



Research-inspired Policy and Practice Learning in Ethiopia and the Nile Region

Promoting Sanitation and Hygiene to rural households in the Southern Nations, Nationalities and Peoples Region, Ethiopia.

Experiences of Health Extension Workers and Community Health Promoters

Seleshi Behailu, Hawassa University
Getachew Redaie, Hawassa University
Dereje Mamo, Bureau of Health, SNNPR
Desta Dimtse, RiPPLE Programme Regional Coordinator

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RiPPLE Office, c/o WaterAid Ethiopia, Kirkos Sub-city, Kebele 04, House no 620, Debrezeit Road, PO Box 4812, Addis Ababa, Ethiopia

Acknowledgements and disclaimer

This is the report of the research study carried out in 2009 on experiences of health extension workers (HEWs) and community health promoters (CHPs) in the Southern region of Ethiopia (SNNPR), in two districts ('woreda') - Halaba Special Woreda and Mirab Abaya Woreda - in relation to promotion of sanitation and hygiene in rural communities.

Aspects of S & H - including excreta disposal (construction and use of latrines), personal hygiene (hand washing at critical times) and water handling (e.g. safe storage of water in the household) - are promoted as part of the Health Extension Programme (HEP) of the Ministry of Health, amongst its different elements. The aim is to bring about changes in behaviour of communities and households in relation to their sanitation and hygiene practices.

The project of which the study forms part was initiated by the regional Health Bureau and the RiPPLE Programme, with the participation of the Woreda Health Offices. The research has taken place thanks to the contributions of:-

- **Dereje Mamo** of the Bureau of Health (M.Sc in Health Monitoring and Evaluation) and **Desta Dimtse**, RiPPLE Programme Regional Coordinator in SNNPR (M.Sc in Natural Resources Management);
- **Sileshi Behailu**, Master in Public Health, lecturer at the College of Medicine and Health Sciences at Hawassa University and **Getachew Redaie**, M.Sc in Environmental Science, also lecturer at the same College at Hawassa University;
- **Peter Newborne** of the Overseas Development Institute-ODI who provided support and guidance during the earlier phases of the project (from project design, including definition of research questions), through to the reporting stage, and including attendance at the Workshop.

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The findings from the study in the two woredas were discussed at a Workshop held in Hawassa, SNNPR, on March 10th, 2010 which was convened by the RiPPLE Programme on behalf of the research team. The Workshop brought together a selected group of HEWs and CHPs to discuss the findings of the study in the two woredas - and to assist in the drawing out of practical lessons from the study. A representative of the Regional Health Bureau and Woreda Health Offices from the two woredas attended the Workshop.

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List of Acronyms

| | |
|-------------|---|
| AWD | Acute Watery Diarrhoea |
| Cell | Sub-Kebele level structures of government encompassing 20 households |
| CLTS | Community-Led Total Sanitation |
| CHP(s) | Community Health Promoter(s) |
| CKI(s) | Community Key Informant(s) |
| DA | Development Agent |
| DFID | Department for International Development of the UK Government |
| FGD(s) | Focus Group Discussion(s)/Discussants |
| Halaba | A special Woreda in SNNPR, one of the study districts |
| HEP | Health Extension Package or Health Extension Programme |
| HEW(s) | Health Extension Worker(s) |
| HH(s) | Household(s) |
| HWF | Hand Washing Facilities |
| Idir | A social organisation by community supporting each other |
| Kebele | Lowest level of government administrative structure (sub-district) |
| KI(s) | Key Informant(s) |
| MDGs | Millennium Development Goals |
| Mirab Abaya | A Woreda in Gamo Gofa Zone of SNNPR, one of the research districts |
| NGOs | Non-governmental organisations |
| S & H | Sanitation and Hygiene |
| SNNPR | Southern Nations Nationalities and Peoples Region, one of the regions of Ethiopia |
| WaSH | Water, Sanitation and Hygiene |
| WHO | Woreda Health Office |
| Zone | Government administrative structure between Region and Woreda to which the Regional council delegates coordination and administration responsibilities over Woredas |

Executive Summary

This research study confirms that health extension workers (HEWs) and community health promoters (CHPs) in the Southern Region (SNNPR) of Ethiopia are going about their work of informing households on improved sanitation and hygiene practices and are succeeding in persuading many households to change their behaviour. The system of health extension is working and making a contribution to improvement of life in rural communities. Key informants in the communities value the work of the HEWs and CHPs.

This does not mean that attaining improvements in sanitation and hygiene practice is simple and straightforward. Commentators, in Ethiopia and internationally, recognise that bringing about behaviour change in relation to sanitation and hygiene is not a 'one-off' activity - promotional agents need to provide follow up, with repeated visits to households, until the desired behaviour changes.

This study suggests that there are many lessons to be learned from the experience in the two study woredas in SNNPR, as well as a number of resource and capacity constraints which HEWs and CHPs currently face - which need to be addressed.

Examples of resourcing innovations which the HEWs/CHPs and key informants in the communities believe would produce tangible benefits in sanitation and hygiene promotion are as follows: construction of health posts in the kebeles which currently lack this facility; more IEC (information, education and communication) materials at health posts and for work with households/communities; provision to HEWs and CHPs of bicycles, in response to transportation problems; accommodation for HEWs constructed in or very close to the compound of the health post, to reduce their travel to and from the kebele.

Applying these lessons and removing the constraints would enable HEWs and CHPs to work at their full potential, resulting in a boost to progress in promotion of sanitation and hygiene.

Alongside the work of HEWs and CHPs, sustainable behaviour change arises out of the active collaboration of influential actors in the kebele and the community. The HEWs and CHPs interviewed are applying the support of religious leaders, school directors, idir leaders, respected elderly community members and development agents, in both promotion of sanitation and hygiene messages and action (including model households), and enforcement of better practice. Meanwhile, the degree of coordination with NGOs and other stakeholders in the region could usefully be strengthened, to assist HHs in moving up the sanitation ladder.

A system of rewards for good performance of HEWs and CHPs has not yet been established in either woredas. Lack of incentives has pushed some CHPs to resign. CHPs are volunteers who are committed people, approaching their tasks generally with dedication. An incentive mechanism to ensure that the motivation of CHPs is maintained, to help retain them in their roles, should be established as soon as possible. Both HEWs and CHPs express themselves as willing to learn lessons, in order to improve their own performance in promotion of sanitation and hygiene. The Bureau of Health could usefully review the measures for capacity-building of HEWs and CHPs and plan for more training.

The experience of the HEWs and CHPs in SNNPR constitutes an instructive example of the achievements and challenges of promotion, in rural communities, of sanitation and hygiene as part of the Ministry of Health's Health Extension Programme-HEP.

I Hypothesis, Research Objectives and Questions

I.1 Research subject

Exploring the experience of Health Extension Workers (HEWs) and Community Health Promoters (CHPs) as promoters of behaviour change in relation to sanitation and hygiene in the Southern Region of Ethiopia-SNNPR.

I.2 Research hypothesis

That the experience of HEWs and CHPs in SNNPR, as agents of behaviour change in sanitation and hygiene, constitutes a lesson for other promoters of sanitation and hygiene in Ethiopia.

I.3 Operational definitions

For the purpose of this study, sanitation and hygiene is defined by reference to the three elements indicated in the following Table:-

Table I.1: Operational definition of sanitation and hygiene, SNNPR, 2010

| No | Items | Descriptions |
|----|------------|--|
| | Sanitation | Safe collection, storage, treatment and disposal of human excreta (faeces and urine) |
| | Hygiene | Safe hand washing practices Safe water storage (by households) |

The Ministry of Health's **Health Extension Programme** (HEP) comprises many elements of which seven relate to 'Hygiene and Environmental Sanitation': see Box I.1. below. The three items *highlighted in italics* in Box I.1 are the focus of this particular study.

