DECLARATION

I hereby declare that the dissertation entitled **HEALTH EXTENSION PROGRAM IMPLEMENTATION IN IMPROVING MOTHER AND CHILD HEALTH: ACHIEVEMENTS AND CHALLENGES IN THE CASE OF BAKELLO KEBELE ADMINISTRATION** submitted by me for the partial fulfillment of the MSW to Indira Gandhi National open university, (IGNOU) New Delhi in my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirement for any other program study. I also declare that no chapter of this manuscript in whole or in parts is lifted and incorporated in this report from any earlier work done by me or others.

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CERTIFICATE

This is certifying that Mr. Abebe Ayal Nigat student of MSW from Indira Gandhi National Open University, New Delhi was working under my supervision and guidance for his project work for the course **MSWP-001.** His project work entitled HEALTH **EXTENSION PROGRAM IMPLEMENTATION IN IMPROVING MOTHER AND CHILD HEALTH: ACHIEVEMENTS AND CHALLENGES IN THE CASE OF BAKELLO KEBELE ADMINISTRATION** that he is submitting, his genuine and original work.

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Abstract

Background: - To meet the 4th and the 5th millennium development goal the government Ethiopia has developed different policies and strategies. Health extension program is one of the strategies started to implement at kebele level to improve mothers and children health. What success achieved and what challenges faced during the implementation of extension program in Bakello kebele of Bassona worana woreda was the motive of this research.

Objective: - what achievements are recorded and what challenges faced since the implementation of health extension program to improve mother and child health in Bakello kebele administration.

Methods: - the study was conducted in Amhara region, North Shoa Zone, Bassona worana Woreda Bakello kebele from October – November 2013. The study populations were mothers who have children under five years, health development army and health extension workers who live in Bakello and health extension supervisor and health center head who directly involved in the implementation of health extension program in the kebele. The data was collected by using questioner, FGD and interview. Data analysis was done by using percentage and qualitative analysis.

Result: - 72 respondents participated in providing response for structured questioners, FGD and interviews.

Based on this, the finding discloses that there are a number of improvement on health status of maternal services provision, children and mothers vaccination, personal and

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environmental hygiene, nutritional status of children after the implementation of health extension program in the kebele.   ,.

On the other hand there are still a number of obstacles that challenged effective implementation of maternal and child health in the kebele. Availing quality services in the health institutions and awareness problem on the child and mother health are still areas that need further improvement.

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KEYWORDS

Health development army: is a strategy that helps the community to implement health extension program in organized form.

Health extension worker: are deploying at each village (Kebele) of two salaried female Health Extension Workers (HEW) who are trained for a year at Technical and Vocational Training and Education Centers.

Health extension program: aims to creating healthy environment and healthful living by making available essential health services at the grass roots level.

Neonatal mortality: the probability of dying within the first month of life

Post-neonatal mortality: the difference between infant and neonatal mortality

Infant mortality: the probability of dying before the first birth

Child mortality: the probability of dying between the first and fifth birthday

Under-5 mortality: the probability of dying between birth and the fifth birthday

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ACRONYMS

ANC-	Anti natal care
BCC-	Behavioral change and communication
EDHS-	Ethiopia demographic and health survey
EFY-	Ethiopian fiscal year
FGD-	Focus group discussion
FMOH	Federal ministry of health
HC-	Health center
HAD-	Health development army
HEP-	Health extension program
HES-	Health extension supervisor
HEW-	Health extension worker
HSDP-	Health sector development plan
HIV/AIDS-	Human immune deficiency virus / acquired immune deficiency syndrome
MDG-	Millennium development goal
MOH-	Ministry of health
MOFED-	Ministry of finance and economic development

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MMR-	Maternal mortality rate
NNP-	National nutrition program
ORS-	Oral rehydration salt
PHC-	primary health care
PNC-	Post natal care
TBA-	Traditional birth attendant
TTBA-	Trained traditional birth attendant
U5MR-	Under five mortality rate
UNE	United nation in Ethiopia
VCHW-	Volunteer community health worker

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CHAPTER ONE: INTRODUCTION

1.1. Background of the study

According to Federal democratic republic of Ethiopia ministry of health (2010) "Before the 1990s, Ethiopia's health care delivery system was ineffective and inefficient, characterized by top heavy and uncoordinated planning and implementation. The health service system had eight specialized vertical programs: malaria and other vector-borne diseases, tuberculosis prevention and control, leprosy control, HIV/AIDS and other sexually transmitted disease prevention and control, the expanded program on immunization, control of diarrheal diseases, acute respiratory diseases control and prevention, and control of micronutrient deficiency diseases. Though the priorities were correct, the programs were poorly integrated and lacked appropriate direction and management, leading to inefficiency and limited impact. Country health problems were dominated by preventable and communicable diseases, which constituted 60–80% of the disease burden (FMOH 2010a). Aggravating this was the rapidly growing population and poor infrastructure, which had been crippled by the decades of war and neglect. The health institutions were few compared to the size of the population, ill equipped, and inequitably distributed. In 1994, roughly 50 percent of Ethiopia's health facilities were in urban areas with over 30 percent needing either major repair or replacement.

The sector was further characterized by an acute and chronic shortage of human resources coupled with poor community and private sector participation in service delivery and management.

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Following 1994 health policy of the country, the government started implements different health plans. The 1st health sector development plan which started in 1997/98 which ends 2001/2002 is an output of the policy to improve primary health care. But to be more accessed primary health care services to the community health extension program started in 2003 trough out the country. Ethiopia as country attains a number of results since the implementation of health extension program, which are important to improve primary health care. Similarly, improvements recorded on mother and child health after the implementation of the program throughout the country. However, to meet objective of MDG 4&5, the data shows that the country needs walk long way. The following are some of different literatures' that shows county status on maternal and child health.

The major health problems of the country remain largely preventable communicable diseases and nutritional disorders. Despite major progresses have been made to improve the health status of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor. Figures on vital health indicators from EDHS 2005 show life expectancy of 54 years (53.4 years for male and 55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010 and more than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often a combination of these conditions. These are very high levels, though there has been a gradual decline in these rates during the past 15years.

In terms of women health, MMR has declined to 590/100,000 though it still remains to be among the highest. The major causes of maternal death are obstructed/prolonged

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labor (13%), ruptured uterus (12%), severe pre-eclampsia/ eclampsia (11%) and malaria (9%). Moreover, 6% of all maternal deaths were attributable to complications from abortion. Shortage of skilled midwives, weak referral system at health centre levels, lack of inadequate availability of bemonc and cemonc equipment, and under financing of the service were identified as major supply side constraints that hindered progress. On the demand side, cultural norms and societal emotional support bestowed to mothers, distance to functioning health centers and financial barrier were found to be the major causes."

As the government illustrates in the document even there is an improvement after the implementation of three HSDPs still mother and child health not meet sate objectives of MDG. Because of this the government gives due emphasis for primary health care in general and maternal and child health in particular improvement on fourth HSDP too. After taking lesson from previous implementing HSDP experience the government tries to design and implement more applicable strategies.

According to the government experience told that lack of skilled man power mainly mid wife, weak referral system, lack of medical equipment are the main one which need improvement to implement fully health extension program. Still community culture, beliefs and others are challenges that need attention to achieved health extension program objectives. The 4th health sector development plan developed to mitigate such problems.

Ethiopian journal of reproductive health 77(May 2007) "In Ethiopia, it is estimated that 61 percent of households have access to an improved source of drinking water with access in urban areas much higher than in rural areas (94 percent and 56 percent,

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respectively). In urban areas, 90 percent of households have access to piped water compared to only 13 percent of rural households. On the other hand, the major source of improved drinking water in the rural areas, which is 39 percent, is protected spring. An estimated 75 percent of health problems of the country are due to infectious and communicable diseases, which could be easily prevented or controlled by applying simple sanitary measures. However, they still contribute to the high morbidity and mortality, especially among infants and children.

Infant and under five mortality rates were recorded at 77 and 123 per 1000 live births, respectively , whereas, the maternal mortality ratio stood at 673 per 100,000 live births, which are still the highest among sub-Saharan African countries .

In a similar manner, contributions from communities and their direct participation in health activities have been hampered for years. As a result, communities were not given opportunities to play an active role in deciding the type of activities they want, and get involved in the kind of actual service they receive. In similar setting where communities take active participation to produce their health, results showed significant improvement in the health of the population."

Still preventable diseases are the main causes of high maternal and child morbidity and mortality rate in the country generally and rural part of the country in particular as the literature indicated. As the research shows that lack of pure water and lack of community active participation during the implementation of primary health care at kebele level are the main factors, which contributed negatively on maternal and child health. As health extension, philosophy indicates community involvement is most significant to enhance sense of ownership. Still community involvement is not as

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expected which highly affected community health in general and mother and child health in particular.

Desta Mekonnen (2011) disclose that "Infant and child mortality is a factor that can be associated with the well-being of a population and taken as one of the development indicators of health and socioeconomic status and also indicates a life quality of a given population, as measured by life expectancy. That is why reduction of infant and child mortality is a worldwide target and one of the most important key indexes among millennium development goals (MDGs). Hence its indication is a very important for evaluation and public health strategy. Thus, it is an area that many researchers focus and that has attracted the attention of policy-makers and program implementers worldwide. One of the most important targets of millennium development goals (MDGs) that introduced in 2000 at the United Nations millennium summit was reducing infant and under-five child mortality rates by two-thirds from the 1990 levels by 2015."

Now a day mother and child health takes as indicator of development for any nation in the world. From this point of view the country again needs more effort to improve maternal and child health.

Federal minster of health, health extension and education center (2007) document illustrate that "The extension program (HEP) is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of primary health care, it is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom.

The health extension program is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. 30000 health extension workers (HEWs)

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have been deployed by 2009 for this particular mission. It is expected that almost all of the activities listed in the national child survival strategies are to be implemented through the health extension program.

The HEP has the following objectives: create a healthy society and reduce rates of maternal and child morbidity and mortality is goal of health extension program.

- Improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas.
- Ensure ownership and participation by increasing health awareness, knowledge, and skills among community members.
- Promote gender equality in accessing health services.
- Improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through hews.
- Reduce maternal and child mortality.
- Promote healthy life style are the main objectives of health extension program.

Employed two female health extension workers in each kebele, constructed health post in each kebele and equipped these health posts with the necessary equipments and facilities are the main implementing strategy of health extension program.

Health extension program focused on three components and 16 packages."

After signing MDG summit the government of Ethiopia developed different policies that are important to achieve millennium development goal. To implement these policies and achieved stated objectives the government develops different implementing strategies that help the government to change polices in to practices.

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Health extension program is one of the strategies that the government of Ethiopia designed to improve primary health care throughout the country by stretching the services at kebele level. At kebele level transfer knowledge and skill at house hold level which help the house hold to take responsibility on the life of mothers, neonatal and child health. The services provided by two female health extension workers who have cloth relationship with mothers and children.

In addition two health extension workers health development armies expect to work closely with health extension workers. At kebele level the services provided both at the center/ health post / and at community level by providing door-to-door services. To provide quality and appropriate services infrastructure of health post services should be avail properly.

In general, as the above different facts indicated there are improvement in mother and child health but not as expected to meet MDG of 4 &5. This need design different plan and strategies which enhance and improve maternal and child health. This plan and strategies should be come out either from implementation experiences or researcher results. When use experience of implementation it is possible to expand best practices experience to other area for better implementation. Nevertheless, this strategy sometimes faces challenges to duplicate other area because of cultural and environmental factors. To overcome such challenge area context research more advantages by identifying the challenge and provide area context solutions for a given problems. The research is not identified only challenges but try to identify best achievements and elucidate how important the achievements were. That is why this research focused on specific kebele to identify challenges and best practices. Because

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of this, the research focused on to identified what are challenges after the implementation of the program on mother and child health which hider to meet MDGs. Moreover, identify what are successes that accomplished after the implementation of health extension program, which is important to enhance more mother and child health success.

To improve implementation of health extension program and achieve objectives of the program the government use different strategies based on the challenge faced during implementation. One of the strategies that the government uses is to identify achievements and challenges during the implementation of health extension program that are important to meet health extension program objectives.

Achievements and challenges that face during the implementation of health extension program are not similar across the board due to different reasons. Some of the factors are accessibility of health institution infrastructure, culture difference, and inaccuracy of information. Because these factors, attention need to be taken in to consideration on different areas and clearly identified achievements and challenges of these area. Both achievement and challenge are more accurate and increase probability of improvement of implementation when the data supported by the research.

This research is conduct in identifying two issues after the implementation of health extension program in general and mother and child health in particular. These are;

- To assess and identify success that will be achieved after the implementation of health extension program on maternal and child health.

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- To assess bottlenecks that needs attention for the future to improve maternal and child health since the implementation of health extension program.

1.2. Statement of the Problem

This research topic was select because of the following main reasons.

- Mother and children health are still a challenge for Ethiopian government to achieve the 4th and the 5th Millennium Development Goal.
- Because of this, maternal and child health is prior issue of the government's health policy.
- During informal discussion with health professionals, health extension program has faced several challenges.

The Bakello kebele was selected because the researcher knows the kebele for not less than 8 years. More over research has not yet been conducted in this kebele regarding health extension program.

The research was designed to achieved the following points:

- Providing evidence based data on achievements of health extension implementation in the kebele.
- Providing evidence based data on challenges of health extension implementation in the kebele.

After the implementation of health extension program different researchers have conducted researches on health extension program from different perspective in diverse areas and came up with the following results.

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According to the study conducted by Ahmed Abdella (2010) complication of pregnancy and child birth, poor neonatal care management and poor health and nutrition of mothers are the main causes of maternal and child deaths.

Similarly, government HSDP 4 illustrates that most preventable disease and nutritional disorders are still the main health problem of the country in general and child and mother health in particular.

More over Tigist G/selassie and Mesganaw Fantahun (2012) study confirmed that acute respiratory infections, diarrheal disease, malaria malnutrition and vaccine preventable disease are the major cause of child death.

According to MaNHEP FORMATIVE research report(2011) Increase team work among team leader, heath extension workers and traditional birth attendant, confidence and competent of HEW in provide MNH and community recognize usefulness of health extension worker and health extension workers understand their duties are some of improvements shows after the implementation of health extension program

Improved utilization of family planning, antenatal care services and HIV test show significant improvement as stated by the Araya Medhanyie and his friends study(2012)

1.3. Objective of the study

1.3.1. General objective: the general objective of this research was to identify the achievements recorded and the challenges faced since the implementation of health extension program to improve mother and child health in Bakello kebele administration.

1.3.2. **Specific objectives**; the specific objectives were;

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1. To identify main success on the health of mother and children after implementation of health extension program in the kebele

2. To identify main challenges on the health of mother and children after implementation of health extension program in the kebele

1.4. Research questions

The study is expected to respond to the following research questions after the implementation of health extension program on mothers and children health.

1. Disclose what achievements are observed on health of mother and child so far in Bakello kebele administration after the implementation of HEP.
2. The challenges observed in maternal and child health during the implementation of HEP.

1.5. Scope and Area of the Study

Because of time and other resource constraints, the research was made to focus on the achievement and challenge on mother and child health not overall package of health extension program in one kebele. Moreover, the research tries to focus on one manageable kebele to identify achievements, challenges, and forward recommendations on mother and child health.

1.6. Research Methodology

Achievements and challenges were carried on the health of mothers and children after the implementation of health extension program in Bakello kebele/the smallest administrative units in Ethiopia/ in Bassona worana district in North Shoa Zone. To conduct this research both quantitative and qualitative methods were employed.

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Interview and focused group discussion were used for qualitative method. Questionnaires were administered to collect quantitative data.

1.6.1. Sample

In order to draw representative sample, the study employed different sampling techniques. Purposive or judgment sampling was found appropriate and the selection was made based on the accessibility from woreda town. Out of thirty-one Kebeles in the woreda Bakello, kebele was selected because of its proximity.

The research includes sub kebeles/ gots/. Bakello has 5 sub kebeles/*got*s/ each got is represented in the study. From each gots, 7-8 mothers/care givers who have children under five years old and 5-6 Health development armies selected using systematic random sampling by taking every six number from the list of HEWs.

The study populations are 39 mothers and caregivers having children under five years, 2 kebele Health extension workers, 29 kebele health development army and 2 health extension program supervisors from Keyit health center. According to data observed from kebele health extension workers, there are 200 mothers and caregivers between age 15-49 and 200 kebele health development army registered in the kebele.

The required sample size is 20% of mothers and caregivers who have children from 0-5 years, 14.5 % of kebele health development army, 2 health extension workers of the kebele and one health extension program supervisor and 1 health center head. Mother/care givers and kebele health development army were selected using systematic random sampling techniques. FGD participants were selected from the same population. Amharic version of questionnaire was used to collect data from each

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participants of the study. The questionnaires were tested in small group of similar population and improved based on the feedback obtained.

Informed consents of the respondents have been consulted. Privacy and confidentiality has been maintained and the researcher explained to the respondents the objective of and procedures of the study.

1.6.2. Tool for data collection

The researcher used both quantitative and qualitative methods to gather information related to socio economic characteristics, child feeding practices, child health, personal hygiene, mother's pre and post natal services, about challenges during the implementation of health extension program, type of services that have been provided in the health post, supportive, monitoring and evaluation system of health extension program. The following were the main tools used to collect data.

1.6.2.1. Questionnaire: questionnaire was used as one of quantitative data collection tool. It was filled by using data collectors. The rationale of administering the survey questionnaire using data collectors was because the study population comprises rural dwellers where most of them are illiterate and it is to avoid errors and boost correct response rate.

1.6.2.2. Interview: The study administered depth interviews with care givers/mothers, health development army, HEWs and supervisors, to obtain detail information from both the beneficiaries and services providers. Accordingly, two HEWs, five HDA, two HEW supervisor and five mothers/care givers participated in the interviews.

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1.6.2.3. Focus Group Discussion: in addition to the interviews, separate FGD sessions were also held with one-group mother/care givers and another group HDA to generate qualitative data. Each group had 6-8 individuals.

