problems and action planning has led to an increase in positive attitudes and preventive health practices. In particular, the local iddir<sup>14</sup> established by the communities to set social norms and support community members at times of need, was found to be very effective in facilitating the acceptance and practices of preventive

<sup>14</sup> A social organization established by community members, usually to help each other with modest amounts of money, labor and deeds during mourning, marriage, and/or other social occasions.

health care in the community, often more so than the kebele administration. The implementation of the “model family” approach has been critical in helping other community members understand the benefits of and apply preventive health practices. Further, the clear improvement in children’s health as a result of vaccination programs and environmental sanitation has stimulated action from other community members to immunize their children and build additional pit latrines.

- *Improved Collaboration and Teamwork Between the HEWs and VCHWs.*  
HEWs and VCHWs have been working well together to improve community health by increasing community knowledge, addressing social norms, advocating against harmful traditional practices and increasing use of available preventive and curative services. The coordination of outreach efforts by the VCHWs with the services provided by the HEWs at the health post, resulted in an increase in the use of family planning and other health services.
- *Improved Delivery of Basic Health Services.*  
One of the most important achievements may be the rapid diagnosis and treatment of malaria at the health post level, especially in malaria endemic communities.

### **3.10 Suggestions for the Way Forward**

HEWs had many suggestions for building on their achievements and improving the performance of the HEWs in particular and the HEP overall, as did staff from the WHOs and RHBs, which included:

- Standardizing and monitoring recruitment of HEWs to ensure fair representation from their community.
- Improving HEW knowledge and skills in safe delivery and on other health topics as relevant to their communities.
- Publicly recognizing the efforts of HEWs at regional and national levels.
- Providing opportunities for HEWs to learn from each other.
- Facilitating HEW outreach efforts.
- Establishing HEWs as civil servants with similar rights and benefits as that of other civil servants.
- Equipping health posts with basic medicines, such as painkillers, ensuring equitable distribution of equipment and supplies, and establishing and/or improving the logistics system at health post level.
- Ensuring adequate staff are in place at the health post and woreda levels to implement and monitor the HEP.
- Improving support to the HEWs, especially in supportive supervision.

A positive community environment is critical to the success of the HEWs and the HEP, which can be facilitated by the following actions:

- Train and educate kebele administrators and community members to better understand the objectives of the HEP and their role in its implementation, and to strengthen their involvement.
- Provide special recognition of model families who encourage other families to adopt the HEP.
- Establish a standardized incentive structure for VCHWs.
- Strengthen communication between HEWs and their health post with health centers, kebeles, WHOs and ZHDs.
- Improve accountability of key staff at the different administrative levels in HEP-related responsibilities.
- Disseminate information about the HEP through FMOH communication channels.

## 4. Discussion and Conclusion

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This assessment aimed to identify underlying factors contributing to and affecting performance of the HEWs working in select kebeles, to learn more about what works well and what needs strengthening to improve HEW performance and ultimately the HEP. The goal was to share these experiences with stakeholders and make realistic recommendations to improve HEW performance to meet the HEP objectives. Although this is not a representative sample of the country, the assessment team believes that the findings and recommendations presented in this assessment provide a strong foundation for further discussion and follow-up, and that the lessons learned can be applied in other regions.

One of the most positive findings of the assessment is that the vast majority of HEWs are highly committed to implementing results-based interventions. The findings also reflect, however, that key administrative, programmatic, and logistical gaps hinder HEW performance and commitment, and that there are opportunities to improve this situation. To address these gaps and take advantage of opportunities will strengthen the performance of all HEWs and ultimately the HEP results.

### *4.1 Major Factors that Affect Performance of the HEWs*

The assessment identified key underlying factors that both positively and negatively affect the performance of HEWs.

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

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

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

- HEWs lacking adequate knowledge and skills to manage labor and delivery;
- Health posts lacking supplies and equipment and/or HEWs not knowing how to use them correctly;
- Frequently overburdened HEWs, especially when they work alone, which was the case in 30.9% of the health posts assessed;
- Absence of supportive supervision; supervisory visits that were often didactic and focused on fault-finding instead of working with HEWs to propose solutions;
- HEW supervisors lacking adequate knowledge, skills, and management support to provide supportive supervision;
- Infrequent supervisory visits for hard-to-reach areas, with inadequate funds for transport and per diem;

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

It is obvious that preventive health care knowledge, attitudes, and practices in the assessed communities have improved since the HEWs started to provide services. In particular, communities acknowledge the improvements in the health of women and children; this was corroborated by the HEWs and other stakeholders.

However, even though the HEP is designed to provide only health promotion information and preventive care, there is still a clear need for curative services. (Though, in the opinion of the assessment team, the provision of curative services is beyond the scope of the HEWs' abilities at present.) While the FMOH/HEEC considers how to improve community access to curative care, it is important to educate communities on the purpose of the HEP, its benefits and limitations, and the role of the HEWs. At the same time, the HEWs need improved supportive supervision and technical updates from the WHO to be able to carry out their duties effectively.

Since the assessment was completed, the HEP staff members at the RHB have already begun to take action to address some of the identified problems, specifically:

- Conducting a one-month training for community nurses, clinical nurses, environmental sanitation experts in supportive supervision techniques;
- Assigning more HEWs to health posts as needed, and ensuring health posts are adequately equipped and supplied;
- Strengthening the involvement of woreda and kebele administrations to coordinate the HEP, including defining more clearly the working relationships between all involved in the implementation of HEP implementation; and
- Ensuring that the HEP is a clearly defined responsibility for health care decision-makers and implementers at regional, zonal and woreda levels through incorporating specific HEP-related tasks and functions in their job descriptions.

## **4.2 Recommendations for Next Steps**

The assessment team identified several key recommendations for immediate action.

**HEWs:** The HEP officials need to carefully follow the HEP Policy and Guidelines in ensuring that HEWs are assigned to the same kebele from where they were recruited and that there are adequate numbers of HEWs (a minimum of two) assigned to each health post, with special attention paid to geographical terrain and settlement patterns. More specialized pre-service and in-service training needs to be provided to improve the HEW's skills in safe delivery and referral of women and should include adequate opportunities for practical skills development in well-equipped facilities with skilled mentors. Consideration should also be given for including additional training for HEWs in some basic curative services. The rights and benefits of HEWs as government employees need to be redefined and clearly articulated to include days off, annual leave, and opportunities for job transfer. Standardized criteria should be established and/or used to objectively measure job performance and results that incorporate national standards and include specific criteria responsive to each woreda and kebele community. Awards and professional development opportunities are also important ways to publicly recognize the efforts of outstanding HEWs, and worthy of inclusion in the HEP.

**Supportive supervision:** Provide training to supervisors in mentoring skills, how to conduct supportive supervision to improve HEW performance, and how to fix and operate equipment in health posts. The HEP and its various administrative levels need to ensure adequate funds for regular supportive supervision and establish a regular schedule of supervision and monitoring with HEWs, model families and VCHWs.

**Health posts:** Complete construction of health posts and residential quarters in communities that lack these facilities, and fully equip health posts, including a radio/tape recorder for awareness creation and to record testimonials from community members for experience sharing and advocacy.

**Administrative and community support:** Establish a regular schedule of meetings at woreda level with the WHO, woreda administration, kebele administration, and key community stakeholders (e.g., school directors, representatives of women's associations, farmers' associations, religious groups, and social organizations) to discuss the HEP and also for regional review meetings between the RHB, ZHD and WHOs to share experiences and lessons learned. Activities should be jointly planned by these groups.

Finally, the assessment team recommends that the FMOH considers a nationally representative assessment of the HEP to continue documenting and compiling evidence that could be used to further strengthen both the performance of HEWs and the HEP nationally, and identify best practices in scaling up a large-scale national community-based health program approach for other countries to learn from and apply.