Box I.1: **Elements of health extension programme in Ethiopia, 2009**

| | |
|---|--|
| <p>1. Hygiene and Environmental Sanitation</p> <ul style="list-style-type: none"> • <i>Excreta disposal</i> • Solid and liquid waste disposal • <i>Water quality control</i> • Food hygiene • Proper housing • Arthropods and rodent control • <i>Personal hygiene</i> <p>2. Disease Prevention and Control</p> <ul style="list-style-type: none"> • HIV/AIDS and other sexually transmitted disease prevention & control • TB prevention and control • Malaria prevention and control • First Aid | <p>3. Family Health Service</p> <ul style="list-style-type: none"> • Maternal and child health • Family Planning • Immunisation • Adolescent Reproductive Health • Nutrition <p>4. Health Education and Communication</p> |
|---|--|

1.4 Key Research objectives

- To investigate how HEWs and CHPs are going about their roles of promoting behaviour change in relation to sanitation and hygiene in rural communities
- To produce locally-generated, authoritative, qualitative insights into the experience of HEWs and CHPs in promoting behaviour change
- To consider how the experience of HEWs and CHPs in the study woredas to-date provides pointers as to how the performance of HEWs and CHPs, as agents of behaviour change, may be strengthened in future
- To share the research findings and lessons with other woredas in SNNPR and other regions in Ethiopia.

1.5 Detailed Objectives

- To investigate the ways the HEWs and CHPs are working to stimulate the interest of members of the community towards change of behaviour in sanitation and hygiene (messages and demonstrations to communities, and/or other actions with communities)
- To identify which techniques/approaches HEWs and CHPs use to promote changes in behaviour relating to hand-washing, water storage and latrines (construction, use and cleaning)
- To identify actual/real challenges of CHPs and HEWs in promoting sanitation and hygiene, as well as ways of working which they have evolved as solutions
- To identify constraints which HEWs and CHPs are facing and the needs of CHPs and HEWs which need to be addressed if their roles in the promotion of sanitation and hygiene are to be strengthened in the future.
- To learn from the experiences of the HEWs and CHPs interviewed in the study woredas as lessons for application by HEWs and CHPs in other areas of SNNPR and other regions of Ethiopia.

1.6 Research questions

- How HEWs and CHPs are working to promote changes in behaviour relating to hand-washing, water handling and latrines (construction, use and cleaning)
- To what extent HEWs and CHPs are spending their time in the promotion of sanitation and hygiene and the average frequency of their visits to individual households (HHs)
- What words and messages do HEWs and CHPs use to talk about sanitation and hygiene? For example, are HEWs and CHPs talking about the benefits of health, or other benefits like dignity and privacy? What are the HEWs and CHPs saying to communities to stimulate their interest?
- What things are HEWs and CHPs showing to HHs to persuade them that they should change their old practices/malpractices?

- What other types of interaction with community members are HEWs and CHPs employing?
- How do the HEWs and CHPs try to persuade HHs which show themselves to be reluctant to change their habits, to convince them that behaviour change in relation to sanitation and hygiene is important?
- As alluded above, what are the actual/real challenges which HEWs and CHPs face while promoting sanitation and hygiene in the rural communities of SNPPR?

How does the experience in SNNPR indicate that the performance of HEWs and CHPs, as agents of behaviour change, may be strengthened in future?

2 Context of the study

2.1 Research districts

2.1.1 *Halaba special Woreda*

The town of Halaba special Woreda, Halaba Kulito, is located 90 km south of the capital city of SNNPR, Hawassa. Administratively, the Woreda is organised into 78 Kebeles (sub-districts), of which two are urban and 76 rural. Halaba has a total area of 973.76 km² (which is equivalent to 97,376 hectares) with a total population of 253,038. The dominant ethnic group was Halaba followed by Silte while the dominant religion was Islam (94%) (CSA, 2007).

Halaba is found between 1,554 and 2,149 metres above sea level. The annual mean temperature and rainfall ranges from 17 to 20°C and 857 to 1,085 mm respectively.

Information obtained from Woreda Water Resource Office and Woreda Health office indicated that (according to available official records) safe water supply and sanitation coverage was 50% and 55% respectively. The level of accessibility to health facilities, the percentage of individuals having access to health facilities (not including health posts) was 56 %. In recent years, communities in many parts of Halaba have experienced unavailability/serious limits on access to water, especially during the dry season.

Information obtained from the Halaba special Woreda health office indicated that a total of 138 HEWs and 950 CHPs were working in the Woreda in 2009 (the time of data collection). The total population of 15 kebeles selected by the study is estimated, according to official figures set out in **Table 2.1.**, at 39,256, over 8,075 households, and there are in total 186 CHPs working in those 15 kebeles and 22 HEWs (again as set out in Table 2.1). That represents an average of 211 persons and 43 households for each CHP. In Huleteгна Ashoka kebele, the number of CHPs as compared with the number of households is low (on average 1 CHP for 77 HHs). The range in the other kebeles is between 20 and 56 HHs on average per CHP. According to the standard set by the regional health bureau one CHP serves 20-50 households.

The total number of HEWs who had left their job (for different reasons) was recorded by the woreda health office to be 29, since the deployment of the HEWs in 2009. The total number of health posts and health centers was 41 and 7 respectively. In 2009, in 34 out of the 78 kebeles, there was one HEW in post, the other 44 kebeles had two HEWs.

Table 2.1: Kebeles in HALABA special Woreda, SNNPR, selected for study by this RiPPLE research project, December 2009

| Name of kebele | Number of HHs | Estimated Population | Number of CHPs | Number of HEWs | Distance from Halaba town |
|-------------------|---------------|----------------------|----------------|----------------|---------------------------|
| Gofessa | 574 | 2811 | 11 | 2 | 21 |
| Hayimele | 536 | 2582 | 14 | 1 | 12 |
| Dubesso | 400 | 2000 | 10 | 2 | 18 |
| Andegna Ashoka | 422 | 2022 | 9 | 1 | 10 |
| Huletegn Ashoka | 619 | 2737 | 8 | 1 | 14 |
| Gurura Gucho | 600 | 3000 | 12 | 1 | 17 |
| Rokeneni Tefo | 381 | 1905 | 8 | 1 | 25 |
| Felka | 401 | 2475 | 20 | 1 | 16 |
| Kunche Yeye | 490 | 2450 | 10 | 1 | 20 |
| Huletegn Kunicha | 382 | 1539 | 11 | 2 | 30 |
| Galeto | 356 | 1745 | 8 | 2 | 5 |
| Misirak Gortancho | 805 | 4025 | 17 | 2 | 8 |
| Huletegn Tefo | 462 | 2262 | 14 | 2 | 25 |
| Hamata | 528 | 2268 | 14 | 2 | 9 |
| Shewako | 1119 | 5435 | 20 | 1 | 20 |

2.1.2 Mirab Abaya woreda

Mirab Abaya woreda is located in the Gamogofa Zone of SNNPR. The woreda covers a land area of 1,613km² (which is equivalent to 161,300 hectares). The centre of the Woreda, Birbir, is located 230 km from Hawassa. According to the 2007 report of the central statistics authority, the total population of the woreda was 81,608 (CSA 2007). Administratively, (as as the date of the research) the woreda was divided into 24 kebeles (1 urban and 23 rural). The dominant ethnic group was Gamo (85%) followed by Wolayita (9%). Protestant (52%), Orthodox Christian (41%), Muslim (5%), and Catholic were among the main religions in descending order.