1.6.3. Data analysis

The qualitative data obtained using interviews, FGDs were carefully sorted, and similar ideas were organized in to similar categories. Then, it was qualitatively analyzed in words. That means the qualitative data was described and discussed by establishing connections or links between the views of informants. By doing so, effort was made to interpret the arguments behind each idea.

On the other hand, data's from the questionnaire was analyzed descriptively and presented using tables, percentiles and frequencies – selected findings of the survey were attached in the appendix.

1.7. Organization of paper

Chapter one mainly focuses on introduction part of the research. Chapter two discuss the background of Bakello kebele situation and profiles related to mother and child health, followed by a theoretical framework and literature reviewed in chapter three. Results of the study part are presented in chapter four followed by discussion model in chapter five. Summery and recommendation parts presented in chapter six and finally, the reference and annexes parts presented at the last page of the paper.

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CHAPTER TWO

BACKGROUND OF THE STUDY AREA

The research was conducted in Bakello kebele of Basona Worana Woreda, North Shoa Zone, and Amhara Region. Bakello kebele is one of 31 Kebeles in Basona worana woreda. The kebele is located on the main route from Addis Ababa to Dessie that is 144 km from Addis Ababa and 14 km from Debre Berhan, the town of north shoa zone, Debre Berhan woreda and Basona worana.

Bassona worana is one of the 27 woredas in north showa zone administration. Subsistence agriculture is the primary means of living for the residences of the woreda. Health extension program has been implemented since 2005 at woreda level. Now a health extension program has been implemented in all Kebeles of the woreda.

The kebele has a total population of 5327, according to the 2005 EFY data of woreda economic and finance development office. From this, total population of female residence are 2635 and 2688 are male residences. The kebele has 5 sub Kebeles/gots/. Like other rural kebele, subsistent agriculture and animal husbandry are means of income for kebele residences.

Most of the kebele's topography is full of up and down and dominated by cold weather conditions. Farming activities mostly depend on summer rain/June to August/is means of cultivation of the kebele. In some sub Kebeles, irrigation is practiced.

Some part of the kebele has different infrastructures like electricity and transportation.

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Regarding social services the kebele has general primary school /from grade 1-8/ since 1948 EC six preschools and one health post. In addition to health post services the kebele is one of the six Kebeles that is being served by the health center of Keyit which is 5 Km distance on the average.

Health post of the kebele has been functional since 2004 EFY. In the health posts, two female health extension workers have been serving the residence in addition to their door-to-door services.

Health extension program have been implemented since December 2005 in the kebele. To implement health extension program woreda health offices design different strategies. Among the strategies, health development army is the main one.

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CHAPTER THREE

LITERATURE REVIEW

3.1. Health extension program implementation in Ethiopia

1. The HEP Concept: Definition and Principle

According to Federal minster of health, health extension and education center (2007) “The Extension Program (HEP) is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of PHC, it was designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom.

HEP is similar to PHC in concept and principle, except HEP focuses on households at the community level, and it involves fewer facility-based services.

The HEP is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. It is expected that almost all of the activities listed in the National Child Survival Strategies are to be implemented through the HEP.

2. Philosophy and Goals of HEP

The philosophy of HEP is that if the right knowledge and skill is transferred to households they can take responsibility for producing and maintaining their own health. The overall goal of the HEP is to:

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- Create a healthy society and reduce rates of maternal and child morbidity and mortality.

The objectives of the HEP include:

- To improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas.
- To ensure ownership and participation by increasing health awareness, knowledge, and skills among community members
- To promote gender equality in accessing health services
- To improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through HEWs
- To reduce maternal and child mortality
- To promote healthy life style

3. Components of HEP

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

Disease Prevention and Control

Family Health

Hygiene and Environmental Sanitation

Health Education and Communication

4. Health extension program planning, monitoring and evaluation system

Planning Processes

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The HEWs, in collaboration with the members of the Kebele Council, begin work by first conducting baseline surveys. Based on the survey findings, health problems are identified and prioritized, and plans of action are prepared. The draft plans of action are submitted to the Woreda Council through the Kebele Council for approval. Once approved, the plans are disseminated to the Woreda Health Office, Regional Council and Regional Health Bureau.

Monitoring and Evaluation

Monitoring and evaluation are integral and important components of the HEP and contain both technical and managerial purposes. Monitoring is the process of regularly reviewing achievements and progress towards the goal. In this context, monitoring is the process of measuring, analyzing, and communicating information on the implementation of the HEP for effective decision making at all levels.

Evaluation is carried out to assess whether objectives are met and to determine the effectiveness and efficiency of the program. This helps to correct and improve the future planning process.

Monitoring and evaluation have to be built into the program from the outset as an integral part of the planning process. Monitoring and evaluation requires a health management information system to measure progress against objectives indicators and targets. Both qualitative and quantitative methods can be used to evaluate HEP. Tools or techniques to be used in collecting qualitative data are observations, in-depth interviews, and focus group discussions. In quantitative evaluations, tools used should include surveys. Quantitative and qualitative data are used together to give a clearer picture of the situation about the performance of the program.

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The HEWs collect information with standardized reporting formats. The HEWs must keep accurate and timely records of their activities. The information captured is passed on to the Kebele Council and Woreda Health Office for review and action. At the Kebele level, the Kebele Committee, HEP and VCHW meet weekly and provide a report to the Kebele cabinet on program implementation. During town hall meetings, the communities identify weaknesses and strengths and provide ideas for improvement.

Indicators of HEP

Immunization, breastfeeding, use of Oral Rehydration Salt (ORS), adolescent parenthood, antenatal care, assisted delivery, contraceptive use, and tetanus toxoid immunization.

Access to and utilization of preventive and promotive health services, referrals, adequately-staffed and well-maintained health posts, participation in basic health/demographic data collection, provision of financial support for Health Posts."

According to health extension program manual health extension program give priority on the preventive parts than curative one. Creating awareness and improve the knowledge of the community can increase the owner ship of the community to prevent communicable disease is the main philosophy of health extension program. Health extension program was categorized under 4 components and 16 packages. Family health is one of the components of health extension program. Maternal and child health is one of the packages under family health components.

The manual also stated that planning started from the kebele and use monitoring and evaluation as integral part of planning. All concerned bodies participated during

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monitoring and evaluation. Immunizations, breastfeeding, use of Oral Rehydration Salt (ORS), antenatal care, assisted delivery and contraceptive use some of indicators.

3.2. Main cause of Maternal and child death

According Ethiopian journal of reproductive health 77(May 2007) "In Ethiopia, it is estimated that 61 percent of households have access to an improved source of drinking water with access in urban areas much higher than in rural areas (94 percent and 56 percent, respectively). In urban areas, 90 percent of households have access to piped water compared to only 13 percent of rural households. On the other hand, the major source of improved drinking water in the rural areas, which is 39 percent, is protected spring. An estimated 75 percent of health problems of the country are due to infectious and communicable diseases, which could be easily prevented or controlled by applying simple sanitary measures. However, they still contribute to the high morbidity and mortality, especially among infants and children.

Infant and under five mortality rates were recorded at 77 and 123 per 1000 live births, respectively , whereas, the maternal mortality ratio stood at 673 per 100,000 live births, which are still the highest among sub-Saharan African countries .

In a similar manner, contributions from communities and their direct participation in health activities have been hampered for years. As a result, communities were not given opportunities to play an active role in deciding the type of activities they want, and get involved in the kind of actual service they receive. In similar setting where communities take active participation to produce their health, results showed significant improvement in the health of the population."

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As the result stated there are improvements on the life of children but still communicable disease has significant contribution for child morbidity.

Based on the study of Tigist G/selassie and Mesganaw Fantahun(2011) “Nearly 11 million children die every year in the world, before reaching their fifth birthday and most of these deaths occur during their first year of life. The great majority of the deaths take place in developing countries. More than half of these deaths are due to acute respiratory infections, diarrhea, measles, malaria and HIV/AIDS. In addition, malnutrition underlies 54% of all child deaths.

The major causes of morbidity and mortality in Ethiopian children less than 5 years old are acute respiratory infections (mainly pneumonia), diarrheal diseases, and malaria, malnutrition and vaccine preventable diseases.”

Tigist and Mesganaw concluded that respiratory infection, diarrhea, measles, HIV/AIDS and malnutrition are the main cause of children less than 5 years old.

According to Ahmed Abdella (2010) study “Globally, at least 585, 000 women die each year due to complications of pregnancy and child birth (1). More than 70% of all maternal deaths are due to five major complications: hemorrhage, infection, unsafe abortion, hypertensive disorders of pregnancy, and obstructed labor. The majority of maternal deaths (61%) occur in the postpartum period, and more than half of these take place within a day of delivery.

The poor health and nutrition of women and the lack of care that contributes to their death in pregnancy and childbirth also compromise the health and survival of the infants and children they leave behind. It is estimated that nearly two-third of the 8 million infant deaths that occur each year is largely from poor maternal health and

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hygiene, inadequate care, inefficient management of delivery, and lack of essential care of newborn.

An estimated 40% of pregnant women (50 million per year) experience pregnancy-related health problems during or after pregnancy, and childbirth, with 14% suffering serious or long-term complications. Consequently, 300 million women suffer from pregnancy related health problems and disabilities, including anemia, uterine prolapsed, fistula, and infertility.

Many factors affect the outcome of pregnancy from the onset of any obstetric complication.

The outcome is most adversely affected by delayed treatment. Delay in treatment is the result of many factors. These delays are described as the three phases of delay:

Delay i: lack of information and adequate knowledge about danger signals during pregnancy and labor; cultural/ traditional practices that restrict women from seeking health care; lack of money

Delay ii: out of reach of health facilities; poor road, communication network, community support mechanisms

Delay iii: inadequate skilled attendants, poorly motivated staff, inadequate equipment and supplies, weak referral system, procedural guides. ”

According to Ahmed Abdella research results complication of pregnancy and childbirth, post partum period, poor health and nutrition of women are the main cause of maternal death. More over significant number of pregnant women experienced pregnancy related problem during or after pregnancy. Delays the treatments of these problems are intensified mothers problem.

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As stated by the document of Ministry of Finance and Economic Development and the United Nations in Ethiopia (2012) “Between the early 1990s and 2004/05, the infant mortality rate fell from 122 to 77 per 1,000 live births, a drop of almost forty per cent. Under-five mortality rates (USMR) have also been steadily falling. There has been a significant acceleration in mortality reduction since the introduction of the HEW programme in 2005. The 2011 DHS recorded an average under-five mortality rate of 88 over the five years before 2011 with a figure of 133 for the period between five and ten years before the survey, hence Ethiopia is on track for reaching the goal of reducing under-five mortality to 68 by the end of the Growth and Transformation Plan period. A package of interventions at the community level, if well implemented will further reduce U5MR significantly by averting up to an additional 182,500 under-five deaths per year. The biggest returns will be due to community-based case management of pneumonia, provision of ORS, exclusive breastfeeding, hand washing, improved sanitation and skilled care because the current coverage of these high, impact interventions is still quite low. Although not featured in the analysis, reduction of malnutrition will also have a major effect since it is an underlying cause of more than half of under-five deaths. A preliminary comparison of levels of malnutrition in the 2005 and the 2011 DHS using the new WHO standard indicates that stunting has declined from 52 to 44 per cent, underweight from 34 to 29 per cent and wasting from 12 to 10 per cent.

The maternal mortality ratio, was measured at 871 maternal deaths per 100,000 live births in 2000 (DHS 2000) and fell to 673 in 2005 (DHS 2005), and DHS 2011 reports 676. Caution must be taken with the DHS figures since there is a wide confidence

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interval of the order of plus or minus 80 points from the mean estimates that are average figures for the fifteen-year period leading up to the time of the survey.

Malnutrition is a major threat to the survival and development of Ethiopian girls, boys and women. Concerted implementation is needed to achieve the impact objective of the National Nutrition Programme (NNP), the improvement of the nutritional and micronutrient status, especially of mothers and children, through cost-effective and sustainable interventions. According to the DHS 2005, 27 per cent of women are chronically malnourished (BMI <18.5 cm) and three in ten women and adolescent girls aged 15-19 are undernourished. The National Nutrition Programme Baseline Survey (2010) shows that among children aged 6 to 59 months, 38 per cent are stunted, 12 per cent were wasted and 34 per cent were underweight. The trend in percent of children exclusively breastfed is from 49 per cent in 2005 to 52 percent in 2011 according to the DHS surveys in those two years. The NNPBS found 51 per cent exclusively breastfeeding among children 0-5 months and 46 per cent of mothers responded that they had initiated breastfeeding within an hour of birth. Twenty nine per cent of breastfeeding and 38 per cent of not breast feeding children 6-23 months meet the requirement of minimum dietary diversity and 75 per cent of breastfeeding and 59 per cent not breast feeding children 6-23 months meet the requirement for minimum meal frequency."

According to the report done by MOFED and UN in Ethiopia after the implementation of HEP under five and maternal mortality rate reduced significantly. Still malnutrition is treating to achieve MDG of mother and child health.

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Family health department, FMOH(2005) was stated “The maternal mortality ratio in Ethiopia is estimated to be 871/100,000 live births13. This compares with an average of 910 for sub-Saharan Africa (WHO). As with much information on mortality, the only estimates for attributable causes of maternal mortality come from health facilities and are subject to self-selection bias. FMOH reports from this source show that complications resulting from abortion account for 32% of all maternal deaths, obstructed labor 22%, sepsis 12%, haemorrhage 10% and hypertension 9%. Malaria, anemia and HIV/AIDS contribute to about 20% of maternal deaths and contribute to prenatal mortality.

Population-based data on causes of under-5 mortality in Ethiopia do not exist, but there are useful reports and estimates from various sources. These can be used to obtain an adequate picture of the major causes of child death.

The FDRE MOH facility-based surveillance system reports that in 2002-03 there were 2,409 deaths due to malaria. According to facility records14, pneumonia is the leading cause of child deaths accounting for 40% of deaths in this age group. Malaria accounts for 21%. A 2001 Roll Back Malaria (RBM) baseline survey estimated that 28% of mortality in under-5 children is attributable to malaria. FMOH data do not include causes of death for children other than infants, and appreciable mortality from diarrhea and pneumonia, particularly in association with malnutrition and HIV is expected to occur in the one to four year age.

Measles remains a problem in Ethiopia, due mainly to the low measles immunization rate (estimated coverage of 51% in 2001). A total of 3,797 cases and 58 deaths due to measles were reported in 2002-03. While this figure followed a successful

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measles vaccination campaign in 2002-03, such campaigns may not be sustainable in the long-term, and it seems reasonable to attribute a slightly larger proportion of mortality to measles in Ethiopia."

The strategy stressed that pneumonia; malaria and measles are main cause of child mortality. On the other hand, abortion obstructed labor, sepsis, haemorrhage, malaria, anemia and HIV/AIDS the main cause of maternal mortality.

3.3. Achievements on maternal and child health since the implementation of HEP

Araya Medhanyie and his friends' (2012) come up with the following findings "The first HEW deployment started in 2003. Since then family planning, antenatal and postnatal services and HIV testing demands increase from time to time. On the other hand, their deployment and work have not showed any improvement in utilization of health facilities for delivery, postnatal check up and use of iodized salt. Primary care facilities; particularly health posts, were almost unutilized by women for maternal health services. Women preferred to visit health centers instead of health posts. Women, who were literate, listened to the radio, participated in income generating activities and had been working towards graduation or graduated as model family were more likely to access and utilize comprehensive maternal health services.

Our finding on family planning is in agreement with other studies conducted in Ethiopia. These studies showed HEWs have improved access to family planning. A study conducted in the southern part of Ethiopia found that women who were able to read and write are more likely to access maternal health services, similar to our findings. This study also showed similar to our findings on ANC that the proportion of women

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who had at least one ANC visit has increased considerably. Nevertheless our study showed the proportion of women who had 4 and more ANC visits as recommended by WHO was still low (48%). Thus, concerted effort by HEWs and VCHWs is necessary to educate women about the importance of having four and more ANC visits. Another important achievement observed in our study is the increase in HIV testing."

Araya and his friends concluded that after the implementation of HEP family planning, prenatal, postnatal and HIV test demand increased. Still visiting health post for post natal services needed further improvement.

MaNHEP FORMATIVE RESEARCH REPORT (2011) stated that "The results of this formative work have clear implications for MNH training, collaborative quality improvement and behavioral change communication (BCC) strategies that form the core of the MaNHEP program.

From the perspective of high-quality home-based delivery of MNH services from birth to 48 hours, there is clearly a need to dramatically increase (1) the competence and confidence of HEWs in providing MNH care, and (2) community recognition of HEWs' usefulness in this area, and 3) the HEWs understanding and practice of their MNH responsibilities. Discussions with mothers highlight that TBAs are considered the most appropriate birth attendants, in part because of the long tradition of practice in these communities, because they are seen as experienced, and because they are frequently relatives or community members. MNH training for HEWs should explicitly focus on increasing their experience delivering babies. MNH training might also benefit from inclusion of strategies that HEWs can use to increase the trust of rural households, along with refresher courses on the management of retained placenta, prolonged labor,

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early child feeding practices, and cord care. BCC messages for communities could then highlight the benefits of a HEWs' presence at the home during birth, which seem to be currently not well recognized by families. This could be done in reference to the specific problems that mothers mentioned in the interviews. There is also a broader need to work with communities and HEWs so each better understands the roles and responsibilities of HEWs.

Within the FLW community, several potentially useful steps could be undertaken to increase teamwork among FLWs and reliance on the collective knowledge of the team. First, there is a need for BCC messages encouraging TBAs to call for HEWs during labor and delivery and for broader messaging to encourage communities and TBAs/ FLW teams to develop a process for notifying HEWs during labor and delivery. There is a clear need to better link TBAs, HEWs, and vCHWs into a network that shares information on currently pregnant women and when births are occurring in the communities. One step towards greater communication among FLWs would be to promote regular meetings between HEWs, VCHWs, and TBAs, which would be facilitated by the construction of clear communication systems between HEWs, VCHWs, and TBAs. This venue could be used also to construct a common and agreed upon referral system."

