MODEL-FAMILY AND vCHPs SURVEY

HEP EVALUATION

RURAL ETHIOPIA

2010

EXECUTIVE SUMMARY

MODEL FAMILY IMPLEMENTATION – HEW SURVEY

Year model-family training started

About 6.8% of kebeles (mainly in Tigray, Amhara, and SNNP regions) initiated training of model-family in 1998. The peak implementation year was 2001. The percentages of kebeles that initiated model-family training in 1999, 2000, 2001, and 2002 were 13.5%, 17.9%, 35.8% and 22.5% respectively.

Preparation for model-family training

In 46% of kebeles, HEWs reported that they prepared evidence based health profile of all households in the kebele. Moreover, HEWs in about 40% of kebeles reported that they studied the demography, socio-economic and cultural conditions of all households in the kebele in preparation for training of model-families.

Household selection process

HEWs in 80.2% of kebeles reported that households that were model in changing others were given priority in the selection process. Member of kebele administration, previously working as CHW/TBA/CBRHA, and interest to practice the HEP service packages were also used as criteria in selection of households in 43.6%, 41% and 38.6% of kebeles, respectively. Moreover, availability of labor and households located in the same neighborhood were used as selection criteria.

HEWs in 85.2% of the kebeles reported that HEWs were responsible for the selection of households for model-family training. Moreover, kebele administration (56.8%), VHPs/CHWs (49.8%), opinion leaders (26.5%), HEW-supervisors (23.7%), and community members (19.75) were involved. In about 16% of the kebeles, graduated model-families were involved in the selection of households for model-family training.

Number of model-family training rounds undertaken per kebele

The total number of kebeles that have started at least one round of model-family training was 214. Among these kebeles, about 21.7% and 22.6% of the kebeles have undertaken one and two rounds of training, respectively. More than a quarter (28.6%) of kebeles have undertaken three rounds of training, while about 26.1% of kebeles have undertaken four or more rounds of model-family training. The average number of model-family training rounds undertaken was 2.4 times per kebele.

Number of households enrolled per round of model-family training

Majority (51%) of kebeles had enrolled between 31-60 households for a round of model-family training. There were some kebeles (19.4%) that enrolled 30 households or less during a round of model-family training, while 29.5% had enrolled 61 households or more.

Level and setting/venue of model-family training

In the majority of kebeles, combinations of various levels of training (at got, at sub-kebel, at kebele and at household level) were used by HEWs. In more than a third (35.6%) of the kebeles, model-family training at household level was used. Overall, model-family training organized at got, sub-kebele and/or kebele levels was used in about 87% of the kebeles. About 13% of kebeles did not organize training sessions at got, sub-kebele and/or kebele levels, and provided training only at household level.

The commonly used places for training included home (40.1%), health post (38.9%), farmers training center (26.6%), and school (18.7%) reported by 40.1%, 38.9%, 26.6% and 18.7% of kebeles, respectively.

Time devoted by HEWs for model-family training

HEWs in majority (73.1%) of these kebeles undertook model-family training organized at got/sub-kebele/kebele levels for one to two days per week. HEWs in 52.5% of kebeles spent 2 hours per training-day (days when they provide training) to provide model-family training at got, sub-kebele, and/or kebele levels. In more than a third (35.3%) of kebeles, HEWs spent three or more hours per training-day organized at got, sub-kebele, and/or kebele levels.

During such training sessions, 5-30 households attended the training in 47% of the kebeles, while 31-60 households attended the training sessions in 45.3% of kebeles.

HEWs in 44% of kebeles that provide training at household level undertook training for three to four days per week at household level, while HEWs in 41% of the kebeles undertook such training one to two days per week. HEWs in about 61% of kebeles visited 8-12 households per day (during days devoted for training), while HEWs in a third (32%) of kebeles reported to have visited between 4-7 households per day.

HEWs in 37% of kebeles spent 30-60 minutes per training visit per household, while HEWs in about 32% of kebeles spent more than 60 minutes per training visit.

Household members who attended model-family training session

HEWs working in 93.1% and 94.2% of kebeles reported that husband and wife, respectively, had ever participated model-family training organized at got, sub-kebele, and/or kebele levels. In nearly half of the kebeles, HEWs reported that female and male child older than 15 years had ever participated in such trainings.

Among kebeles where HEWs provide model-family training at home, wife attend the training in 97.6% of kebeles. HEWs in 88.9% and 88.3% of kebeles reported that husband and female child older than 15 years, respectively, had ever attended training at home. HEWs in a significant proportion of kebeles, also reported that male child older than 15 years (69%); and mother, grandmother and/or mother-in-law (61.9%) had ever attended the training at home.

People involved in training of model-family households

In addition to HEWs, vCHPs (36.8%), HEW-supervisors (30.6%), graduated model-families (14%) were reported to support HEWs in the training of model-family.

HE packages prioritization during training of model-family

Majority of kebeles (78.9%) used criteria to prioritize health extension packages in the training of model-family. Among kebeles that use criteria (n=176), HEWs in 56.2% and 43.5% of kebeles gave priority for HE packages that are easily implementable in terms of time and cost, and HE packages that have high demand from the community, respectively.

Based on the criteria, the five HE packages that were given first priority were immunization (78.3%), excreta disposal (75.7%), maternal and child health (72.4%), personal hygiene (70.1%), and family planning (64.2%). HE packages that were not implemented as first priority by majority of kebeles include adolescent reproductive health (16.7%), control of insects, rodents and other biting species (31.8%), first-aid (36.8%), tuberculosis prevention and control (37.7%) and nutrition (39.8%).

Number of households currently under model-family training

Majority of the kebeles reported that they had households who were under model-family training during the survey. A quarter of the kebeles reported that 30 households or less were under training, while in about 41% of the kebeles, there were 31-60 households under training. Only 13% of the kebeles were not undertaking model-family training.

Drop-out of households during training for model-family

In about 61% of kebeles, HEWs reported that among the households enrolled for model-family training, there were some households that dropped-out from the model-family training before they finish the training.

Time taken to complete a round of model-family training

In 77.5% of kebeles, HEWs reported that they completed a round of model-family training over 3-4 months. In 11% of the kebeles, it took between 1-2 months to complete one round of model-family training; while in

another 11.5% of kebeles, it took 5 months or more to complete the training. Overall, to complete a round of model-family training it took an average of 3.6 months.

Number of model-family graduation rounds undertaken per kebele

Among the kebeles that had initiated implementation of model-family, 71% (153) kebeles had also graduated at least one batch of model-families, which corresponds to an overall coverage rate of 51.3% among all the 298 kebeles covered with HEP. Among kebeles that had graduated model-families, majority (48.1%) had undertaken two rounds of training and graduation. More than a quarter (28.5%) of kebeles had trained and graduated model-families three times.

Afar and Gambella regions were the only regions where there was not any kebele (among surveyed kebeles) that had graduated at least one round of model-family.

Criteria used for determination of model-family graduation

Although HEWs used multiple criteria for decision, construction of a latrine was used as a decision criterion in 77.2% of kebeles. Introduction of over 75% of HE packages and separating domestic animals from human habitation were criteria used in 69.6% and 62.9% of kebeles, respectively. The other commonly used criteria to determine readiness of households for graduation included completing 96 hours of training.

Celebration of graduation

Following the training and the assessment of the eligibility of households for model-family, 82.5% of kebeles celebrated the graduation of model-families with a ceremony. Majority (75.8%) of the kebeles also reported that all graduating model-family households were given a certificate of graduation.

Cumulative number of model-family households graduated

Nearly half (48.15) of the kebeles reported that they have between 51-200 households that had graduated as model-family since the start of the program. More than a quarter (28.5%) of the kebeles reported to have between 201-500 model-family households. The cumulative number of model-family households was less than 50 households in 15.4% of the kebeles, while 5.5% of kebeles reported that between 501-1000 households had graduated as model-family. Among kebeles that had graduated at least one round of model-family, the average total number of households graduated per kebele was 141. Overall, about 8.6% of households had graduated as model-family based on HEWs' report.

Impact of model-family

In majority of kebeles, HEWs had noticed a significant impact or change on all HE packages following the implementation of model-family in the kebele. However, the top three HE packages where HEWs in 95.6%, 88.6% and 88.4% of kebeles, respectively, noticed a significant impact were vaccination, family planning, and latrine construction and utilization.

Model-family implementation methods resulting in significant impact

HEWs in majority (85.4%) of kebeles reported that making house-to-house visits to meet household members to provide training at household level resulted in a significant impact. Using model-families to show positive changes and organizing community training with role models was also reported to result in a significant impact in 41.6% and 39.1% of kebeles, respectively.

MODEL-FAMILY IMPLEMENTATION – HOUSEHOLD SURVEY

Selection of households for model-family training

Among the over 7000 households surveyed, 838 households (11.2%) reported that their households were selected to participate in model-family training. There was a significant variation among the regions. Nearly a third (31.7%) of respondents in Tigray region reported that their household was selected for model-family training.

According to households that were not selected for training, majority (60.7%) stated that they don't know about model-family or why they were not selected for model-family training and about 18% thought that their households did not fulfilled the selection criteria.

According to households selected for training, the reasons for selection of their households were interest of the household to become model-family (40.2%), and the household head is a member of kebele counsel (25.4%). The people who were involved in selecting of households were HEWs (60.7%), community members (14.5%), and kebele counsel (14%).

Model-family training

About 61% of respondents reported that their household was investigated for living and health conditions by HEWs prior to mode-family training.

Among the 838 households selected, 56.9% (517) households reported that they had participated in model-family training. Among all households sampled for the HEP evaluation, overall 6.4% of households had ever participated in the model-family training.

Among the household members, husband (70.4%) and wife (36.1%) were reported to participate in the model-family training. Child household members over the age of 15 years and under 15 years were reported to have participated in 15% and 10% of the households, respectively.

Other than HEWs, the involvement of other health personal in the training of model-family was low. HEW-supervisors (11%), vCHPs (7.5%), and graduated model-families (6.5%) were reported to have been involved in training.

Nearly two-thirds (63.5%) of respondents reported that they attend training organized at kebele level. Training organized at sub-kebele and got levels was attended each by about 18% of households. About 42% of respondents reported that they received the training individually at household level. The most commonly used places for model-family trainings were at home (44.4%) and health post (43.7%). Model-family training sessions were also held at farmer training center (32.3%) and school (17.7%).

Majority (57.2%) of respondents reported that training at school/health post/FCT were organized for an average of one to two days per month, while 27.2% of respondents reported that such training were organized for three to four days per month. The overall average duration of the training sessions was 85 minutes.

Over half of respondents stated that they were visited 1-2 days per month by HEWs, and a similar proportion of households were visited 1-2 days per month by vCHPs. About half of respondents stated the training sessions at household level lasted for 30-60 minutes, while about a third stated that it lasted for less than 30 minutes.

HEP packages that were given priority as reported by about two-thirds of respondents each included food hygiene, HIV/AIDS prevention and control, personal hygiene, and family planning. HEP packages that was less frequently reported as priority areas included first aid, adolescent reproduction health and tuberculosis prevention and control.

Generally, the most frequently reported activities implemented by households were related to environmental hygiene and sanitation.

Model-family graduation

Among the households that had participated in model-family training, about two-third reported that they graduated as model-family prior to the survey.

Among all households sampled for the HEP evaluation, overall 4.3% of households had graduated as model-family training. Tigray region had the highest proportion of model-family households (12%), followed

by Amhara (4.9%) and Oromia (4.5%). There were no households that graduated as model-family among the households that were sampled from Afar, Gambela, and Harari regions.

Among the respondents who graduated as model-family, 62.7% reported that they graduated after 3-4 months of training. About 22% of respondents stated that the model-family training took only 1-2 months before graduation, while 15.5% stated that the training took 5 or more months.

Among households graduated as model-family, about two-thirds of respondents reported that their home was assessed to determine the eligibility of the household for graduation. A similar proportion of respondents reported that they were given a certificate of graduation during a graduation ceremony.

Readiness of model-families to support the community

Majority of respondents expressed their readiness to support the community. About 93% of the respondents said that they would encourage other households to start model-family training, 87.5% of respondents expressed their readiness to educate other households in their neighborhood on HEP services, and 84.5% would like to work as vCHP. Some (4.3%) of the respondents were already serving their community as vCHP.

Model-family coverage

Overall, among the over 7000 households sampled for the HEP evaluation survey, 4.3% of households were model-families; 2.1% of households were under model-family training at the time of the survey; and 4.8% of households were selected to start model-family training but had not yet participated in the training prior to the time of survey. There was significant variation in the coverage of households by model-family among the regions. Nearly a third of households in Tigray region were either graduated as model-family (12%), or currently under training (9.1%), or selected to start training (10.6%).

VOLUNTARY COMMUNITY HEALTH PROMOTERS (VCHPS)

Profile of the interviewed volunteer community health promoters (vCHPs)

From the 298 surveyed rural kebeles, in ten regional states of the country that were covered by HEP, 50.3% had Volunteer Community Health Promoters (vCHPs) and most of the vCHPs interviewed, (60%) were from SNNP and Amhara. A total of 615 vCHPs participated in the study, of which 73.7 % (448) were male. Two thirds of the interviewed vCHPs were between 25 and 39 years old. 48.4% had completed from grade 5 to grade 9 and 23.9% had completed from grade 1 to grade 4. Across all regions, 85.7% of interviewed vCHPs were married.

VCHPs recruitment and training

48% of the interviewed vCHPs indicated that health extension workers (HEWs) were involved during the selection of vCHPs and 45% indicated that district health officers were involved. The most commonly indicated selection criterion was acceptance by the community (93.4%). Being “socially active” and having interest to volunteer was also a common criterion, indicated by 83.7% of vCHPs. Somewhat surprisingly, from the provided alternatives, previously working as a conventionally recognized community worker (e.g., CHWs/TBAs/CBRHA) was the least common criterion, mentioned by only 40.6% of vCHPs.

51.1% of vCHPs had mentioned that they were trained from one to three days before serving the community; this report is in agreement with the national HEP implementation guideline. 84.9% of interviewed vCHPs indicated that their training included the entire health extension package. VCHPs had also indicated that 51.2% of their trainers were the district health office staffs followed by HEW trainers with 47.8%.

VCHPs roles, tasks, and workload

Overall 38.9% of the vCHPs had said there were 20 to 40 HHs assigned for them, this is in line with Ethiopia HEP implementation guideline. The alternative “to provide services to selected households to enable them to be transformed to model households” was selected by 60.4 % the vCHPs as an activity that was assigned for them while they start the work. House to house visit to educate or provide help for HHs was the

promotion strategy that 68% vCHPs used to give help for their beneficiaries. 51.2% vCHPs had indicated that on average they visit 4 to 6 HHs and 77% of vCHPs had mentioned to spend from 1 to 2 hours in each HHs.

Providing women/men with condom for contraception and for HIV/AIDS prevention was the first major activity to be mentioned by vCHPs as their duty. The next higher percentage as a duty was also reported for, provision of women with oral contraceptive pills with 23.4% and treat diarrheal cases with "ORS" 18%. However, there were also considerable proportion of vCHPs that have indicated provision of treatment for malaria, analgesic and the contraceptive Depo-Provera. It should be noted that vCHPs are not expected to provide any curative treatment and hence need to be clearly informed about their duties and responsibilities. HEWs should insure about their duties during supervision and monitoring vCHPs work.

Refreshment training, support and levels of awareness

VCHPs from Tigray, with 58.6% indicated that they have received refreshment training. 34.2% of vCHPs from both Amhara and SNNP indicated that they have received refreshment training. However, only 11.7% of vCHPs from Oromia indicated that they received refreshment training after they started their work as a vCHPs. 59.9% of the interviewed vCHPs indicated refreshment training and 43.3% indicated on-the-job support by HEWs and HEP supervisors as important mechanisms to improve their knowledge and skills.

Supervision of vCHPs and Incentives/benefits for vCHPs

85.9% of vCHPs have expressed that they get regular supervision from HEWs. Lastly it is also important to note that though they are volunteers and are working with out payment, 77.5% of vCHPs had feel that they should receive some kind of incentive for their services.

MODEL-FAMILY AND vCHPs SURVEY

HEP EVALUATION

RURAL ETHIOPIA

2010

TABLE OF CONTENTS

LIST OF TABLES

1. INTRODUCTION

1.1 BACKGROUND

Ethiopia established a Health Sector Development Program (HSDP), in 1997/8. Although, the overall performance of the health sector had improved under HSDP, in particular in urban areas, the success to reach essential services to the people at the grass roots level through HSDP had been quite limited. The major challenges of the health system included low access to health care services, widespread poverty, inadequate access to clean water and sanitation facilities, and low health service utilization. The higher cost associated with expansion of standard health services, and the long time lag between production and deployment of higher-level health professionals such as doctors continued to be the main challenges to address the health problems of rural and marginalized communities with the existing socio-economic situation of the country. The challenges were overwhelming, and the standard health system through the HSDP model could not address the major challenges. As a result, overall levels of disease burden, and child and maternal mortality appeared hardly to have shifted significantly in the six years that followed. For this reason, maternal and child mortality as well as the incidence of the major killers such as HIV/AIDs and malaria continued to be one of the highest in the world.

In 2004, Ethiopia launched Health Extension Program (HEP), to expand the national health program to include community based health interventions as a primary component of the HSDP. HEP is “a package of basic and essential promotive, preventive and curative health services targeting households in a community, based on the principle of Primary Health Care (PHC) to improve the families’ health status with their full participation”.

Rapid expansion of HEP services is a core component of the broader health system, and it is one of the strategies adopted with a view to achieving universal coverage of primary health care to the rural population by 2009, in a context of limited resources. The overall goal of HEP is to create a healthy society and reduce maternal and child morbidity and mortality rates. The specific objectives include: 1) reduce morbidity and mortality of children and mothers; 2) reduce morbidity and mortality from HIV/AIDS, tuberculosis and malaria through development of community skills and knowledge; 3) prevent diseases caused by malnutrition, poor personal hygiene and contaminated food; 4) prevent accidents and emergency illnesses, and administer first-aid to the injured and sick; and 5) develop community awareness, knowledge and skills in rural Ethiopia to prevent contamination from common sources including human excreta, animal wastes and pesticides.

1.2 HEP IMPLEMENTATION APPROACHES

HEP targets households to improve the health status of all household members. It encourages for the full participation of families and promotes the use of locally appropriate technologies and the skills and wisdom of communities. HEWs spend 75 percent of their time visiting families in their homes and performing outreach activities in the community. HEP aims to enable families

and the communities, in general, to produce their own health as a commodity in a way that is similar to their experience in producing agricultural products. This can be realized when all families are trained and have introduced the model-family packages, which is the first approach in HEP implementation.

The second approach involves community outreach, where HEWs involve the community in planning, implementation, and evaluation of the program, which ensures the full participation of the community to bring sense of ownership and sustainable changes in the community. The HEP implementation manual states the need to involve volunteer community health promoters (vCHPs), individuals from the community who are selected and trained on key health packages to help their community. vCHPs are expected to apply the health education in their own households and provide help for HEWs by mobilizing the community and by acting as role model in the community in order to form more model households. Moreover, HEWs use the traditional associations like Ekub and Edir and involve women and youth associations in the community. HEWs disseminate the preventive and promotive health messages through these mobilized community members.

Lastly, HEWs spent the remaining 25 percent of their time providing services at the health posts, including preventive health services such as delivery, immunizations and injectable contraceptives, and limited basic curative services such as first aid, and treatment of malaria, dysentery, intestinal parasites and other ailments. In addition HEWs are trained to refer cases to the nearest health center when more complicated care is needed.

1.3 MODEL FAMILY PACKAGE IMPLEMENTATION PROCESS

1.3.1 Selection of households for model-family training

Household for model-family training are selected based on the following criteria: ability to easily follow and understand the envisaged training; readiness to be model for other families; readiness for change; and willingness and ability to convince and change others. Such families are considered to be influential in the community and can convince the people in the community for change. During the first few model-family training, it is recommended that households with those who have been models in the agricultural extension program, traditional birth attendants, volunteer community health workers, health focal persons in the kebele. These groups of people are believed to be ready for change and they can also influence the behavior and practice of the community members.

1.3.2 Training of model-family

Training at central location: The training site is located in central place at in an average distance for all the participants in the training. In one round of four months training, about 40-60 families are enrolled in the training. On an average year, about three rounds of model family trainings are conducted. The trainings have time schedule and two hours of training are delivered per day. The training comprises a total of 96 hours of training on basic hygiene and environmental sanitation (30 hours), family health care (42 hours) and disease prevention and control (24

hours). The trainings are interactive with questions and answers, group discussions and role plays are also used.

Home Visit: During the course of the theoretical training, the HEWs continue to make regular home visits to help the trainee community members to implement what they have learnt in practical terms. One HEW reaches 6-8 houses per day to teach and guide the trainees on practical activities. The HEW is expected to visit and interact with one family member at least eight times during the course of the four months.

Prioritization of model-family packages: The model family packages that are given first priority to be implemented by households include activities that are very easy and cheap to implement, and activities that do not contradict with the community's value. This strategy ensures acceptability by the community and facilitates the scale up of the changes in the community. In general the introduction of model family packages is undertaken in three phases.

Table 1.1: Phased introduction of model family packages to households during model family training

Phase I activities	**Phase II activities**	**Phase III activities**
Maintaining personal hygiene	Food and Environmental sanitation	Female Genital Mutilation
Building and using latrines	Home sanitation and waste disposal	Uvulactomy
Storing and using clean potable water	Solid and liquid waste management/disposal	Milk tooth extraction
ANC, delivery and postnatal care services	Prevention and Control of flies and insects	Blood letting
Immunization services	Preparation and feeding of nutritional foods	Early marriage
Breastfeeding and complementary feeding	Supplementary food for children	
Family Planning service	Treatment of sick child at home/health facility	
Pregnant and lactating women feeding	Youth reproductive health and premarital HIV testing	
Infant care	TB prevention and control	
Malaria prevention and control	Benefits of First Aid treatment	
HIV/AIDS prevention and control	Identification and prevention of epidemics	

1.3.3 Graduation of model-families

Households who took model family training are evaluated for their works and changes within six months after completion of training. Households adopting and applying more than 75% of the 16 health service packages of the HEP and fulfill other criteria, get certificate of completion and graduate as model families. On their graduation, other people from the neighboring community are invited so that it brings impressions to these invited people, which helps to expand the program to these neighboring communities and the graduating families promise in front of the people for their commitment in addressing what they have learnt. Some of the necessary indicators used for evaluating households to determine if they should be graduated as model family are:

- Construction of toilet and appropriate use
- Preparation of dry waste disposal area for use
- Keeping the hygiene of food preparation utensils
- Keeping personal hygiene
- Keep and use water appropriately
- Keeping the health of mothers and children

- Use of mosquito bed net, seeking immediate treatment for malaria illnesses
- Knowledge on HIV/AIDS with no stigma and discrimination towards those living with HIV/AIDS

1.3.4 Responsibilities of graduated Model Families

- Keep the work of the health extension activities and be role models for others
- Gather every month for experience sharing
- In addition to changing their own behavior, model-families are expected to mobilization the community for the health activities and influence their neighbors and relatives through diffusion of health messages to bring behavioral change for improved health outcome.

1.3.5 Expansion of the Model Family Package

Lessons learnt while implementing the HEP through the model families help to expand the model family package. From the lessons learnt while training the first 40 model families in the first round, the HEWs apply the lessons to train 45 model families in the second round and 55 model families in the third round for four months each. In the first one year, both of the HEWs train and graduate 280 model families. In the second year 60 new families are trained in 4 months in one group and two of the HEWs train and graduate 360 model families in the second year. In the third year also, 60 new families are trained in four months time in one group and 360 model families graduate in a one year time. Therefore, in three years time all families in one kebele become model families. However, to make all the families model families, it doesn't take three years. Voluntary community health promoters (vCHPs) who graduated as model family teach their neighbors and relatives to facilitate the graduation of model families. The vCHPs are assigned voluntarily 5-10 families to train and graduate as model families and this helps in expanding the model family package in the community. Moreover, model families teach other households by going home to home to convince and bring the desired changes. Through time, the dissemination of the information by the model families reaches all the community members.