At the time of the research study, a total of 50 HEWs (commonly 2 HEWs per kebele) and 422 CHPs were working in the woreda (on average, 1 CHP per 382 hectares). The total population of 15 kebeles selected by the study was estimated, according to official figures set out in **Table 2.2.**, at 42,174, comprised of 7,686 households, and there were in total 246 CHPs working in those 15 kebeles (again as set out in Table 2.2). That represented an average of 171 persons and 31 households for each CHP. In Feregossa kebele, the number of CHPs as compared with the number of households is quite low, on average 1 CHP for 66 households. Apart from Wankie kebele, where the figures was relatively low too (46), the range was between 20 and 37 HHs on average per CHP. As noted above, according to the standard set by the regional health bureau, one CHP served 20-50 households.

According to the woreda health office, only one HEW has left her job since the deployment of the HEWs. The total number of health posts and health centres was 26 and 4 respectively. Only two

kebeles have two health posts. Health posts, led by two female HEWs, are administratively accountable to woreda health offices and technically supported by the nearby health centre. The main objective of health posts is to focus on preventive and promotional aspects of health care, i.e. promotion of measures to eliminate/reduce an environment which is harmful to living and health; prevention of major infectious disease and epidemics; mobilising and empowering the community in health matters. The majority of health posts have a maximum of three rooms and all promotional services at this level are provided free of charge. The curative services provided in health posts include family planning, immunisation, first aid, treatment for malaria, etc..

2.2 Research sites

Fifteen kebeles from Halaba and fifteen kebeles from Mirab Abaya (a total of 30 kebeles) were selected for this study. Representatives from the woreda health offices, the RiPPLE woreda facilitating offices, the regional RiPPLE coordinating office and the research team were involved in the establishment of selection criteria. The criteria included the following:- number of graduate HHs, availability of hand washing facilities, utilisation of sanitation facilities, safe water storage and recurrence of Acute Watery Diarrhoea (AWD) which eventually resulted in selection of 5 best, 5 medium and 5 low kebeles from each woreda ('best', 'medium' and 'low', therefore, in terms of the above criteria). Further, accessibility and proximity of kebeles was given due consideration in the process of selection of the study kebeles (with those chosen representing a range of levels of accessibility and proximity).

Table 2.2: Kebeles in MIRAB ABAYA woreda, SNNPR, selected for study by this RiPPLE research project, December 2009

| Name of kebele | Number of HHs | Estimated Population | Number of CHPs | Number of HEWs |
|-----------------|---------------|----------------------|----------------|----------------|
| Korga Geremo | 218 | 1090 | 6 | 2 |
| Delbo | 530 | 3456 | 18 | 2 |
| Omolatie | 1253 | 6265 | 19 | 2 |
| Feregossa | 234 | 1424 | 9 | 2 |
| Molie | 870 | 4350 | 19 | 2 |
| Wankie Wajefo | 837 | 3632 | 30 | 2 |
| Fetalie Dorenje | 147 | 932 | 7 | 2 |
| Fura | 279 | 1395 | 14 | 2 |
| Ugayehu | 309 | 1545 | 15 | 2 |
| Algie | 634 | 3170 | 20 | 2 |
| Kola Mulato | 565 | 2825 | 15 | 2 |
| Yaki | 507 | 3073 | 14 | 2 |
| Kola Balena | 354 | 1770 | 17 | 2 |
| Doshie | 226 | 1130 | 6 | 2 |
| Ankober | 1230 | 6117 | 37 | 2 |

3 Research methodology

3.1 Study design and period

An exploratory cross-sectional study was conducted from December 1st to 14th, 2009 in order to investigate the experience of HEWs and CHPs as agents of promotion of behaviour change in relation to sanitation and hygiene.

3.2 Sources of data

The primary source of information was HEWs, CHPs, community key informants and focus group discussants who were identified in the selected kebeles in each of the two study woredas (Halaba and Mirab Abaya). Meanwhile, the data set out in Table 2.1 and Table 2.2 had been collected by RiPPLE staff in the two woreda, based on secondary sources. All the study participants were informed about the purpose of the study and verbal consent was obtained before interviewing and questioning them.

3.3 Sample size determination

The total number of in-depth interviewees was determined to be 90 (30 HEWs, 30 CHPs and 30 community key informants) and the number of focus group discussions was 18, so as to avoid saturation of data, with this sample size applied equally in both research districts.

3.4 Sampling techniques

As stated above, in collaboration with the woreda health offices and the RiPPLE woreda facilitating offices, along with research team members, the kebeles identified in each of the research districts were categorised into three levels (low, medium and high) according to the chosen criteria, and convenience sampling techniques (accessibility and proximity of kebeles) were applied to select the actual study kebeles in each of the two Woredas, with an equal number of study subjects (HEWs, CHPs, key informants and focus group discussants) falling within each level/category. Then, HEWs, CHPs, community key informants and focus group discussion participants were identified using purposeful sampling technique and/or snowball sampling techniques. Further, years of service as a HEW/CHP was taken into account, and also fluency in Amharic was given due consideration in the selection of respondents, particularly for the HEWs and CHPs.

3.5 Data collection methods

A qualitative method of data collection was employed in this study. Data for this study were collected in in-depth interviews which followed a standard set of listed questions for the HEWs, CHPs and key community informants, with guiding questions prepared for the focus group discussions. The study entailed conducting of 90 in-depth interviews (15 HEWs, 15 CHPs and 15 community key informants from Halaba and 15 HEWs, 15 CHPs and 15 community key informants from Mirab Abaya) and 18 focus group discussions (9 from Halaba and 9 from Mirab Abaya).

The average time for in-depth interviews and focus group discussions ranged from 1 hour to 2 hours and 30 to 40 minutes respectively, depending on the participants' time commitment on the day of the interview/discussion. Both the in-depth interviews and the focus group discussions were conducted at the time of the interviewee's and discussants' convenience. During the interviews, the research

team members guided the interviewees through the questions in order to obtain as clear and full answers as possible, and the facilitators of the focus groups actively directed the participants through the set of questions, guiding the debate and probing for responses.

3.6 Data entry and analysis

The data from each research district were entered and summarised separately. If the theme of one of the responses in one questionnaire was found to be similar with that of the other, it was not entered twice. Responses of questions which did not show thematic similarities were collected together from all respective questionnaires. Only different themes explored from questionnaires were collected together to form other general and broad themes. When differences in themes emerged from each research district, it was taken as a difference between the two research districts. Then, themes emerged from the informants' stories were pieced together to form a broad picture of their collective experience, thematic analysis was used to analyse the collected data.

3.7 Dissemination of results

The findings from this research study are set out in this report, together with conclusions and recommendations, and the findings together with practical lessons are set out in the separate summary note (as described above, in the Acknowledgements). This report will be published as a RiPPLE Working Paper. The note will be translated into Amharic. The report and the note will, first, be disseminated within the two woredas and within the region. Subsequently, the RiPPLE Programme and the Bureau of Health will seek to promote the outputs of this research more widely within Ethiopia and beyond (e.g. at seminars, workshops, and conferences). The researchers from the University of Hawassa may also seek to publicise the study via national and international journals.