This formative research report concludes that MNH services from birth to 48 hours increase that helps health extension workers to improve competence and confident on their work, increase community recognition for health extension worker works. In addition, teamwork between TBAs, HEALTH EXTENSION WORKER and vCHWs improve from time to time.

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According to Medhanyie et al. BMC Health Services Research (2012) "This study has shown HEWs have brought essential maternal health care closer to the rural population in Ethiopia. Nevertheless, their success is not for all components of maternal health services. HEWs brought improvement in utilization of family planning, ANC and HIV testing but not in assisting births. The perception that HEWs' may be less competent in assisting births, the huge workload they already have, poorly equipped health posts and strong cultural beliefs supporting home births, make it unreasonable at the present time to expect substantial change in where and how women give birth. These challenging factors call for innovative strategies to support the efforts of HEWs in identifying risky mothers, birth preparedness and to improve their referral to health centers where midwives and better facilities for assisting births are available."

The research come up with the following findings because of less competent in assisting birth, high workload, poor facility in health post and cultural influence HEALTH EXTENSION WORKER birth assistance is still need further improvement. On the other hand, Family planning and antenatal care show positive improvements.

Desta Mekonnen (2011) disclose that "Infant and child mortality is a factor that can be associated with the well-being of a population and taken as one of the development indicators of health and socioeconomic status and also indicates a life quality of a given population, as measured by life expectancy. That is why reduction of infant and child mortality is a worldwide target and one of the most important key indexes among millennium development goals (MDGs). Hence its indication is a very important for evaluation and public health strategy. Thus, it is an area that many researchers focus and that has attracted the attention of policy-makers and program implementers worldwide. One of the most important targets of millennium development goals (MDGs) that introduced in 2000 at the United Nations millennium summit

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was reducing infant and under-five child mortality rates by two-thirds from the 1990 levels by 2015."

Now a day mother and child health takes as indicator of development for any nation in the world. From this point of view the country again needs more effort to improve maternal and child health.

3.4. Challenges on maternal and child health during the implementation of HEP

According to Federal democratic republic of Ethiopia ministry of health (2010) document stated the following challenges. These are;

- "Absence of 24 hours a day and 7 days a week services in most health facilities especially in health centers & unavailability of HEWs on weekend/night
- Low quality of service provision (Long waiting time, poor counseling service, lack of privacy)
- Inadequate organization of hospital services to effectively handle emergencies.
- Shortage of adequate and safe blood
- Poor delivery room environment and poor attitude of the health workers
- Service inaccessibility & transportation problem
- Absence of separate neonatal units in most of the hospitals
- Weak referral system, service integration and supportive supervision.
- Shortage, high turnover, and insufficient skill of midwives and delivery attendants due to poor quality of training
- Slow procurement and distribution of medicines and supplies leading to shortage at service delivery point & Poor stock management

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- ❖ Lack of FP Method mix
- ❖ High family planning unmet need
- ❖ Limited availability of adolescent and youth friendly reproductive health services
- ❖ Lack of awareness & misconception on RH & CH Services
- ❖ Religious & cultural problems & traditional practices/beliefs
- ❖ Low health seeking behavior
- ❖ Insufficient resources."

According to the document low quality of services, weak referral system, shortage and turnover of staff, poor health facilities and other are the main challenges that face during the implementation of health extension program.

Araya Medhanyie and his friends (2012) come up with challenges of the following "The HEWs did not succeed in improving utilization of health facility delivery, PNC check up and use of iodized salt. This calls for urgent interventions into the HEP. Innovative approaches are needed to improve HEWs effectiveness in relation to these services. Similar to our study, another study also showed no progress in skilled birth assistance and postnatal care coverage in Ethiopia since 1998. Contrary to the findings of a cross sectional study among 60 households in Tigray region which was conducted at the earlier stages of the HEP implementation, our study revealed the proportion of women who were assisted for birth by trained traditional birth attendants (TTBAs) is much higher than those assisted by HEWs. This might be due to the fact that the number of TTBAs in a kebele is higher than the number of HEWs. It might be also TTBAs are tried and tested by women and seen to be experienced in conducting deliveries. Perhaps they could be closer and accessible to village women. On the other hand low

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competency and confidence of HEWs in assisting births, less favorable working conditions at the health posts, workload and walking long distances at night to assist births at home might also be attributed to this low performance of HEWs in assisting births."

According to Araya and his friends research findings health extension worker intervention is not improving utilization of health facility delivery, postnatal care check up and use of iodized salt. This shows that during delivery still family and traditional birth attendant roll is high.

According to Charlotte Warren(2010) study has the following findings "When families do seek care for their newborns, remedies from traditional healers is often preferred to skilled health workers because of cultural and religious beliefs, poor access to health facilities, (including distance and terrain) and financial barriers. The baby has great potential as a channel for interventions – as the baby's health is the prime motivation and justification for behavior and practices. By encouraging mothers to seek care for the infant, one can also target the mother's health and promote healthy newborn practices**."**

Appropriately, to the finding distance of health institution, topography and financial problem increase the influence of traditional healers.

Another study of Charlotte Warren(2010) on the same year stated the following findings "As of 2005, it was clear that progress in Ethiopia toward achieving the MDG 5 indicators of maternal mortality reduction by three-quarters by 2015, and increased skilled birth attendance use, was slow at best. The only relevant indicators that could have contributed to the possible decline in the MMR from 871 in the early 1990s to 673 in 2005, was the decreased fertility rate rather than improvements in maternal health

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care services or their use. The continuing large unmet need for family planning signals that further uptake is possible with the potential for further fertility and maternal mortality declines.

Causes of maternal mortality may have shifted over time, as hinted by a recent hospital study- away from the septic abortion, ruptured uterus, and hepatitis infection that contributed so significantly in studies of the 1980s and early 1990s, toward the pattern more commonly seen in most developing countries—postpartum haemorrhage and eclampsia being lead causes of maternal death. Studies are few however and far more research on the level and causes of maternal mortality especially at community level in several regional areas are needed to understand present day realities. The contributions of malaria and HIV to maternal mortality also remain unknown but where prevalence of these infections is high, reporting of maternal death with such infection is needed and program inputs directed at prevention or treatment for pregnant women are warranted.

There was no substantial improvement in use of skilled birth attendance for the approximate 10-year period reported by women for the Demographic and Health surveys of 2000 and 2005. Projects which ensured substantial infrastructure improvement in maternal health services continued to see low use as they came to closure.

Evaluations of these projects continued to emphasize some of the barriers they started with—facility infrastructure and human resources for maternal health care at skilled birth attendant and specialist levels being key gaps. Beyond these deficits, the

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projects signaled quality of care issues, in both personal interaction as well as skills, that need attention but which are otherwise undocumented.

Cultural barriers to increased use of skilled care remain substantial (e.g., late recognition of danger signs and decision-making, community ownership), along with barriers due to distance (e.g., transport, costs). The variability of cultural and geographical barriers through this highly diverse country however demands localized solutions.

This requires building local knowledge to ground such solutions as well as the local infrastructure to respond and monitor progress.

In response, the Federal Ministry of Health of Ethiopia has instituted a vision with strategies beginning at community level. In 2003, the government initiated the Health Extension Program (HEP) in 2003 as part of the Health Sector Development Program (HSDP) to improve equitable access to preventive, promotive and select curative health interventions through paid community level health extension workers (HEWs), including delivery care at the household level.

However, while the Government's target of two HEWs per kebele for over 30,000 HEWs has been reached, the 2015 MDG target for the MMR, 218, remains difficult to accomplish.

The HSDP has set a target of 32% use of skilled birth attendant by 2010 but only about 12% use was found in a 2009 survey of the four most populated regions of the country, plus 4% use of HEWs. Even with some use of HEWs for birthing, HEWs have minimal training and virtually no hands-on training in skills needed for normal birthing.

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They also have very little knowledge or skills in the first aid needed to stabilize a woman for referral."

Cultural barriers, distance of health facilities, unskilled birth attendant, unmet need of family planning and high maternal mortality rate due to different problems are challenges that still exist on the health of mothers according to Charlotte Warren study.

*Ethiopian J. Health Dev. (*2010) come up with the following results "Maternal and neonatal morbidity and mortality rates in Ethiopia are among the highest in the world and stem from a range of socio-economic, political and demographic factors. Many of these deaths are preventable. In 2000 less than 30 percent of women attended antenatal care and less than 10 percent delivered with a skilled attendant or in a health facility. Out of the expected 2.9 million deliveries a year, 2.6 million are likely to occur at home with assistance of TBAs (26%), relatives (58%), or alone (6%). Only 3.5 percent of these women are likely to receive any postnatal care.

Obstructed labor (22%), sepsis (12%), hemorrhage (10%) and hypertension (9%) constitute the direct obstetric complications, after unsafe abortion, leading to maternal mortality. Estimates for maternal mortality in Ethiopia (between 1999 and 2005) are around 720 per 100,000 live births.

In 2005 a national Safe Motherhood Community-Based Survey was carried out on behalf of the Family Health Department (FHD) in the Ministry of Health to explore community values and practices surrounding pregnancy, childbirth and the postpartum and neonatal period, the influences of those values and practices on health seeking behavior, and the barriers and enablers to seeking and utilizing health services. The

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survey was carried out across the 11 Regions of Ethiopia in 16 selected sites, which represented a cross-section of livelihoods, gender roles and status, and disparity in access to maternal and neonatal health services. The details of the survey sites are reported elsewhere. Following the production of the final report of the Safe Motherhood Community based Survey (SMCBS), Population Council was requested by JSI/LTK project to carry out more in-depth analysis of the data from four of the regions: Amhara, Oromiya, Tigray, Southern Nations, Nationalities and Peoples Regions. One of the objectives of the SMCBS and the main objective of this paper is to explore the knowledge, attitudes and beliefs, which influence maternal care seeking behavior and practices in pregnancy, labor and childbirth.

Although expectant mothers benefit from high levels of community support, both moral and practical during pregnancy and childbirth, very few decide on delivering with a skilled attendant. Many prefer delivering at home in the company of known and trusted relatives and friends where customs and traditions can be observed.

Even though communities are aware of the dangers around childbirth, contingencies for potential complications are rarely discussed or made. Such that most families hope or pray that things will turn out well.

When things going wrong, precious time is lost in finding resources and man power to assist in the transfer to a health facility. However it has to be recognized that the women and their families are constrained by a number of factors which include distance and cost in reaching a facility as well the fact that important traditions and customs around birth are not recognized by health care providers. Until these socio-cultural

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aspects are recognized by the health care providers and incorporated into the care provided at the health facilities we will continue to see women giving birth at home**.”**

According to this research high home delivery, almost no postnatal services, high maternal mortality rate due to obstructed labor and unsafe abortion, distance of health facility, health care provider less awareness on importance of tradition and custom related to birth are still the major challenge of women health.

3.5. Health development army

According to Federal democratic republic of Ethiopia ministry of health/2010/11/ document role of HDA “HEP is currently implemented in agrarian, urban and pastoral areas of the country. In EFY 2003, much has been done to meet the targets set for the year.

In order to strengthen and improve the HEP, EFY 2003 plan included organization and mobilization of the Health Development Army (HDA) to capacitate families who are lagging behind in terms of adopting safe health practices.

HDA is the key strategy to scale up best practices by organizing and mobilizing families. The HDA will be a network created between five households and one model family to influence one another in practicing healthy life style. This network of families will be provided with technical support and training by Health Extension Workers (HEW) to implement the packages of HEP. HDA will help to expand the successful HEP experiences deeper into communities and families. They will be engaged in the promotion and prevention activities at household and community level, including the regular coordination of structured community dialogue sessions, with the guidance of the HEWs. Thus, HDA will help improve community ownership and scale up the best

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practices. With regard to the organization of the HDA, in EFY 2003 training was carried out in all regions and implementation has been initiated in SNNP and Tigray Regions. Regarding the model family program, progress was made in EFY 2003 to increase the number of graduated households. In EFY 2002, the cumulative number of graduated households was 9,979,706, while the target set for EFY 2003 was to train and graduate additional 3,627,668 households; however, the number of households graduated in EFY 2003 was 2,198,924 (60.6% of the annual target). As a result, the cumulative number of graduated households was 12,178,630 (88.9% of the cumulative annual target). Of note is the fact that this cumulative number (12,178,630) was 69.9% of the total eligible households**."**

According to HSDP 4, performance report Health development army is one of the strategies to implement health extension program. The main purpose of health development army is to scale up best practices and create network between households. By doing so increase graduated households by implementing 16 packages of health extension program.

Negussie Taffa and Francis Obare (2004) disclose that "Significantly, larger proportion of teenage mothers in Ethiopia lived in rural areas; were largely uneducated, poorer, and gave history of divorce, separation or no marriage. Similar situation was observed in the Kenyan dataset. The Uganda dataset revealed half of these picture teenage and adult mothers were comparable on marriage and economic indices. Such observations point to the fact that teenage pregnancy is more associated with poor socio-economic background.

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Teenage mothers initiated unprotected sex early in life that exposed them to young parenthood. Over half of the sexual activity took place within marital union. This situation underscores the burden of reproductive health problems among rural adolescents as victims of harmful traditional practices.

Much of the comparison on reproductive behavior and pregnancy outcome of teenage and adult mothers in the three countries did not show marked differences. Maternal age independently explained the difference in educational achievement and the choice on place of deliver. In other words, failure to enroll in school or early dropout by teenage mothers affected obstetric care utilization, which in turn will exert direct impact on maternal health status and child survival. The study found less evidence of increased risk of operative delivery and low birth weight (below average baby size) among teenage women as a group.

According to these datasets, larger proportions of Ethiopian children had below age average size at birth than those in Kenya and Uganda. The rate of small child size at birth was also three-times higher than the rate found by another study in Addis Ababa. Low birth weight rates ranging from 9 to 17% were reported from studies in sub-Saharan Africa, which is comparable to the current datasets from Kenya and Uganda.
Child health outcome as defined by the rate of immunization, occurrence of morbidities and level of care provided at home during an illness episode, was found to be less dependent on age of the mother. Of the three countries, Ethiopia fared less in most socioeconomic indices and coverage of maternal and child health care services. As a result, being a teenage mother and living in rural areas remained strongly associated with child survival. In the relatively 'urbanized' Uganda where coverage is also better,

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socio-economic variables and reproductive behavior came out as strong determinants of child survival. The dataset from Kenya depicted a mixed phenomenon.

The study generally implies that young mothers are more likely to show similar behavior to their adult counterparts during pregnancy and in child health care practices. Children of young mothers might on the other hand be prone to have severe forms of infections and likely to die of it. In poorer countries such as Ethiopia, where access to basic services is low, living in rural areas is a double disadvantage for teenagers. With better coverage of maternal and child health care services (Uganda and Kenya in this case), factors like education greatly influence the disparity in service utilization and hence the probability of survival for children born to teenage and adult mothers."

The study confirmed that large number of teenage mothers lives in rural area with less education access, poor economic status and without marriage. Because of low basic services access in rural are teenager mothers are highly disadvantaged.

Amare Deribew and his friends'(2007) study confirmed that "There have been a few studies on the determinants and immediate cause of death related to under-five children in Africa. Population based case-control study such as the present study is the method of choice to ascertain determinants and immediate causes of death in developing countries like Ethiopia**.** This study has provided pertinent information about the causes and determinants of death in under-five children for decision makers. The study also tried to control many confounding variables. However, it might have some limitation such as recall bias on symptoms of illness and risk factors. Misclassification of cases in some diseases might occur due to less sensitivity and specificity of the verbal autopsy tools.

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Infant mortality rate (IMR) seems to be declining as compared to that of the national and other community based studies conducted in Butajira and southwestern Ethiopia a decade back. However, neonatal mortality rate is even higher than the figure, which was obtained a decade back. This could be due to lack of intervention strategies that focus on neonatal survival.

In using verbal autopsy questions, multiple causes of deaths might be possible due to the same environmental or behavioral factors or existence of co-morbidity by chance. Measles and malnutrition, for example, can be further complicated by diarrheal diseases or pneumonia.

Some diseases like measles and neonatal tetanus, which have very distinctive symptoms, can be diagnosed with high sensitivity and specificity using verbal autopsy. However, systemic diseases such as malaria, which has no particularly distinctive features, and shares many symptoms with other common childhood diseases such as acute lower respiratory infections, might be diagnosed with low sensitivity as observed in other studies.

In our study, prematurity, pneumonia, neonatal tetanus and sepsis were the major causes of deaths during neonatal periods which have similarity to other studies. Neonatal tetanus that is eliminated in many middle-income countries is still the major cause of death in the study setting. This could be due to low coverage of vaccination of mother with tetanus toxoid and high prevalence of unskilled deliveries as observed in the baseline survey. Significant numbers of neonatal deaths were unspecified which could be due to recall bias. The major causes of deaths in post-neonatal periods were

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pneumonia, diarrheal diseases, malaria and meningitis. This finding is consistent with other studies.

Severe malnutrition and measles respectively accounted about 12.3% and 7.1% of deaths in post-neonatal period.

Though we did not assess all forms of malnutrition the prevalence of malnutrition as underlying causes of death is low as compared to other studies. Several factors such as indoor air pollutions, health seeking behavior, accessibility and utilization of health services could contribute to the high burden of pneumonia in the study settings. Malaria is becoming the major cause of death in post-neonatal periods. This could be due to the appearance of Gilgel Gibe Dam, artificial lake which is favorable environmental conditions for malaria, and low utilization preventive measures such as usage of treated bed nets for under-five children. It was observed that communities around the artificial lake were more likely to have epidemics of malaria. This might need further study on the effect of the dam on the incidence of malaria. The fact that malaria is not suitable for verbal autopsy due to its non-specific presentation might also obscure its true prevalence. Based on pediatrics case definition, HIV/AIDS is contributing about 2% of post neonatal deaths. In other study, HIV/AIDS accounted 3% of under-five deaths whereas in our study, the prevalence might be underestimated because HIV/AIDS is not suitable for verbal autopsy due to its non distinctive features.