1.3.6 Sustaining the model family activities

- Support and follow the model families to keep their activities and not to get behind what they have done
- Support the trained vCHPs to keep the changes in their family and help them to encourage other families to maintain the positive changes
- Support the community to be organized in youth and women associations to strengthen what has been done
- Encourage model families to motivate themselves
- Conduct focused group discussions in different health issues
- Support the community to set rules and regulations that will help to bring social changes

1.4 VOLUNTARY COMMUNITY HEALTH PROMOTERS (VCHPS)

Volunteer health workers in rural Ethiopia being trained and supported by either Ministry of Health (MoH) or NGOs in the country have been giving help for the rural health system and the rural community for several decades. These community health workers are known by different

names like Kebele health representatives, trained traditional birth attendants, HIV/AIDS home based care givers, home based malaria workers, community health workers (CHWs), community based reproductive health agent (CBRHA), health development army (HDA), etc. However, a systematic and organized way of using volunteers in order to support the rural health system of the country has started as a recent phenomenon in the country with the establishment of Health Extension Program (HEP). The Ethiopian HEP implementation manual states that volunteer community health promoters (vCHPs) are individuals from the community who are selected and trained with key health packages and volunteer to help their community. The training provided to them emphasizes mainly on behavioral change and health related activates that are feasible to be implemented by vCHPs. After the training vCHPs are expected to apply the health education in their own households and then they should teach and give help for their friends and neighbors.

Health extension workers (HEWs) select households from their model households, households that have successfully completed the 16 HEP packages, to be vCHPs based on their performance as a model household and their interest. The community is also expected to participate during recruitment of vCHPs. In Kebeles where there are no model households, vCHPs will be recruited from the general community based on community participation. The criteria used to select these vCHPs include: working effectively on the health extension package, member of the community who are interested to volunteer as a health promoter and individuals who are respected by the community. The HEP implementation manual specifies that more than 50% of the vCHPs needs to be women and individuals who at least can read and write. VCHPs provide help for the HEP by giving help for HEWs and by acting as role model in the community in order to form more model households. VCHWs should plan, implement and monitor applicable work plans with HEWs. Moreover, they mobilize the community during campaigns and disease epidemics and they provide education for households on hygiene and environmental sanitation, disease prevention and control and family health education and services.

MODEL-FAMILY IMPLEMENTATION – HEW SURVEY

HEP EVALUATION

RURAL ETHIOPIA
2010

TABLE OF CONTENTS

LIST OF TABLES

TABLE OF FIGURES

3. MODEL FAMILY IMPLEMENTATION – HEW SURVEY

3.1 HEWS' AWARNESS ON MODEL-FAMILY STANDARD

HEWs working in kebeles where training of model-family had started were asked on the HEP standard in the implementation of model-family to determine their understanding of the standard implementation guideline. The questions included the standard on the number of households that should be recruited for training in one round, the total training-hours each household should receive before graduation, and the time period over which the training of a batch of households should be completed.

HEWs working in majority (57.4%) of kebeles reported that 31-60 households should be recruited for training in one round, while HEWs in about 21% and 19% of kebeles said 5-30 households and 60-100 households, respectively, should be recruited for training in one round. With regard to the total training-hours each household should receive, HEWs in 84.7% of the kebeles reported that the standard is 60-96 hours. Similarly, HEWs in 78.6% of kebeles reported that the training of one batch of model-family should be completed within 3-4 months.

Table 3-1: Percent distribution of kebeles by the response of HEWs on the standard number of households, training hours, and duration of training to carry-out one round of model-family training

	Number of households			No. of training-hours		Duration of training in months			No. of HPs
Region	**5-30**	**31 - 60**	**61 - 100**	**30 - 60**	**61 - 96**	**1-2**	**3-4**	**5-6**	
Tigray	9.9	53.4	36.7	14.1	85.9	17.3	63.4	15.9	28
Afar	0.0	100.0	0.0	100.0	0.0	0.0	100.0	0.0	1
Amhara	19.3	51.9	27.6	14.8	81.9	35.9	49.0	13.5	53
Oromia	17.2	53.1	25.7	7.8	81.8	0.0	96.4	0.9	64
Benshangul	38.4	61.6	0.0	23.2	76.8	0.0	57.6	42.4	5
SNNP	18.6	79.8	1.6	3.8	96.2	11.5	88.5	0.0	44
Gambela	100.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	1
Dire Dawa	0.0	0.0	100.0	100.0	0.0	100.0	0.0	0.0	1
Harar	0.0	100.0	0.0	0.0	100.0	0.0	100.0	0.0	4
Somali	80.3	5.2	0.0	19.7	65.7	9.8	57.3	18.4	13
Total	**21.1**	**57.4**	**19.0**	**9.8**	**84.7**	**13.3**	**78.6**	**5.8**	**214**

3.2 YEAR MODEL-FAMILY TRAINING STARTED

Training of model-family started in 1997 in about 1% of kebeles, which were from Tigray and Amhara regions only. The scale-up of model-family implementation to other kebeles and regions was very progressive over the next five years. About 6.8% of kebeles (mainly in Tigray, Amhara, and SNNP regions) initiated training of model-family in 1998. The peak implementation year was 2001. The percentages of kebeles that initiated model-family training in 1999, 2000, 2001, and 2002 were 13.5%, 17.9%, 35.8% and 22.5% respectively. The result for 2002 comprises data from September to January 2002 only, because the survey was done in February 2002.

There were variations in the time of initiation and rate of scale-up of model-family training between the regions. In Tigray region, some kebeles (8.9%) initiated training in 1997, and by 1998 more than half of the kebeles initiated model-family training. In Amhara and SNNP

regions, although some kebeles initiated model-family training in 1997 (Amhara) and 1998 (SNNP), it reached to half of the kebeles only in 2000 in both regions. Dire Dawa and Harari regions started in 2000. Afar, Benshangul, and Somali regions started in 2001, while Gambela only started in 2002.

Table 3-2: Percent distribution of kebeles that initiated model-family training by year training was initiated and region, rural Ethiopia 2010

Region	1997	1998	1999	2000	2001	2002*	No. of HPs
Tigray	8.9	44.5	8.3	12.1	14.4	11.9	28
Afar	0.0	0.0	0.0	0.0	100.0	0.0	1
Amhara	1.7	12.5	17.5	20.7	26.9	19.0	53
Oromia	0.0	0.0	8.0	7.6	51.1	33.3	64
Benshangul	0.0	0.0	0.0	0.0	38.4	61.6	5
SNNP	0.0	4.2	22.1	35.2	27.8	5.1	44
Gambela	0.0	0.0	0.0	0.0	0.0	100.0	1
Dire Dawa	0.0	0.0	0.0	100.0	0.0	0.0	1
Harar	0.0	0.0	0.0	25.0	25.0	50.0	4
Somali	0.0	0.0	0.0	0.0	29.4	56.1	13
Total	**1.0**	**6.8**	**13.5**	**17.9**	**35.8**	**22.5**	**214**

*The result for 2002 comprises data from September to January 2002 only, because the survey was done in February 2002.

3.3 PREPARATION FOR MODEL-FAMILY TRAINING

3.3.1. Preparatory activities

HEWs undertake various activities in preparation for the implementation of model-family. In 46% of kebeles, HEWs reported that they prepared evidence based health profile of all households in the kebele. Moreover, HEWs in about 40% of kebeles reported that they studied the demography, socio-economic and cultural conditions of all households in the kebele in preparation for training of model-families. Once households were selected for model-family training, HEWs in about 43% and 36% of kebeles reported that they studied the household and health conditions, respectively of the recruited households prior to training. In about a quarter (23.3%) of the kebeles, HEWs undertook orientation of stakeholders on HEP and their duties.

Table 3-3: Preparatory activities undertaken by HEWs before carrying-out model-family training

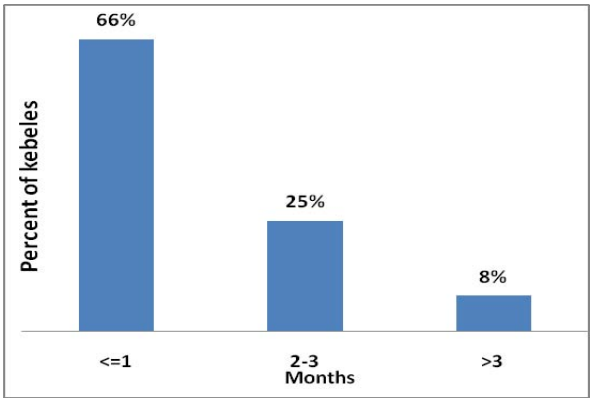
Region	Activities targeting all households in the kebele			Activities targeting recruited HHs		Orientation of stakeholders on HEP & their duties	No. of HPs
	Prepare evidence based health profile	Study the demography	Study the socio-economic & cultural conditions	Study the conditions of households	Study the health conditions		
Tigray	47.5	78.9	64.4	38.0	41.5	26.0	28
Afar	100.0	0.0	100.0	0.0	0.0	0.0	1
Amhara	39.9	39.9	38.0	31.4	34.2	31.9	53
Oromia	56.4	42.5	47.1	56.9	30.0	18.2	64
Benshangul	38.4	57.6	100.0	57.6	61.6	0.0	5
SNNP	44.0	39.5	29.1	35.0	50.8	26.8	44
Gambela	0.0	100.0	0.0	100.0	0.0	0.0	1
Dire Dawa	0.0	0.0	0.0	0.0	0.0	100.0	1
Harar	50.0	25.0	25.0	25.0	100.0	0.0	4
Somali	5.2	9.2	27.6	42.9	4.0	4.0	13
Total	**45.9**	**41.4**	**40.6**	**42.9**	**35.9**	**23.3**	**214**

3.3.2. Time needed to undertake preparatory activities

In about two-third (66%) of kebeles, HEWs reported that they had carried out the preparatory activities over one month period. In a quarter of the kebeles, it took between 2-3 months to carry out the preparatory activities, while in about 8% of the kebeles it took more than 3 months.

.

Figure 3.1: Percent distribution of kebeles by the time taken to undertake preparatory activities for model-family training



3.3.3. Reason for taking longer time to undertake preparatory activities

HEWs in the kebeles where the preparatory activities took more than one month were asked why it took that much time. The main reasons (challenges) reported in majority of these kebeles were lack of community interest (47.8%), lack of support from kebele administration (40.2%), lack of sectoral collaboration (34.9%) and lack of support from district health office (30.7%). There was variation on the reported challenges among the regions. In Tigray region, the main reasons were lack of support from kebele administration, lack of sectoral collaboration, and lack of support from district health office, which were reported in 71.2%, 71.8%, and 45.9% of kebeles respectively. The reasons reported in Amhara were lack of support from kebele administration (55%), lack of sectoral collaboration (39.8%), and lack of support from district health office (38%). In SNNP and Oromia regions, lack of community interest was the main reason reported in 79.2% and 52.1% of kebeles respectively.

Table 3-4: Main reasons reported by HEWs for taking longer time to undertake the preparatory activities

Region	Lack of community interest	Lack of support from kebele council	Lack of sectoral collaboration	Lack of support from district health office	Lack of support from HEW-supervisor	Lack of supplies	Lack of support from nearby HC	Conflicting priorities	No. of HPs.
Tigray	37.1	71.2	71.8	45.9	40.7	34.8	33.5	20.7	16
Afar	0.0	100.0	100.0	0.0	0.0	0.0	0.0	0.0	1
Amhara	27.1	55.0	39.8	38.0	33.2	15.5	22.7	3.4	22
Oromia	52.1	31.6	24.7	29.6	25.2	21.0	12.1	5.9	18
Benshangul	52.5	47.6	47.6	71.3	71.3	71.3	47.6	0.0	4
SNNP	79.2	22.7	27.7	19.7	16.6	19.3	16.6	19.3	13
Gambela	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Harar	0.0	0.0	0.0	100.0	100.0	0.0	0.0	0.0	1
Somali	21.5	0.0	0.0	0.0	40.5	0.0	0.0	0.0	4
Total	**47.8**	**40.2**	**34.9**	**30.7**	**28.3**	**20.0**	**18.5**	**9.6**	**80**

3.4 HOUSEHOLD SELECTION PROCESS

3.4.1. Criteria for selection of households for model-family training

Household characteristics

HEWs were asked what household characteristics were used as criteria in the identification and selection process of households for model-family training. HEWs in 80.2% of kebeles reported that households that were model in changing others were given priority in the selection process. Member of kebele administration, previously working as CHW/TBA/CBRHA, and interest to practice the HEP service packages were also used as criteria in selection of households in 43.6%, 41% and 38.6% of kebeles, respectively. Being a member of a party or an association was used as a selection criterion in about a third of the kebeles. Female household head and young household head were also used as selection criteria in 21.7% and 20.2% of kebeles, respectively. There was some variation in the relative importance of these household characteristics by region.

Table 3-5: Household characteristics used in the selection of households for model-family training

Region	Model in changing others	Member of kebele council	CHW/ TBA/ CBRHA	Interested to practice HEP	Member of an association	Sex of household head		Age of household head		Relative of HEW	No. of HPs
						Female	Male	Young	Old		
Tigray	75.3	73.0	79.7	25.4	50.4	16.1	10.5	10.5	8.0	14.5	28
Afar	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	1
Amhara	66.6	63.9	49.5	23.1	42.9	15.0	8.4	24.5	4.8	34.6	53
Oromia	88.4	43.3	41.7	50.4	31.6	22.8	19.4	23.4	13.7	5.4	64
Benshangul	80.8	57.6	76.8	42.4	57.6	76.8	57.6	57.6	57.6	57.6	5
SNNP	90.6	25.9	24.5	45.9	14.7	24.1	11.3	17.5	10.0	5.5	44
Gambela	100.0	100.0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Dire Dawa	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Harar	75.0	75.0	50.0	25.0	25.0	75.0	25.0	25.0	25.0	75.0	4
Somali	38.7	8.0	34.1	8.0	15.0	32.9	0.0	0.0	9.2	0.0	13
Total	**80.2**	**43.6**	**41.0**	**38.6**	**30.4**	**21.7**	**13.2**	**20.2**	**10.2**	**13.3**	**214**

Social and environmental factors

In addition to the household characteristics used as criteria for selection of households for model-family training, HEWs also reported the use of facilitating social and environmental conditions in the selection of households. The three most commonly used facilitating social and environmental conditions in selection of households included availability of local materials, availability of labor and households located in the same neighborhood, which were reported by HEWs in 49.5%, 45.7% and 45.7% of kebeles, respectively.

Table 3-6: Facilitating social and environmental conditions used in the selection of households for model-family training

Region	Availability of local materials	Availability of family labor	Group of households located in the same neighborhood	Households located close to health post	Availability of basic household data on record	Rich/affluent family that can easily become a model household	No. of HPs
Tigray	71.1	43.1	59.7	55.8	38.3	27.8	28
Afar	100.0	0.0	100.0	0.0	0.0	0.0	1
Amhara	42.4	40.1	48.6	38.0	10.6	36.2	53
Oromia	43.2	44.8	43.9	31.9	41.0	27.6	64
Benshangul	100.0	76.8	19.2	57.6	38.4	19.2	5
SNNP	61.8	57.1	46.6	46.0	40.5	31.7	44
Gambela	100.0	100.0	0.0	100.0	100.0	0.0	1
Dire Dawa	100.0	100.0	100.0	100.0	100.0	0.0	1
Harar	75.0	50.0	25.0	50.0	50.0	0.0	4
Somali	31.8	23.6	24.2	32.9	23.7	0.0	13
Total	**49.5**	**45.7**	**45.7**	**38.7**	**32.4**	**29.1**	**214**

3.4.2. People involved in the selection of households

HEWs in 85.2% of the kebeles reported that HEWs were involved in the selection of households for model-family training. In more than half (56.8%) of the kebeles, it was reported that kebele administration was involved in the selection of households. VHPs/CHWs were also involved in selection of households in almost half of the kebeles. In about a quarter of the kebeles, HEWs reported that opinion leaders and HEW-supervisors were involved. The interesting finding is that in about 16% of the kebeles, graduated model-families were involved in the selection of households for model-family training.

The involvement of HEWs in selection of households for model-family training was the highest in SNNP region, where they were involved in 94.4% of kebeles. On the other hand, the involvement of kebele administration, VHPs/CHWs, HEW-supervisors, and graduated model-family was higher in Tigray region, where they were involved in about 76.5%, 78.2%, 50.7% and 38.3% of kebeles, respectively.

Table 3-7: People involved in the selection of households for model-family training

Region	HEWs	Village administration	VHPs/ CHWs	Opinion leaders	HEW Supervisor	Community members	Graduated model-family	No. of HPs
Tigray	78.5	76.5	78.2	21.2	50.7	32.9	38.3	28
Afar	100.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Amhara	84.3	57.0	53.3	28.9	16.6	25.0	10.3	53
Oromia	88.2	63.3	42.1	31.6	25.0	20.4	20.4	64
Benshangul	80.8	57.6	100.0	57.6	0.0	19.2	19.2	5
SNNP	94.4	42.6	56.4	16.1	27.5	14.1	7.1	44
Gambela	100.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Dire Dawa	100.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Harar	75.0	100.0	0.0	50.0	75.0	25.0	25.0	4
Somali	32.2	58.4	23.7	34.7	0.0	5.2	29.5	13
Total	**85.2**	**56.8**	**49.8**	**26.5**	**23.7**	**19.7**	**16.0**	**214**

3.5 MODEL-FAMILY TRAINING

3.5.1. Number of model-family training rounds undertaken per kebele

The total number of kebeles that have started at least one round of model-family training was 214. Among these kebeles, about 21.7% and 22.6% of the kebeles have undertaken one and two rounds of training, respectively, since the start of HEP. More than a quarter (28.6%) of kebeles have undertaken three rounds of training, while about 26.1% of kebeles have undertaken four or more rounds of model-family training since the start of the model-family in the kebele. Among the kebeles that have started training of model-family households, the average number of model-family training rounds undertaken was 2.4 times per kebele.

Majority of kebeles in Amhara (39%) and SNNP (43.5%) regions had undertaken at least four rounds of model-family training. About a quarter (26.5%) of kebeles in Tigray region and only 9.6% of kebeles in Oromia region had undertaken at least four rounds of model-family training. About a third of kebeles in Oromia region had undertaken one round of model-family training since the start of HEP in the kebele. Kebeles in SNNP region undertook an average of 3.6 rounds of model-family trainings, and kebeles in Tigray and Amhara regions undertook, on average, 3.1 and 3.3 rounds, respectively.

Table 3-8: Percent distribution of kebeles by the number of model-family training rounds undertaken since the start of the strategy

Region	1	2	3	>=4	Average number	No. of HPs
Tigray	7.9	22.9	38.8	26.5	**3.1**	28
Afar	100.0	0.0	0.0	0.0	**1.0**	1
Amhara	16.5	15.1	29.4	39.0	**3.3**	53
Oromia	32.2	29.6	28.6	9.6	**2.2**	64
Benshangul	42.4	0.0	19.2	38.4	**2.5**	5
SNNP	12.3	15.8	28.4	43.5	**3.6**	44
Gambela	100.0	0.0	0.0	0.0	**1.0**	1
Dire Dawa	0.0	0.0	100.0	0.0	**3.0**	1
Harar	25.0	50.0	25.0	0.0	**2.0**	4
Somali	27.8	42.7	15.0	0.0	**1.9**	13
Total	**21.7**	**22.6**	**28.6**	**26.1**	**2.4**	**214**

3.5.2. Number of households enrolled per round of model-family training

Data on the number of households enrolled for model-family training during the last three rounds of training was collected. There was a huge variation in the number of households selected and enrolled per round of model-family training within and between regions. Moreover, the number of households enrolled per round increased over the last three rounds. Majority (51%) of kebeles had enrolled between 31-60 households for model-family training during round one. Among the kebeles that had undertaken at least two rounds of model-family training (a total of 167 kebeles), about 44% of kebeles had enrolled between 31-60 households during the second round. Among kebeles that had undertaken three or more rounds of model-family training (a total of 121 kebeles), about 41% had enrolled between 31-60 households during the third training. There were some kebeles that enrolled 30 households or less during a round of model-family training, although the proportion of kebeles decreased over the three rounds – 19.4%, 12.3% and 6.4% of kebeles during the first, second and third rounds, respectively. On the other hand, 29.5%, 38.9% and 45.4% of the kebeles had enrolled 61 households or more during the first, second and third rounds of the model-family training, respectively.

Table 3-9: Percent distribution of HPs by number of HHs enrolled per model-family training round, rural Ethiopia 2010

Region	Round-1				Round-2				Round-3			No. of HPs
	<=30	31-60	>60	Total	<=30	31-60	>60	Total	<=30	31-60	>60	
Tigray	14.4	51.9	33.7	28	12.2	33.3	42.6	26	15.0	21.8	36.6	20
Afar	0.0	100.0	0.0	1	-	-	-	0	-	-	-	0
Amhara	22.4	48.3	29.3	53	22.1	43.1	34.8	46	9.9	62.0	28.2	36
Oromia	13.3	44.6	42.2	64	9.3	47.3	42.0	44	0.0	24.8	68.3	26
Benshangul	80.8	19.2	0.0	5	0.0	100.0	0.0	1	0.0	0.0	0.0	1
SNNP	12.9	72.4	14.8	44	0.0	50.1	43.5	38	2.5	43.1	46.7	34
Gambela	100.0	0.0	0.0	1	-	-	-	0	0.0	0.0	100.0	0
Dire Dawa	100.0	0.0	0.0	1	0.0	0.0	100.0	1	0.0	0.0	100.0	1
Harar	0.0	100.0	0.0	4	0.0	66.7	33.3	3	0.0	0.0	100.0	1
Somali	80.3	5.2	14.5	13	67.1	0.0	0.0	8	100.0	0.0	0.0	2
Total	**19.4**	**51.1**	**29.5**	**214**	**12.3**	**44.2**	**38.9**	**167**	**6.4**	**41.4**	**45.4**	**121**

3.5.3. Level and setting/venue of model-family training

Level of training

HEWs were asked at what level they usually provided the training of households selected for model-family. In the majority of kebeles, combinations of various levels of training (at got, at sub-kebel, at kebele and at household level) were used by HEWs. In more than a third (35.6%) of the kebeles, model-family training at household level was used, where HEWs met with each selected household individually to provide specific training for the specific household.

Overall, model-family training organized at got, sub-kebele and/or kebele levels was used in about 87% of the kebeles. HEWs working in more than half (56.6%) of the kebeles reported that they provided training at got level. With this approach, all households selected from a specific got were trained as a group rather than individually. HEWs in about 24.6% of kebeles provided training at sub-kebele level, where all households selected from a specific sub-kebele received training as a group. In 29% of kebeles, all households selected in the kebele for model-family training received training as a group. About 13% of kebeles did not organize training sessions at got, sub-kebele and/or kebele levels, and provided training only at household level.

There was some variation between the regions on the proportion of kebeles that used the various levels of training. Training at got level was commonly used in Tigray region (81.5%), whereas training at household level was commonly used in Amhara region (48.4%). Training at sub-kebele level was more practiced by kebeles in Oromia region – by 38.4% of kebeles.

Setting/venue of model-family training

The setting of model-family training is the place where HEWs meet with households (individually or as a group) to provide training. The commonly used settings for training included home, health post, farmers training center and school reported by 40.1%, 38.9%, 26.6% and 18.7% of kebeles, respectively. Only 44.4% of kebeles used demonstration unit for sanitation during training of model-families.

Training of model-family households at home was most commonly used in Amhara region (56% of kebeles), while it was used only by 32% of kebeles in Oromia region. Training at the health post was most commonly used in SNNP region (in 63.6% of kebeles) followed by Tigray region (in 54.7% of kebeles), while health post was used only by 37% and 18% of kebeles in Amhara

and Oromia regions, respectively. Schools and farmers training centers were mainly used for training in Tigray region, where it was used in more than half of the kebeles.