## **Annexes**

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- Annex 1 Case Stories
- Annex 2 Key Informant Interview for Health Extension Workers
- Annex 3 Facility Review of Health Post
- Annex 4 Facility Review of Living Quarters
- Annex 5 Key Informant Interview for Woreda Health Office – HEP Supervisor
- Annex 6 Key Informant Interviews for Zonal Health Department - HEP Supervisor
- Annex 7 Key Informant Interview for Regional Health Bureau – HEP Supervisor
- Annex 8 Focus Group Discussion with Female Beneficiaries
- Annex 9 Focus Group Discussion with Male Beneficiaries
- Annex 10 Focus Group Discussion with Voluntary Community Health Workers
- Annex 11 Focus Group Discussion with Health Extension Workers
- Annex 12 Guide for Stakeholders Meetings
- Annex 13 HEWs Reported Performance Satisfaction in Implementing the 16 HEP Packages in their Catchment Area
- Annex 14 Health Practices Observed in Communities During Observations of Residential Quarters in Both Amhara and SNNPR
- Annex 15 Technical Contributors in Assessment Design, Implementation, Analysis and Report Writing

## Annex 1 – Case Stories

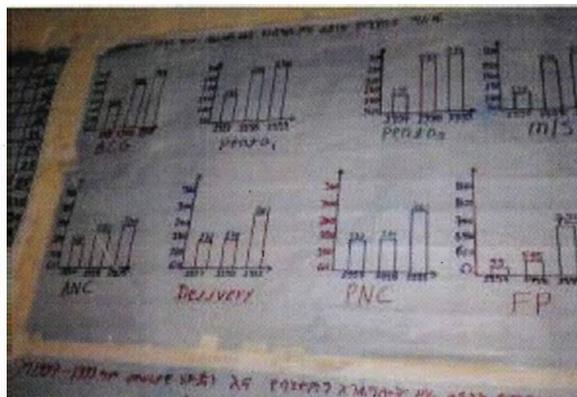
### Aynalem Getachew, HEW

My name is Aynalem Getachew and I am 25. I have been working in this kebele since 1997 EC (2005). The kebele has 1,534 households and a total population of 7,551.

The health post is 15 kilometers away from the health center and I am the only HEW in the kebele. I have to cover all the households with the help of volunteers.

When I first arrived at the kebele, the community expected me to give them the same services that they used to get from the health center, and so became resistant to the efforts I made to promote preventive health care. However, as time passed, the catchment community has become active implementers of the HEP and the results have been very positive. Over a three year period (1997 to 1999 EC or 2005-2008):

- Child immunization coverage has increased from 36% to 99.5%.
- Pit latrine construction coverage increased from 35% to 80%.
- Family planning service utilization rose from 5% to 60%. (An interesting side-note: these days, family planning users in my kebele are also promoting the services to their non-user neighbors!)
- Ante-natal care utilization increased from 40% to 76%.



Graph showing achievement trends in the HEP packages in Aynalem (2005 – 2007 or 1997 – 1999 EC).



45.1% (34/74) of community members practice hand washing after going to the lavatory.

Three days or more a week, I visit households to educate them and follow up on hygiene, family planning, immunizations, ante-natal care and delivery. I cover 1,534 households with the help of VCHWs by assigning them to each cell in the kebele. The contributions of the kebele administration, religious leaders, rural development agents, teachers and the 'iddir' are also high. We solve many of the problems through community conversations.

I feel that I am lucky because the community is taking over much of the health responsibility that I have been bearing alone.

### Woizero (W/o) Worknesh Mengesha, Model Family Member

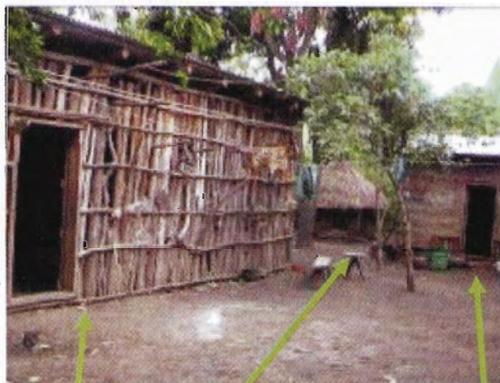
From the gate of the compound, one sees a green conical mosquito net hanging over a bed next to the window. Standing by the door of the house was W/o Worknesh. She is a 35-year-old housewife with no formal schooling. Her husband, Ato Digisa Decha, 50, is a farmer. The two have lived in this kebele for about 29 years, and they have six children.

W/o Worknesh reported that at the time the HEW recruited the family to become a model family, Ato Digisa Decha was not home and had no time to attend trainings. Therefore, she volunteered to undergo the training alone, eventually receiving her certification.



Worknesh telling her story. Her community established an *iddir* to support community members in time of need. This was considered to be more influential than the kebele administration in facilitating the acceptance and practice of preventive health care among the community members.

Discussing her experiences following graduation, she began implementing and practicing the techniques she had learned. As a result, she witnessed important changes in her life style and the family's health. Recalling the family's previous experiences, she mentioned that they had no sanitary toilet in the backyard. Instead, they used to go out into an open field for this purpose. They never thought of washing their hands after going to the toilet, and they lived in the same room with their cattle and hens. Mosquitoes bred in nearby standing water because the family did not drain the stagnant water, unaware that doing so would prevent becoming ill with malaria. In addition, they did not know how to safely handle drinking water or keep utensils clean. They practiced no family planning, and they didn't immunize their children.



Manger

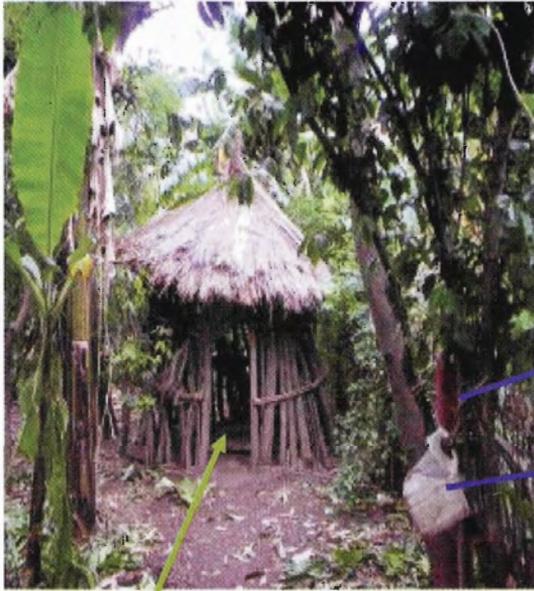
Chicken Coop

Kitchen of W/o Worknesh

Now she tells us that all these past experiences have "gone away with the wind." Today she proudly speaks about the exemplary role she plays in the community. Her youngest child is fully immunized and healthy. The family has constructed a pit latrine with a cover to keep away flies, and a plastic jar fitted with a faucet and ash (in place of soap) are available for hand washing after use of the latrine.

The family disposes its solid waste in a trench prepared for that purpose and buries the waste when the trench is full. They have built a manger, hencoop and a kitchen separate from the living rooms of the household members. W/o is vigilant about preventing water from collecting in the compound, where it can breed mosquitoes, by draining and getting rid of broken clay pots or utensils that may hold water.

Explaining her reasoning as to why she placed one of the family beds adjacent to the window in the salon and covered it with an ITN, she said that the mosquitoes that get into the room via the window will first rest on the ITN and die. She also underscored that her family is enlightened on the importance of family planning for the health of the mother and children.



*Pit latrine with cover*



*Water jar and container holding ashes for hand washing*

Speaking about the role that the *iddir* (social organization) played in maximizing the influence of the HEP in her locality, she said:

**“Unlike others, the iddir in our locality provides financial and/or other support to whomever is a resident, irrespective of being a member of the iddir or not. Therefore, more than the kebele administration, our iddir has been more effective in facilitating the acceptance and practice of preventive health care in the community. It has helped establish a social norm on preventive health care that every household has to respect.”**

Currently she teaches neighbors to help them adopt similar healthy practices. She reported that she often teaches during coffee ceremonies and at planned or casual social gatherings. Worknesh recommends continuous, strong health education and follow up as being vital to make an impact on the health knowledge, attitudes and practices of her community.