Among the socio-economic factors, maternal education was significantly associated with under-five mortality.

This fact had been confirmed by different literatures in different countries. However, the very wide confidence interval of the odds ratio of maternal education in

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the present study is an indicative of inadequate sample size. Under-five mortality was doubled in mother less than 20 years of age compared to above 20 years as observed in other studies.

Among the intermediate variables, vaccination status of the child and next birth interval were significantly associated with under-five mortality. Breast-feeding was also protective of under-five mortality although it was not significant. This non-significant finding in our study could be due to small sample size. The importance of breast-feeding and vaccination as protective factors of under-five mortality were mentioned in different literatures. Next birth interval was significantly associated with under-five mortality. The attention of mothers to the newborn baby and neglecting the older sibling in giving care might have contributed to the high number of death of the older children. Family planning and antenatal care follow-up were not associated with under-five mortality, unlike other studies. This could be explained by homogeneity of the study population with respect to these variables. None of the environmental risk factors were associated with mortality which is in contrast to other studies.

The main reason could be either due to similarity of the study population with respect to most of the environmental variables especially housing conditions or source of water for drinking.

The effects of behavioral variables on survival of children were assessed using health belief model. Good practice and positive perception of mothers on the severity of illness and benefit of some treatment were protective for under-five mortality. Although it was not based on health belief models, some practices such as no action for diarrhea, acute respiratory infections and malaria were associated with high mortality in the

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Butajira study and other study elsewhere. Positive perceived benefits for some treatments were found to be protective of under-five mortality. Mothers who had positive Perceived severity and benefits were more likely to take the aforementioned actions. Mothers who had negative perception on the above actions might seek help from traditional means, which might not be helpful for the survival of the child. In the final model, most of the variables that were statistically significant in each component of the conceptual framework retained their significance. Maternal education, practice, perception on Determinants of under-five mortality in Gilgel Gibe Field Research Center 7 benefits of some treatment and severity of illnesses are the predictors of under-five survival.

In conclusion, neonatal mortality rate has increased as compared to the result of other study conducted a decade back around the same area. The major causes of death in under-five children are pneumonia, malaria, diarrheal diseases, low birth weight, meningitis and neonatal tetanus. Among many variables, vaccination status, maternal education, practice and perception of mothers on severity of common illness and benefits of some modern treatment were the best predictor of under-five mortality. Cognizant of this fact, we recommend that mothers should be trained to practice key child survival interventions like antenatal care follow-up, skilled-based delivery, use of oral rehydration salt and homemade fluids, vaccination and impregnated bed nets (ITN).The literacy status of women should be improved so that they can care their children for better child survival."

The study confirmed that pneumonia malaria, diarrheal diseases, low birth Wight, meningitis, neonatal tetanus and malnutrition are the main cause of neonatal mortality.

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CHAPTER FOUR

RESULTS

The objective of the thesis is to investigate the achievement observed and existing challenges after the implementation of health extension program on the health of mothers and children. The aims of this chapter is to give explanation about collected data's on results achieved, existing challenge and what do next to improve the health of mother and child health.

4.1. Description of the Study Participants

72 female respondents participated in the study from Bakello kebele administrative residence, Bakello health post and Keyit health center. Among them 39 were mothers who have children below five year, 29 were kebele health development army and 4 were key informant/ two health extension workers, one health extension supervisors and one health center head.

Mother respondents demographic descriptions

39 mother respondents participated by answering questioners. 93% of mother participants are in childbearing age and 100% participants are engaged in faming activities. Among the participants, 76.9% are married, 46.1% are illiterate, 38% are 4-8

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family size, 94.9% have under five children and 94.9% are live in the kebele 5 years and above.

Health development army respondent demographic descriptions

29 women health development army were participated in the study. From participants, 100% are engaged in farming activities, 79.3 are married, 24.1% are illiterate, 76% have under five children, 62.1% are elected since 2005 EFY and 82.7% are in the age of childbearing.

Key informant respondents demographic descriptions

From 4 key informants who were participated in the study 100% of them have work experiences on health extension program, 50% of them have diploma and 25% of them has degree educational level, 50% are health extension worker and 100% are female and between the age of 25-35 years old.

4.2. The results achieved so far on mothers and children health after the implementation of health extension program in the kebele.

After the implementation of health extension program improvements have been seen on the health of mothers and children. 'On the question how mothers prevent their children from different disease.' Mother respondents responded that Wash children's cloths and properly cleaning feeding materials, feeding balanced diet and first breast

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milk, washing their cloths, taking children to health institution as soon as they see symptom of illness, are the main measures that they take mostly after the implementation of health extension program.

Key informants on their part responded about changes on the health of mothers and children after health extension program intervention are improved using the following parameters:

- Breast-feeding: Nowadays, most mothers practice breast-feeding up to 6 months without additional food. Moreover, some mothers not perform traditional practices like giving water and butter immediately after birth instead giving breast milk.
- Family planning: At present mothers use long-term family planning methods than short-term methods. This shows that they have understood the importance of family planning. Before continuous awareness was given on the importance of family planning, mothers believe that FP was a cause of complicated delivery.
- Delivery: Thanks to HDA and HEW the number of mothers who deliver at health institution has increased from time to time and mother's death due to delivery is minimized.
- Vaccination: nowadays the number of mothers who vaccinate themselves and their children is increasing from time to time like tetanus and other vaccination. More over, all children take and complete all type of vaccination.
- Prenatal services: mothers are expected to visit four times during pregnancy period for prenatal services but on the average mothers visit two times.
- Post natal services: after delivery services mothers follow up either in their home or at health institution.

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- Children's' death: children's death due to communicable disease and measles are minimized significantly in kebele because of vaccination services.
- Child nutrition: mothers can feed their children properly at home, even children who are in problem of malnutrition have recovered easily from outreach therapeutic program
- Neonatal death: comparatively minimized because of the above mentioned activities in the kebele.
- Under five-year mortality: significantly minimized because of the above mentioned activities done in the kebele.
- Mothers who need health professional during delivery: mothers are more interested in delivering at health institution than their home. The number of mothers who use ambulance services is increasing from time to time.

As data collected through interview on the above issues has come up with similarly findings like communicable disease prevalence rate decreased, measles vaccination coverage increased and breast feeding immediately after delivery increased. Few years ago convincing mothers to use family planning was challenging, but at present mothers started to use long term family planning services. Mothers who deliver in health institutions are increasing from time to time and children suffering by malnutrition decreased.

During FGD mothers explained improvements like use contraceptive methods, immunized children properly and search prenatal services increased.

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These findings show that data's that collected using different data collection methods are come up with similar finds on improvements of children and mothers health after implementation of HEP in the kebele.

4.3. What challenge do mothers and children face during the implementation of HEP?

Parallel to achievements there are challenges during the implementation of health extension program to improve mothers' and children's' health in the kebele.

According to the data that collected through questioner from mother respondents were came up with anemia, vomiting, stress, influenza, stomachache, diarrhea, eyestrain, typhus, typhoid and prolonged cough are the main cause of mother and children mortality. Because of these 61.5% of participants were visited health institutions to get medical treatment for their children in 2005 EFY. In the same year, 41.0 % mothers visited health institution to got treatment in the health institution for themselves.

In addition, health development army confirmed that they faced challenges while performing their duties. These are;

Low awareness of mothers on children health, some mothers are not interested to participate in training programs of mothers and children, because of time constraint, mothers do not go to health institution to seek advices and mothers' low educational background is the main challenge for health development army.

According to key informants, the following are some of the challenges on maternal and child health. These are;

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- ❖ Prolonged delivery, Unsafe abortion, blood pressure, bleeding and prolonged placenta discharge, traditional birth attendant high participation during delivery;
- ❖ High influence of harmful traditional practices, shortage of ambulance services and scattered settlement that make difficult to reach each child at house hold level;
- ❖ Less accessibility of the transport services, women's loss of interest in attending meetings, Malnutrition, poor personal and environmental hygiene;
- ❖ Poor balance diet and poor mother's health status are challenges to improve mothers and children health according to key informal respondents.

According to the data collected through interview pneumonia, diarrhea and tetanus are the main killer diseases of children in the kebele. On the other side acute upper respiratory tract infection, Diarrhea, pneumonia, Acute fibril illness, Eye disease, Trauma, Helmentasis, disease of musculoskeletal, Acute malnutrition & Skin infection are the main ten top killer disease at the health center level. In addition, Homology, sepscise, unsafe abortion, prolonged delivery/obstructed are the main killer diseases of mothers.

On mothers FGD session high workload, distance of health institution and high responsibility at household level are challenges that hinder them to visit health institution according to the appointment given by health professionals. In addition, participants raise their dissatisfaction concerning services provision at the health center. They said that mothers did not received adequate services in the health institution. One participant mother said, "One health professional insulted her because of some sanitary

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problem when she went to health institution to seek prenatal services. Such mistreatment from professionals discouraged her from going again to health institution."

On FGD, most health development armies are not interested to work as health development army because of time constraints and family responsibility at home. They are not willing to face challenges from group members and health extension workers. One health development army member explained her dissatisfaction that she was elected in her absences without her consent and she does not have any concept on the role and responsibility of health development army. Because of this, she is not able to fulfill her responsibility.

During selection process of health development army educational level was not given due attention. After selection was done, no proper orientations were given for health development army about their responsibilities. Furthermore supportive supervision, experience sharing, empowerment and working materials were not given proper attention.

Questioner, interview and focused group discussion came up with similar research findings on the challenge of mothers and children's.

79.5% of mother respondents delivered at home, 48.7% of them did not receive prenatal services, and 64.1% of the respondents did not get postnatal services. 30.8% of respondents did not use family planning methods and 38.5%of them did not received HIV test. 51.3% of mothers got support from their family and 28.2% of mothers delivered by the help of traditional birth attendant during delivery. 84.5% of mothers fed their children four and more than four time per day. 51.3% mothers responded that age

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gap between their children is below four years. 84.6% of respondents know at what stage their children should complete vaccination fully. 84.6% of mothers received training on how to feed their children. 51.3% of them received training by health professionals and 38.5% of them received training by the help of NGOs. 100% mothers responded that they feed their children only mother breast until the age of six month.

On the other side; health development army respond on existing practices of health extension program as follows,

39.3% and 34.5% of HDA did not take any training about mothers and children health respectively. 13.8% of mothers delivered at home according to health development army respondents. Only 39.3% respondents replied that mothers under their supervision had taken HIV test when they were pregnant.

31.0% of the respondents replied that mothers under their supervision did not receive prenatal services and 62.1% respondents replied that mothers under their supervision did not get postnatal services. 24.1% of mothers delivered at home. 17.2% of children died before they celebrated their first year. 82.7% of the health development armies are responsible for five and above mothers.

4.4. What are existing practices to improve mothers and children’s health?

The data collected from mothers through questionnaire regarding existing practices of children and mother hearths are presented as follows;

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According to key informants' response, training have been provided for mothers on child feeding practices, mothers need to get health services in their home because of time limitation and health post distances from their residence. Using one to five structure/health development army /, health extension workers and kebele administration, both health post and health center provided postnatal services for mothers who delivered in their home. Lastly, to improve the health of children vaccination, growth monitoring, medical treatments that face serious mal nutrition problem/OTP/ services provided. On job training for HEW related to their job the support were provided by health center.

Health education on nutrition, postnatal services, and family planning services has been provided at household level to improve mothers and children healths as health extension worker respond during interview. As health extension supervisor explained during interview session, the following structure was designed to implement health extension program. At woreda level, professionals were assigned to give support on 31 kebele on cluster based. At cluster level, one health center supervised five health posts. From each cluster / health center/ professionals assigned to each kebele/ health post to support health extension workers. At kebele level, one to five structures were designed which have five houses holds next to this 25-30 household organized as one group, next structure is the kebele administration offices and lastly kebele health extension workers.

The objective of health development army is to create awareness on the importance of postnatal and prenatal services, family planning and taking care for their children. It is also helps to encourage mothers to deliver in the health institution, and to

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persuade them to practices 8 kinds of health package. In addition, it is a means to create awareness on the importance of breast-feeding, Tell mothers to fight against harmful traditional practices and the use of vaccination.

On the other side as the kebele document showed in 2005 e.c vaccination coverage reached 56%, 56 mothers have attended prenatal services, 70 mothers have attended postnatal services, 6 mothers have delivered in the health post and 56 pregnant women have taken HIV test.

Most documented data's have similar outcome with data's collected using questioners and interviews.

4.5. Planning process, monitoring and evaluation and indicators of HEP

Data was also collected on how panning, monitoring and evaluation process of health extension program took place in research kebele. Participants' response presented as follows;

During their FGD health development army came up with the following responses. Health development army got supervision from health extension workers and from team leader. support how strengthen community structure like 1 to 5 and 1 to 30, assist to share experiences among health development army, avail reference materials, teach us how to help mothers, give training for us are some of the support that health extension worker provide for health development army. Lastly, they submit their report either once in a month or in twice a month.

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Key informants/health extension workers/ on their part provided their response as follows. During planning, implementation, monitoring and evaluation, all kebele management bodies, health development army, figure community members, woreda health offices, health professionals who provided supportive supervision for HEW, health extension workers and NGOs are actively participating. Provided problem solving supervision, organized different workshop, financial and material support are the main activities which are being provided by health centre to health post and HEW.

Health extension supervisor explained the main actor of health extension program planning, implementation and monitoring and evaluation process are presented as follow during the interview time.

During planning: the plan that was developed by the woreda health offices explained by health center professional for health extension and kebele management body, HEW and kebele administrative bodies explain the plan for group and one to five leaders , Through this process any one can raise any question for clarification on the plan.

During implementation: health development workers and kebele administrative chairperson play leading role. HEW lead day-to-day activities professionally and chairperson played leading role in facilitating group leaders and one two five leaders on each sub kebeles.

Monitoring and supervision: health professionals from health center are responsible to provided monitoring and supervision for health extension workers. Kebele chairperson support health extension workers to solve challenges that face at the level of group leaders and one to five women structures. Challenges that not

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give solution on the health center and health extension workers reported to woreda health offices to mitigate the challenge. If the challenge is not solved by woreda health offices the challenge shares to woreda counsel management body. Health extension workers prepare and submit report on weekly, monthly, quarterly, biannual and annual base for health center.

Evaluation: during evaluation session, health extension workers, cluster professionals, woreda health professionals were the main participants. Before started evaluation session, HEWs report presented for the participants. After the discussion took place, constructive feedback was provided for each HEW. To promote positive competition among health extension workers, health center provided rank at health center level for health extension workers. On the other side, woreda health office also provided rank for clusters/health centers/.

Health extension workers, professionals who assigned from health center to provided supportive supervision, health center team leaders, health center management committee members, kebele administrative bodies and professionals who assigned from woreda health offices are the main concerned bodies to provide supportive supervision.

4.6. What will do in the future to improve mother and child health through health extension program?

To achieve the objective of health extension program by solving existing challenges of mother and children health, the following points need due attention.

Key informant respond following points on the their questionnaire

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Facilitating the construction of mothers resting room around the health center, collect contribution for mothers based on one birr for one mother principles, prepare foods and organize coffee ceremony until mothers delivered and back to home in the health center are very essential. Organizing women in one to five structures, providing continuous training for mothers and organizing pregnant women workshop. In addition, improve transport infrastructure, increase number of ambulance, create awareness on the issue of mother's health for the community and encourage mothers to take their children to health institutions when they got some kind of health problem.

Furthermore, improve malnutrition problem, strengthen children immunization services, enhance prenatal and postnatal services, strengthen MTCT services, support the community to produces health in every house and create sense of ownership on health of mothers and children in the community are important areas which need attention to improve mother and children health more.

Use health development army structure properly and effectively is important to reach at 100% women delivery at the health institution level only. Use experiences sharing, provide supportive supervision and duplicate success in other area are important tools to improve mother and child health.

During interview key informants again forward the following points to improve mother and child health.

Proposed points were:

- properly utilize women health development army formation of the community and organized youth

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- reduce staff turnover and provide continuous supervision,
- Strengthen health center and health post network
- support professionals to have skill and positive attitude towards their job
- Improve collaboration among government offices, GO and NGO,
- Improve community awareness and women participation,
- Minimized influence of husbands,
- Increase ambulance services,
- Increase budget allocation for the program,
- Minimize cultural influences.
- Encourage food preparation and coffee ceremony around health institution.
- Create awareness about the issues of mothers and children health status,
- Increase number of ambulance in the woreda level, encouraged women to know their expected delivery date, strengthen one birr for one mother strategy, which is important for pregnant women, motivate mothers who deliver in the health institution, and continues training for health professionals who participate on health extension program implementation.
- Strengthen pregnant women conference.
- Strive to meet zero delivery at home

Finally yet importantly, Health extension workers, kebele management bodies, group leaders, one to five structure leaders, health center professionals and woreda health office professionals are play leading role to achieve the above points.

More over key informants identify the role of different partners as follow

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- Family: the family should be active participant of family discussion session, which focuses on pregnancy issues.
- Community: the community properly and actively participate already existing structure like one to five formations.
- Health development army: take this responsibility properly.
- Kebele administration: monitoring the activity and identify the challenge and support HEW to mitigate identified problems.
- Health center: provide support and supervision on health extension program implementation for health extension worker
- NGO: fill gaps of skill and knowledge on child and mother health by organized different trainings/workshops session in the community.

To solve challenges that were identified during monitoring and evaluation: support HEW whether solve the challenge, use meetings as experience sharing methods, follow up identified challenges tackled according to the feedback or not and Insist woreda management to intervene on some challenges if the challenge needs their intervention.

To strengthen existing structures: Enhance community awareness on the importance of existing structure for the community to improve maternal and child health, crate network among the structures that crated from woreda to kebele, give continuous support for one to five leaders and create competition among them and woreda health offices should be give continues training for health extension workers.

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Mother who participated on FGD come up with the following points to improve more the health of mother and child.