4 Results of the study

Representatives of HEWs, CHPs, community key informants and focus group discussants from each woreda were selected to be interviewed about: how the CHPs, supported by the HEWs, are going about the task of promoting behaviour change in relation to sanitation and hygiene and how their experience as an agents of behaviour change may be further strengthened in the future. All study subjects were interested and volunteered to give an interview or participate in a focus group.

4.1 Roles and responsibilities

Respondents were asked to list the general roles and responsibilities of HEWs and CHPs. They confirmed that their key roles were to provide to communities the package of elements of the Health Extension Programme (HEP). As described in the Box in section 1.3 of this report, the HEP comprises both curative services (e.g. treatment of diseases and preventive services, e.g. personal hygiene - hand-washing).

The CHPs and HEWs talked about the HEP, with its many elements. Community key informants told how the majority of HEWs and some CHPs were active in e.g. vaccination days, although the HEWs and CHPs considered that they give good place to the elements which are related to 'Hygiene and Environmental Sanitation', namely: 'excreta disposal' (construction and use of latrines), personal hygiene' (e.g. hand washing) and 'water handling' (safe storage in the home).

The preventive elements of the HEWs' and CHPs' roles involves continuous education on sanitation and hygiene to communities, including selection and communication of messages on sanitation and hygiene as well as demonstrations and actions to persuade HHs to make changes in their behaviour - followed by monitoring of the progress made by HHs. Additionally, the responsibilities of HEWs and CHPs include the functions, which are less well-known, of leading the activities of the health posts in each kebele and linking the community with health professionals.

Woreda health offices have the responsibility of supervising HEWs who in turn have the responsibility of supervising CHPs – this is discussed further below.

The key informants in the communities reported that, overall, they value the work of the HEWs and CHPs. Key informants in the communities and participants in focus groups recognised that CHPs and HEWs had played a role in improving the health of communities; the majority of HHs, it was reported, are making efforts to use sanitation and hygiene facilities in accordance with the promotion by HEWs/CHPs.

The common agreement, however, among respondents was that bringing about behaviour changes in relation to sanitation and hygiene in rural communities is not easy. Respondents reported that the tasks assigned to CHPs and HEWs were time-consuming and difficult, by their nature - and the challenge is made harder due to the existence of a number of constraints. For example, none of the health posts had any means of transport and communication and the HEWs and CHPs had to move from house to house for visits, in rural areas with low population density. In Halaba special woreda (a district which covers a large geographical area), the majority of HEWs were reported as being based in Halaba town causing an estimated 5 working days per month on average spent in travelling, alone. The study has reported the case of HEWs (in Halaba woreda) who do not have a health post (office) in the kebele for which they are responsible. At the same time, lack of resources and facilities at the

health post are reported as also hindering many HEWs from fully discharging their role and responsibilities.

The inherent challenge of bringing about behaviour change was recognised. Hygiene promotion is not a 'one-off' activity: promotion by HEWs and CHPs needs to be maintained, until the desired behaviour changes - to achieve behaviour change which is lasting, frequent follow-up visits and regular monitorings are needed.

Other reported constraints are the limited number of HEWs and CHPs and the need to increase their capacity with training (see further below).

4.2 Time and visits

HEWs are expected to spend 75 % of their time visiting HHs and performing outreach activities in the community while the remaining 25% is at health post. CHPs are expected to be community leaders and to hold periodic meetings with the community. Accordingly, findings from focus group discussions indicated that the majority of HHs had received visits at monthly or less frequent intervals, less in case of CHPs. HEWs and CHPs also indicated that they were conducting 3 repeated visits per 2 months and 1 visit per 2 months respectively. One HEW at Mirab Abaya also informed that she was visiting HHs 3 times per year. Therefore, one can conclude that this frequency of visiting HHs coupled with inadequate time could not guarantee the adoption of new behaviours and skills. At the same time, participants of focus groups of mothers from Mirab Abaya indicated that:-

“CHPs were telling HHs to do something or to come to the health post while moving on the road. The majority of them did not teach HHs in a formal way like that of HEWs”.

In principle, under the HEP, each HEW is responsible for 500 households. The study found on average over 30 kebeles where higher levels of responsibility existed in practice: 582 in Halaba, 546 in Mirab Abaya; one HEW reported that she was responsible for 1,119 HHs. This increased work load has implications for quality because, as the number of HHs for which a HEW increases, the frequency of the HEWs visits to each HH will tend to decrease.

The average time spent during HH visits for sanitation and hygiene promotion in Halaba special woreda was reported as being as follows: HEWs 45 minutes average; CHPs 37 minutes, which was adequate, compared with less time in Mirab Abaya woreda: HEWs 16 minutes; CHPs 34 minutes.

HEWs and CHPs reported the following rate of visits to each HH (an average rate over the two woredas): HEWs, 3 visits every 2 months; CHPs, 1 visit in 2 months. The frequency of HEWs' visits to each HH is found to be good; but, for CHPs, who live in the community close to HHs for whom they are responsible, it is desirable to increase the frequency to one visit for one month.

In principle, according to the HEP, each CHP is responsible for between 20 and 50 households. The study found on average 32 and 35 HHs in Halaba and Mirab Abaya respectively.

Table 4.1: Summary results of time and visits of HEWs and CHPs and associated variables, Halaba and Mirab Abaya, 2010

| S. No | Item | Halaba | | Mirab Abaya | |
|-------|---|--------|-------|-------------|-------|
| | | CHPs | HEWs | CHPs | HEWs |
| | Average age of respondent | 32.38 | 21.13 | 34.07 | 25 |
| | Average experience of HEWs and residence period of CHPs | 28.6 | 2.4 | 34.2 | 3 |
| | Average number of CHPs working per kebele | - | 14 | - | 16.4 |
| | Average number of HHs accountable to a CHP and HEWs | 32.38 | 582 | 35.09 | 546 |
| | Average number of days per month in which CHPs spent with HEWs | 3.27 | - | 0.25 | - |
| | Average number of days spent per month with HHs by CHPs and HEWs | 5.2 | 14.45 | 6.25 | 14.4 |
| | Average number of Hours spent per month to move from their residence to the health post | 0 | 38.84 | 0 | 0 |
| | Average number of days per month in which HEWs spent with CHPs | - | 2.3 | - | 2.42 |
| | Average number of days spent per month, meeting for non health activities | 1.5 | 2.3 | 1.8 | 5 |
| | Average number of days spent per month, meeting for health activities | 2.4 | 2.5 | 1.27 | 3.8 |
| | Average number of frequencies in which HEWs and CHPs sent for training per month | 0.125 | 1.07 | 0.057 | 1.04 |
| | Average number of days spent per month for S & H | 2.7 | 6.75 | 0.73 | 10.36 |
| | Average number of frequencies of visiting HHs per month | 0.36 | 1.6 | 0.64 | 1.5 |
| | Average number of minutes waited while teaching HHs | 37.42 | 45 | 33.64 | 15.66 |

4.3 Context/Actual activities

HEWs and CHPs were asked to elaborate what had been said to HHs in relation to promotion of sanitation and hygiene.

The HEWs and CHPs reported that they talked to HH members, particularly mothers, about the advantages and disadvantages of washing hands at critical times, better water handling and construction and proper utilisation of latrines among their key tasks. That included informing HHs about how latrines and hand washing facilities may be constructed/prepared and how water containers should be handled. Here, details of the things communicated to HHs include key practices in relation to safe water storage in the home (using containers with small openings), construction of latrines with accessories from locally available materials, and information conveyed about hand washing and hygiene (washing hands using either soap or ash, at critical times). These aspects of sanitation and hygiene were all discussed by HEWs and CHPs with members of HHs in order to impress on them how improved sanitation and hygiene practice contributes to reduction of related associated morbidities and mortalities especially in children.