4. What was your educational level when you were recruited for the post?  
1) 10<sup>th</sup> grade \_\_\_\_\_ 2) 10<sup>th</sup> +1 \_\_\_\_\_ 3) 10<sup>th</sup> +2 \_\_\_\_\_ 4) 12<sup>th</sup> and above \_\_\_\_\_
5. How many health extension workers are there in your health post? \_\_\_\_\_
- 5.1 What is your job description?
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
6. Who recruited you (the HEW) for the post?  
1) The kebele administration \_\_\_\_\_ 2) The community I live with \_\_\_\_\_  
3) The community and the kebele administration \_\_\_\_\_ 4) My School \_\_\_\_\_  
5) Other (Specify) \_\_\_\_\_
7. Where were you living before you were recruited for training to be a HEW?  
1) Same with this place 2) Different from this place

**Interviewer:**

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

8. How long does it take to get to the HP on foot from here (your home where you were recruited from) ?  
1) Half an hour \_\_\_\_\_ 2) An hour \_\_\_\_\_ 3) Two hours \_\_\_\_\_ 4) Three hours \_\_\_\_\_  
5) Half a day \_\_\_\_\_ 6) Too far to be reached on foot \_\_\_\_\_
9. How do you see the sufficiency of the knowledge and skills that you acquired during training as a HEW for performing your duties?  
1) More than enough \_\_\_\_\_ 2) Just enough \_\_\_\_\_ 3) Not enough \_\_\_\_\_  
4) Don't know \_\_\_\_\_

**Interviewer:**

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

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

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

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**Interviewer:**

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

12. What health extension packages are performed in your HP?

		Yes w/ probing	Yes w/o probing	No
12.1	Environmental health and sanitation			
	12.1.1 Solid waste disposal	1	2	3
	12.1.2 Sanitary pit latrine construction & utilization	1	2	3
	12.1.3 Potable water protection	1	2	3
	12.1.4 Insects, rodents and other pest control	1	2	3
	12.1.5 Housing construction and management	1	2	3
12.2	Health care education	1	2	3
12.3	Personal hygiene	1	2	3
12.4	Nutrition and health	1	2	3
12.5	Adolescent reproductive health	1	2	3
12.6	Family planning	1	2	3
12.7	HIV/AIDS and tuberculosis prevention	1	2	3
12.8	Vaccination	1	2	3
12.9	Maternal and child health	1	2	3
12.10	Malaria prevention and control	1	2	3
12.11	Reproductive health related harmful traditional practices	1	2	3

**Interviewer:**

*For those packages that are reported not to have been performed at the HP (i.e., where code 3 is circled in the above question), you need to further ask the respondent why that particular package was not performed by the HP.*

13. Name of package that was not performed: \_\_\_\_\_

Reasons for not being performed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14. Name of package that was not performed: \_\_\_\_\_

Reasons for not being performed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

15. Name of package that was not performed: \_\_\_\_\_

Reason for not being performed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. Name of package that was not performed: \_\_\_\_\_

Reason for not being performed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. For how long have been serving in this HP?

1) Less than a year \_\_\_\_\_ 2) One year \_\_\_\_\_ 3) Two years \_\_\_\_\_ 4) Three years \_\_\_\_\_

18. For how many more years are do you plan to work in this HP?

1) \_\_\_\_\_ # Months 2) \_\_\_\_\_ # Years \_\_\_\_\_ 3) \_\_\_\_\_ Not decided

4) \_\_\_\_\_ No more years

**Interviewer:**

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

**18.1 Reason for saying not ready to work any more in the HP.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. Out of the health extension packages, how many of them do you think that you have performed satisfactorily?

- 1) All of them \_\_\_\_\_ 2) More than half \_\_\_\_\_ 3) Half of them \_\_\_\_\_ 4) A quarter of them \_\_\_\_\_  
 5) Non of them \_\_\_\_\_

**Interviewer:**

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

20. How did you exhibit such a satisfactory performance?

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

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**Interviewer:**

Follow the instruction given for Question 12 while dealing with the next question (Question 22).

22. Out of the health extension packages that you have performed in your HP, which ones do you think have brought about significant impact?

		Yes w/ probing	Yes w/o probing	No
22.1	Environmental health and sanitation			
22.1.1	Solid waste disposal	1	2	3
22.1.2	Sanitary pit latrine construction & utilization	1	2	3
22.1.3	Potable water protection	1	2	3
22.1.4	Insects, rodents and other pest control	1	2	3
22.1.5	Housing construction and management	1	2	3
22.2	Health care education	1	2	3
22.3	Personal hygiene	1	2	3
22.4	Nutrition and health	1	2	3
22.5	Adolescent reproductive health	1	2	3
22.6	Family planning	1	2	3
22.7	HIV/AIDS and tuberculosis prevention	1	2	3
22.8	Vaccination	1	2	3
22.9	Maternal and child health	1	2	3
22.10	Malaria prevention and control	1	2	3
22.11	Reproductive health related harmful traditional practices	1	2	3

23. What were the strategies used while performing the health extension packages that have brought about significant impact?

	Yes w/ probing	Yes w/o probing	No
23.1 Closely consulting with the community by making house to house visit	1	2	3
23.2 Organizing group community training which enables me to have role models in the community	1	2	3
23.3 By using the trained community members to do various advocacy activities among the community	1	2	3
23.4 Preparing a model demonstration center which is helpful to enrich the knowledge and attitudes of the community that can eventually affect their decision towards positive change	1	2	3
23.5 Other, specify below	1	2	3

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

	Yes w/o probing	Yes w/ probing	No
24.1 We plan the HEP and related activities together	1	2	3
24.2 They play a coordination role in the implementation of the HEP and related activities	1	2	3
24.3 They undertake follow up and supervision with us in the implementation of the HEP and related activities	1	2	3
24.4 They mobilize the community, government offices, NGOs for the implementation of the HEP and related activities	1	2	3
24.5 We don't have any working relationship	1	2	3
24.6 Other, specify below	1	2	3

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25. How do you describe the contribution of the community in the various activities that the health post has performed so far?

	Yes w/o probing	Yes w/ probing	No
25.1 Participated while the HP prepares its plans	1	2	3
25.2 Participated in health activities carried out by the HP	1	2	3
25.3 Participated in the monitoring & evaluation of the health service activities carried out by the HP	1	2	3
25.4 Participated in the HEP by providing & utilizing local materials	1	2	3
25.5 Contributed to our success by cooperating and working with voluntary community health workers	1	2	3
25.6 She/he did not participated at all	1	2	3
25.7 Other, specify below	1	2	3

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

1) Yes there are \_\_\_\_\_ 2) No there are not \_\_\_\_\_ 3) Don't know \_\_\_\_\_

**Interviewer:**

*If the answer for the last question is '1' (Yes there are), then record the respective number in questions 26.1 - 26.6. Put '0' if they are not available there.*

- 26.1 Traditional birth attendants (TBAs) \_\_\_\_\_
- 26.2 Community-based Reproductive Health Agents (CBRHAs) \_\_\_\_\_
- 26.3 Voluntary community promoters \_\_\_\_\_
- 26.4 Voluntary community counselors \_\_\_\_\_
- 26.5 Peer educators \_\_\_\_\_
- 26.6 Home-based care and support providers \_\_\_\_\_

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

1) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2) We don't have any working relationship. \_\_\_\_\_

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

1) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

2) We did not face any problem. \_\_\_\_\_

**Interviewer:**

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

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

		Yes w/o probing	Yes w/ probing	No
29.1	Community	1	2	3
29.2	Woreda Health Office	1	2	3
29.3	Religious leaders	1	2	3
29.4	Community leaders	1	2	3
29.5	Voluntary workers	1	2	3
29.6	NGOs operating in the area	1	2	3
29.7	Other, specify	1	2	3
29.8	Did not need any help	1	2	3

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

1) To some extent \_\_\_\_\_ 2) Everything \_\_\_\_\_ 3) Not at all \_\_\_\_\_

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

1) Once in two weeks \_\_\_\_\_ 2) Once a month \_\_\_\_\_ 3) Once in three months \_\_\_\_\_

4) Once in six months \_\_\_\_\_ 5) As required \_\_\_\_\_

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

1) More than enough \_\_\_\_\_ 2) Quite enough \_\_\_\_\_ 3) Not enough \_\_\_\_\_ 4) Don't know \_\_\_\_\_

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

1) Very well \_\_\_\_\_ 2) Not as much as expected \_\_\_\_\_ 3) Don't know \_\_\_\_\_

**Interviewer:**

*If the answer to question 33 is '2' (Not as much as expected), then skip question 34 and ask question 35.*

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

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

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

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**Interviewer:**

Follow the instruction given for Question 12 while dealing with the next question (Question 37.1-37.6).

37. What working relationship does the HP have with the Woreda Health Office?

		Yes w/o probing	Yes w/ probing	No
37.1	The health center takes care of our referrals	1	2	3
37.2	It sends us feedback on the back of the referral slip when the patient returns after having been provided with the service	1	2	3
37.3	Works closely with us in collaboration with the Woreda Health Office on prominent health issues and provides us with expert support	1	2	3
37.4	Makes sure that the HP does not run out of necessary supplies such as vaccines	1	2	3
37.5	Provides us with support on some health related issues	1	2	3
37.6	Other, specify	1	2	3
37.7	Do not have any working relationship	1	2	3

**Interviewer:**

If the answer to question 37.7 is '1' or '2' (Do not have any working relationship), then ask the following two questions (question 38 & 39).