- More services should be provided at house hold level
- Health institution should be ready both in material and in professionals to provide proper services for mothers and children.
- Health professionals should be treat properly their client

During FGD Health development army on their part, propose the following points to meet objective of health development army concept.

- It is better if selection processes based on volunteerism and consider educational level.
- After the selection health development army should got proper orientation what they do.
- Lastly, supportive supervision, give attention for working materials and continuous empowerment of health development army should need attention.

Data collected using different data collection methodologies came up with similar information that shows how data collection tools are important collect information from the respondents.

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CHAPTER FIVE

DISCUSSION

Identify the challenge and improvement of mother and children health after the implementation of health extension program is an important part to design proper strategy to tackle existing challenges and keep best practices that have been achieved so far. Based on this understanding, the research has identified the following achievements and challenges.

Following the implementation of health extension program in Bakello kebele, a number of improvements and challenges are recorded on the health of mother and child as the study disclose. The main area of improvements and challenges are;

5.1. Improvements recorded

Improvements recorded on the health of mothers and children health

The research disclosed the following achievements after the implementation of health extension program on mothers and children health. Breast feeding practices and personal hygiene of mothers are improved. Maternal and child mortality rate decreased, utilization of family planning methods, vaccination coverage and prenatal and postnatal service demand increased. Improved child nutrition, mothers who need health professional support during delivery increased and minimize communicable disease prevalence were the main area that show significant improvement regarding the health of child and mother. This finding has similar out come with research findings of Araya

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Medhanyie and his friends' (2012), Charlotte Warren. (2010), FDRE MOH (2010/11), MaNHEP FORMATIVE RESEARCH REPORT(2011), Medhanyie et al. BMC Health Services Research (2012) and MOFED and the UNE(2012)

Improvements on health institutions services

Trained mothers on feeding practices, importance of post natal services and family planning, constructed waiting room for pregnant women in health center, conducted pregnant women conference, provided organized immunization program, provide services at household level, tried to create ambulance access, established health post and tried to improve health facilities after health extension programs implemented in the kebele.

Improvement on coordination of health extension program

Supported concerned bodies to participate in planning, implementation, monitoring and evaluation sessions, established and practiced different community structures, implemented different supportive supervision at different level, created positive competition among health extension and health centers. These achievements have similar out come with the report of FDRE MOH(2010/11)

5.2. Existing challenges

Challenges on the health of mothers and children health

High prevalence of communicable disease, low postnatal and prenatal service utilization, prolonged delivery and unsafe abortion, delivered at home, illiteracy rate, harmful traditional practices, low awareness of mothers on children health, poor

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balanced diet and large family size are some challenges of mothers and children health that still exist. These research findings show similar out came with the research conducted by Ahmed Abdella (2010), Amare Deribew and his friends' (2007), Charlotte Warren (2010), Charlotte Warren (2010), *Ethiopian J. Health Dev. (*2010), Family health department, FMOH(2005), Medhanyie et al. BMC Health Services Research (2012), MOFED and UNE(2012),Negussie Taffa and Francis Obare (2004) and Tigist G/selassie and Mesganaw Fantahun (2011).

Challenges on health institutions services

Shortage of ambulance services, less accessibility of the transport services, low awareness of mother on their health and children health, poor personal and environmental hygiene, poor services and counseling provision at health institution, poor health facility, high turnover of health staff, These findings have similar result with other researchers like Ahmed Abdella(2010), Charlotte Warren(2010), *Ethiopian J. Health Dev. (*2010), FDRE MOH (2010), Medhanyie et al. BMC Health Services Research (2012), Negussie Taffa and Francis Obare (2004).

Challenges on coordination of health extension program

High number of illiterate health development army, not properly trained. Most stakeholders do not actively participate on planning, implementation, monitoring and evaluation, especially from woreda health offices and supportive supervision is inconsistent.

Health development army selection, training on mother and child health, implementation, close follow up and supervision process also need attention for better achievement of health extension program implementation in general and mother and

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child health in particularly. In contrary to the principle and guidance of HDA manual health development army selection, training and technical support of health development army is not get due attention at kebele level. Consistent with this findings Ethiopian government health extension program manuals and health sector annual performance reports confirmed that HDA implementation still need further improvement. These results of the research are against the government documents like FDRE MOH(2010/11), FMOH, health extension and education center (2007).

To reverse existing challenges and to improve mothers and children health the following points should be addressed according to the research results.

To enhance mothers' active participation on health extension program provide frequent training frequently for mothers on the issues of mother and child health, create awareness on the issue of mother's health for the community and strengthen MTCT services.

Support the community to produces health in every household level; create sense of ownership in the community, minimized influence of husbands and cultural influences need attention for mothers' active participation in health extension programs.

Health institutions should perform the following activities to improve mothers and children health by Strengthen pregnant women conference, construct mothers resting room around health institution and collect contribution for mothers based on one birr for one-mother principles.

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Organize coffee ceremony in the health institution until mothers deliver and back home. Motivate mothers to deliver at health institution. Encourage mothers to treat at health institution when they faced health problem. Give immediate treatment for children when over they face malnutrition.

Strengthen children immunization services, enhance prenatal, delivery and postnatal services for mothers and encourage mother to participate actively health development structure.

Woreda health offices on their part should perform to minimize the challenge of health extension program by increasing budget allocation for the program, employee different disciplinary professions and improve transport infrastructure, reduce staff turnover, provide continuous supervision, strengthen health center and health post network, support professionals to have skill and positive attitude towards their job.

Lastly, support HEW to solve problem, use meetings as experience sharing methods, and follow up feedbacks and give for problems that need further attention of sector offices. Other researches and guidelines of the following like Amare Deribew and his friends (2007), FDRE MOH (2010), FMOH, health extension and education center (2007) and MaNHEP FORMATIVE RESEARCH REPORT (2011) confirmed these findings.

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CHAPTER SIX

SUMMERY AND RECOMMENDATION

6.1. Summery

According to the study, the following outcomes are obtained. These are;

Prevalence of communicable disease minimized, child-feeding practices improved, using health institution for different purpose increased, and community started to trust health extension workers, there is an improvement in health facilities, planning, monitoring and evaluation together with stake holders are the main achievement of health extension program on mothers and children health.

Nutritional problem, communicable diseases are still challenges of mothers and children health that are identified by the research.

Furthermore, low family planning and postnatal services, low participation of stakeholders on HEP and distance and poor health facility discourages women to visit health institution regularly.

More over less attention is given for health development army selection, coaching, inadequate ambulance services, high number of illiterate for mothers and health development army are main challenges that need attention to improve mother and children health.

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6.2. RECOMMENDATION

Based on the findings of the study the investigator recommends the following suggestions;

1. Improvements recorded on health extension program implementation like vaccination breast feeding practices and others should be maintained and used as an entry points to improve other challenges.
2. Because of high literacy rate low number of mothers not use family planning utilization that lead to high family size. Therefore attention should be given for mothers education and training.
3. Low awareness on the importance of skilled delivery assistance on one side and cultural barriers on the other side made most mothers delivered at home. So awareness must be raised and barriers removed.
4. Less training provided and high illiteracy rate of health development army are great challenge to meet objective of health strategy, because of this health development army selection and training should get better attention.
5. Misbehavior of some health professionals and poor health facility discourage mothers to seek health services in health institutions. Therefore, professional ethics should maintain and disciplinary measures should be taken.
6. This study indicated that awareness creation, training, workshop and education are not the end result to minimize maternal death. Rather it is important to give emphasis for accessibility of health facility, lack of professional commitments, medication and medical equipment problems, procedural guides to minimize maternal death due to pregnancy complication.

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

Enrollment No.: 099110560

Date of submission: January 2015

Name of study center: Saint marry university collage

Name of the guide: Mr. Tesfye Eijegu

Title of the project: Health extension program implementation in improving mother and child health: Achievements and challenges in the case of Bakello Kebele Administration.

Signature of the student: --

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Date: January 2015

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Proposal

INDRA GANDHI NATIONAL OPEN UNIVERSITY

SCHOOL OF SOCIAL WORK

DEPARTMENT OF SOCIAL WORK

Health extension program implementation in improving mother and child health: Achievements and challenges in the case of Bakello Kebele Administration.

BY

Abebe Ayal

Advisor: Tesfaye Eijigu

July 2014

A Thesis Submitted to the School of social work of Indra Gandhi National Open University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in social work

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INTRODUCTION

According to Federal democratic republic of Ethiopia ministry of health (2010) "Before the 1990s, Ethiopia's health care delivery system was ineffective and inefficient, characterized by top heavy and uncoordinated planning and implementation. The health service system had eight specialized vertical programs: malaria and other vector-borne diseases, tuberculosis prevention and control, leprosy control, HIV/AIDS and other sexually transmitted disease prevention and control, the expanded program on immunization, control of diarrheal diseases, acute respiratory diseases control and prevention, and control of micronutrient deficiency diseases. Though the priorities were correct, the programs were poorly integrated and lacked appropriate direction and management, leading to inefficiency and limited impact. Country health problems were dominated by preventable and communicable diseases, which constituted 60–80% of the disease burden (FMOH 2010a). Aggravating this was the rapidly growing population and poor infrastructure, which had been crippled by the decades of war and neglect. The health institutions were few compared to the size of the population, ill equipped, and inequitably distributed. In 1994, roughly 50 percent of Ethiopia's health facilities were in urban areas with over 30 percent needing either major repair or replacement.

The sector was further characterized by an acute and chronic shortage of human resources coupled with poor community and private sector participation in service delivery and management.

Following 1994 health policy of the country, the government started implements different health plans. The 1st health sector development plan which started in 1997/98

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which ends 2001/2002 is an output of the policy to improve primary health care. But to be more accessed primary health care services to the community health extension program started in 2003 trough out the country. Ethiopia as country attains a number of results since the implementation of health extension program, which are important to improve primary health care. Similarly, improvements recorded on mother and child health after the implementation of the program throughout the country. However, to meet objective of MDG 4&5, the data shows that the country needs walk long way. The following are some of different literatures' that shows county status on maternal and child health.

The major health problems of the country remain largely preventable communicable diseases and nutritional disorders. Despite major progresses have been made to improve the health status of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor. Figures on vital health indicators from EDHS 2005 show life expectancy of 54 years (53.4 years for male and 55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010 and more than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often a combination of these conditions. These are very high levels, though there has been a gradual decline in these rates during the past 15years.

In terms of women health, MMR has declined to 590/100,000 though it still remains to be among the highest. The major causes of maternal death are obstructed/prolonged labor (13%), ruptured uterus (12%), severe pre-eclampsia/ eclampsia (11%) and malaria (9%). Moreover, 6% of all maternal deaths were attributable to complications

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from abortion. Shortage of skilled midwives, weak referral system at health centre levels, lack of inadequate availability of bemonc and cemonc equipment, and under financing of the service were identified as major supply side constraints that hindered progress. On the demand side, cultural norms and societal emotional support bestowed to mothers, distance to functioning health centers and financial barrier were found to be the major causes."

As the government illustrates in the document even there is an improvement after the implementation of three HSDPs still mother and child health not meet sate objectives of MDG. Because of this the government gives due emphasis for primary health care in general and maternal and child health in particular improvement on fourth HSDP too. After taking lesson from previous implementing HSDP experience the government tries to design and implement more applicable strategies.

According to the government experience told that lack of skilled man power mainly mid wife, weak referral system, lack of medical equipment are the main one which need improvement to implement fully health extension program. Still community culture, beliefs and others are challenges that need attention to achieved health extension program objectives. The 4th health sector development plan developed to mitigate such problems.

Ethiopian journal of reproductive health 77(May 2007) "In Ethiopia, it is estimated that 61 percent of households have access to an improved source of drinking water with access in urban areas much higher than in rural areas (94 percent and 56 percent, respectively). In urban areas, 90 percent of households have access to piped water compared to only 13 percent of rural households. On the other hand, the major source

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of improved drinking water in the rural areas, which is 39 percent, is protected spring. An estimated 75 percent of health problems of the country are due to infectious and communicable diseases, which could be easily prevented or controlled by applying simple sanitary measures. However, they still contribute to the high morbidity and mortality, especially among infants and children.

Infant and under five mortality rates were recorded at 77 and 123 per 1000 live births, respectively , whereas, the maternal mortality ratio stood at 673 per 100,000 live births, which are still the highest among sub-Saharan African countries .

In a similar manner, contributions from communities and their direct participation in health activities have been hampered for years. As a result, communities were not given opportunities to play an active role in deciding the type of activities they want, and get involved in the kind of actual service they receive. In similar setting where communities take active participation to produce their health, results showed significant improvement in the health of the population."

Still preventable diseases are the main causes of high maternal and child morbidity and mortality rate in the country generally and rural part of the country in particular as the literature indicated. As the research shows that lack of pure water and lack of community active participation during the implementation of primary health care at kebele level are the main factors, which contributed negatively on maternal and child health. As health extension, philosophy indicates community involvement is most significant to enhance sense of ownership. Still community involvement is not as expected which highly affected community health in general and mother and child health in particular.

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Desta Mekonnen (2011) disclose that “Infant and child mortality is a factor that can be associated with the well-being of a population and taken as one of the development indicators of health and socioeconomic status and also indicates a life quality of a given population, as measured by life expectancy. That is why reduction of infant and child mortality is a worldwide target and one of the most important key indexes among millennium development goals (MDGs). Hence its indication is a very important for evaluation and public health strategy. Thus, it is an area that many researchers focus and that has attracted the attention of policy-makers and program implementers worldwide. One of the most important targets of millennium development goals (MDGs) that introduced in 2000 at the United Nations millennium summit was reducing infant and under-five child mortality rates by two-thirds from the 1990 levels by 2015.”

Now a day mother and child health takes as indicator of development for any nation in the world. From this point of view the country again needs more effort to improve maternal and child health.

Federal minster of health, health extension and education center (2007) document illustrate that “The extension program (HEP) is a defined package of basic and essential promotive, preventive and selected high impact curative health services targeting households. Based on the concept and principles of primary health care, it is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom.

The health extension program is the main vehicle for bringing key maternal, neonatal and child health interventions to the community. 30000 health extension workers (HEWs) have been deployed by 2009 for this particular mission. It is expected that almost all of

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the activities listed in the national child survival strategies are to be implemented through the health extension program.

The HEP has the following objectives: create a healthy society and reduce rates of maternal and child morbidity and mortality is goal of health extension program.

- ❖ Improve access and equity to preventive essential health interventions at the village and household levels in line with the decentralization process to ensure health care coverage to the rural areas.
- ❖ Ensure ownership and participation by increasing health awareness, knowledge, and skills among community members.
- ❖ Promote gender equality in accessing health services.
- ❖ Improve the utilization of peripheral health services by bridging the gap between the communities and health facilities through hews.
- ❖ Reduce maternal and child mortality.
- ❖ Promote healthy life style are the main objectives of health extension program.

Employed two female health extension workers in each kebele, constructed health post in each kebele and equipped these health posts with the necessary equipments and facilities are the main implementing strategy of health extension program.

Health extension program focused on three components and 16 packages."

After signing MDG summit the government of Ethiopia developed different policies that are important to achieve millennium development goal. To implement these policies and achieved stated objectives the government develops different implementing strategies that help the government to change polices in to practices.

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Health extension program is one of the strategies that the government of Ethiopia designed to improve primary health care throughout the country by stretching the services at kebele level. At kebele level transfer knowledge and skill at house hold level which help the house hold to take responsibility on the life of mothers, neonatal and child health. The services provided by two female health extension workers who have cloth relationship with mothers and children.

In addition two health extension workers health development armies expect to work closely with health extension workers. At kebele level the services provided both at the center/ health post / and at community level by providing door-to-door services. To provide quality and appropriate services infrastructure of health post services should be avail properly.

In general, as the above different facts indicated there are improvement in mother and child health but not as expected to meet MDG of 4 &5. This need design different plan and strategies which enhance and improve maternal and child health. This plan and strategies should be come out either from implementation experiences or researcher results. When use experience of implementation it is possible to expand best practices experience to other area for better implementation. Nevertheless, this strategy sometimes faces challenges to duplicate other area because of cultural and environmental factors. To overcome such challenge area context research more advantages by identifying the challenge and provide area context solutions for a given problems. The research is not identified only challenges but try to identify best achievements and elucidate how important the achievements were. That is why this research focused on specific kebele to identify challenges and best practices. Because

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of this, the research focused on to identified what are challenges after the implementation of the program on mother and child health which hider to meet MDGs. Moreover, identify what are successes that accomplished after the implementation of health extension program, which is important to enhance more mother and child health success.

To improve implementation of health extension program and achieve objectives of the program the government use different strategies based on the challenge faced during implementation. One of the strategies that the government uses is to identify achievements and challenges during the implementation of health extension program that are important to meet health extension program objectives.

Achievements and challenges that face during the implementation of health extension program are not similar across the board due to different reasons. Some of the factors are accessibility of health institution infrastructure, culture difference, and inaccuracy of information. Because these factors, attention need to be taken in to consideration on different areas and clearly identified achievements and challenges of these area. Both achievement and challenge are more accurate and increase probability of improvement of implementation when the data supported by the research.

This research is conduct in identifying two issues after the implementation of health extension program in general and mother and child health in particular. These are;

- To assess and identify success that will be achieved after the implementation of health extension program on maternal and child health.

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- ❖ To assess bottlenecks that needs attention for the future to improve maternal and child health since the implementation of health extension program.

Statement of the Problem

This research topic was select because of the following main reasons.

- ❖ Mother and children health are still a challenge for Ethiopian government to achieve the 4th and the 5th Millennium Development Goal.
- ❖ Because of this, maternal and child health is prior issue of the government's health policy.
- ❖ During informal discussion with health professionals, health extension program has faced several challenges.

The Bakello kebele was selected because the researcher knows the kebele for not less than 8 years. More over research has not yet been conducted in this kebele regarding health extension program.

The research was designed to achieved the following points:

- ➢ Providing evidence based data on achievements of health extension implementation in the kebele.
- ➢ Providing evidence based data on challenges of health extension implementation in the kebele.