During the interviews and focus groups discussions, the traditional practices in the communities were discussed, namely open defecation/urination - in both Halaba special woreda and Mirab Abaya. Many key informants and focus group members made reference to the consequences of those

traditional practices - for example, the extent of the smell which made it difficult to walk across HH compounds, as well as the nuisance from flies.

One point which emerged from the study was that HEWs and CHPs refer to the health benefits of improved sanitation and hygiene with little use of other arguments to persuade members of the HH. The issue of privacy and dignity was not given due emphasis in the teaching and learning processes.

In terms of messages, an example of things which HEWs/CHPs say when talking to HHs (at least, at the time of the research) is that covering up faeces is beneficial, as per the practice of cats. HEWs supported their messaging with Information, Education and Communication (IEC) materials, when these were available. As for demonstrations, a key technique was reported to be use of model latrines installed in/around the compounds of HHs who act as models themselves, and so-called 'tippy taps' (a hand washing facility made from locally available materials) to further strengthen the teaching and learning process. HEWs said they actively performed actions in front of HHs to show actually them how things were done - what the HHs should do themselves - also allowing HH members to practice what had just been said/learnt, i.e. learning by doing. As alluded above, they were using IEC teaching aids (posters and figures) to drive home the message and help HHs to remember the messages over time.

HEWs and CHPs reported that they evaluate HHs' progress in adopting improved sanitation and hygiene practices by observing the following kinds of indicators: existence of sanitation facilities (latrines) in/near the compound; existence and extent of use of paths to those facilities/the latrine; standard of cleanliness and degree of smell of latrines; residual degree of smell in the compound; presence or absence of hand washing facility with soap and/or ash at the entry to the latrine; existence of cups for drinking water in the home (with separated/isolated cups for drinking purposes only) . The HEWs/CHPs said they employ ways to cross-check actual practices of HHs, for example asking them to drink water and then observing how they do it (whether they handle water safely), questioning one HH as to the practices of its neighbour in handling water, disposing of faeces and washing hands. The perception of one HH on another is one test of good practice.

As to HHs which persist in bad practices, most HEWs and CHPs commented to researchers on the process by which complaints are made to HEWs and CHPs, as a first step, and then up to kebele officials as a higher authority. In other words, while the HEWs and CHPs are primarily responsible for promotion, it is the community leaders and the community members (in community conversations, collectively, and the kebele officials to whom they turn for enforcement, supported by other influential actors, as necessary, for example, religious leaders, school directors, idir leaders, elderly people, and development agents (see below).

Enforcement is sometimes essential to compel reluctant HHs. Currently, punishment for offences (like open defecation or urination) varies substantially between kebeles, from a small fine (e.g. 20 birr), to prohibition from social events or safety-net programmes, to imprisonment and even social out-casting. Examples were cited of children shouting at people caught in open defecation/urination and naming and shaming them, even at community meetings and community conversations. A few kebeles had already formulated by-laws relating to open defecation/urination, whilst others were in the process of developing such rules, but those were the minority - the majority of kebeles had yet to produce by-laws governing such malpractices within communities. HEWs and CHPs said that they saw such explicit supportive legislative measures as being necessary for the actual implementation and execution of changed sanitation and hygiene practice. Nevertheless, they also firmly believe that

enforcement alone will not bring long term behavioural changes at HH and community level, e.g. latrines may be constructed and used at first, but not used in a lasting way.

HEWs and CHPs were mobilising communities to construct communal latrines in places where people are expected to congregate in large numbers. Alongside HH latrines, communal latrines have a role in rural areas, e.g. at kebele meeting places.

Discussants in the focus groups in both Halaba and Mirab Abaya woredas reported that use of teaching aids by HEWs and CHPs in their visits to HHs was much too limited. One young FGD participant in Halaba commented:- “It is only really at the health post that posters and pictures are used as teaching aids. I have never seen a single CHP and HEW who has come with teaching aids in his hand when he or she was doing household visits”.

4.4 Accounts of success

The key informants in the communities reported that they value the work of HEWs and CHPs, and respondents to the survey recognised the benefits of change from traditional practices.

All the focus groups reported that, since promotion of measures for improving S & H practices, reductions in incidence of diarrhoea have been clearly noticeable. In the two study woredas, benefits for HHs, in terms of health, are reported. The adoption of improved sanitation and hygiene practices, as promoted by the HEWs/CHPs, is observed to be associated with a substantial reduction in incidence of diarrhoea in the two woredas studied. Community key informants and participants in the focus groups recognised that CHPs and HEWs had together played a role in improving the health of communities.

While primary responsibility for sanitation and hygiene promotion is assigned to the HEWs and CHPs, HEWs and CHPs in the study areas are reported as involving influential actors in the community and the kebele, including (as noted above), religious leaders, school directors, idir leaders, and elderly people for the accomplishment of their missions. Another example is the development agents (DAs) working for the Bureau of Agriculture who are responsible for selecting HHs to benefit under the ‘safety-net’ program. The DAs can provide useful support to promotion of sanitation and hygiene activities. Involving such influential local actors reduces the burden on the HEWs and CHPs, and helps to ensure continuity of promotion of the HEP. Sustainable behaviour change comes from active collaboration of actors in the community and the kebele alongside the HEWs and CHPs. For example, kebele officials and local leaders not only support promotion activities, but also implement improved sanitation and hygiene practices themselves. Community conversations were referred to by HEWs/CHPs as being a useful approach.

As to challenges faced by HEWs and CHPs in promotion of behaviour change in relation to sanitation and hygiene, the following were cited by respondents:-

- the role of CHPs, as unsalaried volunteers with relatively little training as compared with HEWs, is particularly challenging when faced with HHs which are reluctant to change their sanitation and hygiene practices; as noted above, hygiene promotion is not a ‘one-off’ activity; nevertheless, resistance from some HHs could be reduced, and even overcome, by repeated visits;
- variable practice relating to subsidies: some kebeles are receiving hand-outs of e.g. soap, jerry cans, T-shirts and plump nets, others are not; among persons interviewed during this survey (and, more widely, among researchers and commentators in SNNPR and Ethiopia), opinion is divided as

to whether the subsidies which are given are effective in promoting real behaviour change - and whether they create dependency in the receiving kebeles, as well as resentment in neighbouring kebeles;

- the HEWs and CHPs reported that environmental conditions - for example, soil erosion due to heavy rain, termites, surface run-off - created problems for latrine construction which affect promotion of sanitation and hygiene.

The HEWs and CHPs reported hearing the following types of negative response and closed attitude from some HH members: *“We are poor, we can't do anything”*; *“A woman's only role is to serve the husband, kids and the family”*; *“Being diseased is the will of God”*; *“You are doing this for your own selfish reasons”*; *“We will do the things you suggest later”*; *“If I do what you say, what will you give me?”* *“Our ancestors always used these practices. What about our parents who used open field defecation and urination throughout their life time? They did not have latrines, they were fetching water from the same source, and they were eating their food in a worst condition than us. Yet, nothing happened to them! So what's the problem if we follow the same practices as our parents and ancestors”*.

Approaches to dealing with such reluctant HHs, mentioned by HEWs and CHPs, were community conversations, collaboration of influential actors and frequent follow-up.

Additionally, some key informants said they suspected that HEWs and CHPs were giving materials like soap, jerry-cans and bed nets to their parents, relatives and close friends and that this was a discouragement to other HHs from adopting the desired behaviour.