Table 3-10: Level and setting of model-family training by region, rural Ethiopia 2010

Region	Level of training				Setting (place) of training				Demonstration unit used	No. of HPs
	At household	At got	At sub-kebele	At kebele	At home	At health post	At farmers training center	At school		
Tigray	32.6	81.5	27.9	32.9	43.9	54.7	51.6	51.6	55.3	28
Afar	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	0.0	1
Amhara	48.4	60.5	11.2	18.0	56.0	37.0	28.6	14.9	49.8	53
Oromia	26.7	54.1	36.5	27.3	32.0	18.8	24.2	17.5	34.4	64
Benshangul	57.6	38.4	38.4	80.8	57.6	80.8	57.6	0.0	76.8	5
SNNP	38.6	60.4	18.4	36.8	38.6	63.6	27.3	18.4	43.7	44
Gambela	0.0	100.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	1
Dire Dawa	0.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0	100.0	1
Harar	25.0	100.0	0.0	25.0	25.0	50.0	75.0	50.0	100.0	4
Somali	29.4	14.5	23.6	42.7	29.4	46.8	0.0	5.2	77.4	13
Total	**35.6**	**56.6**	**24.6**	**29.0**	**40.1**	**38.9**	**26.6**	**18.7**	**44.4**	**214**

3.5.4. Time devoted by HEWs for model-family training

Time devoted for training at got/sub-kebele/kebele level

The number of kebeles that reported to provide training at got, sub-kebele and/or kebele levels were 186. HEWs in majority (73.1%) of these kebeles undertook model-family training organized at got/sub-kebele/kebele levels for one to two days per week, while HEWs in a quarter of the kebeles undertook such training for three to four days per week. HEWs were also asked for the duration of each training session. HEWs in 52.5% of kebeles spent 2 hours per training-day (days when they provide training) to provide model-family training at got, sub-kebele, and/or kebele levels. In more than a third (35.3%) of kebeles, HEWs spent three or more hours per training-day organized at got, sub-kebele, and/or kebele levels.

When training sessions were organized at got/sub-kebele/kebele levels, about 47% of the kebeles reported that 5-30 households attended the training sessions. A similar proportion (45.3%) of kebeles reported that 31-60 households attended the training sessions.

Table 3-11: Percent distribution of HPs by time spent for model-family training at Sub-kebele/Kebele, rural Ethiopia 2010

Region	No. of days per week			No. of hours per day			No. of HHs per session			No. of HPs
	1-2	3-4	5-6	1	2	3+	5 - 30	31 - 60	61 - 100	
Tigray	63.3	36.7	0.0	7.2	58.0	34.8	40.6	51.7	7.7	26
Afar	0.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	0.0	1
Amhara	65.2	65.2	5.6	13.1	25.3	61.6	47.0	53.0	0.0	38
Oromia	75.1	75.1	2.0	10.6	54.7	34.7	46.6	37.2	16.3	61
Benshangul	52.5	52.5	47.6	0.0	76.2	23.8	47.6	52.5	0.0	4
SNNP	78.3	78.3	0.0	16.2	66.5	17.3	43.0	55.3	1.7	40
Gambela	0.0	0.0	0.0	100.0	0.0	0.0	100.0	0.0	0.0	1
Dire Dawa	100.0	100.0	0.0	0.0	0.0	100.0	0.0	0.0	100.0	1
Harar	50.0	50.0	0.0	0.0	50.0	50.0	0.0	100.0	0.0	4
Somali	79.9	79.9	7.2	7.2	59.6	33.1	92.8	7.2	0.0	10
Total	**73.1**	**24.5**	**2.5**	**12.1**	**52.5**	**35.3**	**47.1**	**45.3**	**7.6**	**186**

Model-family training at home level

Training of model-family at household level was used in 77 kebeles. HEWs in 44% of these kebeles undertook model-family training for three to four days per week at household level, while HEWs in 41% of the kebeles undertook such training one to two days per week. HEWs in about 61% of kebeles visited 8-12 households per day (during days devoted for training) to provide, while HEWs in a third (32%) of kebeles reported to have visited between 4-7 households per day. In about 60% of kebeles, HEWs made 1-2 visits per household over one week period, while in about a third (34.2%) of kebeles, HEWs made 3-4 visits to each household over one week period.

HEWs in 37% of kebeles spent 30-60 minutes per training visit per household, while HEWs in about 32% of kebeles spent more than 60 minutes per training visit. HEWs in less than a third (31%) of kebeles spent less than 30 minutes during a visit to a household to provide model-family training.

Table 3-12: Percent distribution of health posts by HEWs' time spent for model family training at home

Region	No. of days per week			No. of HHs visited per day			No. of visits per HH per week			Time spent per visit (minutes)			No. of HPs
	1-2	3-4	5-6	1-3	4-7	8-12	1-2	3-4	5-6	<30	31-60	<60	
Tigray	12.3	87.7	0.0	0.0	0.0	100.0	12.3	87.7	0.0	0.0	50.4	49.6	**8**
Afar	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Amhara	41.9	41.2	16.9	6.2	30.6	63.2	64.2	33.3	2.6	27.4	21.9	50.8	27
Oromia	35.9	35.7	28.4	0.0	30.7	69.3	50.0	32.7	17.3	29.1	43.3	27.6	19
Benshangul	0.0	0.0	100.0	0.0	100.0	0.0	0.0	0.0	100.0	0.0	100.0	0.0	1
SNNP	46.7	49.9	3.4	15.8	34.6	49.7	71.7	28.3	0.0	48.1	43.4	8.5	17
Gambela	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Dire Dawa	-	-	-	-	-	-	-	-	-	-	-	-	**-**
Harari	100.0	0.0	0.0	0.0	0.0	100.0	100.0	0.0	0.0	0.0	100.0	0.0	1
Somali	78.5	21.5	0.0	21.5	78.5	0.0	78.5	21.5	0.0	0.0	38.1	61.9	4
Total	**41.2**	**44.0**	**14.9**	7.4	32.0	60.6	**59.7**	**34.2**	**6.1**	**31.2**	**37.0**	**31.9**	**77**

3.5.5. Household members who attended model-family training session

Model-family training at got/sub-kebele/kebele level

HEWs working in 93.1% and 94.2% of kebeles reported that husband and wife, respectively, had ever participated model-family training organized at got, sub-kebele, and/or kebele levels. In about half (49.3) of the kebeles, HEWs reported that female child older than 15 years had ever participated in such trainings. HEWs in a similar proportion (48%) of kebeles also reported male child older than 15 years had ever participated in the model-family trainings. In a significant number of kebeles, HEWs reported that mothers, grandmothers, fathers, grandfathers also participated in model-family training organized at got, sub-kebele, and/or kebele levels.

Table 3-13: Percent of kebeles by HH members who participate model-family training at Got/Sub-kebele/Kebele level, rural Ethiopia 2010

Region	Husband	Wife	Female child >15 yrs	Male child >15 yrs	Female child <15 yrs	Male child <15 yrs	Mother, grandmother, mother-in-law	Father, grandfather, father-in-law	No. of HPs
Tigray	95.5	95.8	81.6	82.5	14.8	14.8	75.6	66.8	26
Afar	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Amhara	100.0	98.2	52.0	34.7	15.0	12.2	35.4	33.1	38
Oromia	100.0	94.4	44.6	53.7	8.5	8.6	42.3	42.3	61
Benshangul	76.2	100.0	100.0	100.0	47.6	47.6	71.3	71.3	4
SNNP	92.5	92.5	45.6	47.7	20.0	20.0	38.9	31.0	40
Gambela	100.0	100.0	100.0	100.0	0.0	0.0	100.0	0.0	1
Dire Dawa	100.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Harari	100.0	100.0	100.0	75.0	75.0	50.0	100.0	100.0	4
Somali	5.6	79.7	51.2	5.6	7.2	0.0	45.2	7.2	10
Total	**93.1**	**94.2**	**49.3**	**48.0**	**13.5**	**12.6**	**42.3**	**37.4**	**186**

Household members who attended model-family training at home

Among kebeles where HEWs provide model-family training at home, wife attend the training in 97.6% of kebeles. HEWs in 88.9% and 88.3% of kebeles reported that husband and female child older than 15 years, respectively, had ever attended training at home. HEWs in a significant proportion of kebeles, also reported that male child older than 15 years (69%); and mother, grandmother and/or mother-in-law (61.9%) had ever attended the training at home. In more than half of the kebeles, it was reported that female and male children younger than 15 years and father, grandfather and/or father-in-law had ever attended the training at home.

Table 3-14: Household members who have ever participated during training of model-families at home

Region	Husband	Wife	Female child >15 yrs	Male child >15 yrs	Female child <15 yrs	Male child <15 yrs	Mother, grandmother, mother-in-law	Father, grandfather, father-in-law	No. of HPs
Tigray	100.0	100.0	100.0	87.7	36.9	36.9	75.4	0.0	8
Afar	-	-	-	-	-	-	-	-	-
Amhara	97.0	97.0	92.3	74.8	53.1	62.5	70.6	52.7	27
Oromia	93.7	100.0	88.2	69.1	60.5	48.8	62.8	56.0	19
Benshangul	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	1
SNNP	79.3	100.0	87.4	67.6	52.7	44.2	65.5	65.5	17
Gambela	-	-	-	-	-	-	-	-	-
Dire Dawa	-	-	-	-	-	-	-	-	-
Harari	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	1
Somali	40.5	61.9	42.9	0.0	38.1	57.1	61.9	0.0	4
Total	**88.9**	**97.6**	**88.3**	**69.0**	**53.8**	**51.6**	**66.9**	**52.2**	**77**

3.5.6. People involved in training of model-family households

In addition to HEWs, vCHPs were reported to support HEWs in the training of model-family in 36.8% of kebeles. HEW-supervisors were also involved in 30.6% of kebeles. The most interesting finding was that graduated model-families were involved in the training of model-family in about 14% of kebeles. The involvement of vCHPs was the highest in SNNP (59.6%) and Tigray (58%) regions. Higher involvement of graduated model-families was also reported from kebeles in Tigray region (26%).

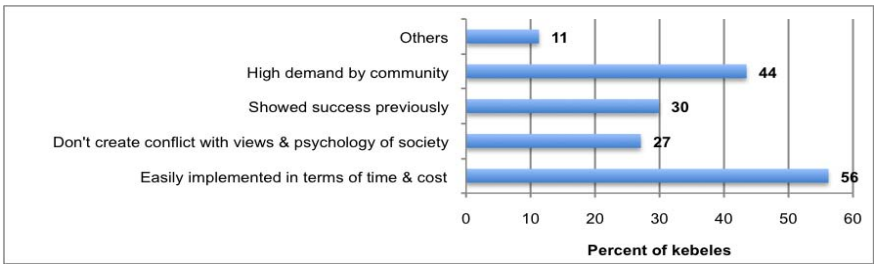
Table 3-15: Percent of kebeles that involved other trainers for training of model-family, rural Ethiopia 2010

Region	HEW Supervisors	Graduated model-families	vCHPs	CHWS	Others	No. of HPs
Tigray	64.9	26.1	58.0	44.9	4.0	28
Afar	0.0	0.0	0.0	100.0	0.0	1
Amhara	39.9	12.3	41.8	17.7	16.1	53
Oromia	31.6	16.1	17.9	14.5	11.9	64
Benshangul	0.0	19.2	100.0	100.0	0.0	5
SNNP	17.6	9.7	59.6	22.2	8.9	44
Gambela	0.0	0.0	0.0	0.0	0.0	1
Dire Dawa	100.0	0.0	0.0	0.0	0.0	1
Harari	75.0	25.0	0.0	25.0	0.0	4
Somali	9.2	15.0	9.2	0.0	10.4	13
Total	**30.6**	**14.0**	**36.8**	**19.0**	**11.4**	**214**

3.5.7. HE packages prioritization during training of model-family

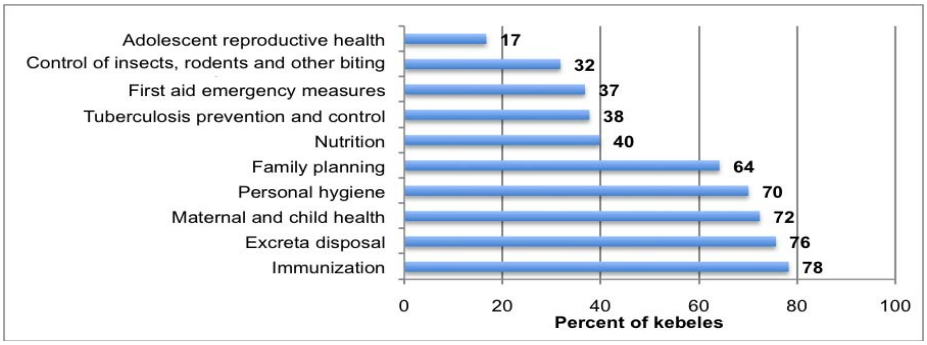
Majority of kebeles (78.9%) used criteria to prioritize health extension packages in the training of model-family. Among kebeles that use criteria (n=176), HEWs in 56.2% and 43.5% of kebeles gave priority for HE packages that are easily implementable in terms of time and cost, and HE packages that have high demand from the community, respectively. Implementation of HE packages that showed success previously and that didn't create conflict with the views and psychology of the community was given priority in 29.9% and 27.1% of kebeles, respectively.

Figure 3.2: Percent of kebeles by criteria used in prioritizing HE packages in training of model-family, rural Ethiopia 2010



Based on the above criteria, the five HE packages that were given first priority were immunization (78.3%), excreta disposal (75.7%), maternal and child health (72.4%), personal hygiene (70.1%), and family planning (64.2%). HE packages that were not implemented as first priority by majority of kebeles include adolescent reproductive health (16.7%), control of insects, rodents and other biting species (31.8%), first-aid (36.8%), tuberculosis prevention and control (37.7%) and nutrition (39.8%).

Figure 3.3: Percent of kebeles that gave first priority for HE packages in model-family training, rural Ethiopia 2010



3.5.8. Number of households currently under model-family training

Majority of the kebeles reported that they had households who were under model-family training during the survey. The number of households enrolled in the training, however, varied within and between regions. A quarter of the kebeles reported that 30 households or less were under training, while in about 41% of the kebeles, the number of households who were being trained was between 31-60 households. Only 13% of the kebeles were not undertaking model-family training, because they had just completed training or undertaking preparatory activities.

Table 3-16: Percent distribution of kebeles by number of HHs under model-family training during the survey, rural Ethiopia 2010

	Number of households					No. of
Region	**0**	**<=30**	**31-60**	**>60**	**Not stated**	**HPs**
Tigray	9.1	30.6	16.6	30.2	13.4	28
Afar	0.0	0.0	100.0	0.0	0.0	1
Amhara	16.5	29.4	39.4	12.5	2.3	53
Oromia	17.7	18.0	37.9	20.2	6.2	64
Benshangul-Gumuz	0.0	80.8	19.2	0.0	0.0	5
SNNP	7.3	19.5	60.0	13.2	0.0	44
Gambela	0.0	100.0	0.0	0.0	0.0	1
Dire Dawa	0.0	100.0	0.0	0.0	0.0	1
Harari	0.0	0.0	100.0	0.0	0.0	4
Somali	0.0	85.5	0.0	0.0	14.5	13
Total	**13.0**	**25.9**	**40.8**	**15.8**	**4.5**	**214**

3.5.9. Drop-out of households during training for model-family

In about 61% of kebeles, HEWs reported that among the households enrolled for model-family training, there were some households that dropped-out from the model-family training before they finish the training.

The main reasons for households to dropout from model-family training as reported by HEWs were lack of financial resources (37.4%), lack of time to attend the trainings (32.2%), having other priorities (21.1%), lack of materials (20%), not being interested to become model-family (17.8%), and lack of labor (16.1%). Moving out of the village and difficult family situation were also reported by some kebeles as reasons for dropped-out households.

Table 3-17: Main reasons for dropouts of households from model-family training

Region	**Lack of financial resources**	**Lack of time to attend the trainings**	**Other priorities**	**Lack of material**	**Not interested in becoming model-family**	**Lack of labor**	**Moved out from the village**	**Difficult family situation**	**No. of HPs**
Tigray	39.4	21.5	29.8	39.4	21.5	41.8	32.7	10.8	10
Amhara	49.3	24.8	31.5	22.1	21.6	19.2	8.6	4.3	35
Oromia	35.3	35.5	26.9	22.2	19.8	9.4	8.4	8.8	37
Benshangul	66.7	100.0	0.0	0.0	66.7	33.3	0.0	0.0	3
SNNP	30.1	37.0	7.3	17.6	14.3	10.2	13.1	10.5	30
Dire Dawa	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Harari	0.0	75.0	75.0	0.0	25.0	0.0	50.0	50.0	4
Somali	26.1	26.1	0.0	0.0	0.0	48.0	11.3	7.3	9
Total	**37.4**	**32.2**	**21.1**	**20.0**	**17.8**	**16.1**	**10.9**	**8.0**	**129**

The number of households that dropped-out of model-family training by region and round of training is presented in the table below. Overall, majority (73%) of kebeles did not have any dropouts in round one model-family training, and over half of the kebeles did not have dropouts in round two and three model-family training. On average about 6, 11, and 16 households were reported to have dropped-out from the training during round one, two and three, respectively.

Table 3-18: Percent distribution of kebeles by number of HHs dropout from model-family training, rural Ethiopia 2010

	No. of HHs dropped-out					
Round	**0**	**1-10**	**11-30**	**>30**	**Overall average**	**Total**
Round 1	73.1	10.6	10.0	6.3	**6**	153
Round 2	52.8	17.4	13.5	12.7	**11**	115
Round 3	54.6	19.3	7.4	18.7	**16**	64

3.5.10. Time taken to complete a round of model-family training

In 77.5% of kebeles, HEWs reported that they completed a round of model-family training over 3-4 months. In 11% of the kebeles, it took between 1-2 months to complete one round of model-family training; while in another 11.5% of kebeles, it took 5 months or more to complete the training. Overall, to complete a round of model-family training it took an average of 3.6 months.

Table 3-19: Percent distribution of kebeles by number of months it took to complete a round of model-family training

Region	1-2 months	3-4 months	5+ months	Average months	No. of kebeles
Tigray	25.6	54.8	19.6	3.4	21
Afar	-	-	-	-	-
Amhara	18.1	55.5	26.4	4.3	40
Oromia	5.7	88.8	5.5	3.1	44
Benshangul-Gumuz	0.0	50.0	50.0	4.5	2
SNNP	9.0	91.0	0.0	3.4	35
Gambela	-	-	-	-	-
Dire Dawa	100.0	0.0	0.0	1	1
Harari	0.0	100.0	0.0	4	3
Somali	0.0	60.1	39.9	4.5	7
Total	**11.0**	**77.5**	**11.5**	**3.6**	**153**

3.6 MODEL-FAMILY GRADUATION

3.6.1. Number of model-family graduation rounds undertaken per kebele

Among the sample kebeles, 214 kebeles had initiated implementation of model-family. Among the kebeles that had initiated implementation of model-family, 71% (153) kebeles had also graduated at least one batch of model-families, which corresponds to an overall coverage rate of 51.3% among all the 298 kebeles covered with HEP. Among kebeles that had graduated model-families, majority (48.1%) had undertaken two rounds of training and graduation. More than a quarter (28.5%) of kebeles had trained and graduated model-families three times, and about 5.5% of kebeles undertook four or more rounds of graduation. About 15.4% of the kebeles had trained and graduated only one time since they had initiated implementation of model-family in the kebele.

Afar and Gambella regions were the only regions where there was not any kebele (among surveyed kebeles) that had graduated at least one round of model-family, while there were some kebeles that had started training of model-family. Kebeles in Benshangul, Dire Dawa, Harare and Somali regions had undertaken one or two rounds of model-family graduation.

3.6.2. Number of households graduated per round of model-family training

Data on the number of households graduated as model-family during the last three rounds of training was collected from kebeles that had graduated at least one round of model-family households. There was a huge variation in the number of households graduated per round of model-family training within and between regions. Moreover, the number of households graduated per round varied over the last three rounds.

Table 3-20: Percent distribution of kebeles by number of model-family HHs graduated per round, rural Ethiopia 2010

	Round-1					Round-2					Round-3				
Region	<=30	31-60	>60	Average	No. of kebeles	<=30	31-60	>60	Average	No. of kebeles	<=30	31-60	>60	Average	No. of kebeles
Tigray	29.7	45.6	24.7	**47**	21	0.0	50.4	49.6	**71**	16	29.0	43.5	27.5	**50**	7
Afar	-	-	-	**-**	-	-	-	-	**-**	-	-	-	-	**-**	-
Amhara	38.4	41.6	20.0	**45**	40	37.1	43.5	19.5	**44**	35	27.6	53.5	19.0	**46**	22
Oromia	9.3	48.9	41.8	**61**	44	16.0	52.2	31.9	**58**	28	10.5	39.9	49.6	**72**	12
Benshangul	100.0	0.0	0.0	**21**	2	-	-	-	**-**	-	-	-	-	**-**	-
SNNP	15.9	75.4	8.7	**50**	35	0.0	64.4	35.6	**67**	30	6.9	91.1	2.0	**50**	22
Gambela	-	-	-	**-**	-	-	-	-	**-**	-	-	-	-	**-**	-
Dire Dawa	100.0	0.0	0.0	-	1	100.0	0.0	0.0	-	1	0.0	0.0	100.0	-	1
Harar	66.7	33.3	0.0	**32**	3	-	-	-	**-**	-	-	-	-	**-**	-
Somali	89.4	10.6	0.0	**21**	7	100.0	0.0	0.0	**25**	2	-	-	-	**-**	-
Total	**23.5**	**53.2**	**23.3**	**51**	**153**	**12.6**	**38.6**	**46.3**	**57**	**112**	**15.5**	**65.2**	**19.3**	**54**	**64**

3.6.3. Criteria used for determination of model-family graduation

Once HEWs complete the training of households for model-family, HEWs are expected to decide if the households should graduate as model-family. HEWs were asked for the criteria they used to determine if a household that had received model-family training should be graduated as model-family. Although HEWs used multiple criteria for decision, construction of a latrine was used as a decision criterion in 77.2% of kebeles. Introduction of over 75% of HE packages and separating domestic animals from human habitation were criteria used in 69.6% and 62.9% of kebeles, respectively. The other commonly used criteria to determine readiness of households for graduation included completing 96 hours of training, using smoke free and/or fuel saving stove, having hand washing facility, and fully vaccinating all <5 years, which were used by 55.5%, 54.4%, 54.2%, and 53.8% of kebeles, respectively.

Table 3-21: Percent of kebeles that ysed criteria for determination of whether a household should graduate as model-family, rural Ethiopia 2010

Region	Constructed latrine	Introduced over 75% of HEP packages	Separated domestic animals from human habitation	Trained for 96 hours	Using smoke free &/or fuel saving stove	Has hand washing facility	All <5 years fully vaccinated	Separated area for food preparation/ kitchen	If malarious, members sleep under bednet	Gained knowledge & attitudinal change	Has a vegetable garden	Others	No. of HPs
Tigray	85.9	75.8	74.3	76.6	65.5	62.1	67.8	52.8	42.4	4.0	15.0	0.0	28
Afar	100.0	0.0	0.0	0.0	100.0	100.0	0.0	100.0	100.0	0.0	0.0	0.0	1
Amhara	81.7	82.0	69.1	60.9	77.4	66.0	60.6	63.6	39.5	30.1	30.4	4.2	53
Oromia	73.0	72.2	64.2	53.8	47.6	51.1	39.4	52.0	28.4	14.7	10.7	5.1	64
Benshangul	80.8	38.4	100.0	76.8	57.6	57.6	80.8	57.6	19.2	0.0	19.2	0.0	5
SNNP	87.0	62.2	62.6	52.3	50.2	55.8	72.1	41.1	47.6	19.3	26.9	4.7	44
Gambela	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	0.0	100.0	0.0	0.0	1
Dire Dawa	100.0	0.0	100.0	0.0	0.0	0.0	100.0	100.0	0.0	100.0	0.0	0.0	1
Harar	50.0	75.0	75.0	25.0	75.0	50.0	0.0	50.0	0.0	0.0	50.0	0.0	4
Somali	28.8	31.8	14.4	38.0	5.2	5.2	19.6	5.2	9.2	28.8	0.0	14.5	13
Total	**77.2**	**69.6**	**62.9**	**55.5**	**54.4**	**54.2**	**53.8**	**49.6**	**36.0**	**19.6**	**19.4**	**5.0**	**214**

3.6.4. People involved in the assessment of eligibility for graduation

In about 94.5% of kebeles that had graduated model-family, assessment of the households who completed the model-family training was undertaken to determine the eligibility of the households for graduation. The type of people who were involved and their level of engagement in the assessment of households for model-family graduation are presented by region in table below. The people who were involved in such assessment in order of frequency included HEWs, HEW-supervisor, kebele administration, VHP/CHW, and woreda heath office, who were reported to be involved in 67.6%, 52.4%, 40.7%, 28.1% and 24.8% of kebeles, respectively.