After the implementation of health extension program different researchers have conducted researches on health extension program from different perspective in diverse areas and came up with the following results.

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According to the study conducted by Ahmed Abdella (2010) complication of pregnancy and child birth, poor neonatal care management and poor health and nutrition of mothers are the main causes of maternal and child deaths.

Similarly, government HSDP 4 illustrates that most preventable disease and nutritional disorders are still the main health problem of the country in general and child and mother health in particular.

More over Tigist G/selassie and Mesganaw Fantahun (2012) study confirmed that acute respiratory infections, diarrheal disease, malaria malnutrition and vaccine preventable disease are the major cause of child death.

According to MaNHEP FORMATIVE research report(2011) Increase team work among team leader, heath extension workers and traditional birth attendant, confidence and competent of HEW in provide MNH and community recognize usefulness of health extension worker and health extension workers understand their duties are some of improvements shows after the implementation of health extension program

Improved utilization of family planning, antenatal care services and HIV test show significant improvement as stated by the Araya Medhanyie and his friends study(2012)

Objective of the study

1. General objective: the general objective of this research was to identify the achievements recorded and the challenges faced since the implementation of health extension program to improve mother and child health in Bakello kebele administration.

2. **Specific objectives**; the specific objectives were;

1. To identify main success on the health of mother and children after implementation of health extension program in the kebele

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2. To identify main challenges on the health of mother and children after implementation of health extension program in the kebele

Research questions

The study is expected to respond to the following research questions after the implementation of health extension program on mothers and children health.

3. Disclose what achievements are observed on health of mother and child so far in Bakello kebele administration after the implementation of HEP.
4. The challenges observed in maternal and child health during the implementation of HEP.

Scope and Area of the Study

Because of time and other resource constraints, the research was made to focus on the achievement and challenge on mother and child health not overall package of health extension program in one kebele. Moreover, the research tries to focus on one manageable kebele to identify achievements, challenges, and forward recommendations on mother and child health.

Research Methodology

Achievements and challenges were carried on the health of mothers and children after the implementation of health extension program in Bakello kebele/the smallest administrative units in Ethiopia/ in Bassona worana district in North Shoa Zone. To conduct this research both quantitative and qualitative methods were employed. Interview and focused group discussion were used for qualitative method. Questionnaires were administered to collect quantitative data.

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Sample

In order to draw representative sample, the study employed different sampling techniques. Purposive or judgment sampling was found appropriate and the selection was made based on the accessibility from woreda town. Out of thirty-one Kebeles in the woreda Bakello, kebele was selected because of its proximity.

The research includes sub kebeles/ gots/. Bakello has 5 sub kebeles/*got*s/ each got is represented in the study. From each gots, 7-8 mothers/care givers who have children under five years old and 5-6 Health development armies selected using systematic random sampling by taking every six number from the list of HEWs.

The study populations are 39 mothers and caregivers having children under five years, 2 kebele Health extension workers, 29 kebele health development army and 2 health extension program supervisors from Keyit health center. According to data observed from kebele health extension workers, there are 200 mothers and caregivers between age 15-49 and 200 kebele health development army registered in the kebele.

The required sample size is 20% of mothers and caregivers who have children from 0-5 years, 14.5 % of kebele health development army, 2 health extension workers of the kebele and one health extension program supervisor and 1 health center head. Mother/care givers and kebele health development army were selected using systematic random sampling techniques. FGD participants were selected from the same population. Amharic version of questionnaire was used to collect data from each participants of the study. The questionnaires were tested in small group of similar population and improved based on the feedback obtained.

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Informed consents of the respondents have been consulted. Privacy and confidentiality has been maintained and the researcher explained to the respondents the objective of and procedures of the study.

Tool for data collection

The researcher used both quantitative and qualitative methods to gather information related to socio economic characteristics, child feeding practices, child health, personal hygiene, mother's pre and post natal services, about challenges during the implementation of health extension program, type of services that have been provided in the health post, supportive, monitoring and evaluation system of health extension program. The following were the main tools used to collect data.

1. Questionnaire: questionnaire was used as one of quantitative data collection tool. It was filled by using data collectors. The rationale of administering the survey questionnaire using data collectors was because the study population comprises rural dwellers where most of them are illiterate and it is to avoid errors and boost correct response rate.

2. Interview: The study administered depth interviews with care givers/mothers, health development army, HEWs and supervisors, to obtain detail information from both the beneficiaries and services providers. Accordingly, two HEWs, five HDA, two HEW supervisor and five mothers/care givers participated in the interviews.

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3. Focus Group Discussion: in addition to the interviews, separate FGD sessions were also held with one-group mother/care givers and another group HDA to generate qualitative data. Each group had 6-8 individuals.

Data analysis

The qualitative data obtained using interviews, FGDs were carefully sorted, and similar ideas were organized in to similar categories. Then, it was qualitatively analyzed in words. That means the qualitative data was described and discussed by establishing connections or links between the views of informants. By doing so, effort was made to interpret the arguments behind each idea.

On the other hand, data's from the questionnaire was analyzed descriptively and presented using tables, percentiles and frequencies.

Organization of paper

Chapter one mainly focuses on introduction part of the research. Chapter two discuss the background of Bakello kebele situation and profiles related to mother and child health, followed by a theoretical framework and literature reviewed in chapter three. Results of the study part are presented in chapter four followed by discussion model in chapter five. Summery and recommendation parts presented in chapter six and finally, the reference, proposal and annexes parts presented at the last page of the paper.

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ANNEXES

1. Tables and graphs

1.1. Tables

Table 1.1.1: General information on mothers respondents

Characteristics	Frequency	Percent	Remark
1. Occupation / n=39/			
Farming	39	100	
2. Marital status / n=39/			
Married	30	76.9	
Not married	2	5.1	
Divorced	7	17.9	
3. Educational status / n=39/			
Illiterate	18	46.1	
Read and write	9	23.1	
Grade 1-4	4	10.2	
Grade 5-8	7	17.9	
Grade 9-10	1	2.6	
4. Number of total children/ n=39/			
<4 year	24	61	
4-8 years	15	38	
5. Age of youngest child/ n=39/			

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<5 year	37	94.9	
5 and above	5	5.1	
6. Age of oldest child/ n=39/			
<5 year	9	23.1	
5-10 year	6	15.4	
11-15 years	10	25.6	
>15 year	14	35.9	
7. Number of year lived in the kebele/ n=39/			
<5 year	2	5.1	
5-10 year	6	15.4	
Above 10	31	79.5	

Table 1.1.2: General information on health development army respondents

Characteristics	**Frequency**	**Percent**
1. Occupation / n=29/		
Farming	29	100
2. Marital status / n=29/		
Married	23	79.3
Not married	5	17.2
Participants not respond	1	3.4
3. Educational status / n=29/		
Illiterate	7	24.1
Read and write	4	13.8

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Grade 1-4	5	17.2
Grade 5-8	8	27.6
Grade 9-12	5	17.2
4. Number of total children / n=29/		
<5 year	19	76
5 year and above	5	20
Participants not respond	1	4
5. When you elected as HDA / n=29/		
Since 2005E.C	18	62.1
Since 2004E.C	7	24.1
Since 1992E.C	1	2.4
Participants not respond	3	10.3

Table 1.1.3: General information on key informant respondents

Characteristics	frequency	percent
1. Educational qualification / n=4/		
10+1	1	25
Diploma	2	50
1st degree	1	25
2. Age / n=4/		
25-35	4	100
3. Current position / n=4/		
HEALTH EXTENSION	2	50

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WORKER		
HES	1	25
HCH	1	25
4. Total work experience/ n=4//		
7 years	1	25
8 years	2	50
13 years	1	25
5. Work experience on current position / n=4/		
7 years	1	25
8 years	2	50
1years	1	25

Table 1.1.4: Mother's response regarding existing practices of mothers and children health

Characteristics	**Frequency**	**Percent**
1. Where did you deliver your youngest child? /n=39/		
Home	31	79.5
Health center	2	5.1
Hospital	4	10.3
Participants not respond	2	5.1
2. Do you get prenatal services? /n=39/		
Yes	20	51.3
No	19	48.7
3. Do you get postnatal services? /n=39/		

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Yes	9	23.1
No	25	64.1
Participants not respond	5	12.8
4. Do you have privet toilet? /n=39/		
Yes	**39**	**100**
No	**0**	**0**
5. Since when did you start using privet toilet /n=39/		
Before 2007/2008	**10**	**25.6**
Between 2007/2008-2010/2011	**23**	**59.0**
After 2010/2011	**5**	**12.8**
Not specify the year	**1**	**2.6**
6. Do you use family planning services? /n=39/		
Yes	**27**	**69.2**
No	**12**	**30.8**
7. Do you take HIV test during pregnancy? /n=39/		
Yes	**23**	**59**
No	**15**	**38.5**
Participants not respond	**1**	**2.5**
8. Is your child vaccinated? /n=39/		
Yes	**39**	**100**
No	**0**	**0**
9. Is your child vaccinated all kind of vaccination? /n=39/		

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Yes	**39**	**100**
No	**0**	**0**
10. Who provided you support when you delivered your child? /n=39/		
Traditional birth attendant	**11**	**28.2**
Health professional	**8**	**20.5**
Family	**20**	**51.3**
11. How many times do you feed your child per day? /n=39/		
Below three times	**4**	**10.3**
Four times	**7**	**17.9**
Five times	**13**	**33.3**
More than six times	**13**	**33.3**
As necessary	**2**	**5.1**
12. At what age did your the child complete his/her vaccination /n=39/		
9 moth	**33**	**84.6**
8 moth	4	10.3
10 moth	2	5.1
13. What is the age gap between your youngest and his immediate older child /n=39/		
2 years and below	2	5.1
2-4 years	18	46.2
5-6 years	4	10.3
More than 6 years	8	20.5

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No year difference	6	15.4
Participants not respond	1	2.5
14. At what age should children start additional food? /n=39/		
6 moth	39	100
15. Did you take any training about how to feed children? /n=39/		
Yes	33	84.6
No	1	2.5
Participants not respond	5	12.8
16. Who provided you training/n=39/		
Health professionals	20	51.3
NGO	15	38.5
Participants not respond	4	10.3
17. For how long do children feed their mothers breast only? /n=39/		
6 month	39	100

Table 1.1.5: health development army response regarding existing practices of mothers and children health

Characteristics	**Frequency**	**Percent**
1. Did you take any training before on mothers' health of mothers? /n=28/		
Yes	17	60.7
No	11	39.3
2. In your area, where do most mothers give birth? /n=29/		
Home	4	13.8
Health institution	**24**	82.8

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Participants not respond	**1**	**3.4**
3. Are there mothers who died due to delivery/abortion? /n=29/		
Yes	**0**	**0**
No	29	**100**
4. How many mothers use family planning under your supervision? /n=28/		
3 mothers	**5**	**17.9**
2 mothers	**5**	**17.9**
4 mothers	**6**	**21.4**
5 mothers	**6**	**21.4**
16 mothers	**1**	**3.8**
15 mothers	**1**	**3.8**
1 mothers	**1**	3.8
No	1	3.8
I don't know	2	7.6
5. Do mothers take HIV test under your supervision? /n=28/		
Yes	11	39.3
No	9	32.1
I don't know	4	14.3
No pregnant	3	10.7
Participants not respond	1	3.8
6. Do mothers receive postnatal services under your supervision? /n=29/		
Yes	8	27.6
No	18	62.1

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Participants not respond	1	3.4
No pregnant	2	6.8
7. Do mothers get prenatal services under your supervision? /n=29/		
Yes	16	55.2
No	9	32.0
Participants not respond	1	3.4
No pregnant	3	10.3
8. In your area, are their mothers who deliver at home? /n=29/		
Yes	7	24.1
No	20	75.9
9. Did you take any training before on children's health? /n=29/		
Yes	19	66.5
No	10	34.5
10. In your residence, is there any child who died below one year? /n=29/		
Yes	5	17.2
No	24	82.8
11. For how many mothers are you responsible? /n=29/		
4 mothers	4	13.6
5 mothers	19	65.5
8 mothers	2	6.8
30 mothers	2	6.8
40 mothers	1	3.4
Participants not respond	1	3.4

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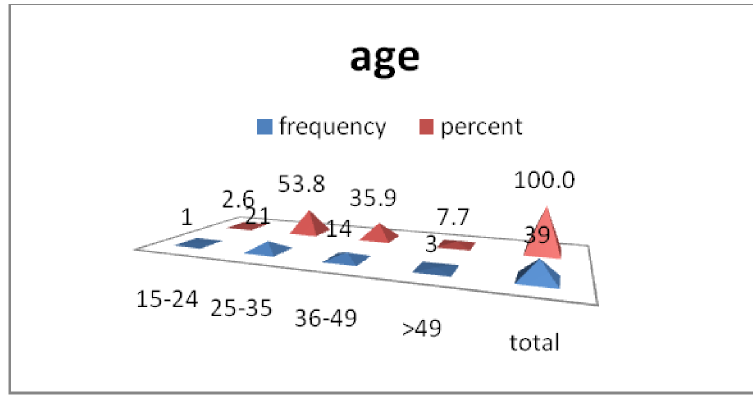
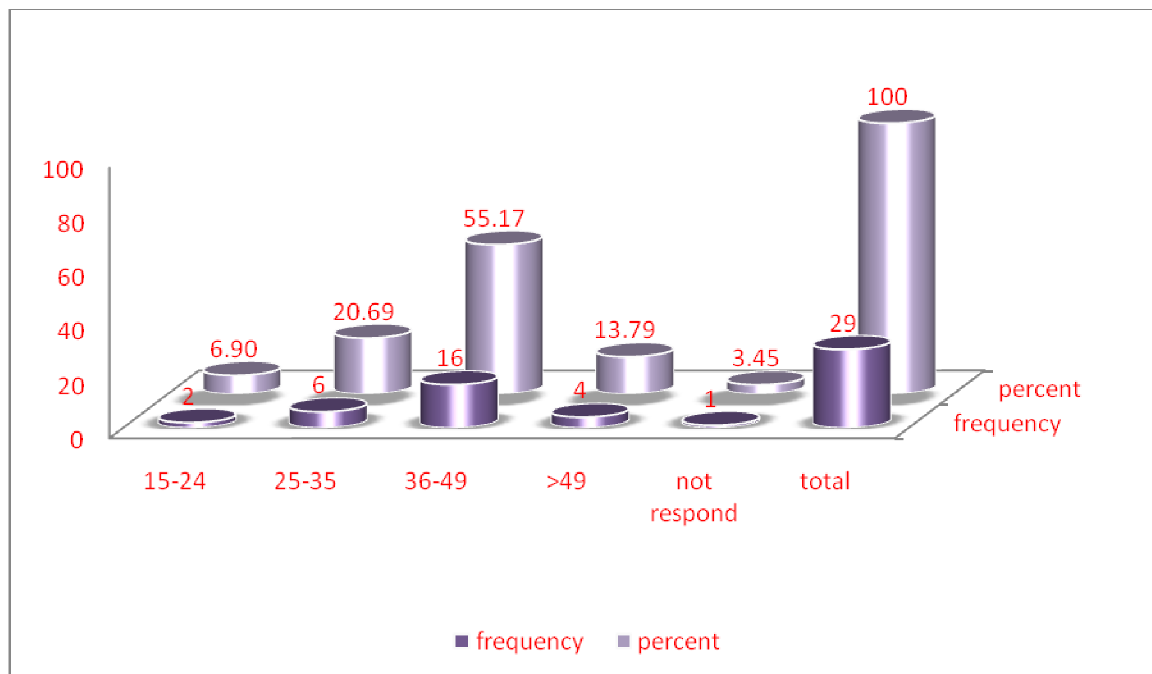
1.2.: Graph

1.2.1: Age of mother respondents



1.2.2: Age of health development army



2. Questioners

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የጹሁፍ መጠይቅ

ዓላማ፡ ለሁለተኛ ዲግሪ ማሟያ ለሚሰራ ጥናት መረጃ ለመሰብሰብ የተዘጋጀ ሲሆን የጥናቱ ውጤት ለትምህርታዊ ዓላማ ብቻ ይውላል፡፡ በመሆኑም ትክክለኛ መረጃ ነው የሚሉትን መልስ በጥያቄው መሰረት ይመልሱ፡፡ የሚሰጡት መልስ ሚስጥራዊነቱ የተጠበቀ ነው፡፡

ስም መፃፍ አያስፈልግም፡፡ በቅድሚያ ስለሚደረግልኝ ትብብር አመሰግናለሁ፡፡

ለእናቶች/አሳዳጊዎች

አጠቃላይ መረጃ

- የመረጃ ሰብሳቢ ስም-----------------------------------
- መረጃው የተሰበሰበበት ቀን-----------------------------------
- መረጃው የተሰበሰበበት ቀበሌ---------------------------------

የተጠያቂ መረጃ

- እድሜ፡ ከ15 ዓመት በታች ☐ ከ15-24 ☐ 25-35 ☐ 36-49 ☐ ከ49 ዓመት በላይ ☐
- የትምህርት ደረጃ፡ ማንበብ መፃፍ የማይችል ☐ ማንበብ መፃፍ የሚችል ☐ ከ1-4ኛ ☐ ከ5-8ኛ ☐ ከ9-10ኛ ☐ ከ11-12ኛ ☐ ዲፕሎማ ከዚያ በላይ ☐
- ጾታ ሴት ☐ ወንድ ☐
- ስራ፡---------------------------
- ምን ያህል ልጆች አሉዎት፡--------------------
- የትዳር ሁኔታ፡ ያገባች☐ የተፋቱ ☐ የተለያየ ☐ ያላገባች☐
- የመጨረሻ ልጅዎ ስንት አመቱ ነው?----------------------------
- የመጀመሪያ ልጅዎ ስንት ዓመቱ ነው? ---------------------
- በቀበሌው ውስጥ ለምን ያህል ዓመት ቆይተዋል?----------------------------