38. What do you think are the reasons for the health center not to establish a working relationship with your HP?

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39. What do you think should be done to establish a good working relationship between your HP and the health center?

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40. In your opinion, what is the best and most remarkable achievement that you consider to be highly exemplary and worthy of further inquiry.

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

## **Annex 3 – Facility Review of Health Post**

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### **Health Post Facility Review**

#### **Part I: Area Identification:**

Region \_\_\_\_\_ Zone \_\_\_\_\_ Woreda \_\_\_\_\_ Kebele \_\_\_\_\_

Name of Health Post \_\_\_\_\_

Date service started: Date \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

#### **Part II: Detailed Questions:**

1. Does the health post (HP) have a road?

- 1) Yes                      2) No

What is the HP's source of water?

- 1) Piped water  
2) Protected well  
3) Unprotected well  
4) Protected spring  
5) Unprotected spring  
6) River  
7) Other, specify \_\_\_\_\_

2. Does the Health Post have toilet facility?

- 1) Yes                      2) No

#### **Note:**

*If the answer for question 2 is 'Yes,' then complete the following:*

- |   |        |       |
|---|--------|-------|
| 3. Is the toilet facility currently in use?                 | 1) Yes | 2) No |
| 4. Was the toilet locked during the visit?                  | 1) Yes | 2) No |
| 5. Does it have water to wash hands with?                   | 1) Yes | 2) No |
| 6. Is the toilet used properly?                             | 1) Yes | 2) No |
| 7. Does the HP have a solid waste disposal pit or the like? |        |       |
|   | 1) Yes | 2) No |

#### **Note:**

*If the answer for question 8 is "1) Yes," complete questions 9 and 10.*

8. Do they use the waste disposal pit properly? 1) Yes 2) No
9. Was the waste disposal pit: 1) Not full yet 2) Full
10. Does the HP have a registration book with client's sex, age and address entries?  
1) Yes 2) No

**Note:**

*If the answer for question is '1) Yes', complete questions 12; if not skip to 13.*

11. Was the registration book used properly? 1) Yes 2) No

12. How many persons benefited from the health service that the HP provides?

Male \_\_\_\_\_ Female \_\_\_\_\_ Total \_\_\_\_\_

13. What was the number of children according to the following age brackets?

14.1 Less than one year \_\_\_\_\_  
 14.2 1-4 Years \_\_\_\_\_  
 14.3 5-9 Years \_\_\_\_\_  
 14.4 10-14 Years \_\_\_\_\_

14. Indicate in the space provided the number of women corresponding to the childbearing age brackets according to the following age categories:

15.1 15-19 Years \_\_\_\_\_  
 15.2 20-24 Years \_\_\_\_\_  
 15.3 25-29 Years \_\_\_\_\_  
 15.4 30-34 Years \_\_\_\_\_  
 15.5 35-39 Years \_\_\_\_\_  
 15.6 40-44 Years \_\_\_\_\_  
 15.7 45-49 Years \_\_\_\_\_

15. Indicate in the space provided the number of pregnant women who had antenatal care at the HP.  
\_\_\_\_\_

16. Indicate in the space provided the number of pregnant women who delivered at home with the help of a HEW. \_\_\_\_\_

17. Indicate in the space provided the number of pregnant women who delivered at the HP.  
\_\_\_\_\_

18. Indicate in the space provided the number of pregnant women who delivered with the help of trained birth attendant. \_\_\_\_\_

19. Indicate in the space provided the number of women who were referred to the next higher level health facility for delivery. \_\_\_\_\_
20. Indicate in the space provided the frequency of home visits that the HEWs ever made. \_\_\_\_\_
21. Does the HP have clear weekly and monthly activity plans?  
 1) Yes                      2) No
22. Did the HEWs have plans for making home visits?  
 1) Yes                      2) No

**Note:**

*If the answer for question 21 is '1) Yes', then answer questions 21, 22, and 23.*

23. How often did they make home visits in a week?  
 1) One              2) Two              3) Three              4) Not clearly indicated
24. Were the achievements of the HP clearly and comparably documented against plans?  
 1) Yes                      2) No
26. Complete achievements of the different immunization activities against the set plans of the HP for each of the following:

Question No	Type of Immunization	Planned	Achieved	% Achieved
26.1	BCG			
26.2	Pentavalent +3			
26.3	Tetanus toxoid (TT 2+)			
26.4	Measles			
Completed vaccination				

## Annex 4 – Facility Review of Living Quarters

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**Facility and Living Quarters Review:** Living quarters of health post (HPs) beneficiaries

**To be visited:** Three at each HP, in a 200 meter radius in three directions

**Informed consent:**

**Moderator:**

*First start by greeting the households, and then introduce yourself by telling them your name, and explain why you were there as stated below to get their consent.*

I am here today to observe the living quarters of this community and take notes on my observations of the different aspects of the health practices undertaken by members of the community. The findings from this will be merged with all the others I observe in this community. Hence, findings from my observation will reflect only the environmental health practices of the community in general. However, if need be, I will ask to take pictures/photos of any best practice worth recording/documenting and include in my report upon the knowledge and consent of the household concerned. I assure you that any observation I document about your living quarters will remain confidential and will in no way be directly associated with you personally. So now I assume that you are aware of the purpose of my visit to your residence.

I would like you also to note that my visit to your living quarters has been planned with the knowledge and permission of the Woreda Health Office, the HP staff, and your kebele administration. Yet, it is your permission that is most important, to allow me to go around and document what I observe. Therefore, may I ask for your permission to let me continue with my visit?

**Reviewer:**

*If the household owner reacted positively, you start visiting and documenting your observations. If the household was not willing, salute and move to the neighboring household and repeat this exercise.*

**Part I: Area Identification:**

Region \_\_\_\_\_ Zone \_\_\_\_\_ Woreda \_\_\_\_\_ Kebele \_\_\_\_\_

1. Relative performance category of the HP: Strong  Weak

**Reviewer:**

*Guided by the statements describing the health practices 2 through 5 and their specifications indicated by the sub-numbers, review the living quarters of the household. In the meantime, document your findings by circling the code numbers “1” or “2” with respect to your observation about the specific practice of the household. Some points like water (spring and ponds) may require asking and going out to the spot to observe.*

**2. Environmental Sanitation**

2.1 Areas of observing practices by the household in preventing infections of communicable diseases:

	Yes	No
2.1.1 Has kept their compounds clean	1	2
2.1.2 Has cleared broken clay pieces and other debris	1	2
2.1.3 Has utensils that can hold water from the backyard	1	2
2.1.4 Has enough space in the backyard for preparing latrine	1	2
2.1.5 Has pit latrine	1	2
2.1.6 Pit latrine hole has a cover	1	2
2.1.7 Has built a hut for the pit latrine	1	2
2.1.8 Has used the pit latrine	1	2
2.1.9 Has kept the latrine clean	1	2
2.1.10 Has enough space in the backyard for preparing solid waste pit	1	2
2.1.11 Has prepared waste disposal pit	1	2
2.1.12 Has used the waste disposal pit properly	1	2
2.1.13 Has enough space in the backyard for preparing manger	1	2
2.1.14 Has separate gates for the families and livestock	1	2
2.1.15 Prepared manger separate from the family living house	1	2
<b>2.2 Source of water</b>		
2.2.1 Has piped water	1	2
2.2.2 Has protected well water	1	2
2.2.3 Has used unprotected well water	1	2
2.2.4 Water pond	1	2
2.2.5 Spring	1	2
2.2.6 Has fenced the spring	1	2
2.2.7 Has protected the spring by casing with cement and stone	1	2
2.2.8 Has prepared drainage for the over flow and / or spilled water	1	2
<b>2.3 The locality is an endemic malaria area</b>		
2.3.1 Household uses ITN.	1	2
<b>3. Household has family health cards.</b>	1	2
<b>4. Household members ever used antenatal care services.</b>	1	2
<b>5. Household families ever used FP services.</b>	1	2

**Reviewer:**

*Thank the household member saying: I thank you very much for your hospitality and willingness to let me review your living quarters and observe your health practices.*