Table 3-22: Type of personnel who are involved in the assessment of the eligibility for graduation

Region	Percent of kebeles where assessment was undertaken by					Assessment not done	Total
	HEWs	HEW supervision	kebele council	VHP/CHW	WHO		
Tigray	87.9	69.9	62.4	63.1	26.0	10.8	21
Amhara	72.0	32.6	41.5	32.6	30.1	0.0	40
Oromia	82.3	62.9	45.1	10.3	18.0	4.3	44
Benshangul	100.0	0.0	100.0	100.0	0.0	0.0	2
SNNP	48.9	60.8	35.1	38.4	29.5	6.1	35
Dire Dawa	100.0	100.0	100.0	0.0	0.0	0.0	1
Harari	100.0	66.7	33.3	0.0	33.3	0.0	3
Somali	18.8	0.0	0.0	10.6	10.6	40.2	7
Total	**67.6**	**52.4**	**40.7**	**28.1**	**24.8**	**5.5**	**153**

3.6.5. Celebration of graduation

Following the training and the assessment of the eligibility of households for model-family, 82.5% of kebeles celebrated the graduation of model-families with a ceremony. Majority (75.8%) of the kebeles also reported that all graduating model-family households were given a certificate of graduation. All graduating model-families in about 5.9% of kebeles were given a gift, while only the best performing households were given a gift in about 6.4% of kebeles. On the other hand, in 7.2% of kebeles graduating model-families were not given a certificate or a gift when they graduated as model-family.

Table 3-23: Celebration of model-family graduation and type of incentives or gifts given to graduating households

Region	Percent of kebeles celebrated	Type of incentive or gift given to graduating model-families				No. of kebeles
		A certificate	A gift	A gift to the best performing	Not given	
Tigray	89.0	68.8	14.6	0.0	16.6	21
Amhara	94.1	90.3	7.5	0.0	2.2	40
Oromia	95.2	76.3	2.9	15.3	0.0	44
Benshangul	100.0	100.0	0.0	0.0	0.0	2
SNNP	67.2	73.4	6.8	4.3	8.9	35
Dire Dawa	100.0	100.0	0.0	0.0	0.0	1
Harari	100.0	100.0	0.0	0.0	0.0	3
Somali	0.0	0.0	0.0	0.0	78.9	7
Total	**82.5**	**75.8**	**5.9**	**6.4**	**7.2**	**153**

3.6.6. Cumulative number of model-family households graduated

Nearly half (48.15) of the kebeles reported that they have between 51-200 households that had graduated as model-family since the start of the program. More than a quarter (28.5%) of the kebeles reported to have between 201-500 model-family households. The cumulative number of model-family households was less than 50 households in 15.4% of the kebeles, while 5.5% of kebeles reported that between 501-1000 households had graduated as model-family. Cumulative number of model-family households of more than 200 households per kebele was only reported from Tigray, Amhara, Oromia and SNNP regions. The majority of kebeles in the other regions had graduated less than 50 households. Among kebeles that had graduated at least one round of model-family, the average total number of households graduated per kebele was 141. Among the regions, SNNP (165) and Amhara (146) had the highest average number of households graduated.

Table 3-24: Percent distribution of kebeles by cumulative number of model households graduated, rural Ethiopia 2010

Region	<=50	51-200	201-500	501-1000	Not stated	Average no.	No. of kebeles
Tigray	25.9	34.2	35.8	4.2	0.0	131	21
Amhara	13.0	56.7	23.5	6.8	0.0	146	40
Oromia	16.2	48.7	27.5	6.2	1.4	134	44
Benshangul	100.0	0.0	0.0	0.0	0.0	21	2
SNNP	4.4	47.8	36.4	4.8	6.7	165	35
Dire Dawa	0.0	100.0	0.0	0.0	0.0	132	1
Harari	66.7	33.3	0.0	0.0	0.0	32	3
Somali	89.4	10.6	0.0	0.0	0.0	28	7
Total	**15.4**	**48.1**	**28.5**	**5.5**	**2.5**	**141**	**153**

According to HEWs' data on the total number of households in the kebele and the cumulative number graduated as model-family, the percent of households graduated was estimated for all kebeles. Overall, about 8.6% of households had graduated as model-family. There was a difference between the regions, where 15.6% and 10.1% of households from SNNP and Amhara regions, respectively, had graduated as model-family, which were the highest among all regions.

Table 3-25: Percent of households who graduated as model-family by region, rural Ethiopia 2010 (n=292)

Region	No. of households graduated (mean)	No. of households in the kebele (mean)	Percent graduated (mean)
Tigray	104	1217	8.5
Amhara	100	987	10.1
Oromia	82	885	9.3
Benshangul	5	308	1.6
SNNP	134	858	15.6
Dire Dawa	66	812	8.1
Harari	24	2557	0.9
Somali	13	922	1.4
Total	**72**	**838**	**8.6**

3.6.7. Cost to become model family

HEWs were asked to provide the estimated total average cost incurred by households in their respective kebele to become a model-family household. HEWs in 39.2% of the kebeles stated that they did not know the cost incurred by households to become model-family. About one in

ten kebeles reported that it costs households <200 Birr to become model-family households. HEWs in 15.5% and 16.6% of kebeles reported that it costs households 200-499 Birr and 500-999 Birr, respectively to become model-family. The cost incurred by households to become model-family was reported to be 1000-5000Birr in 17.6% of the kebeles. The overall mean cost (for those kebeles who reported an estimate of cost) to become model-family was Birr 871.00. In Tigray, Oromia and SNNP, the mean cost was more than Birr 800.00, while in Amhara it was only Birr 363.00.

Table 3-26: Percent distribution of kebeles by reported total average cost to become a model-family, rural Ethiopia 2010

Region	1 - 199	200 - 499	500 - 999	1000 - 5000	Don't know	Mean cost	No. of HPs
Tigray	7.8	21.7	30.4	34.6	5.6	**925**	28
Afar	0.0	0.0	0.0	0.0	100.0	**-**	1
Amhara	12.6	32.1	5.1	6.0	44.3	**363**	53
Oromia	7.5	6.6	22.1	18.1	45.7	**1115**	64
Benshangul	19.2	0.0	0.0	0.0	80.8	**40**	5
SNNP	14.5	15.2	18.0	20.0	32.3	**838**	44
Gambela	0.0	0.0	0.0	0.0	100.0	**-**	1
Dire Dawa	0.0	0.0	0.0	0.0	100.0	**-**	1
Harari	50.0	25.0	0.0	0.0	25.0	**125**	4
Somali	14.5	0.0	9.8	38.7	37.0	**1541**	13
Total	**11.0**	**15.5**	**16.6**	**17.6**	**39.2**	**871**	**214**

HEWs were also asked to provide the estimated average cost incurred by households to build a basic latrine in the kebele. HEWs in majority (53.2%) of kebeles reported that the cost incurred by households to build a basic latrine was <200 Birr. HEWs in 16.5% of kebeles reported that it cost households 200-499 Birr to build a basic latrine. In 13.9% of the kebeles, the cost was reported to be 500-3000 Birr. HEWs did not know the cost to build a basic latrine in 16.4% of the kebeles. The overall mean cost (for those kebeles who reported an estimated cost) to build a basic latrine was Birr 302.00. There was variation among the regions. The mean cost to build a basic latrine in Tigray and Oromia was Birr 468.00 and Birr 491.00, respectively, while the mean cost in Amhara and SNNP regions was Birr 83.00 and Birr 154.00, respectively.

Table 3-27: Percent distribution of kebeles by reported average cost to build a basic latrine, rural Ethiopia 2010

Region	1 - 199	200 - 499	500 - 3000	Don't know	Mean cost	Total
Tigray	21.7	37.3	38.6	2.5	**468**	28
Afar	100.0	0.0	0.0	0.0	**-**	1
Amhara	80.5	12.3	0.0	7.2	**83**	53
Oromia	43.2	20.3	19.9	16.6	**491**	64
Benshangul	100.0	0.0	0.0	0.0	**36**	5
SNNP	54.5	14.1	5.7	25.7	**154**	44
Gambela	0.0	0.0	0.0	100.0	**-**	1
Dire Dawa	0.0	0.0	0.0	100.0	**-**	1
Harari	75.0	25.0	0.0	100.0	**131**	4
Somali	22.6	0.0	48.5	28.9	**594**	13
Total	**53.2**	**16.5**	**13.9**	**16.4**	**302**	**214**

3.7 FOLLOW-UP OF MODEL FAMILY

3.7.1. Impact of model-family

HEWs were asked for their assessment of impact or change they noticed on the various health extension packages following the implementation of model-family in the kebele. In majority of kebeles, HEWs had noticed a significant impact or change on all HE packages following the implementation of model-family in the kebele. However, the top three HE packages where HEWs in 95.6%, 88.6% and 88.4% of kebeles, respectively, noticed a significant impact were vaccination, family planning, and latrine construction and utilization. On the other hand, relatively small proportion of kebeles reported to have noticed a significant impact on some of the HE packages. HEWs only in 45.3%, 52% and 65.2% of kebeles reported that they noticed a significant impact on adolescent reproductive health, insect and pest control, and housing construction, respectively. From a quarter to a third of the kebeles reported that they had not noticed any impact or change on these HE packages.

Table 3-28: Percent distribution of kebeles by the impact of model-family on implementation of HE packages following graduation

HE packages	Significant impact has been noticed	No impact or change has been noticed	Not implemented	Not applicable	Not stated	Number of kebeles
Vaccination	95.6	1.6	0	0.4	2.3	214
Family planning	88.6	8.1	0	0.9	2.3	214
Latrine construction and utilization	88.4	7.4	3.2	0.0	1.1	214
Personal hygiene	82.3	13.2	2.3	0.0	2.3	214
Maternal and child health	81.5	10.9	4.8	0.4	2.3	214
Solid waste disposal	74.6	18.5	4.3	0.0	2.6	214
Potable water protection	74.1	19.4	2.1	3.6	0.8	214
Malaria prevention and control	73.4	12.7	3.4	7.9	2.6	214
HIV/AIDS and tuberculosis prevention	72.2	23.0	2.5	0.0	2.3	214
Housing construction & management	65.2	27.0	4.5	1.0	2.3	214
Insect, rodents, and other pest control	52.0	33.2	13.9	1.0	0.0	214
Adolescent reproductive health	45.3	34.3	16.1	1.7	2.7	214

3.7.2. Model-family implementation methods resulting in significant impact

The various methods that are used by HEWs in the training of model-family include house-to-house visit, using model-families to show positive changes, community training with role models, using trained community members for advocacy, using community leaders, and using model demonstration centers. HEWs were asked for the best model-family training approach that resulted in a significant impact in the implementation of HE packages. HEWs in majority (85.4%) of kebeles reported that making house-to-house visits to meet household members to provide training at household level resulted in a significant impact. Using model-families to show positive changes and organizing community training with role models were also reported to result in a significant impact in 41.6% and 39.1% of kebeles, respectively. In similar proportion (38.9%) of kebeles, using trained community members for advocacy activities resulted in a significant impact. In more than a quarter of kebeles, using positive and supportive community leaders and using model demonstration centers resulted in significant impact in the training of model-family.

Table 3-29: Model-family implementation strategies resulting in significant impact, rural Ethiopia 2010

Region	By making house to house visit	Using model families to show positive changes to others	Organizing community training with role models	Using trained community members for advocacy activities	Using positive and supportive community leaders	Using model demonstration center	Others	Total
Tigray	89.1	53.4	38.4	53.2	27.0	38.4	0.0	28
Afar	0.0	100.0	0.0	0.0	0.0	0.0	0.0	1
Amhara	82.7	41.2	48.5	39.4	36.8	32.0	1.9	53
Oromia	86.5	41.1	34.1	39.2	29.1	14.8	4.1	64
Benshangul	76.8	100.0	57.6	57.6	80.8	38.4	0.0	5
SNNP	90.1	38.3	40.8	37.8	18.6	38.7	3.7	44
Gambela	100.0	100.0	0.0	0.0	0.0	0.0	0.0	1
Dire Dawa	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1
Harari	25.0	75.0	50.0	50.0	100.0	75.0	0.0	4
Somali	70.5	39.9	24.8	25.4	31.8	5.2	0.0	13
Total	**85.4**	**41.6**	**39.1**	**38.9**	**28.5**	**26.2**	**2.9**	**214**

3.8 CONCLUSION

Overall about two-thirds of the kebeles have started training of model-family households. Kebeles that have not yet started training of model-family are mainly from Afar, Benshangul-Gumuz, and Gambela regions, where the HEP program has started recently. There is a need to facilitate the implementation of model-family training in these regions as well as all kebeles in other regions.

Preparatory activities

The preparatory activities such as study of the health profile, demography, socio-economic and household conditions prior to start of model-family households took more than a month in some of the kebeles. Lack of community interest was the main reason stated by HEWs. However, at the infancy of the program where only an average of three rounds of model-family training has been conducted, it is unlikely to have difficulty in finding households that would volunteer to become model-family. At least until some portion of the community that are interested to become model-families (innovators and early adopters), model in changing others, previously working as community health workers, and members of the kebele administration and associations have been trained, there should be enough pool of households to be recruited. It will still require strong dedication of the HEWs to persuade and recruit households for training. Moreover, lack of support from kebele administration and district health office was among the main reasons for taking more time to undertake preparatory activities. Thus, there should be strong support from the kebele administration and district health office to facilitate mobilization of households and to guide the HEWs in implementing model-family as per the standard of the HEP. The preparatory activities help the HEWs to understand the community prior to selection of households for training. This study showed that majority of HEWs undertake only one or the other preparatory activities but not all the key preparatory activities. It requires a clear guideline on what, how and when to do in preparation for the model-family training to ensure that all HEWs undertake all the key preparatory activities regularly and consistently.

Selection of households

The criteria used for the selection of households to be trained in model-family followed the established HEP standard on selection criteria in majority of kebeles. The most commonly used household selection criteria in order of frequency include households who are model in changing others, member of kebele administration, previously working as CHW/TBA/CBRHA, and interested to become model in HEP. However, it was not all kebeles that used all the selection criteria, hence it is important to ensure that all kebeles use all applicable household selection criteria for model-family training. It should be noted that the importance of the selection criteria could vary with local situation and overtime with increasing coverage of model-family. With increased model-family coverage of the households in the kebeles – when most households who fulfill the selection criteria will have graduated as model-family over time, the remaining households should still be selected to be trained without considering the selection criteria. Thus, the importance of using the selection criteria is during the first few rounds of training in each kebele, where households who are ready to change and be model for other families and who are willing and have the ability to convince and change others should be strictly selected so that they can diffuse the health messages to other households and some of these graduated model households (innovators) can also directly involve in training of other households in the kebele along with the HEWs.

In addition to using the specific household characteristic criteria in selection of households, HEWs also used some social and environmental conditions as selection criteria in order to facilitate the model-family training process. These factors include availability of local materials, availability of labor and household locations (selection of households residing in the same neighborhood to be trained at once).

Number of households and duration of training in a round of training

There is an indication that the established HEP standard on the implementation of model-family training was not widely known by all HEWs. This includes the number of households that should be selected and trained at once (40-60 households), the number of training hours each household should receive before graduation (96 hours) and the number of months over which the training should be completed (3 months). Although majority of kebeles implemented the model-family training as per the standard, HEWs in some kebeles did not follow the standard strictly. This has an implication on the speed of the scale-up as well as on the quality of the training. When HEWs select and train fewer households than the recommended number of households to be trained at once, it will take longer time to reach all households in the kebele slowing down the scale-up of model-family training. Moreover, if a round of model-family training takes 5-6 months to complete, then it would only be possible to do a maximum of two rounds of training per year slowing down the scale-up to all households.

On the other hand, when the number of households selected at once is very big, when the number of training hours is less than the recommended 96 hours, and the training is completed in less than 3 months, it would be impossible for households to introduce and practice the health service packages, which would affect the quality of model-family training. Quality is particularly important because implementation in such a way would nullify the effectiveness of the strategy.

Level and setting/venue of model-family training

The setting/venue (the place where HEWs meet with households) for model-family training used by majority of kebeles include home, health post, farmers training center and school. Model-family training was given at got level, at sub-kebele level, at kebele level and/or at household level, and majority of kebeles used combinations of the various levels of training. The established HEP standard recommends that selected households should receive the model-family training as a group at kebele, sub-kebele or got level, followed by household visits to ensure households are introducing the health packages and provide additional support. Overall, model-family training organized at got, sub-kebele and/or kebele levels was used in about 87% of the kebeles. However, about 13% of kebeles did not use model-family training sessions organized at got, sub-kebele and/or kebele levels, but provide the training only at household level, where HEWs meet with each selected household individually to provide specific training for the specific household. Household level training as the only training approach would consume HEWs' time and take more time to complete a round of model-family training slowing down the scale-up to all households.

Household members who attend model-family training

Compared to model-family trainings organized at got/sub-kebele/kebele levels, training given at home provides an opportunity for all household members to participate in the training. In model-family training organized at got/sub-kebele/kebele levels, it was either the husband or wife who attended the training in majority of kebele, while the involvement of the other household members was reported in less than half of the kebeles. However, during model-family training at home, all household members participate in the training, particularly female and male children, which is important for the implementation of adolescent reproductive health. HEWs also reported that making house-to-house visits to provide additional support and follow-up of model-family households was the best method to achieve a significant impact in bringing change. Thus, in addition to providing training model-family households at got and sub-kebele levels, it is important that all HEWs also train model households at household level.

Time allocated by HEWs for model-family training

Majority of HEWs follow the HEP established standard on the time spent for model-family training organized at kebele, sub-kebele and got levels. HEWs in majority of kebeles provide model-family training for one to two days per week and spent about 2 hours per training day. In kebeles where household level training was undertaken, 3-4 days per week was devoted by majority of HEWs for model-family training and 8-12 households were visited per day. However, there were still a significant number of kebeles where the standard was not followed. This has an implication on the quality of the model-family training and the duration to complete a round of model-family training.

Prioritization of health packages during model-family training

The HEP model-family implementation standard recommends implementing the health packages and other activities in three phases. Majority of HEWs also prioritized the implementation of the health packages. Priority was given to health packages that are easily

implementable and have high demand from the community. Using these and other criteria, immunization, excreta disposal, maternal and child health, personal hygiene and family planning were given first priority, which is in line with the HEP standard. These are among the health packages recommended to be implemented during the first phase as per the HEP standard.

Number of model-family training rounds implemented per year

The established HEP standard in the implementation of model-family recommends that each HEW should undertake four rounds of model-family trainings per year. However, considering the year when model-family training was started in the kebeles, the cumulative number of model-family training rounds per kebele is low relative to the expected number of training rounds over the duration since the training was started. Some of the factors observed in this study, which may contribute to the slow implementation include the time taken to do the preparatory activities and the longer time it took to complete a round of model-family training. The other factors that could also contribute to the slow implementation of model-family are the reported lack of support from kebele administration and district health office, and the lack of community interest. Four rounds of model-family training per year (as per the established HEP standard) also seems unrealistic considering the time needed to do the preparatory activities, selection of households and training. However, more than what has been done could be achieved with clear implementation standard and guideline, and strong support and involvement of kebele administration and district health office in the mobilization of the community and selection and training of model households.

Involvement of other people (other than HEWs) in model-family training

It is encouraging to note that HEWs are supported by the kebele administration, vCHPs, opinion leaders and community members, HEW-supervisors and graduated model-families in selection of households for model-family training. However, the involvement of kebele administration and vCHPs was reported only in half of the kebeles, while the involvement of the others was reported only in a quarter or less of the kebeles. Similarly, HEWs are supported by vCHPs, HEW-supervisors, and graduated model-families in the training of model-families, however, the involvement was reported in a third or less of the kebeles. The interesting finding is that graduated model-families are participating in selection and training of other households.

3.9 RECOMMENDATIONS

- There is a need to prepare a clear model-family package implementation guideline. The guideline should include the established standard on the selection process of households; the number of households selected to be trained at once; time allocation by HEWs for model-family training; number of total training hours and over how many months the training should be completed; level and venue of training (particularly the need to make house-to-house visits following the theoretical training); prioritization of introduction of the health packages; and the roles and responsibilities of other key players in the implementation of model-family package.

- Strengthen the support of kebele administration in all steps of the implementation of model-family package.

- The woreda health office and HEW-supervisors should ensure that the implementation of model-family package is as per the HEP standard.

MODEL-FAMILY IMPLEMENTATION – HOUSEHOLD SURVEY

HEP EVALUATION

RURAL ETHIOPIA

2010

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

4. MODEL FAMILY IMPLEMENTATION – HOUSEHOLD SURVEY

4.1. SELECTION OF HOUSEHOLDS FOR MODEL-FAMILY TRAINING

4.1.1. Households who were selected for model-family training

All households sampled for the overall HEP assessment were asked whether their household have been selected for model-family training in health extension package program. Among the over 7000 households surveyed, 838 households (11.2%) reported that their households were selected to participate in model-family training. There was a significant variation among the regions. Nearly a third (31.7%) of respondents in Tigray region reported that their household was selected, while only about one in ten respondents in Amhara, Oromia, SNNP, Benshangul-Gumuz, and Somali regions were selected for model-family training.

Table 4-1: Percent of households who were selected for model-family training, rural Ethiopia 2010

Region	HHs who were selected for training		No. of respondents
	No. of HHs	Percent	
Tigray	224	31.7	679
Afar	1	0.5	200
Amhara	188	11.0	1496
Oromia	210	10.3	1774
Benshangul	31	11.4	399
SNNP	103	8.0	1197
Gambela	1	0.1	722
Dire Daw	1	1.0	100
Harar	18	18.8	96
Somali	61	13.0	383
Total	**838**	**11.2**	**7046**

4.1.2. Household selection criteria for model-family training

Respondents who reported that they were selected for model-family training were asked for the reason why their households were selected. The most frequently stated reasons for selection of their households were interest of the household to become model-family (40.2%), the household head is a member of kebele counsel (25.4%), the HEW is a relative of the household (10.1%), previously working as CHW (8.9%), and the household is close to the health post (7%). There was some variation in the relative importance of these household characteristics by region.

Table 4-2: Among HHs who were selected for model-family training, percent who stated the reason why they were selected, rural Ethiopia 2010

Region	Interested	Member of kebele administration	Relative of HEW	Previously working as CHW	Reside close to HP	Don't know	Other	Total
Tigray	70.9	23.9	13.1	10.2	4.7	1.2	1.5	224
Afar	100.0	-	-	-	-	-	-	1
Amhara	38.8	33.2	10.6	9.6	6.6	3.1	11.7	188
Oromia	30.8	23.3	9.6	4.4	6.8	2.6	7.4	210
Benshangul	52.0	57.4	5.7	35.3	-	-	8.7	31
SNNP	25.2	16.2	10.7	12.9	6.7	1.4	8.9	103
Gambela	-	-	-	-	-	-	-	1
Dire Dawa	100.0	-	-	-	-	-	-	1
Harari	33.3	38.9	5.6	22.2	-	5.6	5.6	18
Somali	54.4	25.9	-	12.4	20.4	3.9	6.5	61
Total	**40.2**	**25.4**	**10.1**	**8.9**	**7.0**	**2.4**	**7.8**	**838**

Respondents who reported that their households were not selected for model-family training were asked what they thought was the reason that they were not selected. Majority (60.7%) of respondents stated that they don't know about model-family or why they were not selected for model-family training. About 18% of respondents thought that their households did not fulfilled the selection criteria for model-family training. Lack of interest and commitment (for time, material, and/or money) was stated as a reason by 8.9% of respondents. Few (5.9%) respondents also acknowledged that they were not selected because model-family and HEP in general started recently in their community. There was some variability on the importance of the stated reasons among the regions.