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የእናቶችን ጤና በሚመለከት

1. የመጨረሻ ልጅዎን የተገላገሉት የት ነው? ቤትዎ ☐ ጤና ጣቢያ ☐
   ሆስፒታል ☐
   መልስዎ እቤት ከሆነ ለምን?---
2. ከወሊድ በፊት የቅድመ ወሊድ አገልግሎት አግኝተዋል? አዎ ☐ የለም ☐
   ካገኙ ምን--
   ----
3. ከወሊድ በኃላ የድህረ ወሊድ አገልግሎት አግኝተዋል? አዎ ☐ የለም ☐
   ካገኙ ምን--
4. በቤትዎ የግል መጸዳጃ ቤት አለ ?አዎ ☐ የለም ☐
5. ካለ ከመቼ ጀምሮ---
6. የቤተሰብ ምጣኔ አገልግሎት ተጠቃሚ ነዎት? አዎ ☐ አይደለሁም ☐
7. የቤተሰብ ምጣኔ አግልግሎት የሚጠቀሙት ለምንድን ነው?-------------------------
8. ከመውለድዎ በፊት የኤች አይቪ ምርመራ አድርገው ነበር? አዎ ☐ የለም ☐
9. በአካባቢው ባለፈው አንድ ዓመት ውስጥ እናቶች በአብዛኛው የሚታመሙት በሽታ ምንድን ነው?---
   ----

የህፃናትን ጤና በሚመለከት

1. ልጅዎ ክትባት ተከትቧል? አዎ ☐ አልተከተበም ☐
2. ልጅዎ የክትባት ዓይነቶችን ተከትቦ አጠናቋል? አዎ ☐ አላጠናቀቀም ☐
3. የመጨረሻ ልጅዎን ሲዎልዱ እገዛ ያደረገለዎት? ልምድ አዋላጅ ☐ ሃኪም ☐
   ቤተሰብ ☐
4. ባለፈው አንድ ዓመት ከአምስት ዓመት በታች ያሉ ልጆችዎን አሞብዎት ያውቃል ?
   አዎ ☐ አያውቅም ☐
5. ልጅዎን በቀን ለምን ያህል ጊዜ ይመግባሉ?--------------------------------
6. ከአምስት አመት በታች ያለ ልጅዎ ከተዎለደ/ች በኃላ ለባለፈው አንድ ዓመት ለምን ያህል ጊዜ ጤና ጣቢያ/ጤና ኬላ ሂዳለች/ሂዷል? ከሁለት ጊዜ በታች ☐ ከ2-4 ጊዜ ☐

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5-8 ጊዜ ☐ 9ና ከዚያ በላይ ☐

ከሄደ ለምን?--

፯. አንድ ህፃን በተወለደ በስንተኛ ጊዜው ክትባት መጨረስ እንዳለበት ያውቃሉ?-----------

፰. በልጆችዎ እድሜ መካከል ማለትም በመጨረሻ ልጅዎ እና ከሱ በላይ ባለው ልጅ መካከል ያለው የእድሜ ልዩነት ምን ያህል ነው?-------------------

፱. ህፃናት ተጨማሪ ምግብ መጀመር ያለባቸው በስንት ወራቸው ነው? በ8 ወር ☐ በ12 ወር ☐ በ6 ወር ☐ በ18 ወር ☐

፲. ስለ ልጆች አመጋግብ ትምህርት/ስልጠና አግኝተው ያውቃሉ? አዎ ☐ የለም ☐

ከወሰዱ በማን?---

11. ልጅዎ ምን ምን ክትባት ተከትቧል?--

1፪. ህፃናት ለስንት ወር የእናቶችን ጡት ብቻ መጥባት አለባቸው? ለ8 ወር ☐ ለ12 ወር ☐ ለ6 ወር ☐ ለ18 ወር ☐

13. ልጅዎ እንዳይታመምበዎት ምን ጥንቃቄ ያደርጋሉ?---

----

14. በአካባቢው ባለፈው አንድ ዓመት ውስጥ ህፃናት በአብዛኛው የሚታመሙት በሽታ ምንድን ነው?--

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አመሰግናለሁ

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የጹሁፍ መጠይቅ

ዓላማ፡ ለሁለተኛ ዲግሪ ማሟያ ለሚሰራ ጥናት መረጃ ለመሰብሰብ የተዘጋጀ ሲሆን የጥናቱ ውጤት ለትምህርታዊ ዓላማ ብቻ ይውላል፡፡ በመሆኑም ትክክለኛ መረጃ ነው የሚሉትን መልስ በጥያቄው መሰረት ይመልሱ፡፡ የሚሰጡት መልስ ሚስጥራዊነቱ የተጠበቀ ነው፡፡

ስም መፃፍ አያስፈልግም፡፡ በቅድሚያ ስለሚደረግልኝ ትብብር አመሰግናለሁ፡፡

ለጤና የልማት ሰራዊት

አጠቃላይ መረጃ

- የመረጃ ሰብሳቢ ስም------------------------------------
- መረጃው የተሰበሰበበት ቀን-----------------------------------
- መረጃው የተሰበሰበበት ቀበሌ---------------------------------

የተጠያቂ መረጃ

- እድሜ፡ ከ15 ዓመት በታች ☐ ከ15-24☐ 25-35 ☐36-49 ☐ ከ49 ዓመት በላይ ☐
- የትምህርት ደረጃ፡ ማንበብ መፃፍ የማይችል☐ ማንበብ መፃፍ የሚችል☐
  ከ1-4ኛ☐ ከ5-8ኛ☐ ከ9-10ኛ☐ ከ11-12ኛ☐
  ዲፕሎማ ከዚያ በላይ ☐
- ጾታ፡ ሴት ☐ ወንድ ☐
- ስራ፡-----------------------
- ምን ያህል ልጆች አሉዎት?----------------------
- አሁን በትዳር ላይ ነዎት?--------------------------
- የጤና ልማት ሰራዊት ሆነው የተመረጡት መቼ ነው? ----------------------

የእናቶችን ጤና በሚመለከት

1. የእናቶች ጤናን በሚመለከት ስልጠና ወስደው ያውቃሉ? አዎ ☐ አላውቅም ☐
2. በአካባቢያችሁ እናቶች በአብዛኛው የሚወልዱት የት ነው? በቤት ☐ ጤና ተቋም☐

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3. መልስዎ ቤት ከሆነ ከወለዱ በኃላ ወደ ጤና ጣቢያ ይሄዳሉ?--------------------
4. እርስዎ በሚኖሩበት ቀበሌ ከውርጃ/ከወሊድ ጋር በተያያዘ በአለፈው 1 ዓመት የእናቶች ሞት አጋጥሞት ያውቃል?አዎ ☐ የለም ☐
5. መልስዎ አዎ ከሆነ ስንት እናት ☐
6. እርስዎ ስንት እናቶችን ይከታተላሉ☐
7. እርስዎ ከሚከተተሏቸው እናቶች ምን ያህሉ የወሊድ መከላከያ ይጠቀማሉ? --------
8. እርስዎ ከሚከታተሉዋቸው እናቶች ነፍሰጡር በነበሩበት ወቅት ምን ያህሉ የኤች አይቪ ምርመራ አድርገው ነበር?---------------------
9. እርስዎ ከሚከታተሉዋቸው እናቶች ድህረወሊድ ክትትል የሚያደርጉ እናቶች አሉ? አዎ ☐ የለም ☐ አለ ካሉ ምን ያህል-------------------
10. እርስዎ ከሚከታተሉዋቸው እናቶች ቅድመ ወሊድ ክትትል የሚያደርጉ እናቶች አሉ?☐ዎ ☐ም አለ ካሉ ምን ያህል-------------------
11. እርስዎ በሚኖሩበት አካባቢ ባለፈው አንድ ዓመት በቤት ውስጥ የወለደች እናት አለች? አዎ ☐ የለም ☐ ካለ ምን ያህል----------------------
12. የእናቶችን ጤና በተመለከተ የምትሰሩት ስራ ምን ምን ነው?---------------------------
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13. እነዚህን ስራዎች ስትሰሩ ምን ምን ችግር ያጋጥማችኋል?-----------------------------
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የህፃናትን ጤና በሚመለከት

1. የህፃናትን ጤናን በሚመለከት ስልጠና ወስደው ያውቃሉ? አዎ ☐አላውቅም ☐
2. ባለፈው አንድ ዓመት እርስዎ በሚኖሩበት ቀበሌ ከአንድ ዓመት በታች የሆኑ ህፃናት ሞት ተከስቷል? አወ ☐ የለም ☐
3. ህፃናትን በሚመለከት የምትሰሩት ስራ ምንድን ነው?------------------------------
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4. እነዚህን ስራዎች ስትሰሩ ምን ምን ችግር ያጋጥማችኂል?--------------------------
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ተጨማሪ

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1. የእናቶችንና የህፃናትን ጤና በሚመለከት ለምትሰሩት ስራ ተጠሪነታችሁ ለማን ነው?---
2. በምትሰሩት ስራ ዙርያ ከባለሙያ ምን ክትትልና እገዛ ይደረግላችኋል?--------

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3. የምትሰሩትን ስራ በምን ያህል ጊዜ ሪፖርት ታደርጋላችሁ?---------------------

አመሰግናለሁ

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የጹህፍ መጠይቅ

ዓላማ፡ ለሁለተኛ ዲግሪ ማሟያ ለሚሰራ ጥናት መረጃ ለመሰብሰብ የተዘጋጀ ሲሆን የጥናቱ ውጤት ለትምህርታዊ ዓላማ ብቻ ይውላል። በመሆኑም ትክክለኛ መረጃ ነው የሚሉትን መልስ በጥያቄው መሰረት ይመልሱ። የሚሰጡት መልስ ሚስጥራዊነቱ የተጠበቀ ነው።

ስም መፃፍ አያስፈልግም። በቅድሚያ ስለሚደረግልኝ ትብብር አመሰግናለሁ።

ለኤክስቴንሽ ጤና ባለሙያ

አጠቃላይ መረጃ

- የመረጃ ሰብሳቢ ስም-------------------------------------
- መረጃው የተሰበሰበበት ቀን----------------------------------
- መረጃው የተሰበሰብበት ቀበሌ---------------------------------

የተጠያቂ መረጃ

- እድሜ፡ ከ15 ዓመት በታች ☐ ከ15-24 ☐ 25-35 ☐ 36-49 ☐ ከ49 ዓመት በላይ ☐
- የትምህርት ደረጃ፡ 10+1 ☐ 10+2 ☐ 10+3 ☐ ዲፕሎማ ☐
  የመጀመሪያ ዲግሪ ☐ ሁለተኛ ዲግሪ ☐
- ጾታ ሴት ☐ ወንድ ☐
- የስራ ልምድ ጠቅላላ--------------------
- አሁን ባሉበት ሙያ ያለዎት የስራ ልምድ-------------------
- በቀበሌው የጤና ባለሙያ ሁነው የተመደቡት ከመቼ ጀምሮ ነው?-------------------

የእናቶችን ጤና በሚመለከት

1. ለእናቶች ስለህፃናት አመጋገብ ስልጠና ይሰጣል? አዎ ☐ የለም ☐
2. እናቶች የጤና አገልግሎቱን ማግኘት የሚፈልጉት የትነው በቤት ☐ በማዕከል ☐
   ለምን ይመስለዎታል ---
3. የጤና ኤክስቴንሽን ፕሮግራሙ ከተተገበረ በኃላ በእናቶች ጤና ዙርያ የታዩ ለውጦች ካሉ ቢዘረዘሩ
   3.1. የህፃናትን ጡት ማጥባት በተመለከተ---

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3.2. የቤተሰብ እቅድ ተጠቃሚነትን በተመለከተ-----------------------------------

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3.3. የእናቶች ሞትን ከመቀነስ አኳያ---

3.4. የእናቶች የክትባት ተጠቃሚነት በተመለከተ------------------------------------

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3.5. የቅድመ ወሊድ ክትትልን በተመለከተ--

3.6. የድህረ ወሊድ ክትትልን በተመለከተ--

3.7. እናቶች በሚወልድበት ወቅት የጤና ባለሙያን ከመፈለግ አኳያ-----------

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4. በቀበሌው ውስጥ የእናቶች ጤናን ለማሻሻል የሚሰሩ ስራዎች አሉ---------------------
   ካሉ ምን ምን ናቸው--

   ----

5. በወሊድ ወቅት የሚያጋጠሙ ዋና ዋና ችግሮች ምን ምን ናቸው?----------------------

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6. ከጤና ኬላ ውጭ የሚወልዱ እናቶች ቢኖሩ እንዴት ማወቅ ይቻላል?-------------------
   ከታወቀስ በኃላ ምን ድጋፍ ይደረጋል?---

7. የእናቶችን ጤና ለማሻሻል ሲሰራ ያጋጠሙ ችግሮቸ ካሉ ቢዘረዘሩ------------------------

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8. በእናቶች ጤና የምዕት አመቱን የልማት እቅድ ለማሳካት በቀበሌ ምን መደረግ አለበት
   ብለው ያስባሉ? --

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የህፃናትን ጤና በሚመለከት

1. በቀበሌው ውስጥ የህፃናት ጤናን ለማሻሻል የሚሰሩ ስራዎች አሉ--------------------
   ካሉ ምን ምን ናቸው---

   ----
2. የጤና ኤክስቴንሽን ፕሮግራሙ ከተተገበረ በኃላ በህፃናት ጤና ዙርያ የታዩ ለውጦች ካሉ ቢዘረዘሩ ለምሳሌ፡

2.1. የህፃናትን ክትባት በተመለከተ--

2.2. የህፃናትን አመጋግብ በተመለከተ---

2.3. የህፃናትን ጡት ማጥባት በተመለከተ--

2.4. ከአንድ ዓመት በታች የህጻናትን ሞት በተመለከተ----------------------------------
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2.5. ከአምስት በታች ዓመት የህጻናትን ሞት በተመለከተ-------------------------------
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3. የህጻናት ጤና ለማሻሻል ሲሰራ ያጋጠሙ ችግሮች ካሉ ቢዘረዘሩ---------------------
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4. በህጻናት ጤና የምዕት አመቱን የልማት እቅድ ለማሳካት በቀበሌ ምን መደረግ አለበት ብለው ያስባሉ? ---
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ተጨማሪ

1. ስራዎችን በአግባቡ መስራት ይቻል ዘንድ ለጤና ኤክስቴንሽን ባለሙያዎች ምን ድጋፍ መደረግ አለበት ብለው ይስባሉ? ለምሳሌ
   በስልጠና--
   ድጋፍ በማግኘት--
   ክትትልና እገዛ በመስጠት--
   ----
2. በቀበሌው የህፃናትና እናቶችን የሚመለከቱ ስራዎች ሲሰሩ እነማን ይሳተፋሉ? ለምሳሌ
   በእቅድ---

   በትግበራ--

   በክትትል ወቅት--

   በግምገማ---
   ----
3. ጤና ጣቢያው ለጤና ኬላው የሚሰጠው እገዛ፡

2.1. በቁሳቁስ---

2.2. ሙያዊ እገዛ---

2.3. በገንዘብ---

2.4. የስራ ላይ ስልጠና በመስጠት---

አመሰግናለሁ

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የጽሁፍ መጠይቅ

ዓላማ፡ ለሁለተኛ ዲግሪ ማሟያ ለሚሰራ ጥናት መረጃ ለመሰብሰብ የተዘጋጀ ሲሆን የጥናቱ ውጤት ለትምህርታዊ ዓላማ ብቻ ይውላል፡፡ በመሆኑም ትክክለኛ መረጃ ነው የሚሉትን መልስ በጥያቄው መሰረት ይመልሱ፡፡ የሚሰጡት መልስ ሚስጥራዊነቱ የተጠበቀ ነው፡፡

ስም መፃፍ አያስፈልግም፡፡ በቅድሚያ ስለሚደረግልኝ ትብብር አመሰግናለሁ፡፡

ለጤና ኤክስቴንሽን ሱበርቫይዘር

አጠቃላይ መረጃ

- የመረጃ ሰብሳቢ ስም-----------------------------------
- መረጃው የተሰበሰበበት ቀን-----------------------------------
- መረጃው የተሰበሰበበት ቀበሌ--------------------------------

የተጠያቂ መረጃ

- እድሜ፡ ከ15 ዓመት በታች☐ ከ15-24☐ 25-35☐ 36-49☐ ከ49 ዓመት በላይ ☐
- የትምህርት ደረጃ፡ 10+1 ☐ 10+2 ☐ 10+3 ☐ ዲፕሎማ ☐

  የመጀመሪያ ዲግሪ ☐ ሁለተኛ ዲግሪ ☐
- ጾታ፡ ሴት ☐ ወንድ ☐
- የስራ መደብ፡------------------
- የስራ ልምድ ጠቅላላ፡----------------------
- አሁን ባሉበት ሙያ ያለዎት የስራ ልምድ፡----------------

የእናቶችን ጤና በሚመለከት

1. የጤና ኤክስቴንሽን ፕሮግራሙ ከተተገበረ በኃላ በእናቶቸ ጤና ዙርያ የታዩ ለውጦች ካሉ ቢዘረዝሩ

1.1. የህፃናትን ጡት ማጥባት በተመለከተ---

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1.2. የቤተሰብ እቅድ ተጠቃሚነትን በተመለከተ--

1.3. የእናቶች ሞትን ከመቀነስ አኳያ--

1.4. የእናቶች የክትባት ተጠቃሚነት በተመለከተ--

1.5. የቅድመ ወሊድ ክትትልን በተመለከተ--

1.6. የድህረ ወሊድ ክትትልን በተመለከተ--

1.7. እናቶች በሚወልድበት ወቅት የጤና ባለሙያን ከመፈለግ አኳያ-----------------------------
----

2. የእናቶች ጤና ለማሻሻል በዋናነት የሚያጋጥሙ ችግሮች ምን ምን ናቸው?------------------
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3. የእናቶች ጤና በማሻሻል የምዕት ዓመቱን ግብ ለማሳካት በዋናነት ምን መደረግ አለበት ብለው ያስባሉ?---
----