## **Annex 5 – Key Informant Interview for Woreda Health Office – Health Extension Program Supervisor**

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

### **Informed consent:**

Greetings,

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

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

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

### **Interviewer:**

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

### **Part I: Area Identification:**

Region \_\_\_\_\_ Zone \_\_\_\_\_ Woreda \_\_\_\_\_

### **Part II: Detailed Questions:**

1. What is the population size of the woreda?

Male \_\_\_\_\_ Female \_\_\_\_\_ Total \_\_\_\_\_

2. How long have you served in your current assignment?
  - 1) Less than a year
  - 2) A year
  - 3) A year and half
  - 4) Two years
  - 5) Two years and half
  - 6) Three years
  - 7) Other, specify \_\_\_\_\_
  
3. How many kebeles are there in your woreda?  
\_\_\_\_\_ # kebeles
  
4. How many HPs are there in your woreda?  
\_\_\_\_\_ # HPs
  
5. How many HEP supervisors are there in your Health Office?  
\_\_\_\_\_ # HEP supervisors
  
6. How frequently do you visit each HP?
  - 1) Once a month
  - 2) Once in two months
  - 3) Once in three months
  - 4) Once in six months
  - 5) Other, specify \_\_\_\_\_
  
7. What do you use as the basis for your plan before going to the HPs to undertake supervision?
  - 1) My monthly working plan
  - 2) My bi-annual working plan
  - 3) When the timing is convenient to undertake the supervision
  - 4) The working plan of the HEW (daily, weekly, monthly, etc.)
  
8. What are the major activities that you do during supervision visits?
  - 1) Coordinate household and community level activities of the health extension workers.
  - 2) Supervise and evaluate the household and community level plan versus achievement.
  - 3) Work on finding solutions and ways to major problems faced by the HEWs.
  - 4) Consult with the HEWs and provide technical assistance taking into account their knowledge and skills.
  - 5) Consult with responsible officials if I feel that further strengthening of the HEW's knowledge and skills are required.
  - 6) Strengthen the working relationship of the HP with existing stakeholders by canvassing such stakeholders along with the HEW.
  - 7) Check whether or not there is proper documentation of the activities being done, and also verify the accuracy of plans and achievements by making cross checks.
  - 8) Compare the various reports sent to the woreda with ones at the HP.
  - 9) Discuss with the HEW and stakeholders on possible solutions with regard to unachieved plans.
  - 10) Organize an introduction and orientation program for the HEWs before they start their work.

9. How many health centers are there in your woreda?

\_\_\_\_\_ # health centres

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

\_\_\_\_\_ # HPs

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

\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

14. What health extension packages are being performed in the HPs?

		<b>Yes w/o probing</b>	<b>Yes w/ probing</b>	<b>No</b>
14.1	<b>Environmental health &amp; sanitation</b>	1	2	3
14.1.1	Solid waste disposal	1	2	3
14.1.2	Sanitary pit latrine construction & utilization	1	2	3
14.1.3	Potable water protection	1	2	3
14.1.4	Insects, rodents and other pest control	1	2	3
14.1.5	Housing construction and management	1	2	3
14.2	Health care education	1	2	3
14.3	Personal hygiene	1	2	3
14.4	Nutrition and health	1	2	3
14.5	Adolescent reproductive health	1	2	3
14.6	Family planning	1	2	3
14.7	HIV/AIDS and tuberculosis prevention	1	2	3
14.8	Vaccination	1	2	3
14.9	Maternal and child health	1	2	3
14.10	Malaria prevention and control	1	2	3
14.11	Reproductive health related harmful traditional practices	1	2	3

15. In your opinion, what proportion of the HEP packages that you mentioned were accomplished by the HPs?

- 15.1 All
- 15.2 About 50%
- 15.3 About one third (33%)
- 15.4 About a quarter (25%)

**Interviewer:**

*If responses to question number 15 were number 15.1 or All, or About 15%, continue asking questions 16 through 18.*

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

\_\_\_\_\_ # HPs or \_\_\_\_\_ % of the HPs

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

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18. What did the WHO contribute to the achievements of the HPs?

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**Interviewer:**

*If responses to question number 15 were number 15.3 or 'About 33%', or number 15.4 or 'About 15%', ask questions 19 and 20.*

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

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20. What did you or the WHO do to try to improve the performances of those HPs?

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21. What are the common health problems in the woreda?

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22. What attempts did the HPs take to manage the health problems that were beyond their capacities?

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23. Do you think that all members from the community who were seeking health services come to the HPs?

- 1) Yes            2) Don't think so            3) Don't know

**Interviewer:**

*If responses to question number 18 were answer number '2' (Do not think so) or '3 do not know,' ask question number 23.*

24. Why did you say so?

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25. In your opinion, how improved is the health of the selected community currently as compared with the time when the HPs did not provide services?

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

25.1 \_\_\_\_\_

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25.2. I never had training in this area.

27. How sufficient was your knowledge and skills to supervise HEWs?

- 26.1 Sufficient            26.2 Insufficient

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

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

## **Annex 6 – Key Informant Interviews for Zonal Health Department - Health Extension Program Supervisor**

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**Key Informant Interview Guide:**      Zonal Health Department (ZHD)

**Informed consent:**

Greetings,

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

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

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

**Interviewer:**

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

**Part I: Area Identification:**

Region: \_\_\_\_\_ Zone \_\_\_\_\_

Responsibility of the respondent: \_\_\_\_\_

**Part II: Detailed Questions:**

1. What is the population size of the zone?

Male \_\_\_\_\_ Female \_\_\_\_\_ Total \_\_\_\_\_

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

- 1) More than three years
- 2) Three years
- 3) More than two years
- 4) Two years
- 5) Others specify \_\_\_\_\_

3. How many woredas are there in your zone?

\_\_\_\_\_ # woredas

4. How many health posts (HPs) are there in the zone? \_\_\_\_\_

5. How many of the kebeles in the zone have HPs? \_\_\_\_\_

Urban kebeles # \_\_\_\_\_

Rural kebeles # \_\_\_\_\_

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

\_\_\_\_\_ # HEP supervisors

6.1 What program sections are represented in the supervisory team?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

- 1) Once a month
- 2) Once in two months
- 3) Once in three months
- 4) Once in six months
- 5) Other, specify \_\_\_\_\_

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

- 8.1 Monthly activity plan
- 8.2 Bi-annually activity plan
- 8.3 As deemed necessary
- 8.4 On the basis of the HEW's routine/ weekly/ monthly plan (underline any of the indicated)

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

Developed \_\_\_\_\_

Developing \_\_\_\_\_

10.1 What are the strong points in the relationship that the HPs have established with the health centers?

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

a. \_\_\_\_\_

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b. No problem areas \_\_\_\_\_

**Interviewer:**

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

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

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

\_\_\_\_\_ # Woredas ( \_\_ %)

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

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

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14. What health extension packages are being delivered in the HPs?

		<b>Yes w/o probing</b>	<b>Yes w/ probing</b>	<b>No</b>
14.1	<b>Environmental health &amp; sanitation</b>	1	2	3
14.1.1	Solid waste disposal	1	2	3
14.1.2	Sanitary pit latrine construction & utilization	1	2	3
14.1.3	Potable water protection	1	2	3
14.1.4	Insects, rodents and other pest control	1	2	3
14.1.5	Housing construction and management	1	2	3
14.2	Health care education	1	2	3
14.3	Personal hygiene	1	2	3

14.4	Nutrition and health	1	2	3
14.5	Adolescent reproductive health	1	2	3
14.6	Family planning	1	2	3
14.7	HIV/AIDS and tuberculosis prevention	1	2	3
14.8	Vaccination	1	2	3
14.9	Maternal and child health	1	2	3
14.10	Malaria prevention and control	1	2	3
14.11	Reproductive health related harmful traditional practices	1	2	3

15. What percent of the HEP packages that you mentioned would you think are accomplished?

- 15.1 All
- 15.2 50%
- 15.3 30%
- 15.4 25%

**Interviewer:**

*If the answer to question 15 is 15.1 (All) or 15.2 (50%), ask question 15.5, 15.6 and 15.7.*

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

\_\_\_\_\_ (number) or \_\_\_\_%

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

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

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**Interviewer:**

*If the answer to question 15 is 15.3 (30%) or 15.2 ('25%) ask questions 15.8 and 15.9.*

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

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

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16. What are the common health problems in the zone?