Table 4-3: Among HHs who were not selected for model-family training, percent who stated the reason why they were not selected, rural Ethiopia 2010

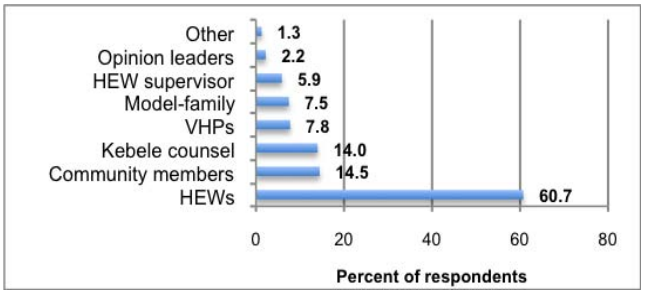
Region	Don't Know model-family or why was not selected	The program started recently	Not fulfilled selection criteria	Lack of interest	Other	Total
Tigray	56.1	3.1	20.7	10.8	9.3	211
Afar	42.4	40.5	4.0	11.0	2.0	198
Amhara	49.3	1.9	30.1	12.8	6.0	1134
Oromia	77.1	3.0	8.8	3.9	7.2	1373
Benshangul	29.8	36.9	22.2	5.9	5.1	334
SNNP	53.0	9.4	20.6	12.0	5.0	1009
Gambela	37.9	11.8	16.6	27.7	6.1	562
Dire Daw	56.7	-	33.0	8.2	2.1	97
Somali	45.1	11.4	28.4	11.1	4.0	303
Total	**60.7**	**5.9**	**18.4**	**8.9**	**6.1**	**5221**

4.1.3. People involved in the selection of households

Respondents who were selected for model-family training were asked to state the people who were involved in selecting their household. Over 60% of the respondents reported that HEWs were involved in the selection of their households for model-family training. 14.5% and 14% of respondents reported the involvement of community members and kebele administration in the selection of households, respectively. VHPs/CHWs were also reported to be involved in selection of households by 7.8%. The

interesting finding is that about 7.5% of respondents reported that graduated model-families were involved in the selection of households for model-family training.

Figure 4-1: Percent of respondents who reported the people involved in their selection, rural Ethiopia 2010

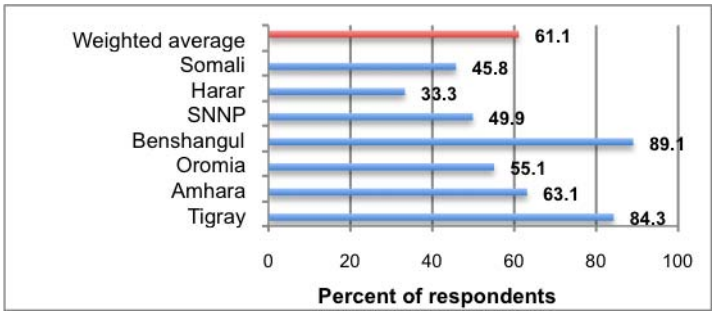


4.2. MODEL-FAMILY TRAINING

4.2.1. Preparatory work

Households that were selected for model-family training were asked if their household was investigation for living and health conditions by HEWs before the start of model-family training. About 61% of respondents reported that their household was investigated for living and health conditions by HEWs prior to mode-family training. There was variation among the regions. Majority (84.3%) of respondents in Tigray reported that their household was investigated for living and health conditions by HEWs, while about half of households in SNNP and Oromia regions were investigated.

Figure 4-2: Percent of households that were investigated for living and health conditions before training, rural Ethiopia 2010



4.2.2. Households who started model-family training

Although households could be selected for model-family training, households might have not participated in the model-family training yet. Thus, to assess the status of model-family training, the respondents who reported that their household was selected for model-family training were asked if any family member ever participated in the model family training. Among the 838 households selected, 56.9% (517) households reported that they have participated in model-family training. These households include households who had graduated and who were under model-family training at the time of the survey.

Among all households sampled for the HEP evaluation, overall 6.4% of households had ever participated in the model-family training. There was huge variation among the regions. More than 20% of households in Tigray region had ever participated in model-family training, while it was only about 6% of households in Amhara and Oromia who had ever participated in the training.

Table 4-4: Percent of respondents who reported that their household had participated in model-family training, rural Ethiopia 2010

Region	No. of households who participated in model-family training	Among households selected for training		Among all households surveyed	
		Percent	No. of respondents	Percent	No. of respondents
Tigray	152	66.5	224	21.1	679
Afar	1	100.0	1	0.5	200
Amhara	95	52.8	188	5.8	1496
Oromia	141	59.5	210	6.1	1774
Benshangul	17	42.6	31	4.9	399
SNNP	46	40.3	103	3.2	1197
Gambela	0	0.0	1	0.0	722
Dire Dawa	1	100.0	1	1.0	100
Harari	14	77.8	18	14.6	96
Somali	50	83.0	61	10.8	383
Total	**517**	**56.9**	**838**	**6.4**	**7046**

4.2.3. Household members who usually attend training

Households who started model-family training were asked to specify the family members who have ever participated in the model-family training and to rate the frequency of participation. Majority (70.4%) of respondents reported that the husband had participated, while about a third (36.1%) reported the wife had participated in the model-family training. Child household members over the age of 15 years and under 15 years were reported to have participated in 15% and 10% of the households, respectively. Respondents reported that among the household members who have ever attended the training, husband and wife attended the model-family training always or most of the time. Female and child household members over the age of 15 years participated always or most of the time in 40% and 33% of households, respectively.

Figure 4-3: Percent of respondents that stated household members who participated in the model family training

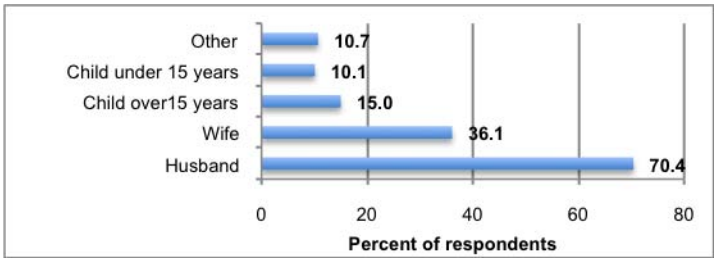
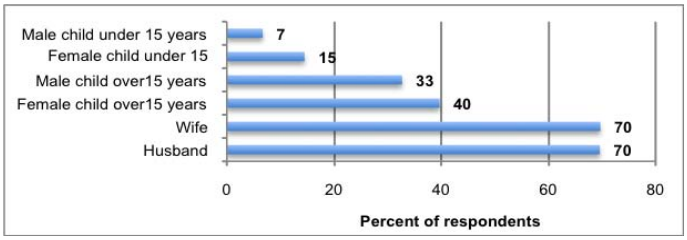


Figure 4-4: Percent of respondents that stated household members who always participated in the model family training among those who ever participated, rural Ethiopia 2010



4.2.4. People who provide model-family training

In addition to HEWs, HEW-supervisors were reported to support HEWs in the training of model-family households by 11% of respondents. Although, 45.7% of respondents reported that there was a vCHP assigned to their household, the involvement of vCHPs in training was reported by only 7.5% of respondents. The most interesting finding was that graduated model-families provide model-family training by 6.5% of respondents. The involvement of vCHPs was the highest in Tigray (26%). Respondents in Tigray (11.9%) and Amhara (10.2%) regions reported relatively higher involvement of graduated model-families.

Table 4-5: Percent of respondents who stated the people who, in addition to HEWs, usually provide model-family training, rural Ethiopia 2010

	People who provide model-family training				No. of
Region	HEW supervisors	vCHPs	Model family	CHWS	respondents
Tigray	9.9	26.1	11.9	7.0	152
Afar	0.0	0.0	0.0	0.0	1
Amhara	6.9	2.9	10.2	0.0	95
Oromia	12.0	4.3	2.3	0.7	141
Benshangul	21.0	0.0	14.0	0.0	17
SNNP	18.3	1.4	2.2	3.2	46
Dire Dawa	100.0	0.0	0.0	0.0	1
Harari	28.6	0.0	0.0	14.3	14
Somali	9.2	0.0	6.8	4.5	50
Total	**11.0**	**7.5**	**6.5**	**2.4**	**517**

Table 4-6: Percent of respondents who stated the responsible people for model-family training at home and at school/health post/FTC, rural Ethiopia 2010

	Responsible for model-family training at home					Responsible for model-family training at school/health post/FTC				
Region	HEWs	vCHPs	Model family	HEW supervisors	Total	HEWs	HEW supervisors	VHPs	Model family	Total
Tigray	98.7	40.8	6.3	0.0	81	81.3	15.3	24.2	5.5	122
Afar	-	-	-	-	0	0.0	100.0	0.0	0.0	1
Amhara	92.9	8.0	5.5	4.8	52	84.3	8.6	0.3	15.0	84
Oromia	97.7	17.9	0.0	2.2	37	87.3	12.8	2.3	3.8	129
Benshangul	100.0	0.0	0.0	0.0	2	100.0	0.0	0.0	0.0	17
SNNP	93.5	13.1	0.0	6.5	15	86.1	29.8	7.1	2.7	38
Dire Dawa	100.0	0.0	0.0	0.0	1	100.0	100.0	0.0	0.0	1
Harari	100.0	25.0	0.0	0.0	4	92.3	53.9	15.4	0.0	13
Somali	49.3	0.0	17.0	17.0	12	93.2	5.6	0.0	2.7	43
Total	**93.8**	**19.6**	**4.2**	**3.5**	**204**	**85.8**	**13.6**	**6.0**	**6.6**	**448**

4.2.5. Level and setting/venue of model-family training

Respondents were asked at what level they usually receive the model-family training. Respondents stated that they attend the model-family training at various levels (such as at got, at sub-kebele, at kebele and at household level). Nearly two-thirds (63.5%) of respondents reported that they attend training organized at kebele level. Training organized at sub-kebele and got levels was attended each by about 18% of households. With these approaches, all households selected from the kebele, or a specific sub-kebele or got were trained as a group rather than individually. About 42% of respondents reported that they received the training individually at household level, where HEWs met with the household members to provide training for the specific household. Respondents were also asked to state the place where model-family training was held. The most frequently stated places where model-family trainings were held included home (44.4%) and health post (43.7%). Model-family training sessions were also held at farmer training center (32.3%) and school (17.7%).

Table 4-7: Percent of households who stated the level and place of model-family training, rural Ethiopia 2010

	Participants attended training organized for				Place where training was held				
Region	All HHs in the kebele	All HHs in the sub-kebele	All HHs in the got	The household	At school	At farmer training center	At health post	At home	No. of respondents
Tigray	54.4	15.6	25.8	57.0	7.4	40.6	39.2	64.1	152
Afar	100.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	1
Amhara	65.9	16.5	21.2	52.4	10.8	38.3	49.2	56.4	95
Oromia	61.5	21.3	15.8	32.1	21.7	34.2	34.6	32.8	141
Benshangul	100.0	14.0	7.0	14.0	54.5	40.3	26.3	14.0	17
SNNP	67.4	17.3	9.7	33.3	19.9	16.8	54.8	35.9	46
Dire Dawa	100.0	0.0	0.0	100.0	100.0	100.0	0.0	100.0	1
Harari	71.4	35.7	21.4	28.6	0.0	35.7	85.7	28.6	14
Somali	78.5	9.2	7.0	26.5	40.1	4.5	65.6	26.8	50
Total	**63.5**	**17.6**	**17.7**	**41.5**	**17.7**	**32.3**	**43.7**	**44.4**	**517**

Majority (70.8%) of respondents reported that HEWs use a sanitation demonstration unit for model-family training of households. At regional level, the use of a sanitation demonstration unit for model-family training was reported by relatively higher percent of respondents in Amhara (79.9%) and Tigray (77.4%).

Table 4-8: Percent of respondents who reported that HEWs built and use a sanitation demonstration unit for model-family raining, rural Ethiopia 2010

Region	Demonstration unit used	Number of respondents
Tigray	77.4	152
Afar	100.0	1
Amhara	79.9	95
Oromia	71.2	141
Benshangul	26.3	17
SNNP	52.7	46
Dire Dawa	100.0	1
Harari	57.1	14
Somali	53.7	50
Total	**70.8**	**517**

4.2.6. Number of training days and duration of a training session

Training at school/health post/FCT

Among the 517 households under model-family training, the number of households that attended training sessions organized at school/health post/FCT was 448. These households were asked for the number days they received training at these places over a month period. Majority (57.2%) of respondents reported that training at school/health post/FCT were organized for an average of one to two days per month, while 27.2% of respondents reported that such training were organized for three to four days per month.

Table 4-9: Percent distribution of respondents by the number of days they participated training organized at school/health post/FTC level per month, rural Ethiopia 2010

	Number of training days per month				Number of respondents
Region	1-2	3-4	5+	Average	
Tigray	61.6	28.4	10.1	2.7	122
Afar	100	0.0	0.0	2.0	1
Amhara	51.9	35.3	12.8	3.0	84
Oromia	65.8	24.8	9.4	2.8	129
Benshangul	21.0	65.0	14.0	3.8	17
SNNP	44.2	24.3	31.6	3.6	38
Dire Daw	100	0.0	0.0	2.0	1
Harar	69.2	7.7	23.1	3.5	13
Somali	41.1	10.1	48.8	4.4	43
Total	**57.2**	**27.2**	**15.6**	**3.0**	**448**

Respondents were also asked for the duration of each training session organized at school/health post/FCT. About a third of respondents stated that the training sessions lasted for less than 60 minutes, and a similar proportion (33.6%) of respondents stated it lasted for 1 – 2 hours. On the other hand, the training sessions were reported to last for more than 2 hours by a third of respondents. The overall average duration of the training sessions was 85 minutes.

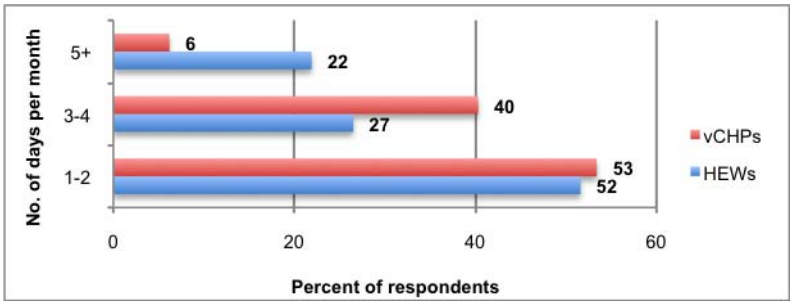
Table 4-10: Percent distribution of respondents by their response on the duration of the training session attended organized at school/health post/FTC level, rural Ethiopia 2010

	Duration of training session (minutes)				
Region	<60	60-119	120+	Average	Total
Tigray	50.3	30.8	18.9	68.9	118
Afar	0.0	100.0	0.0	90.0	1
Amhara	26.6	40.5	32.9	83.1	82
Oromia	28.5	29.6	41.9	90.4	117
Benshangul	21.0	21.1	57.9	104.8	17
SNNP	27.4	27.3	45.3	103.8	38
Dire Dawa	100.0	0.0	0.0	20.0	1
Harari	33.3	25.0	41.7	108.3	12
Somali	28.7	46.3	25.0	73.1	43
Total	**31.8**	**33.6**	**34.6**	**85.0**	**429**

Training at home

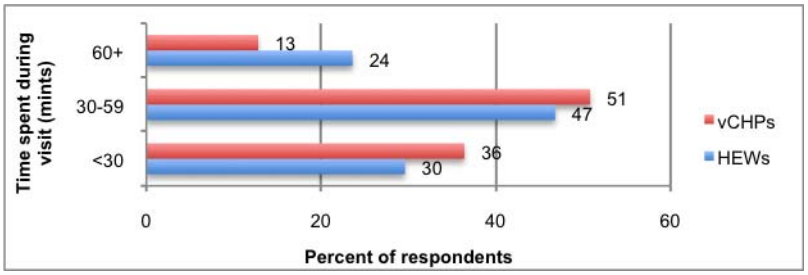
Households who reported that they receive model-family training at home were asked for the number of days that they were visited by HEWs and vCHPs over a month period. Over half of respondents stated that they were visited 1-2 days per month by HEWs, and a similar proportion of households were visited 1-2 days per month by vCHPs. About a quarter and 40% of respondents were visited 2-4 days per month by HEWs and vCHPs, respectively. Only 6% of households were visited by vCHPs for 5 or more days, while 22% were visited 5 or more days per month by HEWs.

Figure 4-5: Percent distribution of respondents by the number of days they were visited by HEWs and vCHPs at home for model-family training per month, rural Ethiopia 2010



About half of respondents stated the training sessions at household level lasted for 30-60 minutes, while about a third stated that it lasted for less than 30 minutes.

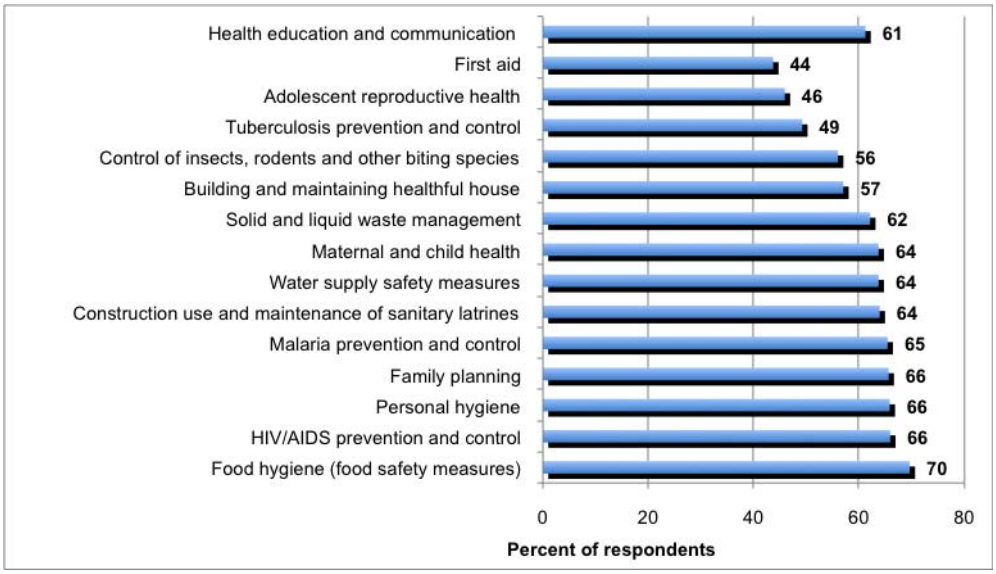
Figure 4-6: Percent distribution of respondents by their response on the duration of training session at home by provider, rural Ethiopia 2010



4.2.7. HEP package prioritization during training

Respondents were asked to identify the HEP packages that were given more attention during training and implementation. HEP packages that were given priority as reported by about two-thirds of respondents each included food hygiene, HIV/AIDS prevention and control, personal hygiene, and family planning. HEP packages that were less frequently reported as priority areas included first aid, adolescent reproduction health and tuberculosis prevention and control.

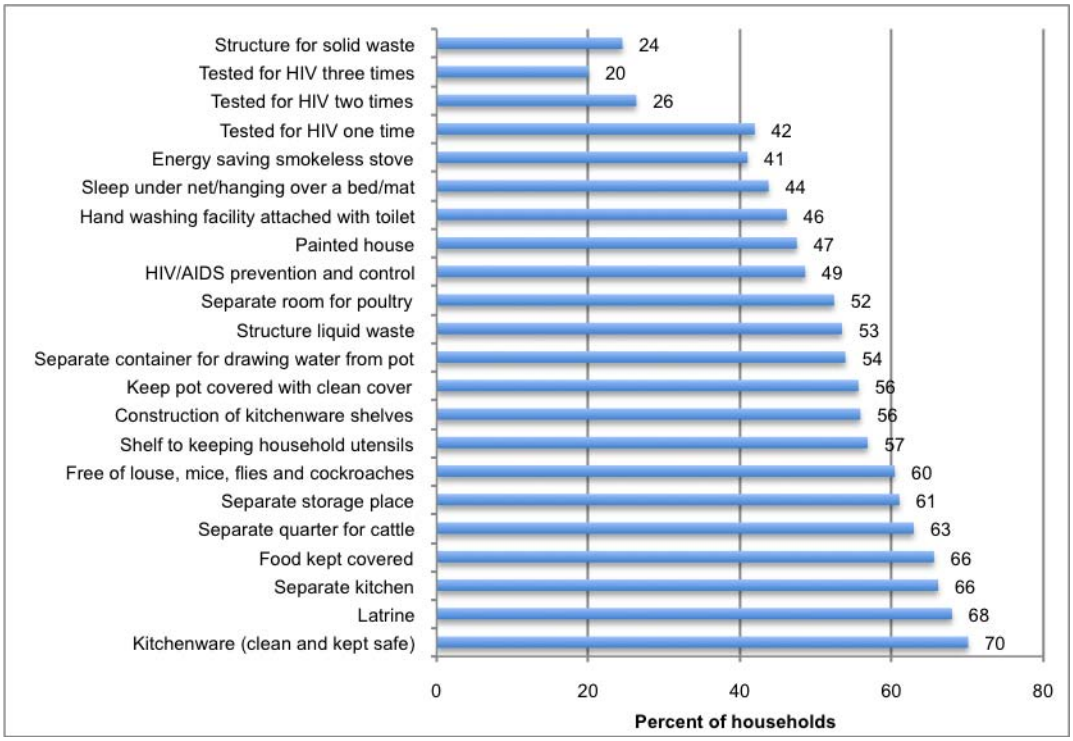
Figure 4-7: Percent of respondents who stated the HEP packages that were given more attention in the model-family training, rural Ethiopia 2010



4.2.8. HEP packages implemented by households

Among a list of various activities presented, respondents identified the activities that were implemented by their household. Generally, the most frequently reported activities implemented by households were related to environmental hygiene and sanitation, among which clean and well kept kitchenware, construction of latrine and separate kitchen were on the top.

Figure 4-8: Percent of respondents who reported the HEP packages implemented by their household, rural Ethiopia 2010



4.1. MODEL-FAMILY GRADUATION

4.1.1. Households who graduated as model-family household

Among the 517 households that had participated in model-family training, about two-third reported that they graduated as model-family prior to the survey. Majority of the respondents from Amhara, Oromia, and Tigray reported their household had graduated as model-family household. None of the respondents who had participated model-family training from Afar and Harari regions had graduated as model-family prior to the time of the survey.

Among all households sampled for the HEP evaluation, overall 4.3% of households had graduated as model-family training. There was huge variation among the regions. Tigray region had the highest proportion of model-family households (12%), followed by Amhara (4.9%) and Oromia (4.5%). There were no households that graduated as model-family among the households that were sampled from Afar, Gambela, and Harari regions.

Table 4-11: Percent of respondents who reported that they graduated as model-family, rural Ethiopia 2010

Region	No. of households who graduated as model-family	Among households who participated training		Among all households surveyed	
		Percent	No. of respondents	Percent	No. of respondents
Tigray	88	57.1	152	12.0	679
Afar	0	0.0	1	0.0	200
Amhara	82	83.6	95	4.9	1496
Oromia	94	72.9	141	4.5	1774
Benshangul	6	42.0	17	2.0	399
SNNP	30	63.9	46	2.1	1197
Gambela				0.0	722
Dire Dawa	1	100.0	1	1.0	100
Harari	0	0.0	14	0.0	96
Somali	7	25.9	50	2.8	383
Total	308	67.4	517	**4.3**	**7046**

Among the households who participated in the model-family training, 179 households had not graduated as model-family at the time of the survey. These households were asked what they thought were the reasons that they had not graduated. Majority (55.1%) stated that they had not graduated because they had not completed the model-family training. Moreover, 8.1% of respondents stated that they were enrolled in the training recently and had not completed the training. The other reasons stated for not yet graduating as model-family were related to challenges and short coming of the households, which includes lack of time (7.3%), lack of materials (3.8%), and did not acquire adequate knowledge (3.7%).