As alluded above, a constraint to greater progress on behaviour change related to sanitation and hygiene is the work load of HEWs and CHPs. To deal with excessive work load where it occurs, appointment of additional HEWs and construction of additional health posts (2 health posts, with 4 HEWs, in relevant kebeles) would be a solution.

As to constraints faced by HHs, lack of resources (manpower, money, time and income) were among the practical difficulties representing deterrents to behaviour change, e.g. lack of materials with which to maintain or renew existing/old sanitation and hygiene facilities. Absence of continuous supervision/monitoring by HEWs and CHPs of those model HHs after graduation was a further loop-hole which can trigger a return by HHs to their old practices.

Model households are reported as being used by some HEWs and CHPs as examples to persuade other HHs. Nevertheless, according to the response of community key informants and focus group discussants, it has been found that some HEWs and CHPs did not have latrines, waste management pits and hand washing facilities in either their residential homes or the health post despite their own preaching to HHs that they should install such sanitation and hygiene facilities. In the key informant interviews, it was clearly expressed that community members expected HEWs and CHPs to maintain good sanitation and hygiene standards in their own home – such poor sanitation and hygiene behaviour of some HEWs and CHPs was considered as one demotivating factor. An example of a comment on this issue is the following from a key informant in Mirab Abaya:-

“Some HEWs and many CHPs are not good models for the communities: they are not doing what they tell us to do. Some HEWs/CHPs do not have latrines and most CHPs do not have hand washing facilities. Their compounds are not examples of good environmental sanitation”.

Shortage of water, particularly in Halaba special woreda, and especially during the dry season, significantly affects the willingness of HHs to use their limited water supplies for hand washing; during rainy seasons people may use unsafe sources, usually ponds, as sources of water, but during dry seasons they do not have any option even for drinking. HEWs and CHPs concluded that unavailability/serious limits on access to water cuts across sanitation and hygiene promotional activities. A CHP in Halaba special Woreda stated that:-

“In the absence of water even for drinking, it is unthinkable to see HHs washing hands at critical times”.

4.5 Approaches

HEWs and CHPs are reported as making their best efforts to achieve success in promotion of sanitation and hygiene. Respondents were also asked about the ways of working which HEWs and CHPs have employed to-date in successfully promoting sanitation and hygiene behaviour change, for overcoming the challenges and difficulties referred to above.

First, the activities relating to sanitation and hygiene are not in principle being lost in promotion by HEWs/CHPs of the overall package of elements in the HEP (but see below the risk of over-burdening of messages).

Another key point is that woreda health offices, to which HEWs are accountable, have a key role to play in supervising HEWs and providing technical support to them. The role of health centres also includes provision of technical support to HEWs. In turn, the HEWs support the CHPs.

When faced with the challenge of HHs which are reluctant to change their sanitation and hygiene practices, HEWs (and some CHPs - less) are sufficiently versatile as to be capable of applying a range of approaches and techniques, namely methods such as community conversations and positive and negative reinforcements of HH motivation. One HEW in Halaba special woreda reported that she had created a competition between HHs which had been effective in stimulating behaviour change.

The researchers discovered that the HEWs and CHPs in the study areas are, in their promotion of sanitation and hygiene, currently giving more attention to passing information to HHs about behaviour change than to developing HH skills to carry it out.

There is need for a shifting of emphasis from information communication on behaviour change to skills development of HHs. The latter has to-date been relatively neglected. HHs may install sanitation and hygiene facilities as a result of the information which they have received, but for usage of those facilities to be sustainable, they need to be skilled at maintaining them.

Promotion of sanitation by HEWs and CHPs in the two woredas is at present focused on construction and use of a first generation of latrines of basic (and sometimes poor) quality. Health promoters (HEWs and CHPs) need to encourage HHs to improve their sanitation and hygiene facilities. Poor quality and design tends, over time, to undermine initial changes in practice. Promotion of HHs to move up the ‘sanitation ladder’ is a good way of avoiding a fall-back in rates of latrine use, after initial success in substantially increasing levels of coverage.

As to messages, respondents reported that HEWs and CHPs tend to promote a number of health issues to HHs at a time, mixing messages from different elements of the package of health issues under the HEP. Mixing messages between, for example, immunisation and S & H, tends to dilute the effectiveness of the promotion. Overburdening HHs with too many messages at one time may result

in laggard HHs. To be effective, a HH visit for hygiene promotion should focus on one issue per visit with a message or messages specific to that issue supported by relevant information

As noted above, involving influential local actors is critical to achieving behaviour change. Religious leaders, community leaders, kebele officials and elderly people can represent examples of good practice leading centres of excellence of sanitation and hygiene promotion, for communicating or endorsing messages to HHs and community audiences at churches, mosques, schools, Idirs, markets and other social gatherings. Any other stakeholders, such as NGOs, who are supporting sanitation and hygiene activities working in the woreda should be asked to support those collaborative efforts (see further below).

Some HEWs said they planned to apply well known approaches like community-led total sanitation (CLTS) and sanitation marketing (advocating a HH who produces slab and distributes to others) as additions to the approaches they were currently using. Others told the researchers that they intended to further strengthen community conversations on identified gaps and weaknesses in sanitation and hygiene practices in order to reach consensus on feasible solutions and applicable approaches. Generally, HEWs said they could bring about significant changes in the area of sanitation and hygiene through continuous education and follow up of HHs, integration of activities and provision of materials and facilities (like soap and the empty containers of bottled water (to be used as hand washing containers) till they develop the desired behaviour).

As explained by HEWs and evidenced by the response of community key informants and FGDs, techniques employed by HEWs in collaboration with CHPs of gathering together community members at community meetings, or meetings at kebele level, included community conversations, sanitation campaigns, ceremonies to celebrate certification/graduation of model HHs, coffee ceremonies.

The approaches of CHPs were perceived by community key informants as being generally less effective than those of HEWs. As alluded above, the role of CHPs, as unsalaried volunteers with relatively little training as compared with HEWs, is particularly challenging. The respondents confirmed that the incentives to HEWs and CHPs were the salary paid to HEWs and training provided to HEWs. There are no other incentives for HEWs and none for CHPs. CHPs are volunteers who are committed people, approaching their tasks generally with dedication. However, lack of incentives has pushed some CHPs to resign. Maintaining the motivation of CHPs and retaining them in their roles requires monetary or non-monetary rewards. A system of rewards for good performance of HEWs and CHPs has not yet been established in either woredas.

4.6 Needs in the future

The researchers asked respondents for their views on what HHs need in order to put into practice the messages on sanitation and hygiene which are communicated by HEWs and CHPs. The answers were that HHs require to have resources to construct or purchase latrine slabs, wood for latrine structures/super-structures, corrugated iron and other materials to serve as latrine roofing, hand washing containers, jerry-cans and other containers in which to collect water, as well as axes, saws, spades and other tools with which to construct the latrine and dig latrine pits. Alongside these physical materials, HHs also need of course the knowledge and skills required to carry out the latrine construction.

As to what resources HEWs and CHPs need to bring in order to facilitate behavioural changes by HHs in relation to sanitation and hygiene, in addition to those listed above, respondents pointed out that, to carry out their role as promotional agents with full effect, HEWs/CHPs should, preferably, be equipped with models of latrines to show HHs, specimens of hand washing containers as well as jerry-cans, slabs, soap to show/give out to HHs. Besides, Information Education and Communication ('IEC') materials - posters, guides/manuals and IEC materials illustrating latrine designs – should be made available so as to make the promotional process more effective.