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17. In your opinion, what differences did you observe about the health problems of the people in the woreda before and after the launching of the HEP?

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

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

## **Annex 9 - Focus Group Discussion with Male Beneficiaries**

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**Questionnaire Designed for Focus Group Discussion to be addressed to:** Male Beneficiaries

**Informed consent:**

**Informed consent:**

**A note to the Moderator:**

*Start first by greeting the participants, giving your name, and telling them from where you came. Then explain why you are here as is stated in the following paragraphs to get their consent.*

We are here today, to discuss with you and gather information, about factors that are associated with the service delivery of your respective health posts. It is believed that being residents of the locality and beneficiaries of the service that the HP gives, you are believed to have a lot of experiences to share regarding the issues associated with the ground level implementation of the HEP. The information that we get from you will be merged with others like you in and outside of this region. Then it will be documented, analyzed, and interpreted by experts to reflect what the service looks like and generate recommendations on what should be done to improve the HEP implementation in general. We value very much each and every bit of the information that all of you can provide to us. Therefore, all of you are kindly requested to actively participate in the discussion. We would also like you to note that our discussions will be tape-recorded to help us recall what has been said and to rightly recall the views when we get back to our posts and document them in writing. I would also like to assure you that whatever you cite remains confidential and in no way will the write up associates the findings with any individual. I hope that each one of you is now aware of the purpose of the discussion session.

Even though this focus group discussion (FGD) is being held with the knowledge and permission of the Woreda Health Office (WHO) and the kebele administration, we would also like to confirm whether or not you are willing to participate in the discussion which may take us about an hour time.

**Moderator:**

*If the discussants react positively, continue the FGD with those who volunteered to participate in the discussion, and allow the rest to leave the session.*

**Part I: Area Identification:**

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

**Discussants number:** \_\_\_\_\_

1.      Region \_\_\_\_\_              Zone \_\_\_\_\_      Woreda \_\_\_\_\_              Kebele \_\_\_\_\_

2.      For how long did you live in this kebele?

- 2.1      One year
- 2.2      Two years
- 2.3      Three years
- 2.4      More than three years
- 2.5      Any other----- (explain)

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

- 3.1 15---19 -----
- 3.2 20---24 -----
- 3.3 25---29 -----
- 3.4 30---34 -----
- 3.5 35---39 -----
- 3.6 40---44 -----
- 3.7 45---49 -----
- 3.8 50 and above -----

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

- 4.1-----been to school                      4.2-----never been to school
- 4.3 How many of you been to primary school (grades 1-4)? -----
- 4.4 How many of you been to grades 5 to 8? -----
- 4.5 How many of you been to senior secondary school (9-12)? -----
- 4.6 How many of you been to tertiary/college level (12+2, 12+4, etc.)? -----

5. How many of you have ever been married?

- 5.1 Never been married \_\_\_\_\_
- 5.2 Widowed \_\_\_\_\_
- 5.3 Divorced \_\_\_\_\_
- 5.4 Separated \_\_\_\_\_
- 5.5 Still married \_\_\_\_\_

**Moderator:**

For question 6, all those stated in number 6.1 through 6.4 are answers. Once you raised and clarified the question:

- Keep on circling code number '1' when they cite the type of the HEP (service) that the HP delivers without probing. They may not cite them sequentially as was put in the questionnaire. Therefore, read through the HEP packages to recall their locations when discussants/respondents cite them. Give them time to recall until they tell you that they have no more to mention
- Look at the type of the health extension package that you have not circled (meaning that they have not cited) starting from 6.1. Then read/cite for them each individual health extension package, and every time you finish reading/citing the particular health package whose number '1' answer code was not marked, ask them if they have anything to tell you about it. If they tell you anything, then circle number '2.' If nothing, circle number '3.'

6. What are the health services that the health post in your kebele is giving?

		Yes without probing	Yes with probing	No
6.1	<b>Hygiene &amp; Environmental Health</b>			
	6.1.1 Excreta disposal	1	2	3
	6.1.2 Solid & liquid waste disposal	1	2	3
	6.1.3 Water supply and safety measures	1	2	3

marked, ask them if they have anything more to tell you about it. If they tell you anything, then circle number '2', if not, circle number '3'.

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

		Yes without probing	Yes with probing	No
8.1	<b>Hygiene &amp; Environmental Health</b>			
8.1.1	Excreta disposal	1	2	3
8.1.2	Solid & liquid waste disposal	1	2	3
8.1.3	Water supply and safety measures	1	2	3
8.1.4	Food hygiene and safety measures	1	2	3
8.1.5	Healthy home environment	1	2	3
8.1.6	Control of insects and rodents	1	2	3
8.1.7	Personal hygiene	1	2	3
8.2	<b>Health Education and Communication</b>	1	2	3
8.3	<b>Family Health</b>			
8.3.1	Maternal and child health	1	2	3
8.3.2	Family planning	1	2	3
8.3.3	Immunization	1	2	3
8.3.4	Nutrition	1	2	3
8.3.5	Adolescent reproductive health	1	2	3
8.3.6	Reproductive health related harmful traditional practices	1	2	3
8.4	<b>Disease Prevention and Control</b>			
8.4.1	HIV/AIDS & other sexually transmitted infections (STIs) & TB prevention & control	1	2	3
8.4.2	Malaria prevention and control	1	2	3
8.4.3	First aid emergency measures	1	2	3

**Moderator:**

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

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

- 9.1 HEWs that came to our homes told us \_\_\_\_\_
- 9.2 We heard about it when we went to the HPs seeking for services \_\_\_\_\_
- 9.3 Friends who heard about it told us \_\_\_\_\_
- 9.4 Community members who heard about it told us \_\_\_\_\_
- 9.5 HEWs told us at the meetings we held \_\_\_\_\_
- 9.6 If the discussants cited some other ways heard, write them in the spaces provided below.

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

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

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**Moderator:**

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

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

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

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

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

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

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

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## **Annex 10 - Focus Group Discussion with Voluntary Community Health Workers**

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### **Questionnaire for Focus Group Discussion (FGD)**

**The FGD Participants:** Voluntary Community Health Workers (VCHWs)

### **Informed consent:**

#### **A note to the Moderator:**

*Start first by greeting the participants and introducing yourself, giving your name and telling them from where you came. Then explain why you are here as stated in the following paragraphs in order to get their consent.*

We are here today, to discuss with you and gather information, about factors that are associated with service delivery of your respective health post (HP). It is believed that because of your close working relationship with the HEWs that have been assigned to the HP and because you are a member of the selected community, we believe that you have a lot of experience to share regarding the issues associated with the practical implementation of the HEP at the ground level. The information that we get from you will be merged with others like you in and outside of this region. Then we will have experts document, analyze, and interpret all the information collected to reflect what the services look like and generate recommendations on what should be done to improve the HEP implementation in general. We value greatly each and every bit of information that every one of you can give us. Therefore, all of you are kindly requested to actively participate in the discussion. We would also like you to note that our discussions will be tape-recorded to help us recall what has been said and to rightly recall the views, after we return to our posts and document this in writing. I would also like to assure you that whatever you cite will remain confidential and that in no way, will any of the write-ups and findings be associated with any individual. I hope that each one of you is now aware of the purpose of the discussion session.

Even though this FGD is being held with the knowledge and permission of the Woreda Health Office and the kebele administration, we would also like to confirm with you directly whether or not you are willing to participate in the discussion which will take about an hour.

#### **Moderator:**

*If the discussants react positively, continue the FGD with those who volunteered to be part of the discussion and allow the rest to leave the session.*

### **Part I: Area Identification:**

Region \_\_\_\_\_ Zone \_\_\_\_\_ Woreda \_\_\_\_\_ Kebele \_\_\_\_\_

**Performance category of the group:** 1) Strong 2) Weak

### **Part II: Discussion Questions**

**Moderator:**

For question 1, all those stated in number 1.1 through 1.4 should be answered, once you raised and clarify the question:

- Keep on circling code number “1” when they cite the type of the HEP (service) that the HP delivers without probing. They may not cite them sequentially as was put in the questionnaire. Therefore, read through the HEP packages to recall their locations on this document when discussants/respondents cite them. Give them time to recall until they tell you that they have nothing more to mention
- Look at the type of the health extension package that you have not circled (meaning what they have not cited) starting from 1.1. Then, read/cite for them each individual health extension package, and every time you finish reading/citing the particular health package whose number “1” answer code was not marked, ask them if they have anything more to tell you about it. If they tell you anything, then circle number “2.” If nothing, then circle number “3”.