Table 4-12: Percent of respondents who stated the reason for not graduating as model-family, rural Ethiopia 2010

Region	Not yet completed the training	Selected recently/lately	Lack of time	Lack of material	Lack of labour	Lack of adequate knowledge	Other/Not stated	Total
Tigray	76.9	1.8	11.6	1.8	1.8	0.0	6.0	47
Afar	0.0	0.0	0.0	0.0	0.0	0.0	100.0	1
Amhara	49.8	5.4	10.0	6.3	0.0	10.0	18.6	11
Oromia	41.8	9.9	9.9	0.0	0.0	0.0	38.4	44
Benshangul	100.0	0.0	0.0	0.0	0.0	0.0	0.0	11
SNNP	18.9	11.5	0.0	25.8	0.0	9.4	34.3	9
Harari	64.3	7.1	7.1	0.0	0.0	0.0	21.4	14
Somali	66.1	13.5	0.0	3.1	0.0	8.7	8.7	42
Total	**55.1**	**8.1**	**7.3**	**3.8**	**0.4**	**3.7**	**21.7**	**179**

4.1.2. Duration of model-family training

Among the respondents who graduated as model-family, 62.7% reported that they graduated after 3-4 months of training. About 22% of respondents stated that the model-family training took only 1-2 months before graduation, while 15.5% stated that the training took 5 or more months.

Table 4-13: Percent distribution of model-families by the duration of training attended prior to graduation, rural Ethiopia 2010

Region	Number of months of training			Number of respondents
	1-2	3-4	5+	
Tigray	6.0	73.9	20.1	88
Amhara	41.5	37.4	21.0	82
Oromia	14.6	78.9	6.5	94
Benshangul	16.7	0.0	83.3	6
SNNP	22.8	50.9	26.3	30
Dire Dawa	0.0	100.0	0.0	1
Somali	0.0	100.0	0.0	7
Total	**21.8**	**62.7**	**15.5**	**308**

4.1.3. Process and criteria used for graduation of model-family

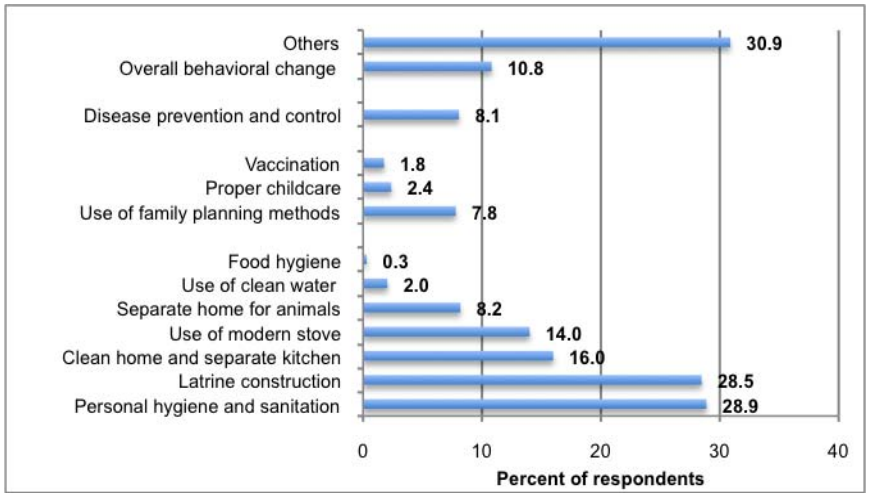
Once the training of households for model-family is completed, HEWs are expected to decide if the households should graduate as model-family. Among households graduated as model-family, about two-thirds of respondents reported that their home was assessed by HEWs/HEW-supervisor/vCHP/kebele council to determine the eligibility of the household for graduation. A similar proportion of respondents reported that they were given a certificate of graduation during a graduation ceremony.

Table 4-14: Percent of graduated model-families who reported that their home was assessed before graduation and who were given a certificate of graduation, rural Ethiopia 2010

Region	Home assessed before graduation	Given a certificate of graduation	Total
Tigray	71.3	68.6	88
Amhara	86.4	82.5	82
Oromia	42.1	46.3	94
Benshangul	100.0	100.0	6
SNNP	78.5	83.8	30
Dire Dawa	100.0	100.0	1
Somali	60.6	60.6	7
Total	65.1	65.7	308

To assess the understanding of households on the criteria used by HEWs in the process, respondents who graduated as model-family were asked what they thought were the criteria used. The most frequently stated criteria were implementation of the HEP packages under the environmental sanitation and hygiene component. About 29% and 28.5% of respondents thought that implementation of personal hygiene and sanitation and construction of latrine, respectively, were used to determine if a household should graduate as model-family. Use of family planning methods was reported by 7.8% of respondents as a decision criterion.

Figure 4-9: Percent of respondents who stated the criteria they thought were used in determining graduation of model-family trainees, rural Ethiopia 2010



4.2. READINESS OF MODEL-FAMILIES TO SUPPORT THE COMMUNITY

Majority of households who participated on model-family training feel that the training they received was useful. One of the key objectives of model-family training is diffusion of health messages to other households. In that respect they are expected to encourage other families to join model-family training, to educate households on HEP, and to serve as vCHP. Their readiness to support the community in this regard was assessed. Majority of respondents expressed their readiness to support the community. About 93%

of the respondents said that they would encourage other households to start model-family training, 87.5% of respondents expressed their readiness to educate other households in their neighborhood on HEP services, and 84.5% would like to work as vCHP. Some of the respondents were already serving their community as vCHP.

Table 4-15: Percent of respondents who stated that the model household training was useful, rural Ethiopia 2010

Region	Percent who stated training was useful	Number of respondents
Tigray	93.8	152
Afar	100.0	1
Amhara	97.0	95
Oromia	99.1	141
Benshangul	100.0	17
SNNP	82.7	46
Dire Dawa	100.0	1
Harari	100.0	14
Somali	98.8	50
Total	**95.7**	**517**

Table 4-16: Percent of respondents who stated that they would support or serve the community, rural Ethiopia 2010

Region	Encourage other families to become model family	Educate other households on HEP	Would like to work as vCHP	Already working as vCHP	Total
Tigray	90.8	81.8	74.9	5.8	152
Afar	100.0	100.0	100.0	0.0	1
Amhara	94.3	90.1	89.4	3.1	95
Oromia	94.9	95.9	86.1	5.5	141
Benshangul	100.0	100.0	94.7	0.0	17
SNNP	81.5	79.3	76.3	3.8	46
Dire Daw	100.0	100.0	100.0	0.0	1
Harar	92.9	78.6	100.0	0.0	14
Somali	96.5	64.5	95.3	0.0	50
Total	**92.6**	**87.5**	**84.5**	**4.3**	**517**

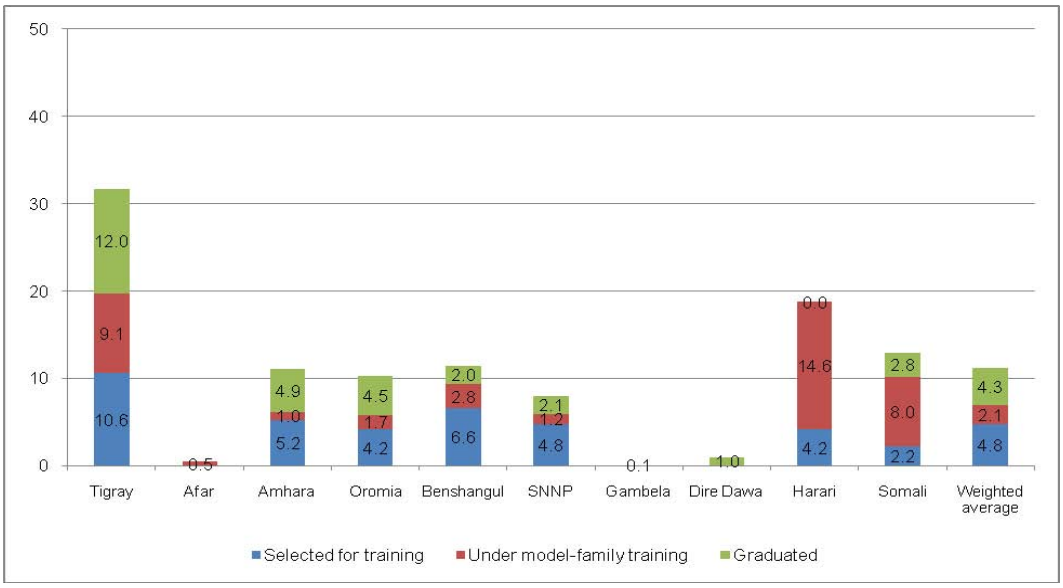
4.3. MODEL-FAMILY COVERAGE

Overall, among the over 7000 households sampled for the HEP evaluation survey, 4.3% of households were model-families; 2.1% of households were under model-family training at the time of the survey; and 4.8% of households were selected to start model-family training but had not yet participated in the training prior to the time of survey. There was significant variation in the coverage of households by model-family among the regions. Nearly a third of households in Tigray region were either graduated as model-family (12%), or currently under training (9.1%), or selected to start training (10.6%).

Table 4-17: Percent of households selected, under training or graduated as model-family based on household survey and HEWs' report, rural Ethiopia

	Percent of households selected, under training and graduated based on sample household survey							Percent of households graduated based on HEWs' report
	Selected but had not started model-family training		Currently under model-family training		Graduated as model-family		No. of respondents	
Region	No. of HHs	Percent	No. of HHs	Percent	No. of HHs	Percent		
Tigray	72	10.6	64	9.1	88	12	679	8.5
Afar	0	0	1	0.5	0	0	200	0
Amhara	93	5.2	13	0.9	82	4.9	1496	10.1
Oromia	69	4.2	47	1.6	94	4.5	1774	9.3
Benshangul	14	6.5	11	2.9	6	2	399	1.6
SNNP	57	4.8	16	1.1	30	2.1	1197	15.6
Gambela	1	0.1	0	0	0	0	722	0
Dire Dawa	0	0	0	0	1	1	100	8.1
Harari	4	4.2	14	14.6	0	0	96	0.9
Somali	11	2.2	43	8	7	2.8	383	1.4
Total	**321**	**4.8**	**209**	**2.1**	**308**	**4.3**	**7046**	**8.6**

Figure 4-10: Percent of households selected, under training or graduated as model-family based on household survey, rural Ethiopia



VOLUNTARY COMMUNITY HEALTH PROMOTERS SURVEY

HEP EVALUATION

RURAL ETHIOPIA

2010

Table of Contents

LIST OF TABLES

TABLE OF FIGURES

5. VOLUNTARY COMMUNITY HEALTH PROMOTERS (VCHPS)

5.1 CHARACTERISTICS OF VCHPS

5.1.1. Regional distribution of sample vCHPs

From the 312 kebeles that were involved in the study, 298 (95.5%) were covered by the health extension program (HEP) with at least one health extension worker (HEW) and 150 (48.1%) were with at least one volunteer community heath promoter (vCHP). From the 298 kebeles that were covered by HEP about half (49.7%) had no vCHP, 14.8% had from one to ten vCHPs, 16.4% had eleven to twenty vCHPs, 9.4% had twenty-one to thirty vCHPs and 9.7% had more than 30 vCHPs.

Table 5.1: Percent of kebeles with vCHPs (among all surveyed kebeles and kebeles covered by HEP), rural Ethiopia 2010

	All kebeles surveyed (n=312)					Kebeles covered by HEP (n=298)						
	Number of kebeles surveyed	Kebeles covered by HEP (with at least 1 HEW)		Kebeles with at least 1 VCHP		No. of kebeles covered by HEP	Percent of kebeles by number of vCHPs					Average no. of vCHPs per kebeles
Regions		No.	%	No.	%		0	1-10	11-20	21-30	>30	
Tigray	28	28	100.0	25	89.3	28	10.7	3.6	17.9	28.6	39.3	26.2
Afar	8	7	87.5	0	0.0	7	100	0	0	0	0	0
Amhara	60	60	100.0	41	68.3	60	31.7	5	26.7	20	16.7	16.3
Oromia	72	71	98.6	33	45.8	71	53.5	33.8	7	4.2	1.4	4.1
Benshang	16	9	56.3	5	31.3	9	44.4	44.4	0	11.1	0	3.9
SNNP	48	45	93.8	41	85.4	45	8.9	24.4	44.4	8.9	13.3	16.8
Gambela	56	55	98.2	0	0.0	55	100	0	0	0	0	0
Dire Dawa	4	3	75.0	1	25.0	3	66.7	0	33.3	0	0	6.3
Harari	4	4	100.0	1	25.0	4	75	0	0	0	25	8.8
Somali	16	16	100.0	3	18.8	16	81.3	6.3	12.5	0	0	2.4
Total	**312**	**298**	**95.5**	**150**	**48.1**	**298**	**49.7**	**14.8**	**16.4**	**9.4**	**9.7**	**9.7**

A total of 615 Volunteer Community Health Promoters (vCHPs) participated in the survey. Majority (95.8%) of the vCHPs interviewed were sampled from SNNP, Amhara, Tigray and Oromia. Due to the very low number of vCHPs interviewed in Harari, Dire-Dawa, Benshangul-Gumuz, and Somali, it is impossible to draw conclusions from these four regions. Nearly three-quarters of the interviewed vCHPs were male.

Table 5.2: Percent distribution of the interviewed vCHPs by region and percent of male vCHPs, rural Ethiopia 2010

Region	vCHPs interviewed			Percent male
	Number interviewed	Percent interviewed	Cumulative %	
Tigray	124	20.2%	20.2%	56.8
Amhara	183	29.7%	49.9%	72.6
Oromia	98	15.9%	65.8%	84.0
SNNP	185	30.0%	95.8%	74.3
Benshangul	9	1.5%	97.3%	100.0
Somali	9	1.5%	98.8%	41.0
Harari	4	0.7%	99.5%	50.0
Dire Dawa	3	0.5%	100.0%	100.0
Total	**615**	**100%**		**73.7**

5.1.2. Age, education and marital status of vCHPs

VCHPs were categorized into 5-year age categories from age 15 to age 69 inclusive. Two thirds of vCHPs were between 25 and 39 years old: 25.3% were aged 25-29, 23.4% were aged 35-39, and 18.2% were aged 30-34. Few vCHPs were <20 or >50 years old. VCHPs were categorized into four groups based on their educational status. 15.4% had completed grade 10 and above, 48.4% had completed grade 5 to grade 9, 23.9% had completed grade 1 to grade 4, and 11.8% had no education. Across all regions, 85.7% of interviewed vCHPs were married and 8.8% were unmarried; very few were either widowed or divorced.

Figure 5.1: Percentage distribution of vCHPs in different age categories, rural Ethiopia 2010

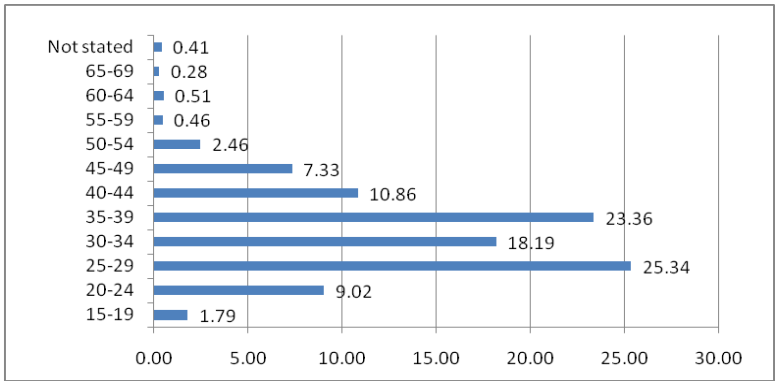


Figure 5.2: Percentage distribution of vCHPs by education level, rural Ethiopia 2010

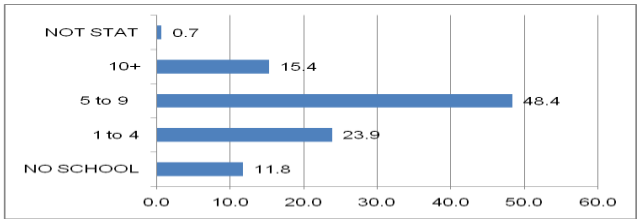
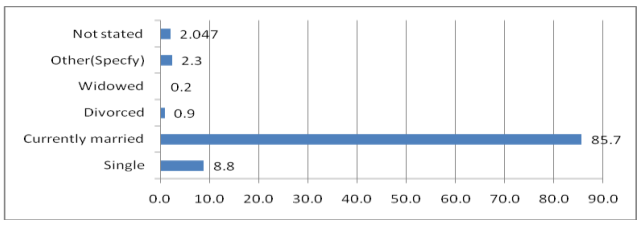


Figure 5.3: Percentage distribution vCHPs of by marital status, rural Ethiopia 2010



5.1.3. Length of service as vCHPs

VCHPs were asked how long they had been active as vCHPs, whether their household had graduated as a model household, and whether they had been participating in their community as traditional birth attendants (TBAs), community Health Workers (CHWs) or community based reproductive health agent (CBRHA) prior to becoming vCHPs. Overall, 39% of vCHPs had been working as vCHPs for less than a year and 53.3% indicated that they had been working for 1 to 3 years. Only about 7.1% of the interviewed vCHPs had been working four years or more. Tigray was the region with the highest percentage of vCHPs (15.5%) who had been active for

the last four years. There appears to be more consistency or fewer turnovers among vCHPs in Tigray compared to the other regions. 46.6% of vCHPs said that their households had graduated as model households within the Health Extension Program. Oromia, SNNP and Amhara had the highest percentage of vCHPs from graduated model households with 52.1%, 48.1% and 45.3%, respectively. Overall, 40.2% of vCHPs mentioned that they had participated as community health workers (TBAs, CHWs or CBRHA) in their area prior to working as vCHPs. Oromia (61.8%) and Tigray (55.5%) had the highest percentage of vCHPs that were working as conventionally recognized community health workers prior to becoming vCHPs.

Table 5.3: Percent distribution of vCHPs years of involvement, prior graduation as model HHs and involvements as TBAs/CBRHA/CHWs before becoming vCHPs by regions, rural Ethiopia 2010

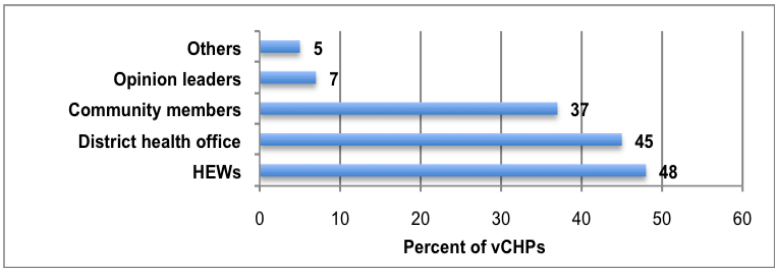
Regions	Years of involvement					Percent graduated as model household	Percent with prior involvements either TBAs/CBRHA/CHW
	<1 year	1 year	2 years	3 years	4+ years		
Tigray	26.5	26.8	17.6	13.6	15.5	37.4	55.5
Amhara	43.2	20.4	16.3	14.8	5.3	45.3	35.3
Oromia	40.9	19.0	17.7	16.4	6.1	52.1	61.8
Benshangul	23.0	77.0	0.0	0.0	0.0	0.0	33.6
SNNP	36.7	13.5	25.2	15.7	9.0	48.1	26.7
Dire-Dawa	66.7	33.3	0.0	0.0	0.0	66.7	33.3
Harari	75.0	0.0	25.0	0.0	0.0	25.0	25.0
Somali	100.0	0.0	0.0	0.0	0.0	41.0	59.0
Total	**39.0**	**18.5**	**19.6**	**15.2**	**7.7**	**46.6**	**40.2**

5.2 RECRUITMENT AND TRAINING OF VCHPS

5.2.1. Recruitment of vCHPs and selection criteria

VCHPs were asked to identify the people who were involved during their recruitment and what criteria were used for selecting them from among other community members. Nearly half (48%) of the interviewed vCHPs indicated that HEWs were involved during their selection. About 45% indicated that district health officers were involved, and 37% said that community members were involved. Finally, 7% of vCHPs indicated that opinion leaders (religious leaders/elders) were involved during their selection.

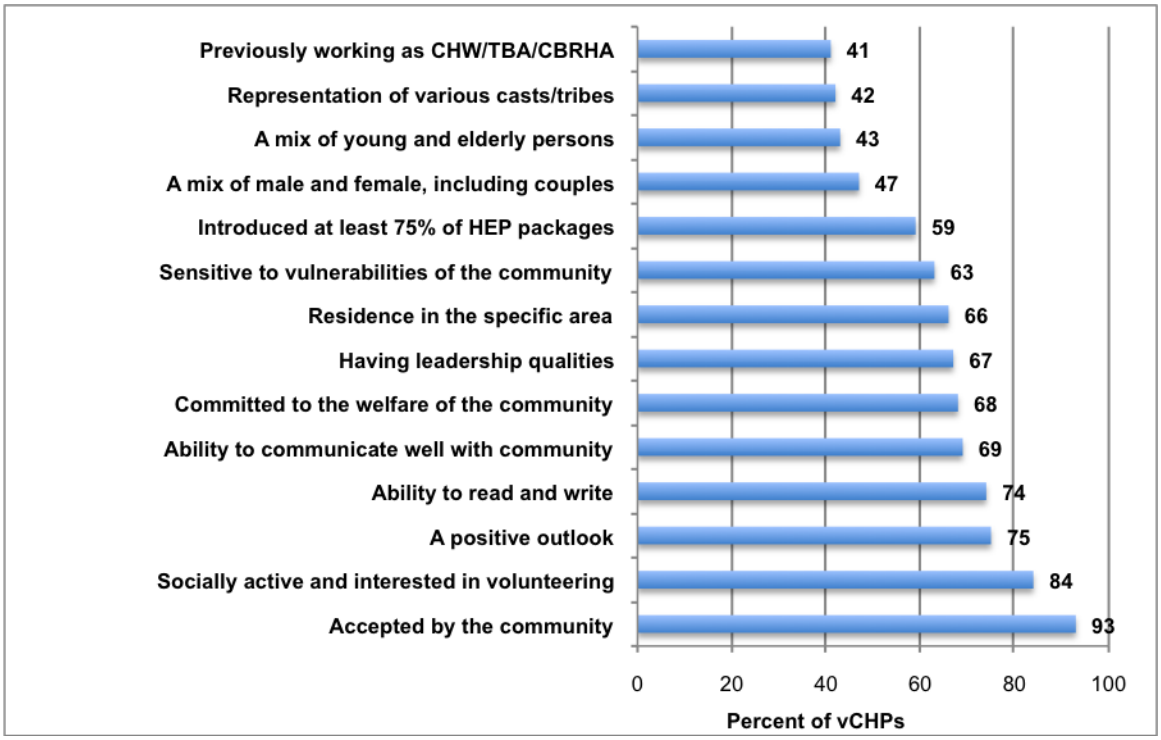
Figure 5.4: Percent of vCHPs who reported the people involved during their recruitment, rural Ethiopia 2010



VCHPs were asked to state the criteria that were used during their selection and recruitment. The most commonly indicated criterion was acceptance by the community (93.4%). Being "socially active" and having interest to volunteer was also a common criterion, indicated by

83.7% of vCHPs. A positive outlook and ability to read and write were both mentioned by approximately three quarters of vCHPs. Having graduated as model-family and introduced at least 75% of the HEP packages was reported by 59% of vCHPs to have been used as a criterion for selection. Somewhat surprisingly, previously working as a conventionally recognized community worker (e.g. CHWs/TBAs/CBRHA) was the least common used criterion, mentioned by only 40.6% of vCHPs. People who have worked as conventionally recognized community health workers (CHWs/TBAs/CBRHA) could have better knowledge and experience enabling them to work as vCHPs.

Figure 5.5: Percent of vCHPS who stated the criteria used for the selection of vCHPs, rural Ethiopia 2010



5.2.2. Duration and content of training

Over half (51.1%) of vCHPs reported that they were trained from one to three days; this is in consistence with what is stated on the HEP implementation manual. Over a third (39.7%) attended 4 to 7 days of training, and 9.2% attended 8 days or more of training to become vCHPs. In Tigray and Oromia, 34.5% and 21.3% of vCHPs, respectively, attended training for 8 days or more.