For the HEWs/CHPs themselves, the respondents said that it would be good for them to be equipped with bags and umbrellas for the purposes of their visits to communities/HHs, together with some form of uniform to identify them in their roles. Currently, lack of means of transportation is hindering HH visits. Provision of bicycles for HEWs and CHPs would be a great advantage.

Accommodation for HEWs at/near health posts in the kebele would save travelling and increase the time when they are carrying out their extension role. A health post should be constructed in the kebeles which currently lack this facility, and health posts should be furnished with necessary materials and equipment, including sanitation and hygiene facilities for demonstration purposes.

Further, lack of means of communication between HEWs, CHPs and respective supervisors, is also hindering the work. The majority of HEWs possess mobile phones, but do not receive funding for purchase of phone cards for work use. Most CHPs cannot anyway afford a mobile phone.

The CHPs and HEWs talked about the demands of promoting the HEP with its many elements but, instead of reducing the number of elements, they proposed increased resources to deliver the HEP package as currently set including the sanitation and hygiene elements. Every HEW and CHP could have a work plan which would assist the challenges of promoting the different elements of the HEP including the sanitation and hygiene.

4.7 Supervision/follow up

The HEWs talked with the researchers about their supervision by woreda health offices, and the health centres. HEWs from Halaba and Mirab Abaya were supervised averagely 4.5 and 2 times per month by their supervisors (from the health center and/or the Woreda health office) respectively. Higher officials of the Kebele, particularly kebele managers, were also supervising them daily. The majority of HEWs considered that these levels of supervision were insufficient, and the supervision system overall was irregular, unplanned and insufficiently supportive. The frequency of supervision was also inconsistent: remote kebeles did not generally receive as much attention as those close to woreda health offices and health centres. The majority of HEWs reported that the supervisors from woreda health offices and health centres were concentrating on the presence or absence of HEWs, not mainly on their performance. HEWs indicated that there had been a high turnover of supervisors. They said they would nevertheless like to receive supervision which was genuinely aimed at providing capacity- building and mentoring.

The HEWs commented that the supervision by Woreda Health offices should be supportive of HEWs, rather than “*inducing them to be angry*”. Supervisors from either of the woreda health offices should aim to provide supervision to HEWs which effectively helps to strengthen the capacity of HEWs and CHPs, including identifying gaps and suggesting solutions.

One of the worst experiences of supervision was in Halaba, where a HEW reported:-

“Supervisors come to the kebele, and then they simply ask us where we were every day of the week. They say: “I heard that you were not around on X day”, but then that does not seem to matter anyway – it is not clear what they are checking for – certainly not our actual performances”.

4.8 How the support of HEWs to CHPs may be further strengthened?

The interviews with the HEWs, the CHPs and community members in focus groups revealed that the working relationship between HEWs, CHPs and HHs is generally good. HEWs without the support of CHPs and CHPs without the support of HEWs would not achieve good progress. The roles of HEWs and CHPs are inter-linked and inter-dependent, and HEWs are making efforts to professionally support CHPs, including helping CHPs to feel motivated in their role.

However, to strengthen the collaboration of HEWs and CHPs, respondents remarked on the need for career development of HEWs, so that they could in turn pass on knowledge to CHPs, to acquaint them with new skills. One of the HEWs at Halaba special Woreda expressed her ambition of getting further education. She said that, after 4 years, there was nothing new she could communicate to CHPs and HHs; over that time, she had imparted all the knowledge she had to offer. Now she wanted to learn more, so she could help communities overcome their “obstacles as much as possible. *“With additional knowledge, what astonishing accomplishments I could achieve”.*

HEWs commented on the lack of a structure allowing for opportunities of career development. All HEWs were interested in such opportunities to further their careers. HEWs reported that they attend extension and weekend education programmes at their own expense, with a view to achieving career development. Nevertheless, HEWs would like to have opportunities to achieve upgrading like other government employees.

Refresher training courses, educational tours and exchange visits for CHPs were reported as being in their infancy, in both woredas. HEWs and CHPs welcome the opportunity to attend training courses.

Some HEWs and CHPs who participated in the survey said they carried out experience-sharing, although this was not organised by woreda health offices.

In order for the role of HEWs to be strengthened further, the woreda health offices will need to make the working environment more conducive to HEWs and their effective working.

As noted above, the capacity to try different approaches is key to dealing with those HHs who are reticent about changing from their traditional practices. Faced with this challenge, HEWs and CHPs would benefit from support or training in applying different methods of persuasion.

Increasing available resources, to satisfy the needs referred to above (e.g. uniform, bicycles, more IEC materials) would reinforce the motivation of HEWs and CHPs, alongside means for recognising good work, for example prizes for hard work and exceptional commitment, training opportunities, as well as monetary rewards. One key informant from Mirab Abaya expressed forcefully the importance of incentives: *“Incentives are spices of life; the more a system provides incentives, the more it generates success”.*

There was common agreement among the respondents that, alongside boosting of available resources for health extension to rural communities, greater opportunities of career development

would help to retain (particularly) HEWs, and CHPs, in order to ensure continuity of promotion of the HEP, including its sanitation and hygiene elements.

During the FGDs it was stated that how CHPs are selected plays a role in determining their effectiveness and the level of their acceptance in the community with whom they work. Selection criteria could be developed to show the clear job descriptions, roles and responsibilities, particularly the role of CHPs as (essentially) volunteers. Motivation to serve the community should remain a selection criterion - becoming a HEW and CHP goes beyond just a desire for incentives.

As noted above, HEWs require more technical support from woreda health offices and health centres.

Health posts are confirmed by the experience in the two studied woredas as being key to delivery of the HEP, including its S & H elements.

4.9 Roles of governmental and nongovernmental organisations

Additionally, respondents commented on the importance, for success of the health extension system, of collaboration of other actors and stakeholders including effective promotion of sanitation and hygiene. As well as an increase in the level of support of government, in terms of resources, and the role of influential actors at community and kebele levels, the active collaboration of those other stakeholders in efforts to help HHs move up the sanitation ladder, would be key. It was commented that NGOs supporting projects in the region did not always coordinate their activities with woreda/regional authorities, or with other NGOs. Persons interviewed told the researchers that the solidarity of, and coordination between, donors, NGOs and other stakeholders in the region needed to be strengthened.

5 Conclusions and recommendations

5.1 Conclusions

Role of health extension workers (HEWs) and community health promoters (CHPs)

- The roles and responsibilities of HEWs and CHPs are well known to the majority of community key informants and FGD participants. HEWs and CHPs also know what duties and functions are expected from them.
- Community leaders and participants in focus groups recognise that CHPs and HEWs have played a role in improving the health of communities.
- The average time spent during HH visits for sanitation and hygiene promotion in Halaba special woreda was reported as being adequate (HEWs 45 minutes average; CHPs 37 minutes), compared with less time in Mirab Abaya woreda (HEWs 16 minutes; CHPs 34 minutes).
- The frequency of HH visits as currently made by HEWs and CHPs may not be enough to guarantee HHs to develop the desired behaviour - it was recognised by respondents that hygiene promotion is not a one-off activity.
- The number of productive working hours of HEWs in Halaba special woreda is being reduced by their needing to move to and from Halaba town. Accommodation for HEWs at/near health posts in the kebele would save travelling time and increase the time when they are carrying out their extension role in communities.