የህፃናትን ጤና በሚመለከት

1. የጤና ኤክስቴንሽን ፕሮግራሙ ከተተገበረ በኃላ በህፃናት ጤና ዙርያ የታዩ ለውጦች ካሉ ቢዘረዘሩ

1.1. የህፃናትን ክትባት በተመለከተ---

1.2. የህፃናትን አመጋገብ በተመለከተ--

1.3. የህፃናትን ጡት ማጥባት በተመለከተ--

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1.4. ከአንድ ዓመት በታች የህጻናትን ሞት በተመለከተ---

1.5. ከአምስት በታች ዓመት የህጻናትን ሞት በተመለከተ---

----

2. የህፃናት ጤና ለማሻሻል በዋናነት የሚያጋጥሙ ችግሮች ምን ምን ናቸው?-------------------

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3. የህፃናት ጤና በማሻሻል የምዕት ዓመቱን ግብ ለማሳካት በዋናነት ምን መደረግ አለበት ብለው ያስባሉ---

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ተጨማሪ

1. የጤና ኤክስቴንሽን ፕሮግራሙን ለማስፈጸም ምን ምን አደረጃጅቶች ተዘርግተዋል?---------

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2. የጤና ኤክስቴንሽን ፓኬጁን ከማስፈጸም አኳያ ለጤና ኤክስቴንሽ ሰራተኞች የሚሰጥ ድጋፍ አለ? አዎ ☐ የለም ☐ መልስዎ አዎ ከሆነ

2.1. ድጋፍ ከመስጠት አኳያ---

2.2. ሱፐርቫይዝ ከማድረግ አኳያ---

2.3. . የስራ ላይ ስልጠና ከመስጠት አኳያ---

3. የቀበሌ ጤና ኤክስቴንሽ ስራዎች ለመስራት እነማን ይሳረፋሉ? ለምሳሌ

3.1. በማቀድ---

3.2. በመተግበር---

3.3. በመከታተልና በመገምገም--

4. በግምገማ/በክትትል የሚለዩ ችግሮችን ለመፍታት ምን እርምጃ ይወሰዳል?-------------------

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አመሰግናለሁ

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የጽሁፍ መጠይቅ

ዓላማ፡ ለሁለተኛ ዲግሪ ማሟያ ለሚሰራ ጥናት መረጃ ለመሰብሰብ የተዘጋጀ ሲሆን የጥናቱ ውጤት ለትምህርታዊ ዓላማ ብቻ ይውላል፡፡ በመሆኑም ትክክለኛ መረጃ ነው የሚሉትን መልስ በጥያቄው መሰረት ይመልሱ፡፡ የሚሰጡት መልስ ሚስጥራዊነቱ የተጠበቀ ነው፡፡

ስም መፃፍ አያስፈልግም፡፡ በቅድሚያ ስለሚደረግልኝ ትብብር አመሰግናለሁ፡፡

ለጤና ባለሙያ

አጠቃላይ መረጃ

- የመረጃ ሰብሳቢ ስም-----------------------------------
- መረጃው የተሰበሰበበት ቀን-----------------------------------
- መረጃው የተሰበሰበበት ቀበሌ---------------------------------

የተጠያቂ መረጃ

- እድሜ፡ ከ15-24 ☐ 25-35 ☐ 36-49 ☐ ከ49 ዓመት በላይ ☐
- የትምህርት ደረጃ፡ 10+1 ☐ 10+2 ☐ 10+3 ☐ ዲፕሎማ ☐
  የመጀመሪያ ዲግሪ ☐ ሁለተኛ ዲግሪ ☐
- ጾታ፡ ሴት ☐ ወንድ ☐
- የስራ መደብ፡------------------
- የስራ ልምድ ጠቅላላ፡----------------------
- አሁን ባሉበት ሙያ ያለዎት የስራ ልምድ፡----------------

የእናቶችን ጤና በሚመለከት

1. ዋና ዋና የእናቶች ገዳይ በሽታዎች መንስዔ ምንድን ነው?-----------------------------------
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2. በወሊድ ወቅት የሚያጋጠሙ ዋና ዋና ችግሮች ምን ምን ናቸው?------------------------

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3. ከጤና ጣቢያ ውጭ የሚወልዱ እናቶች ቢኖሩ እንዴት ማወቅ ይቻላል? -----------------

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ከታወቁስ ምን ድጋፍ ይደረጋል--

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4. የእናቶች ጤና ለማሻሻል በዋናነት የሚያጋጥሙ ችግሮች ምን ምን ናቸው?---------------

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5. የእናቶች ጤና በማሻሻል የምዕት ዓመቱን ግብ ለማሳካት በዋናነት ምን መደረግ አለበት ብለው ያስባሉ?--

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የህፃናትን ጤና በሚመለከት

1. ዋና ዋና የህፃናት ገዳይ በሽታዎች መንስዔ ምንድን ነው? ------------------------------------

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2. የህፃናት ጤና ለማሻሻል በዋናነት የሚያጋጥሙ ችግሮች ምን ምን ናቸው?-------------------

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3. የህፃናትን ጤና በማሻሻል የምዕት ዓመቱን ግብ ለማሳካት በዋናነት ምን መደረግ አለበት ብለው ያስባሉ?--

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ተጨማሪ

1. የጤና ኤክስቴንሽን ፕሮግራሙን ከዚህ በተሻለ ውጤታማ ለማድግ ምን መደረግ አለበት ብለው ያስባሉ---
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2. የጤና ኤክስቴንሽን አፈጻጸም ሲገመገም እንማን ይሳተፋሉ-----------------------------------
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   2.1. በግምገማው የተለዩ መልካም አፈጻጸሞችን ወደ ሌላ ቦታ ለማስፋት ምን ጥረት ይደረጋል---
   ----
   2.2. በግምገማው የተለዩ ችግሮችን/እጥረቶችን ለመቅረፍ ምን እርምጃ ይወሰዳል------

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3. **የፕሮግራሙ አፈጻጸም የተሻለ ለማድረግ ከወረዳ የሚሰጥ ድጋፍ ምን ምን ነው**---------
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አመሰግናለሁ

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ቃለ መጠይቅ

ለእናቶች

1. የቤተሰብ ምጣኔ አገልግሎት ተጠቃሚ ነዎት?------------ምንያህል ጊዜ ተጠቅመዋል----
   በመጠቀምዎ ምን ጥቅም አገኙ?---
   ----
2. ልጅዎ ምን ምን ክትባት ተከትቧል?---
   የት ተከተበ? ---
   የክትባት ካርድ አለው?--
3. የጤና ኤክስቴንሽን ባለሙያዎች የእናቶችን ጤና በሚመለከት ምን ድጋፍ
   ያደርጉላችኋል?--
   ----
4. የጤና ኤክስቴንሽን ባለሙያዎች የህፃናትንጤና በሚመለከት ምን ድጋፍ
   ያደርጉላችኋል?--
   ----
5. አሁን ካለው አገልግሎት የተሻለ አገልግሎት ለማግኘት ምን መደረግ አለበት ብለው
   ያስባሉ?---
   ----
6. ሌላ የሚጨምሩት ነገር ካለ---

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ለጤና ልማት ሰራዊት

1. የእናቶችን ጤና ለማሻሻል የምትሰሩት ስራ ምን ምን ነው?----------------------------------
   ----
2. የህፃናት ጤና ለማሻሻል የምትሰሩት ስራ ምን ምን ነው?-----------------------------------
   ----
3. የእናቶችን ጤና በተመለከተ ለመስራት የተሰጠ ስልጠና አለ?-------- ካለ ምን?----------
   ----
4. የህፃናትን ጤና በተመለከተ ለመስራት የተሰጠ ስልጠና አለ?---------ካለ ምን--------------
   ----
5. እርስዎ ከሚከታተሉዋቸው እናቶች ምን ያህሉ የቅድመ ወሊድ አገልግሎት ተጠቃሚ ነበሩ?-------ምን ያህሉ ልጆቻቸውን በሙሉ አስከትበዋል?---------------------------------
6. እርስዎ ከሚከታተሉዋቸው እናቶች ምን ያህሉ የድህረ ወሊድ አገልግሎት ተጠቃሚ ነበሩ?-----------------------
7. የእናቶች ሞት ለመቀነስ ምን መደረግ አለበት ብለው ያስባሉ?-------------------------------
   ----
   ----
8. የህፃናትን ሞት ለመቀነስ ምን መደረግ አለበት ብለው ያስባሉ?------------------------------
   ----
   ----
9. ሌላ የሚጨምሩት ነገር ካለ---

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ለጤና ኤክስቴንሽን ባለሙያዎች

1. ህፃናትን በሚመለከት ቤት ለቤት የምትሰሩት ስራ አለ?------------------------------
   ካለ ምን?---
2. እናቶቸችን በሚመለከት ቤት ለቤት የምትሰሩት ስራ አለ?----------------------------
   ካለ ምን?---
3. የጤና ኤክስቴንሽኑ በቀበሌው መተግበር ከጀመረ በኃላ በህጻናት ጤና ዙርያ የታዩ መሻሻሎች አሉ?---------------- ካሉ ምን ምን ናቸው?------------------------------------
   ----
4. የጤና ኤክስቴንሽኑ በቀበሌው መተግበር ከጀመረ በኃላ በህጻናት ጤና ዙርያ የታዩ መሻሻሎች አሉ--------- ካሉ ምን ምን ናቸው? --
   ----
5. የእናቶችን ጤና ለማሻሻል በቀጣይ ምን መሰራት አለበት?------------------------------
   ----
6. የህፃናትን ጤና ለማሻሻል በቀጣይ ምን መሰራት አለበት?-------------------------------
   ----
7. የእናቶችን ጤና ከማሻሻል አንጻር የአጋር አካላት ሚና በቀጣይ ምን መሆን አለበት?
   - ቤተሰብ---
   - ህብረተሰቡ---
   - የጤና ልማት ሰራዊት---
   - ቀበሌ አስተዳድር---
   - ጤና ጣቢያ ---
   - መያድ--
   - ሌላ---
8. የህፃናትን ጤና ከማሻሻል አንጻር የአጋር አካላት ሚና በቀጣይ ምን መሆን አለበት?
   - ቤተሰብ---
   - ህብረተሰቡ---
   - የጤና ልማት ሰራዊት---
   - ቀበሌ አስተዳድር---

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- ጤና ጣቢያ --
- መያድ--
- ሌላ---

9. ሌላ የሚጨምሩት ነገር ካለ---

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የቡድን ውይይት

ለእናቶች

1. የድህረና ቅድመ ወሊድን በተመለከተ የሚሰጥ ትምህርት ዓለ?----------------------
   በማን--------------------------
   ምን ጥቅም ሰጥቷችኋል?--
2. የህጻናትን ክትባት በተመለከተ የሚሰጥ ትምህርት ዓለ?------------------------------------
   በማን?---
   ምን ጥቅም ሰጥቷችኋል?--
   ----
3. በቀበሌ ደረጃ አገልግሎቱን በፈለገ ጊዜ ማንም ሰው ማግኘት ይችላል?----------------
4. እናቶች የተሻለ የጤና አገልገግሎት ማግኘት ምን መደረግ አለበት?-------------------------
   ----
5. ህጻናት የተሻለ የጤና አገልገግሎት ማግኘት ምን መደረግ አለበት?-------------------------
   ----
6. የወሊድ መከላከያ መጠቀም ምን ጥቅም አለው?-------------------------------
7. በአርግዝና ወቅት የኤች አይቪ ምርመራ ያደረገ አለ?-------------------------- ለምን ያስፈልጋል?---

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ለጤና ልማት ሰራዊት

1. የእናቶችንና የህጻናትን ጤና ማሻሻልን በተመለከተ ውይይት ታደርጋላችሁ?-------------
   ከሆነ ከማን ጋር---
   ምን ምን ጉዳዮች ይነሳሉ---
   በችግርነት የተነሱ ጉዳዬች አሉ--
   ምን መፍትሄ ተቀመጠላቸው--

   ----
2. ስራችሁን ስትሰሩ ያጋጠሟችሁ ችግሮች---

   ----
3. ስራችሁን በተሻ መልኩ ለመስራት ምን ድጋፍ ሊደረግላችሁ ይገባል ትላላችሁ------------

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ከዶክመንት/ስታቲስቲክስ የሚሰበሰብ

በቀበሌ ደረጃ

1. በ2005 የበጀት ዓም በጤና ኬላው የተገላገሉ እናቶች ብዛት ምን ያህል ነው?-----
   ----
2. በቀበሌ ደረጃ የህፃናት የክትባት ሽፋን ስንት ደርሷል?--------------------------------
3. በቀበሌ ደረጃ ዋና ዋና የህፃናት ሞት ተብለው የሚጠቀሱ በሽታዎች በቅደም ተከተል---
4. በቀበሌው በመውለድ የእድሜ ክልል ውስጥ ያሉ እናቶች ስንት ስንት ናቸው-----
5. በጤና ኬላው ደረጃ ዋና ዋና የእናቶች ሞት ተብለው የሚጠቀሱ በሽታዎች በቅደም ተከተል---
6. በ2005 የበጀት ዓም በቀበሌ ደረጃ የቅድመ ወሊድ ክትትል ያደረጉ እናቶች ብዛት ምን ያህል ናቸው?---
7. በ2005 የበጀት ዓም በቀበሌ ደረጃ የድህረ ወሊድ ክትትል ያደረጉ እናቶች ብዛት ምን ያህል ናቸው?--
8. በቀበሌው ውስጥ ምን ያህል እናቶች የወሊድ መከላከያ ተጠቃሚ ናቸው?---------
9. በቀበሌው ውስጥ በ2005 የበጀት ዓም ምን ያህል ነፍሰጡር እናቶች የኤች አይቪ ምርመራ አድርገዋል ?--
10. ባለፈው አንድ ዓመት በቀበሌ ደረጃ በወሊድ ምክንያት የሞቱ እናቶች አሉ?-------
11. ባለፈው አንድ ዓመት እድሚያቸው ከአምስት ዓመት በታች የሆኑ ህፃናት ሞት መረጃ በቀበሌ ደረጃ አለ? አዎ ☐ የሉም ☐ ካሉ ቁጥራቸው ☐
12. የቀበሌው ጠቅላላ የህዝብ ብዛት ምን ያህል ነው-----------------------------------
13. ከአምስት አመት በታች ህፃናት ያሏቸው እናቶች ስንት ናቸው----------------------
14. ከሁለት አመት በታች ህፃናት ያሏቸው እናቶች ስንት ናቸው----------------------
15. በቀበሌው ስንት የጤና የልማት ሰራዊት አለ--
16. በቀበሌው የጤና ኬላ አገልግሎት መስጠት የጀመረው መቼ ነው-------------------
17. በቀበሌው የጤና ኤክስቴንሽን አገልግሎት መስጠት የተጀመረው መቼ ነው--------

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ጤና ጣቢያ

1. በ 2005 የበጀት ዓመተ በጤና ጣቢያው የተገላገሉ እናቶች ብዛት ምን ያህል ነው? 235
2. በጤና ጣቢያ ደረጃ የህፃናት የክትባት ሽፋን ስንት ደርሷል? 88.5
3. በጤና ጣቢያ ደረጃ ዋና ዋና የህፃናት ሞት ተብለው የሚጠቀሱ በሽታዎች በቅደም ተከተል
   - 3.1. Acute upper respiratory track infection
   - 3.2. Diaharia
   - 3.3. pneumonia
   - 3.4. Acute fibril illness
   - 3.5. Eye disease
   - 3.6. Trauma
   - 3.7. Helmentasis
   - 3.8. disease of musculoskeletal
   - 3.9. Acute malnutrition
   - 3.10. Skin infection
4. በጤና ጣቢያው ስር ካሉ ቀበሌዎች በመውለድ የእድሜ ክልል ውስጥ ያሉ እናቶች ስንት ስንት ናቸው

Keyit health center cachement population profile

No.	Description	Conversion factor	Number	Remark
1	Total population	-	27465	
2	Male	49	13458	
3	Female	51	14007	
4	Total housed hold	4.3	6387	
5	Women at reproductive age	23.61	6482	
6	Non pregnant women	20.36	5575	
7	Expected pregnancy	3.21	879	
8	Expected delivery	2.94	807	

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9	Live birth	2.94	807	
10	Survining infants	2.77	761	
11	Total under five children	5.05	1387	
	Total	100	3708	

5. በጤና ጣቢያ ደረጃ ዋና ዋና የእናቶች ሞት ተብለው የሚጠቀሱ በሽታዎች በቅደም ተከተል homology , sepscise, unsafe abortion, prolonged delivery/obstructed
6. ከመስከረም 1 2005 ዓ.ም ጀምሮ በጤና ጣቢያ ደረጃ የቅድመ ወሊድ ክትትል ያደረጉ እናቶች ብዛት ምን ያህል ናቸው?707
7. ከመስከረም 1 2005 ዓ.ም ጀምሮ በጤና ጣቢያ ደረጃ የቅድመ ወሊድ ክትትል ያደረጉ እናቶች ብዛት ምን ያህል ናቸው? 451
8. በጤና ጣቢያ ደረጃ ከመስከረም 1 2005 ዓ.ም ጀምሮ ምን ያህል ነፍሰጡር እናቶች የኤች አይቪ ምርመራ አድርገዋል? 707 +8
9. በጤና ጣቢያ ደረጃ ምን ያህል እናቶች የወሊድ መከላከያ ተጠቃሚ ናቸው? የረጅም ጊዜ 1641 የአጭር ጊዜ 2900 ጠቅላላ4541
10. ባለፈው አንድ ዓመት እድሚያቸው ከአምስት ዓመት በታች የሆኑ ህፃናት ሞት መረጃ በጤና ጣቢያ ደረጃ አለ? አዎ ካሉ ቁጥራቸው 2
11. ባለፈው አንድ ዓመት በጤና ጣቢያ ደረጃ በወሊድ ምክንያት የሞቱ እናቶች አሉ? አዎ ካሉ ቁጥራቸው 1

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