1. What are the health services that the HP in your kebele is giving?

	Self cited	Cited with probing	Not cited
<b>1.1 Hygiene &amp; Environmental Health</b>			
1.1.1 Excreta disposal	1	2	3
1.1.2 Solid & liquid waste disposal	1	2	3
1.1.3 Water supply and safety measures	1	2	3
1.1.4 Food hygiene and safety measures	1	2	3
1.1.5 Healthy home environment	1	2	3
1.1.6 Control of insects and rodents	1	2	3
1.1.7 Personal hygiene	1	2	3
<b>1.2 Health Education and Communication</b>	1	2	3
<b>1.3 Family Health</b>			
1.3.1 Maternal and child health	1	2	3
1.3.2 Family planning	1	2	3
1.3.3 Immunization	1	2	3
1.3.4 Nutrition	1	2	3
1.3.5 Adolescent reproductive health	1	2	3
<b>1.4 Disease Prevention and Control</b>			
1.4.1 HIV/AIDS & other sexually transmitted infections (STIs) & TB prevention & control	1	2	3
1.4.2 Malaria prevention and control	1	2	3
1.4.3 First aid emergency measures	1	2	3

2. What were the common health problems of the community before the HPs were launched in your community?

2.1 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- a. They had no health problems \_\_\_\_\_
- b. We do not know \_\_\_\_\_

3. From what you recall, which of the health problems do you think have improved since the HP started giving services in your locality?

3.1 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- a. No improvement was observed \_\_\_\_\_

**Moderator:**

*If the answer to question number 3 was number "3.2", skip question number "3.3."*

- b. What are the factors that you assume have helped in improving the health problems of the community?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Which health services of the HP do you appreciate most?

\_\_\_\_\_  
\_\_\_\_\_

5. Which of the health services that the HP provides do you want to improve?

\_\_\_\_\_  
\_\_\_\_\_

6. What have you heard said by the beneficiaries who have been to the HP for services?

\_\_\_\_\_  
\_\_\_\_\_

7. In general, what have you heard among individuals in the selected assessment communities regarding the services rendered at the HP?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Please explain what your relationship is like with the HEWs in the HP. What do they help you with in discharging your community health services?

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9. What would you like to improve (what aspects) in the relationship that you have with the HEWs?

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10. If you have any issues that we did not discuss so far regarding the HEP, please bring them forth for discussion now.

***On behalf of my team, the HP beneficiaries and myself, I whole heartedly thank you for taking your time to come hear and share with us your observation regarding the HEP.***

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## **Annex 11 - Focus Group Discussion with Health Extension Workers**

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**Questionnaire Designed for Group Discussion to be addressed to:** Health Extension Workers

### **Questionnaire for Focus Group Discussion (FGD)**

**The FGD Participants:** Health Extension Workers (HEWs)

### **Informed Consent:**

#### **A note to the Moderator:**

*Start first by greeting the participants, introducing yourself and telling them from where you came. Then explain why you were here as is stated in the following paragraphs to get their consent.*

We are here today to discuss with you and gather information about factors that are associated with the service delivery of your respective health posts (HPs). It is believed that because of your relationship with the Woreda Health Office (WHO), VCHWs, kebele administration, beneficiaries and many other stakeholders, you are believed to have a lot of experience to share regarding the issues associated with the practical implementation of the Health Extension Program (HEP) at ground level. The information that we get from you will be merged with others like you in and outside of this region. Then it will be documented, analyzed, and interpreted by experts to reflect what the services look like and generate recommendations on what should be done to improve HEP implementation in general. We value very much each and every bit of the information that every one of you give us. Therefore, all of you are kindly requested to actively participate in the discussion. We would also like you to note that our discussions will be tape-recorded to help us recall what had been said and to rightly recall your views when we get back to our posts and document them in writing. I would also like to assure you that whatever you cite will remain confidential and in no way will the write up of the findings be associated with any individual. I hope that each one of you is now aware of the purpose of the discussion session.

Even though this FGD is being held with the knowledge and permission of the WHO and the kebele administration, we would also like to confirm whether or not you are willing to participate in the discussion which may take us about an hour time.

#### **Moderator:**

*If the discussants react positively, continue the FGD with those who volunteered to participate in the discussion and allow the rest to leave the session.*

### **Part I: Area Identification:**

Region \_\_\_\_\_ Zone \_\_\_\_\_ Woreda \_\_\_\_\_ Kebele \_\_\_\_\_

**Performance category of the group:** 1) Strong                      2) Weak

### **Part II: Discussion Questions**

**1.** What did the WHO do when you arrived at the health post (HP)?

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**2.** What differences have you observed between the knowledge and skills that you acquired during your training and the actual health service provision that you are experiencing at your HP?

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**3.** How does the community perceive the various health services that are provided by your HP?

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**4.** What are the most serious health problems that the community in your operational area is suffering from?

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**5.** What are the contributions of the community for the successful implementation of the Health Extension Program (HEP) and how did they contribute?

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**6.** In your opinion, how successful was the effort you made to bring about the successful implementation of the HEP?

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**7.** What other improvements do you think are required to significantly maximize the current health service provision in your kebele?

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**8.** Have you ever heard of any word of praise and/or encouragement or criticism and/or dissatisfaction from health service users in the community that you serve?

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**9.** What major changes have you observed after the arrival and functioning of your HP in the area?

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**10.** What are the most frequently sought health service demands in your health post?

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**11.** Where do pregnant women in your community prefer to give birth, and what do you think the reasons are?

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**12.** How many of you have VCHWs in your catchment areas? (Indicate number) \_\_\_\_\_

**13.** How do you describe the working relationship that you have with community volunteers that are operating in your area?

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**14.** Are there any other issues that you need to raise as a discussion point? If so, please raise them and let us discuss them.

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

6.1.4	Food hygiene and safety measures	1	2	3
6.1.5	Healthy home environment	1	2	3
6.1.6	Control of insects and rodents	1	2	3
6.1.7	Personal hygiene	1	2	3
<b>6.2</b>	<b>Health Education and Communication</b>	1	2	3
<b>6.3</b>	<b>Family Health</b>			
6.3.1	Maternal and child health	1	2	3
6.3.2	Family planning	1	2	3
6.3.3	Immunization	1	2	3
6.3.4	Nutrition	1	2	3
6.3.5	Adolescent reproductive health	1	2	3
6.3.6	Reproductive health related harmful traditional practices	1	2	3
<b>6.4</b>	<b>Disease Prevention and Control</b>			
6.4.1	HIV/AIDS & other sexually transmitted infections (STIs) & TB prevention & control	1	2	3
6.4.2	Malaria prevention and control	1	2	3
6.4.3	First aid emergency measures	1	2	3

**Moderator:**

*When someone tells how he knew about it, ask the rest to raise their hands if they had the same response and tally the numbers holding their hands in matching answer.*

7. How did you come to know about the aforementioned health services? *(When someone responds, do not stop but keep on encouraging more them to speak out, until they tell they stop citing).*

HEWs that came to our homes told us \_\_\_\_\_

We heard about it when we went to the HPs seeking for services \_\_\_\_\_

Friends who heard about it told us \_\_\_\_\_

Community members who heard about it told us \_\_\_\_\_

HEWs told us at the meetings we held \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

**Moderator:**

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

10. Which of the health problems that were prevailing most in the days before the HP started service were now reduced?

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

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12. In your opinion, how helpful was the service at the HP in reducing the burden of health problems in the community?

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13. What health services are given for mothers and children at the HP? What changes were observed ever since?

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14. What would you suggest to improve the current health service of the HP?

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

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## **Annex 12 – Guide for Stakeholders Meetings**

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### **Meeting Guide for: Stakeholders**

#### **A note to the Moderator:**

*Start first by greeting the participants, and introducing your name, and telling them from where you came. Then explain why you are there as is stated in the following paragraphs to get their consent*

#### **Informed consent:**

We are here today, to discuss the services and factors associated with the operation of the HPs at your kebeles in particular, and in the woreda in general. As you can observe, participants of this stakeholders meeting are invited from the Zonal Health Department (ZHD), woreda administrative office, health center, woreda line offices, kebele administrations, local associations (women, youth...etc.), social organizations, religious groups, and community elders. In the course of the discussion, it is believed that issues associated with the HPs' service delivery, observed strengths and gaps, contributing factors, involvement of the community in the Health Extension Program (HEP), and future directions will be discussed. You being part of the beneficiary community, tapping your experiences is believed to extraordinarily enrich the assessment findings. Noting that similar discussion meetings were held in other zones and woredas within and outside this region, the information that this meeting generates will be merged with all others for compilation, analysis, interpretation and documentation of findings to help program planners and implementers to understand all beneficiaries' aspects of the HEP.