Interaction by CHPs, and HEWs, with communities and households

- HEWs and CHPs are reported as making their best efforts to achieve success in promotion of sanitation and hygiene - the activities relating to sanitation and hygiene are not being lost in promotion by HEWs/CHPs of the package of elements in the Health Extension Programme-HEP.
- In the focus group discussions (FGDs) and key informant (KI) interviews, it was reported that the messages which HEWs and CHPs were communicating to HHs are simple and the changes of practice they promote are achievable. However, communities required to have materials such as slabs, jerry-cans, and soap.
- HEWs and CHPs were reported as tending to promote a number of health issues to HHs at a time; mixing messages from different elements of the package of health issues under the HEP, between, for example, immunisation and sanitation and hygiene, tends to dilute the effectiveness of the promotion - and overburdening HHs with too many messages at one time may even result in laggard HHs.
- The study noted that, in promoting sanitation and hygiene behaviour change to HHs, both CHPs and HEWs in the two woreda made reference to health benefits, but they tended to ignore the contribution of sanitation and hygiene to dignity and privacy.

- The researchers discovered that the HEWs and CHPs in the study areas are, in their promotion of sanitation and hygiene, currently giving more attention to passing information to HHs about behaviour change than to developing HH skills to carry it out.
- Promotion of sanitation by HEWs and CHPs in the two woredas is at present focused on construction and use of a first generation of latrines of basic (and sometimes poor) quality.
- HEWs and CHPs need to encourage HHs to improve their sanitation and hygiene facilities. Poor quality and design tends, over time, to undermine initial changes in practice.
- The HEWs and CHPs reported hearing negative responses and closed attitudes from some HHs. HEWs/CHPs are tackling the challenge of reluctant HHs with frequent follow-up and other methods like community conversations and support from influential actors at community and kebele levels.
- Even though HEWs and CHPs make use of the authority of kebele officials to tackle reluctant and resistant HHs, HEWs/CHPs consider that threats *alone* are not a guarantee of lasting behaviour change.

Supporting the HEWs and CHPs in their promotional activities

- Lack of resources and facilities at the health post has deprived many HEWs from discharging their role and responsibilities to the communities and CHPs.
- Greater availability of Information Education and Communication ('IEC') materials and models would make S&H promotion more effective.
- For the HEWs/CHPs themselves, the respondents said that it would be good for them to be equipped with bags and umbrellas for the purposes of their visits to communities/HHs, together with some form of uniform to identify them in their roles. Currently, lack of means of transportation is hindering HH visits. Provision of bicycles for HEWs and CHPs would be a great advantage.
- The respondents confirmed that the incentives to HEWs and CHPs are the salary paid to HEWs and training provided to HEWs. There are no other incentives for HEWs and none for CHPs. In particular, CHPs are volunteers who are committed people, approaching their tasks generally with dedication. However, lack of incentives has pushed some CHPs to resign. Maintaining the motivation of CHPs and retaining them in their roles requires monetary or non-monetary rewards.
- Respondents commented that the solidarity of, and coordination between, donors, NGOs and other stakeholders needed to be strengthened.
- Opinion is divided as to whether the subsidies which are given are effective in promoting real behaviour change - and whether they create dependency in the receiving kebeles, as well as resentment in neighbouring kebeles.
- Unavailability/serious limits on access to water (e.g. in Halaba special woreda) cuts across sanitation and hygiene promotion activities, making the challenge of promoting hand washing very difficult, at least during times of water shortage.

Learning opportunities - for CHPs and HEWs themselves

- Opportunities and forum for learning, such as collective meetings, educational tours and exchange visits, which provide an opportunity for CHPs and HEWs to learn from one another, are currently limited; a small number of HEWs and CHPs have compensated for that by doing experience sharing with adjacent kebeles at their own expense.
- In the study areas, HEWs conducted regular meetings with CHPs at least once in a month, to discuss problems faced during service provision and their probable solutions. However, CHPs and HEWs do not currently prepare and share their work plans together.

5.2 Recommendations

The following are the recommendations arising out of this study:-

Role of health extension workers (HEWs) and community health promoters (CHPs)

- Guidance should be provided to CHPs as to the number of working hours per month they are expected to perform.
- There is need for a shifting of emphasis from information and communication on behaviour change to skills development of HHs since the latter has to-date been relatively neglected.
- More IEC (information, education and communication) materials should be made available at health posts and for HEWs and CHPs in their work with HHs/communities.

Interaction by CHPs, and HEWs, with communities and households

- To persuade HHs to adopt new practices, HEWs and CHPs should use arguments on health and privacy as well as referring to the health benefits of improved sanitation and hygiene practice.
- To be effective, a HH visit for sanitation and hygiene promotion should focus on one issue per visit with a message or messages specific to that issue supported by relevant information. Messages for promotion of sanitation and hygiene need to be continually reinforced by demonstrations/actions, so as to make changes in behaviour long-lasting.
- Promotion of HH moves up the 'sanitation ladder' is a good way of avoiding a fall-back in rates of latrine use, after initial success in substantially increasing levels of coverage.
- Improvements in hygiene have to be linked to improvements in water supply in order to reduce problems associated with unavailability or serious limits on access to water, e.g. in Halaba special woreda.
- In order to collaborate effectively together, HEWs need to lead CHPs in a process of joint planning, including organisation by HEWs of meetings with CHPs in a group at least twice a month.

Supporting the HEWs and CHPs in their promotional activities

- Supervisors from either of the woreda health offices should aim to provide supervision to HEWs which effectively helps to strengthen the capacity of HEWs and CHPs, including identifying gaps and suggesting solutions. Supervision by woreda health offices should be genuinely supportive of HEWs.
- It is recommended that the woreda health offices, along with the regional Bureau of Health make available their own funds or obtain additional finance so as to be able to provide materials like umbrellas, more IEC materials and means of transport and communication (a bicycle for each HEW and CHP).
- The Bureau of Health could usefully review the measures for capacity-building of HEWs and CHPs and plan for more training. HEWs and CHPs express themselves as willing to learn lessons, in order to further improve their own performance in sanitation and hygiene promotion.
- By-laws should be written to provide for a more uniform system of punishments for dealing with, for example, open defecation and urination; such explicit supportive legislative measures would support implementation of changed sanitation and hygiene practices.
- The majority of HEWs reported that they visited woreda health offices to collect their monthly salary; this means that the HEWs visit the woreda health office once per month, nearly at the same time. If this practice of collecting salary at the woreda health office is to continue, the HEWs propose that the woreda health offices use it as an opportunity to call a monthly meeting for discussion and experience-sharing between HEWs as a group.
- The development and implementation of clear career structure for HEWs needs attention. HEWs would like to have opportunities to achieve upgrading like other government employees. Either the Health Extension Programme-HEP is adapted to accommodate the ambitions of HEWs or, otherwise, HEWs will tend to move on from their current role to seek opportunities elsewhere.
- Retaining the services of HEWs and especially CHPs is becoming more challenging. A system of rewards for good performance of HEWs and CHPs has not yet been established in either woreda. Some kind of incentive mechanism should be established, as soon as possible, so as to retain HEWs and CHPs and thereby ensure continuity of services.
- Both HEWs and CHPs should undertake experience sharing, with the aim of learning from each others' experience, across communities and kebeles, as that is a key means of enhancing their skills. Experience sharing can be in the form of meetings, exchange visits and educational tours.
- Actors involved in giving of subsidies and other incentives should first carefully assess their impacts. A consistent approach to subsidies - a policy applied by both government and non-governmental organisations in the woreda/region - would be beneficial.

The solidarity of NGOs and other stakeholders in the region needs to be strengthened, since their recognition of the importance of the HEP and its sanitation and hygiene elements is important for encouraging HHs to move up the sanitation ladder.

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