VCHPs were also asked whether their training included all components of the Health Extension Package (maternal and child health, disease prevention and control, environmental sanitation and hygiene). Majority (84.9%) of interviewed vCHPs indicated that their training included the entire health extension package, while the remaining vCHPs reported that the training focused on selected HEP packages. Relatively small percent of vCHPs from Tigray (71.2%) reported that they received the entire HEP.

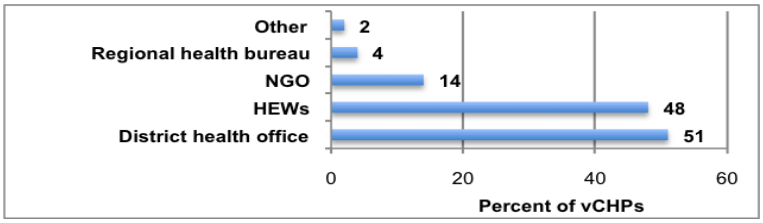
Table 5.4: Percent distribution of vCHPs by duration of training received, rural Ethiopia 2010

Region	Number of training days			Percent who were trained on all HEP packages	Total
	1-3	4 -7	8+		
Tigray	5.9	59.6	34.5	71.2	124
Amhara	68.8	29.1	2.2	92.4	183
Oromia	37.7	41.1	21.3	81.9	98
Benshangul	43.4	0.0	56.6	11.5	9
SNNP	58.0	42.0	0.0	85.2	185
Dire-dawa	0.0	100.0	0.0	100.0	3
Harari	0.0	100.0	0.0	0.0	4
Somali	0.0	75.3	24.7	68.5	9
Total	**51.1**	**39.7**	**9.2**	**84.9**	**615**

5.2.3. Organization of vCHPs training and composition of training teams

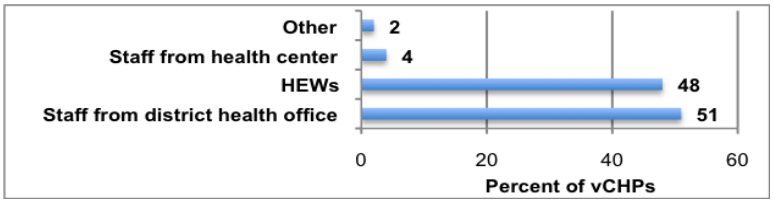
VCHPs were asked about the institutions that organized the vCHP training. Over half (51.2%) of vCHPs indicated that they attended vCHPs training organized by the district health office, while 47.8% mentioned HEWs as organizers of their training. In addition, 13.8% of vCHPs indicated that an NGO took part in the organization of their training. Only 3.7% of vCHPs indicated the involvement of the regional health office in the organization of their training.

Figure 5.6: Percent of vCHPs who stated the organizer of vCHPs training, rural Ethiopia 2010



VCHPs were further asked to indicate who participated as trainers during their training. Over half of the interviewed vCHPs indicated that staff from the district health office participated as trainers, and 48% reported the participation of HEWs as trainers. Only 3.7% of vCHPs mentioned the participation of health professionals from the closest health center.

Figure 5.7: Percent distribution of stakeholders who took part as vCHP trainers, rural Ethiopia 2010



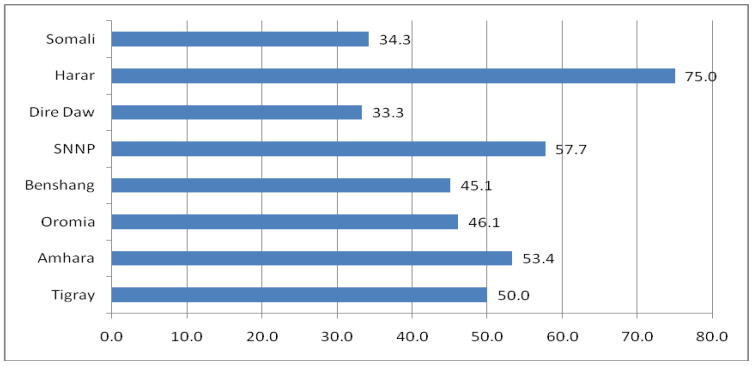
5.3 EXECUTION OF HEP ACTIVITIES

5.3.1. Job description and workplan

In order to understand vCHPs duties and responsibilities and to assess the level of awareness that they have acquired regarding their duties, vCHPs were asked whether they had been served with written job descriptions. In SNNP, Amhara, Oromia, and Tigray, where substantial

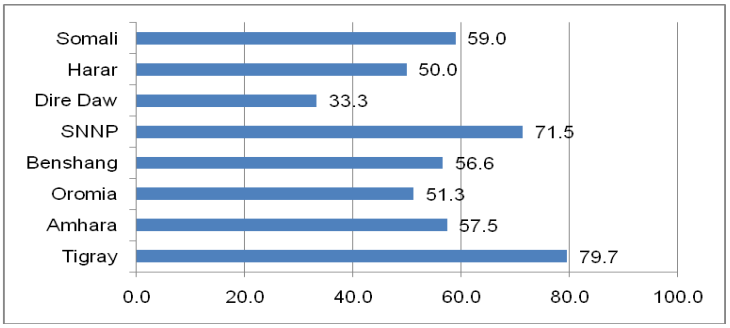
numbers of vCHPs were interviewed, only approximately 50% indicated that they were served with written job description before they began their work.

Figure 5.8: Percent distribution of vCHPs who were served with written job descriptions, rural Ethiopia 2010



VCHPs were asked whether they have a developed work plan for their day-to-day activities. Tigray had the highest percentage (79.7%) of vCHPs who indicated the availability of a developed work plan. In SNNP 71.5% of vCHPs indicated the availability of a developed work plan. Between 50% and 60% of vCHPs in the remaining regions indicated the availability of a developed work plan for their daily activities. As a checklist for their day to day activates, a developed work plan for vCHPs could be a crucial document to facilitate their work, as well as monitoring and evaluation of their duties by the HEWs in their respective kebeles.

Figure 5.9: Percent of vCHPs who had work plan developed for daily activities by region, rural Ethiopia 2010

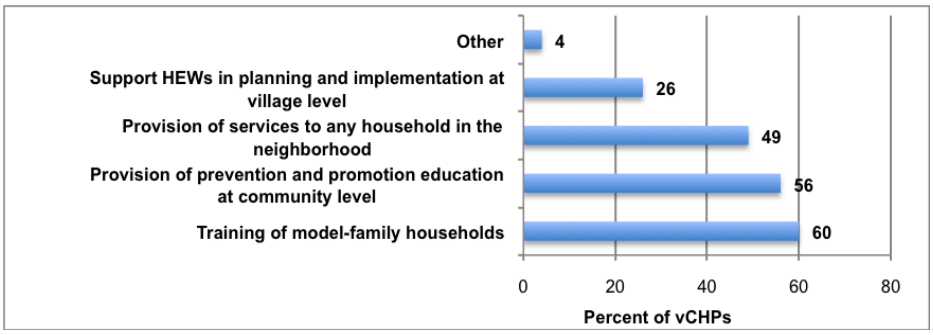


5.3.2. Duties and responsibilities assigned

Overall duties assigned to vCHPs

VCHPs were given various alternatives from which to select activities that were assigned for them when they started their job. Majority (60.4%) of the interviewed vCHPs identified provision of model-family training to selected households. The other two most frequently stated activities were provision of prevention and promotion education at community level (55.6%) and provision of services to any household in the neighborhoods (48.5%). Only 26.3% of the interviewed vCHPs indicated that they support HEWs in the village level planning and implementations. VCHPs are mainly expected to support the HEP by giving help for HEWs, and the HEP implementation manual also describes that vCHWs should plan, implement and monitor applicable work plans with HEWs. The low percentage of vCHPs identifying the overall support for the HEWs as part of their job description suggests low comprehension of expected duties.

Figure 5.10: Percent of vCHPs who stated the overall duties and responsibilities assigned to them, rural Ethiopia 2010



Specific HEP services assigned to vCHPs

VCHPs were provided with lists of HEP packages to identify the services included in their work responsibilities whether they provide the service or not. The least commonly identified packages were tuberculosis prevention and control (60.6%), provision of first aid (41.7%), and provision of adolescent reproductive health education (56.4%). All other packages were identified by 71% to 93% of vCHPs. There was also much variation across regions.

Table 5.5: Percent of vCHPs who stated HEP services as their responsibilities, rural Ethiopia 2010

HEP service packages	Tigray	Amhara	Oromia	Beneshangul	SNNP	Dire Dawa	Harari	Somali	Total
Construction and maintenance of sanitary latrines	100	92.2	87.2	100	96.8	66.7	100	65.7	**93.4**
Solid and liquid waste management	99.3	93.8	79.7	82.7	91.2	33.3	50.0	49.4	**90.2**
Personal hygiene	96.8	86.6	75.6	100	92.1	66.7	100	59.0	**87.2**
Water supply safety measures	93.5	80.3	82.6	77.0	91.5	66.7	100	56.2	**85.9**
Food hygiene (food safety measures)	94.3	67.7	78.3	88.5	86.1	100.0	100	65.7	**79.3**
Building and maintaining healthful house	87.6	84.7	57.0	42.3	79.4	0.0	75.0	0.0	**76.7**
Control of insects, rodents and other biting species	88.8	53.0	75.5	91.3	80.5	33.3	75.0	34.3	**71.2**
HIV/AIDS prevention and control	99.1	75.5	82.7	45.1	91.2	66.7	100	31.5	**84.7**
Malaria prevention and control	90.6	80.1	67.6	100	89.2	33.3	100	78.1	**81.8**
Tuberculosis prevention and control	73.0	39.2	60.7	65.3	77.1	33.3	75.0	41.0	**60.6**
First aid	37.7	30.3	41.5	33.6	54.3	0.0	50.0	24.7	**41.7**
Family planning	93.3	76.3	88.0	65.5	85.9	0.0	100	46.6	**83.7**
Vaccination services	88.4	83.4	70.4	88.5	82.2	33.3	75.0	87.7	**80.8**
Maternal and child health	89.4	69.9	66.5	77.0	83.3	0.0	100	46.6	**75.8**
Nutrition	96.0	51.3	75.6	59.7	81.4	0.0	75.0	37.1	**71.6**
Adolescent reproductive health	74.7	37.6	54.2	74.0	70.5	0.0	25.0	12.4	**56.4**
Health education and communication	90.2	88.7	83.8	100	84.3	33.3	100	43.8	**86.0**
Total Number	**124**	**183**	**98**	**9**	**185**	**3**	**4**	**9**	**615**

Households assigned to vCHPs

VCHPs were asked how many households were assigned to them. Responses were categorized into four levels: 1 - 20, 21 - 40, 41 - 60, and 61 and above. The most common response (38.9%) fell in the 21 - 40 range, while 29.4% of responses fell in the 41 to 60 range.

VCHPs were then asked to indicate the location of the households that were assigned to them relative to their own household. About 39% of the interviewed vCHPs indicated that all the

households assigned to them were located in their neighborhoods, and 45.2% responded that most of the households assigned to them were located in their neighborhoods.

VCHPs were further asked to estimate the distance (in minutes) that it would take them to travel on foot to the furthest household assigned to them. Overall, most vCHPs responded that the farthest household assigned to them was within 10 minutes. However, almost a third of vCHPs in Oromia estimated that the farthest household assigned to them was over 30 minutes away.

Table 5.6: Percent distributions of vCHPs by the number, location and distance of HHs assigned, rural Ethiopia 2010

	Number of HHs allocated per vCHP				Located in vCHP's neighborhoods				Distance (munities) to the furthest household				
Region	**1-20**	**21-40**	**41-60**	**61+**	**All**	**Most**	**Few**	**Not stated**	**1-10**	**11-20**	**21-30**	**30+**	**Total**
Tigray	4.2	80	15.8	0	53.3	42.1	2.4	2.3	38.6	30.5	21.6	9.4	124
Amhara	32.8	33.4	20.8	13	47.2	41.3	9.9	1.6	51.3	17.7	18.5	12.5	183
Oromia	12.9	30.9	27.3	28.9	34.3	47.5	8.4	9.9	24.7	19.3	24.4	31.5	98
Benshangul	0	34.7	8.7	56.6	23	77	0	0	53.8	20.2	26	0	9
SNNP	3.1	36.5	43.3	17.1	30.4	47.8	13.2	8.7	34	25.9	20.7	19.5	185
Dire-Daw	0	33.3	33.3	33.3	33.3	66.7	0	0	100	0	0	0	3
Harar	0	25	75	0	25	75	0	0	0	0	0	100	4
Somali	61.8	19.1	19.1	0	41	59	0	0	49.4	9.6	31.5	9.6	9
Total	**15.26**	**38.93**	**29.43**	**16.37**	**39.2**	**45.2**	**9.8**	**5.9**	**38.3**	**22.2**	**20.9**	**18.5**	**615**

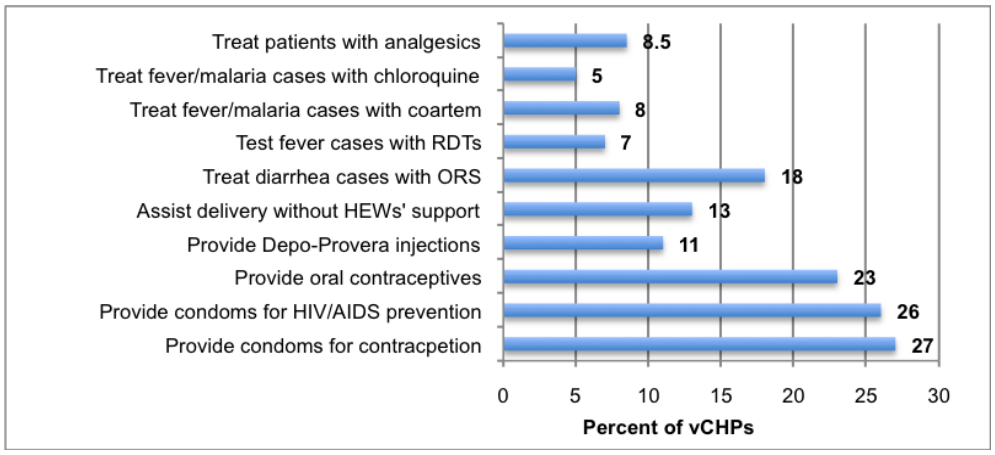
5.3.3. HEP services implemented by vCHPs

Implemented activities based on vCHPs' response

VCHPs were asked to report the specific HEP services they provided to the community. The most commonly reported service was providing women and men with condoms for contraception (27.1%) and HIV/AIDS prevention (25.9%). Providing oral contraceptive pills (23.4%), treating diarrheal cases with ORS (18%), and assisting women during delivery without the support of HEWs (12.6%) were also among the services provided by vCHPs. It is worth noting that the most commonly provided service, providing contraceptives, was still reported by less than 30% of vCHPs.

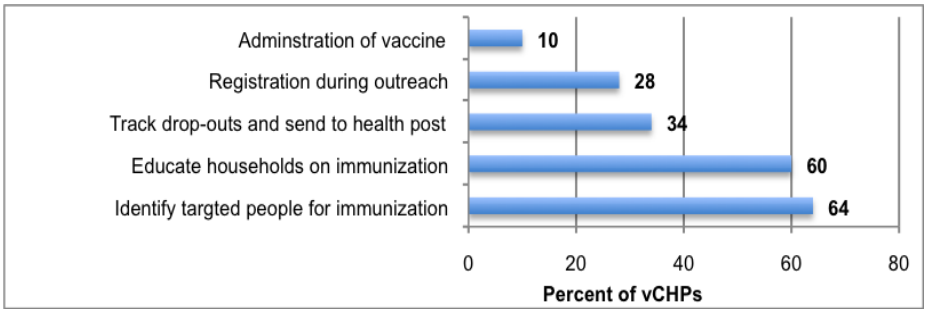
The result indicated that some vCHPs are providing services that are beyond their authorization, for instance, the contraceptive Depo-Provera and some other services like provision of patients with analgesics and treatment of malaria. VCHPs might not mean that they have provided these services by themselves but they might have mobilized the community to get these services and they may express that they have participated. However, if in reality vCHPs had provided these services by themselves, these would have to be corrected immediately and vCHPs should be clear with their duties and responsibilities and need to be frequently monitored and coached by HEWs or other concerned bodies.

Figure 5.11: Percent of vCHPs who reported they provided specific HEP services, rural Ethiopia 2010



Among the activities that are performed during immunization programs, vCHPs were asked to state the activities they perform as vCHPs. Overall, 63.8% of vCHPs indicated that they were involved in the identification of children and women that were targeted for immunization. Moreover, 59.9% of vCHPs indicated that they were involved in educating householders about the importance of immunization. Only 10.4% of vCHPs indicated that they had directly administered vaccines to children and women.

Figure 5.12: Percent of vCHPs who stated the activities they perform during immunization, rural Ethiopia 2010

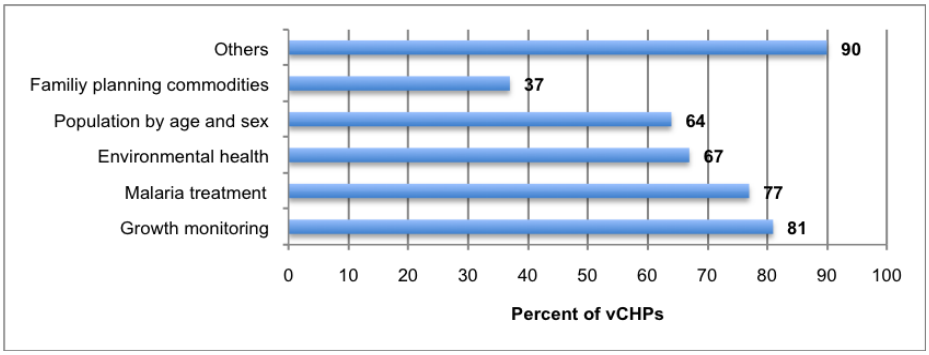


Implemented activities based on record/register

VCHPs were asked whether they keep records/registers of the services they provide for communities. Over half (56.4%) of the vCHPs reported that they have registry or records of the services they provide, but only 18.2% of vCHPs were able to show the registry to the interviewer.

The interviewer compiled the data in the registry or records of vCHPs. Growth monitoring, malaria treatment, and environmental sanitation and hygiene were the most commonly recorded information, which were found in 80.8%, 76.7%, and 67.3% of the vCHPs' records, respectively. Moreover, list of the population by age and sex as well as quantity of family planning commodities were recorded in 64.4% and 37.4% of the vCHPs registers, respectively. The registers or records also had information about other services provided.

Figure 5.13: Among vCHPs who had register/record, percent with services and information recorded, rural Ethiopia 2010



5.3.4. Model-family training by vCHPs

Number of model-families formed

One of the main tasks of vCHPs is to assist HEWs in training model households. About 30% of vCHPs indicated that they formed 1 to 10 model-families; 28% indicated they formed 11 to 20 model-families; and 14.4% indicated they formed more than 20 model-families. However, a considerable percentage of vCHPs (27.6%) indicated that they did not train any model-family.

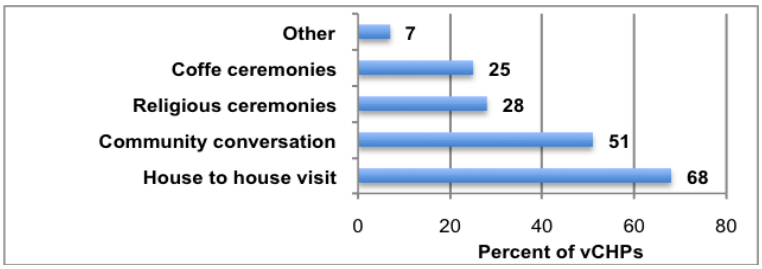
Table 5.7: Percent distribution of vCHPs by number of model-families they formed, rural Ethiopia 2010

Region	0	1-10	11-20	20+	No. of vCHPs
Tigray	20.4	11.8	34.49	33.4	124
Amhara	15.9	43.6	24.2	16.4	183
Oromia	56.6	12.0	24.13	7.2	98
Benshangul	54.9	11.5	0.0	33.6	9
SNNP	22.0	34.2	32.67	11.1	185
Dire-Dawa	66.7	0.0	33.33	0.0	3
Harari	75.0	25.0	0.0	0.0	4
Somali	78.1	12.4	9.56	0.0	9
Total	**27.6**	**29.9**	**28.06**	**14.4**	**615**

Venue used by vCHPs to educate households

VCHPs were asked to list the alternative venues/approaches that they use to educate/provide services for households. Overall 68% of the vCHPs indicated that they educate or provide the services at home through house-to-house visits. About half (51.1%) of the interviewed vCHPs indicated that they use community conversations; while only about one quarter of the interviewed vCHPs indicated that they use religious or coffee ceremonies as venues.

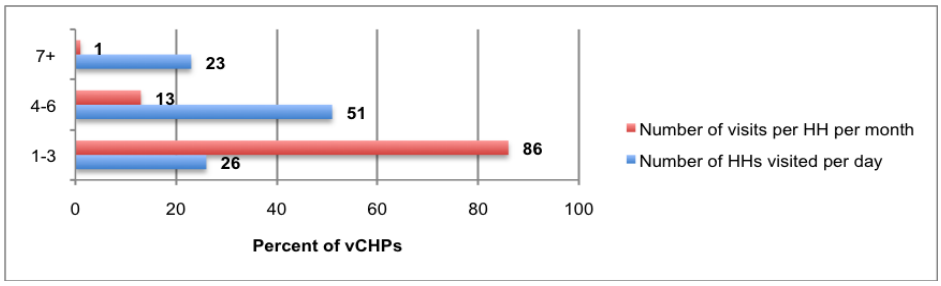
Figure 5.14: Percent of vCHPs who use various venues to implement HEP services to households, rural Ethiopia 2010



Frequency of household visits

VCHPs were asked for the number of households they usually visited per day. Their responses were categorized into three groups (1–3, 4–6, and 7 or more households per day). Majority (51.2%) of vCHPs indicated that on average they visited 4 to 6 households per day. About a quarter (26.3%) and 22.5% of vCHPs indicated that they visited 1 to 3 households and 7 or more households per day, respectively. VCHPs were also asked how many visits they made per month to each household for which they provided services. Majority (85.5%) of the vCHPs responded that on average they made 1 to 3 visits per month to each household.

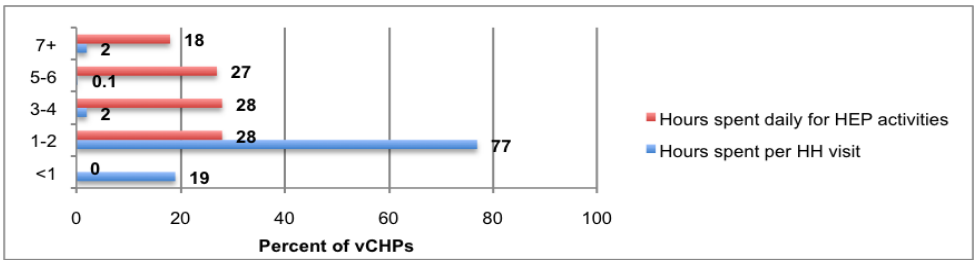
Figure 5.15: Percent distribution of vCHPs by number of HHs visited per day and HH-visits per month, rural Ethiopia 2010



Time spent on household visit and overall HEP activities

VCHPs were asked how many hours they spend on each household visit. Majority (77%) of vCHPs indicated that they spend from 1 to 2 hours in each household, while 18% said that they spend less than an hour. A very small number of vCHPs indicated that they spend 3 hours or more in each household. VCHPs were also asked for the total time (hours) they spend daily for HEP activities. Very comparable percentages of vCHPs indicated that they spend 1 to 2 hours (27.6%), 3 to 4 hours (27.5%) and 5 to 6 hours (27.2%) per day. The remaining (17.8%) vCHPs indicated that they spend 7 or more hours per day working as vCHPs.