The meeting will have two sessions: group work and plenary. Before you break into groups, based on your numbers and organizations that you represent, discussion groups will be formed. Each group will then select its moderator and note taker for the discussion. The groups will all be given different discussion guides to work on to cover a wider span, given the time we have for this meeting. Following your discussion session, reporters of the groups will write down what was discussed and points agreed upon from each of the respective groups for presentation in the plenary. You should therefore note that all views aired by those in each of the groups are highly valued and believed instrumental to the future development of the HEP. Therefore, you are very much advised to take an active role, both in plenary and group work sessions. At times, the discussion points will be tape-recorded to facilitate recalling during the writing up and documenting what has been discussed. I would also like to assure you that whatever you cite remains confidential and in no way will names and individual personalities be associated when narrating the findings. I hope each one of you is now aware of the purpose of the discussion session.

Even though this stakeholders meeting is held with the knowledge and permission of the Woreda Health Office (WHO) and the kebele administration, we need to confirm your willingness to participate. This discussion session will take us about an hour time.

#### **Moderator:**

*If the discussants react positively, continue the FGD with those who volunteered to participate and allow the rest to leave the session.*

#### **1. Number of participants by year of residence in the kebele.**

- 1.1 About three years
- 1.2 About four years
- 1.3 About five years

1.4 More than five years

2. What was your involvement in the establishment of the HPs?

2.1 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2.2 We were not involved \_\_\_\_\_

3. What were the issues that you discussed with the HEW ?

3.1 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3.2 We never had discussed such issues. \_\_\_\_\_

**Moderator:**

*If the group members express views stated in 3.2 or said, "We never discussed such issues," ask 3.3.*

3.3 Why were you not motivated to discuss issues about the health service that the HP was giving?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What community health differences did you observe between the days before and after the HEP was launched in your localities?

4.1 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4.2 No changes were observed in the health of the community \_\_\_\_\_

**Moderator:**

*If the view that the stakeholders expressed was 4.2, 'No changes were observed in the health of the community,' skip number 5 and ask number 6.*

5. What differences did you observe in environmental sanitation in the days before and after the HEP was launched in your localities?

5.1 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5.2 No changes were observed in the environmental sanitation \_\_\_\_\_

6. Which of the health services did you observe as better or best performed among all others?

6.1 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6.2 What was your involvement and contributions in the areas that you explained as having been performed well or best?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6.3 Nothing was performed satisfactorily. \_\_\_\_\_

**Moderator:**

*If the view that the stakeholders expressed was 5.3, 'Nothing was performed satisfactorily,' then go to 6.4*

6.4 What do you think are the reasons for not seeing any commendable performance in the health service delivery of the HP?

\_\_\_\_\_  
\_\_\_\_\_

7. What would you suggest to do differently to enable the health posts perform better than the current?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. What contributions do you think could you make to improve the current health service status?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Which of the existing health problems in your area affect the public most?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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**Principal investigator:** thank them before departure.

*On behalf of all beneficiaries of the HEP and myself, I would like to thank you very much for taking so much of your precious time and actively participating in the meeting to contribute your part for the betterment of the health services that the HPs are providing in your localities.*

**Annex 13 – HEWs Reported Performance Satisfaction in Implementing the 16 HEP Packages in their Catchment Area**

Ser. No	HEP Packages	Responses of HEWs (n = 81)		
		Without Probing %	With Probing %	None %
1	Information, education, behavior change communication	100	-	-
2	Pit latrine construction and usage	92.6	7.4	-
3	Immunization	91.4	8.6	-
4	Family planning	74.1	25.9	-
5	Maternal and child health	59.3	39.5	1.2
6	Solid waste disposal	59.3	39.5	1.2
7	Water sanitation	55.6	40.7	3.7
8	Personal hygiene	55.6	44.4	-
9	Housing construction and management	46.9	51.9	1.2
10	HIV/AIDS	46.9	53.1	-
11	TB control and prevention	46.9	53.1	-
12	Nutrition	30.9	69.1	-
13	First aid, food hygiene and safety measures	28.4	67.9	3.7
14	Malaria prevention and control	27.2	69.1	3.7
15	Adolescent reproductive health	21.0	77.8	1.2
16	Pests and rodent control	19.8	71.6	8.6

## Annex 14 - Health Practices Observed in Communities During Observations of Residential Quarters in both Amhara and SNNPR

Health practices of communities	Total visited	Yes	
		seen	%
Ever been ANC clients	252	149	59.1
Ever been FP clients	252	164	65.1
Households living in malaria endemic areas	252	72	28.6
Residents of malaria endemic sites with areas cleared of broken clay shards, anything that can hold water	72	50	69.4
Households (HHs) in malaria endemic sites using ITN	72	57	79.2
HH in non malaria endemic sites with surrounding areas kept clear and clean	180	129	71.6
HHs have space for pit latrine in backyards	252	237	94
HHs with space to construct pit latrines	237	221	93.2
HHs without space for pit latrines but with a constructed pit	15	9	60
HHs with pit latrines constructed	230	252	91.3
HHs having and using pit latrines	230	215	93.1
HHs who prepared covers for the pit opening	230	81	35.2
HHs who constructed huts for their pit latrines	230	193	83.9
HHs who kept the pit latrine area clean	230	183	79.6
HHs with enough backyard space for solid waste pit	252	174	69
HHs enough backyard space and solid waste pit dug	174	102	58.6
HHs without enough space but with dug solid waste pit	78	28	35.9
HHs who properly utilized the solid waste pits	252	113	44.8
HHs whose backyard had space for building a manger	252	189	75
HHs who had space and built manger	189	121	64
Separated gates for humans and livestock where there is no space	63	19	30.1
HHs who fetch water from spring and other sources	252	116	46
Communities that protected their springs by fencing	116	39	33.6
Communities that protected their springs by cement casing	116	39	33.6
Communities with drainage for wasted water from water springs	116	49	42.2

## **Annex 15 - Technical Contributors in Assessment Design, Implementation, Analysis and Report Writing**

---

On behalf of the Health Extension and Education Center, Federal Ministry of Health, the authors would like to acknowledge the technical expertise and contributions of all listed below. Each individual was involved in some way in the performance-based assessment of HEWs and the underlying factors contributing to their performance in select woredas, which has culminated with this final report, *“Assessment of Factors Contributing to the Performance of Health Extension Workers in Select Woredas of Amhara National Regional State and Southern Nation, Nationalities and People’s Region”*:

*Federal Ministry of Health of Ethiopia/Health Extension and Education Center:*

Mr. Wondwossen Temiess, General Manager  
Mr. Yehuwalaeshet Bekele, Department Head  
Mr. Taeme Gebremariam, Expert Strategic and Information Team  
Mr. Mengistu Tadelle, Expert Strategic and Information Team

*Pathfinder International-Ethiopia:*

Mr. Tilahun Giday, Country Representative  
Dr. Mengistu Asnake, Deputy Country  
Mr. Befekadu Demmissie, Team Leader of Capacity Building and Training  
Mr. Girma Kassie, Team Leader of Monitoring and Evaluation  
Mr. Mehari Belachew, Monitoring and Evaluation Officer  
Mr. Taeme Gebremariam, Expert Strategic and Information Team  
Mr. Mengistu Tadelle, Expert Strategic and Information Team  
Mr. Seid Ali, Regional Field Supervisor, Amhara  
Mr. Hailu Negash, Regional Program Officer, SNNPR

*State Government Health Offices:*

Regional Health Bureaus of SNNPR and Amhara National Regional States  
Zonal Health Departments of Gamogofa, Hadiya in SNNPR and South Wollo, and Awi in Amhara  
Woreda Health Offices of Arbaminch, Misha, Kutaber, and Banja

*ESD Project/Washington DC, U.S.:*

Ms. Jeanette Kesselman, Senior Advisor, Capacity Building & Sustainability  
Mrs. Uchechi Obichere-Roxo, Program Officer  
Ms. Cate Lane, Senior Advisor, Youth  
Ms. Maija Kroeger, Communications Officer