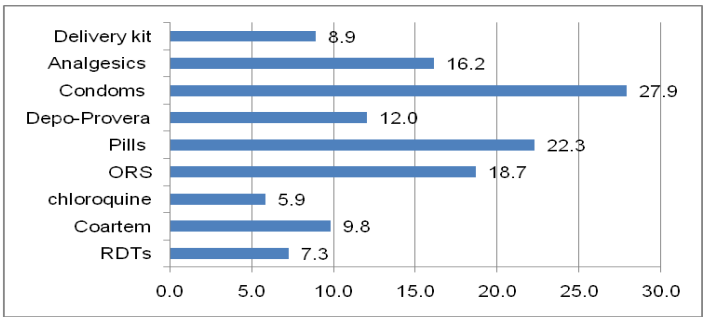
Figure 5.16: Percent distribution of vCHPs by hours spent per HH-visit and daily on HEP activities, rural Ethiopia 2010



5.3.5. Availability of supplies and guidelines

With regards to availability of needed supplies to provide specific services, the most commonly available item was condoms (27.9%). The next most commonly available items were pills for contraceptives (22.3%) and ORS (18.7%). The least commonly available items were delivery (birth) kits (8.9%) and malaria rapid diagnostic tests (RDTs) (7.3%).

Figure 5.17: Percent distribution of needed HEP supplies available to vCHPs, rural Ethiopia 2010



HEP guidelines and manuals were not available widely. Overall 40.3% of the vCHPs indicated that they had HEP implementation guideline and manual. The highest percentage was reported by vCHPs from SNNP (45.9%). Similarly, only 36.2% of the vCHPs indicated that they had visual job aids for counseling and educating households. The highest percentage was reported by vCHPs from Tigray (74.4%). The availability of visual job aids for counseling and educating households was reported by less than 40% of the vCHPs in Amhara, SNNP and Oromia.

Table 5.8: Percentage of vCHPs that had visual job aids for counseling and educating households, rural Ethiopia 2010

Region	Percent who had HEP guideline and manual	Percent of vCHPs who had visual job aids	Total
Tigray	37.0	74.4	124
Amhara	38.6	37.1	183
Oromia	36.5	20.9	98
Beneshangul	11.5	11.5	9
SNNP	45.9	32.9	185
Dire Dawa	0.0	66.7	3
Harari	25.0	25.0	4
Somali	19.1	21.9	9
Total	**40.3**	**36.2**	**615**

5.4 IN-SERVICE TRAINING, SUPPORT AND INCENTIVES

5.4.1 Refresher training

VCHPs were asked whether they received refreshment training during the year preceding the survey, after they started working as vCHPs in their communities. About a third of the vCHPs attended refresher training during the year preceding the survey. Among the regions, majority (58.6%) of vCHPs from Tigray reported that they received training, while only a third of vCHPs from Amhara and SNNP attended a refresher course during the same period. The vCHPs from Oromia (11.7%) were the least to receive refresher course in the year preceding the survey.

Table 5.9: Percent of vCHPs who received refresher training during the year preceding the survey, 2010

Region	Percent who received refreshment training	Total
Tigray	58.6	124
Amhara	34.2	183
Oromia	11.7	98
Beneshangul-Gumuz	100.0	9
SNNP	34.2	185
Dire-Dawa	100.0	3
Harari	0.0	4
Somali	19.1	9
Total	**32.3**	**615**

5.4.2 Supervision of vCHPs

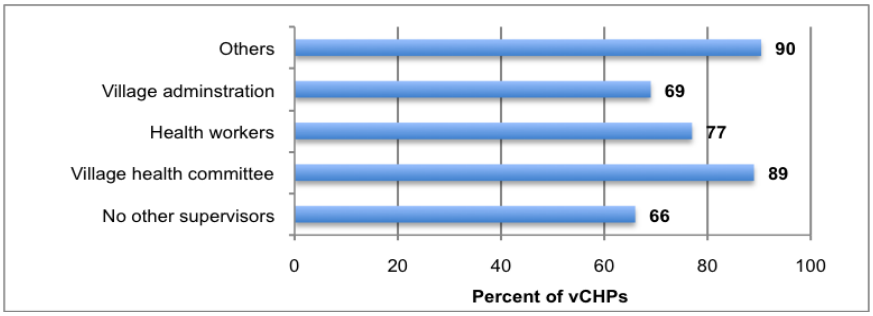
VCHPs were asked whether HEWs regularly supervise their activity. Overall, 85.9% of the vCHPs expressed that they are regularly supervised by HEWs. The highest percentage (98.3%) was reported by vCHPs in Tigray. More than 80% of the vCHPs from SNNP, Amhara and Oromia also indicated that they are regularly supervised by HEWs.

Table 5.10: Percent of vCHPs who were regularly supervised by HEWs, rural Ethiopia 2010

Region	Percent Visited by HEWs	Total
Tigray	98.3	124
Amhara	82.6	183
Oromia	80.0	98
Benshangul-Gumuz	100.0	9
SNNP	89.0	185
Dire Dawa	100.0	3
Harari	75.0	4
Somali	56.2	9
Total	**85.9**	**615**

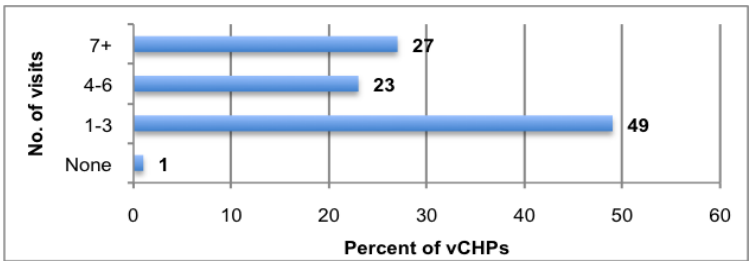
The vCHPs were also asked whether they were supervised by other than HEWs. Majority (89%) of the vCHPs reported that village health committee supervised them, and 76.6% reported that health workers from district health office or health center supervised them. Two-thirds of vCHPs were also supervised by village administration.

Figure 5.18: Percent of vCHPs who were supervised by other than HEWs, rural Ethiopia 2010



VCHPs that were supervised regularly by HEWs were asked for the number of supervisory visits they received from HEWs in the three months preceding the survey. Overall 48.5% of the vCHPs expressed that they were supervised one to three times by HEWs over the three months preceding the survey. About a quarter (23.4%) indicated that they were supervised four to six times, and a little over a quarter reported that they were supervised at least 7 times by HEWs over the same period.

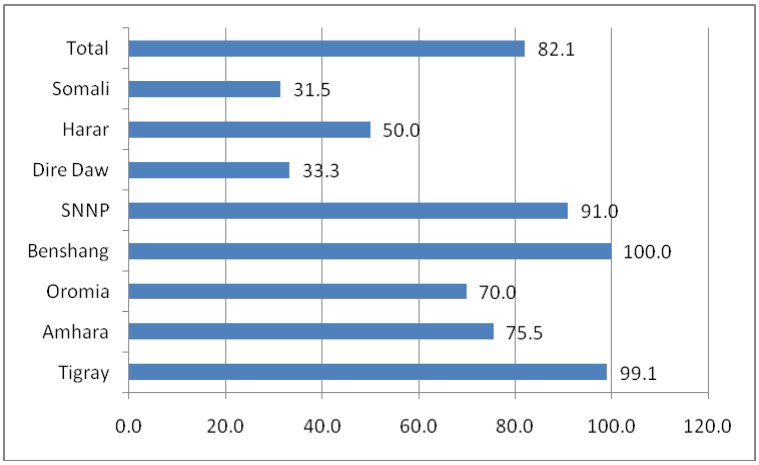
Figure 5.19: Percent distribution of vCHPs by number supervisory visits received from HEWs in the three months preceding the survey, rural Ethiopia 2010



5.4.3 Review meeting with HEWs

The vCHPs were asked whether HEWs have regular review meeting with all vCHPs in the kebele. Majority (82.1%) of vCHPs reported that HEWs have regular review meeting of all the vCHPs in the kebele. Compared to other regions, more vCHPs in Tigray (99.1%) and SNNP (91%) reported that HEWs have regular vCHP review meeting in their respective kebele. Among the vCHPs who reported that HEWs have regular review meeting with vCHPs in the kebele, 58.9% indicated that the review meeting was held monthly, while 26.5% reported to have a weekly review meeting with HEWs.

Figure 5.20: Percent of vCHPs who reported that HEWs have review meeting with vCHPs, rural Ethiopia 2010



VCHPs were asked whether they prepare and submit reports to HEWs. Overall, 55.2% reported that they submit reports to HEWs, but it was confirmed only by 19.1% of vCHPs because they provided an example of a report during the interview. A significant number of vCHPs (42%) indicated that they do not prepare and submit reports to HEWs, which may suggest lack of communication and coordination.

5.4.4 Incentives and benefits

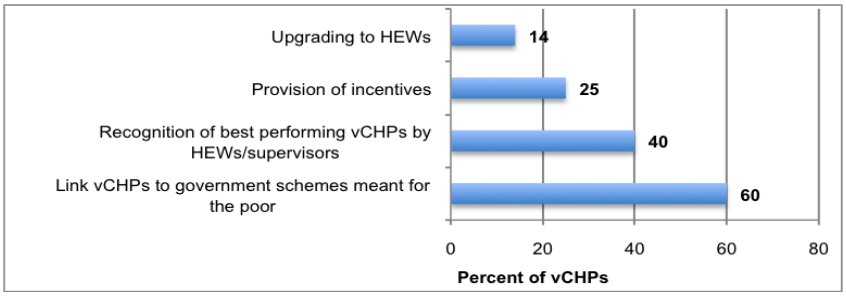
Overall 23.2% of the vCHPs reported that they received incentives in kind or cash for their service as vCHPs and 24.6% reported that they received other benefits such as recognition and better acceptance by the community for being vCHPs. Majority (77.5%) of the vCHPs stated that they should receive some kind of incentive for their service.

Table 5.11: Percent of vCHPs who received any incentive in kind or money, who feel that they should receive some kind of incentive and who get any other benefit for being VHP by Regions, rural Ethiopia 2010

Regions	Percent who received any incentive in kind or cash	Percent who get other benefit	Percent who feel they should receive some kind of incentive for their service
Tigray	27.0	30.3	91.3
Amhara	34.2	24.8	75.5
Oromia	8.4	24.6	56.9
Beneshangul	8.7	11.5	91.3
SNNP	20.6	22.9	88.2
Dire Dawa	0.0	0.0	100.0
Harari	25.0	0.0	25.0
Somali	28.7	24.7	41.0
Total	**23.2**	**24.6**	**77.5**

The vCHPs were asked how their contribution as vCHPs would be recognized best. The most commonly stated best ways to recognize their contribution as vCHPs were “linking vCHPs to different government schemes meant to serve the poor” (60.4%) and “recognition by HEWs/HEP supervisors of high-performing vCHPs during review meetings” (39.5%). About a quarter of vCHPs stated that provision of incentives would be the best way to recognize their service as vCHPs, while 14% thought upgrading to HEWs would be the best way.

Figure 5.21: Percent of vCHPs who stated the best ways of recognizing their role as vCHPs, rural Ethiopia 2010

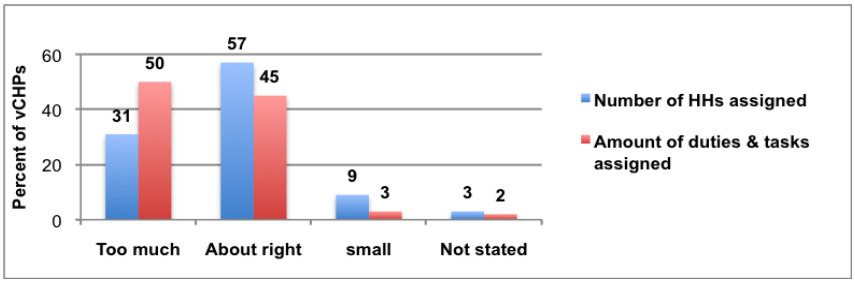


5.5 PERCEPTION AND SATISFACTION OF VCHPS

5.5.1 Perception of vCHPs on workload and level of training

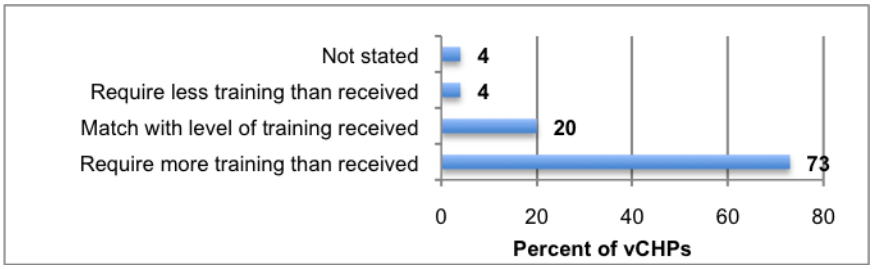
VCHPs were asked to rate the burden of the number of households that are assigned to them. Majority (57.2%) of vCHPs indicated that the number of households assigned to them was “about right”, while a minority (8.7%) indicated that it was small. About a third (31.2%) of vCHPs indicated that the number of households assigned to them was too many. VCHPs were also asked to rate the burden of the tasks and responsibilities assigned. About 45.3% of vCHPs indicated that the tasks and responsibilities assigned to them was “about right”. However, 50% of vCHPs indicated that the tasks and responsibilities assigned to them were “too much”.

Figure 5.22: Percent distribution of vCHPs by the rating on the number of households and amount of tasks and responsibilities assigned to them, rural Ethiopia 2010



Majority (72.9%) of vCHPs indicated that the tasks and responsibilities assigned to them require more training than they have received. Only 19.8% indicated that the tasks and responsibilities assigned to them match the level of training they received. This result likely indicates the confidence of vCHPs to do their job, thus it is advisable that vCHPs receive additional training.

Figure 5.23: Percent distribution of how vCHPs think their training is sufficient to handle the tasks and responsibilities assigned to them, rural Ethiopia 2010



5.5.2 Perception of vCHPs towards the community

VCHPs were asked to express how they feel about the relationships that they have with their assigned households. Overall 97.8% of the vCHPs indicated that they have good relationship with the households assigned to them. Furthermore, vCHPs were asked how they feel about the acceptance of their work by the community. Overall, 96.9% of the vCHPs said that the community accepts them. In addition, 95.9% said that they are contributing to the improvement of the community's health.

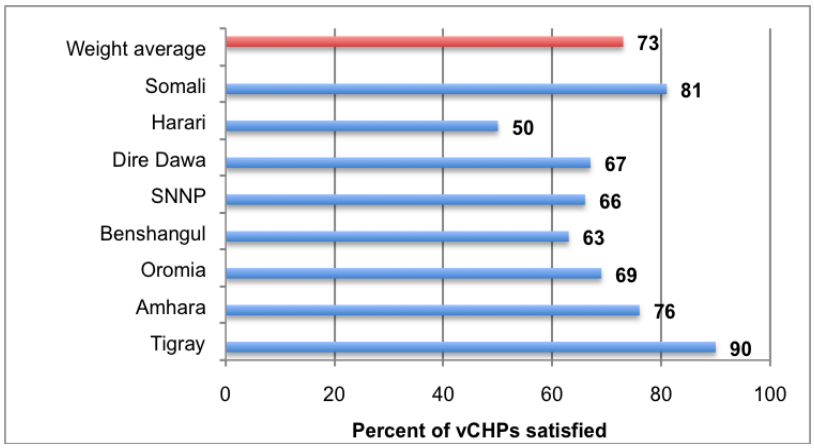
Table 5.12: Percentage distribution of vCHPs that have good relationships with assigned households, feel accepted, and feel they are contributing to their community health improvement by region, rural Ethiopia 2010

Region	Have good relationship with households assigned to them	Feel accepted by the community	Feel they are contributing to the improvement of the community's health
Tigray	100.0	98.4	97.7
Amhara	99.6	97.8	97.2
Oromia	96.7	94.3	94.3
Benshangul	100.0	100.0	100.0
SNNP	96.1	96.9	95.4
Dire Dawa	100.0	100.0	100.0
Harari	100.0	100.0	100.0
Somali	100.0	100.0	75.3
Total	**97.8**	**96.9**	**95.9**

5.5.3 Satisfaction of vCHPs with the level of support they received

VCHPs were asked whether they were satisfied by the level of support they received from village-level institutions such as kebele administrations, schools, and HEWs. Overall, 72.9% of the vCHPs stated that they were satisfied with the support provided by these institutions. The highest percentage of satisfied vCHPs was from Tigray region (90.3%). Among the vCHPs in Amhara, Oromia and SNNP, between two thirds and three quarters expressed satisfaction with the level of support provided by the institutions at the village level.

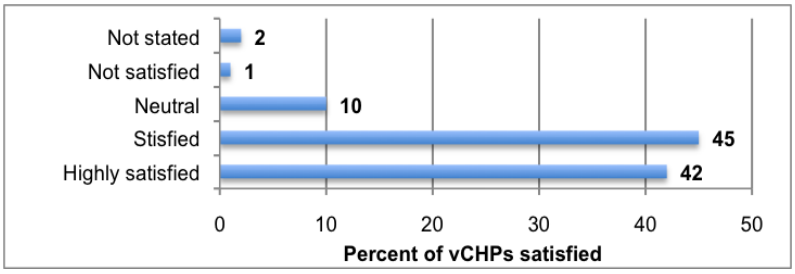
Figure 5.24: Percent of vCHPs satisfied with the support received from institutions at village level, rural Ethiopia 2010



5.5.4 Satisfaction of vCHPs with their role as vCHPs

In order to understand the general level of satisfaction of vCHPs with their role as vCHPs, they were asked to rate the level of their satisfaction. About 42% of the vCHPs reported that they were very satisfied with their role as vCHPs and 45% said that they were satisfied. Only 1% of the vCHPs said that they were not satisfied, while 10% were neutral.

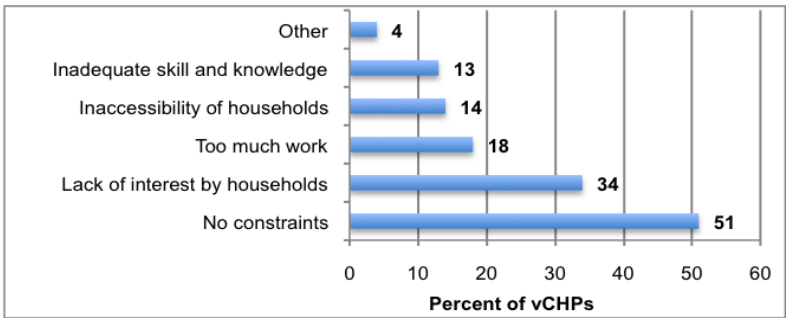
Figure 5.25: Percent distribution of vCHPs by the level of satisfaction with their role as vCHPs, rural Ethiopia 2010



5.5.5 Constraints faced by vCHPs

VCHPs were asked about the constraints that they faced while conducting their activities. Overall 50.7% of vCHPs indicated that they did not face any constraints in performing their duty. However, 33.6% expressed lack of interest of households to receive their services, and 17.8% indicated having too much work as constraint on their activities. Inadequate skill and knowledge as well as inaccessibility of some households were stated as constraints by 13% and 14% of vCHPs, respectively.

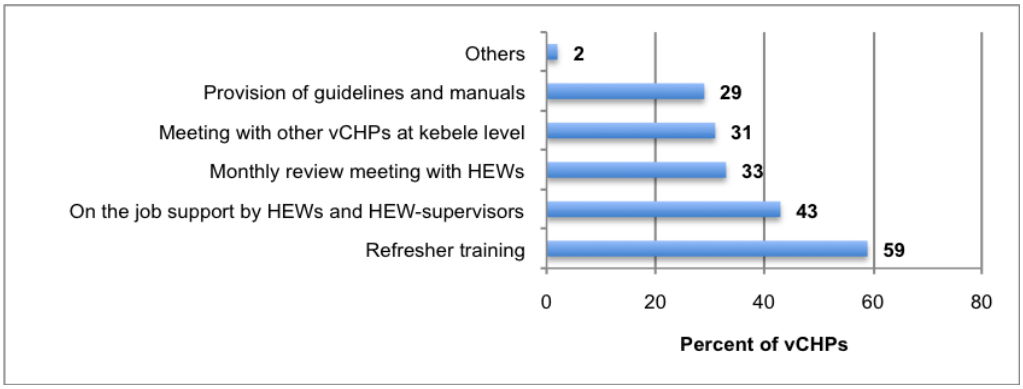
Figure 5.26: Percent distribution of various constraints faced by vCHPs in performing their duties, rural Ethiopia 2010



5.5.6 Mechanisms suggested by vCHPs to improve their knowledge and skill

VCHPs were asked to suggest measures or mechanisms that they think would improve their knowledge and skill on implementing HEP activities. The most commonly suggested mechanisms were refresher training (59.9%) and on the job support by HEWs and HEW-supervisors (43.3%). Monthly review meeting to discuss solutions to commonly faced problems, meeting with other vCHPs at kebele level for experience sharing, and provision of necessary guidelines and manuals were measures suggested each by a third of the vCHPs as important mechanisms to improve their knowledge and skills.

Figure 5.27: Percent of vCHPs who suggested mechanisms to improve their knowledge and skill, rural Ethiopia 2010



5.6 CONCLUSIONS

- Majority of the sampled vCHPs were from Tigray, Amhara, Oromia and SNNP regions. The reason was two fold – the number of kebeles sampled from these regions was larger, and vCHPs were available in most of the sampled kebeles since it has been a while since HEP has been implemented in these regions. Due to the small number of kebeles sampled and unavailability of vCHPs in majority of kebeles sampled, the number of vCHPs interviewed in Harari, Dire-Dawa, Benshangul-Gumuz, and Somali was very small. Thus, it was impossible to draw conclusions from these four regions and regional comparisons were done only among Tigray, Amhara Oromia and SNNP.

- Two-thirds of the vCHPs were between the ages of 25-39 years, and 85.7% were married. Majority (87.7%) of the vCHPs had completed at least one year of school, while 63.8% of the vCHPs had completed at least five years of formal education.
- Although it was not practiced widely, HEWs, district health office and community members were primarily involved in the selection and recruitment of candidates for vCHPs from the community. Acceptance by the community, being "socially active" and having interest to volunteer, a positive outlook and ability to read and write, and graduated as model-family were the most commonly used criteria during their selection. Previously working as a conventionally recognized community worker (e.g. CHWs/TBAs/CBRHA) was the least common used criterion.
- Nearly half of the vCHPs were trained for at least four days to become vCHPs, while the other half were trained for only one to three days, and the entire health extension package was covered during the training of majority (84.9%) of the vCHPs. Staff from the district health office and HEWs had mainly provided the training of vCHPs.
- Model-family training, provision of prevention and promotion education at community level, and provision of services to any household in the neighborhoods were reported by majority of vCHPs as the duties and responsibilities assigned to them. Only a quarter of the vCHPs stated that they planning, implementation, and monitoring of HEP services at kebele level along with HEWs as their responsibility. However, the HEP implementation manual describes that vCHPs should plan, implement and monitor applicable work plans with HEWs, and the low percentage of vCHPs identifying the overall support for the HEWs as part of their job description suggests low comprehension of expected duties.
- Majority of vCHPs were assigned at least 20 households to education and provide services, which is in line with Ethiopia HEP implementation guideline. The HEP implementation manual recommends that each vCHPs need to be assigned from 20 to 50 households. However, there were some vCHPs who were assigned less than 20 households or more than 60 households, which were mainly reported in Amhara and Oromia.

Duties and responsibilities

- The awareness of the vCHPs on their duties and responsibilities was not wide spread. Training of model-family households was the only responsibility stated by majority of vCHPs. Involvement in planning, implementation and monitoring of HEP activities along with HEWs was only stated by about a quarter of vCHPs as their responsibilities. With regard to specific HEP packages, majority of vCHPs stated that they were assigned to provide services on most of the HEP packages. The most frequently stated responsibilities among the environmental sanitation hygiene packages were construction of sanitary latrine, waste management, personal hygiene and water safety measures. HIV/AIDS and malaria prevention and control were the most frequently stated infection prevention packages, while family planning and vaccination were among the most frequently stated maternal and child health service packages. The least widely stated HEP packages as their responsibility were first aid, adolescent reproductive health, and tuberculosis prevention and control. This trend could have been influenced by the training and orientation given by HEWs because similar trend was observed from the HEW performance study.

- Although majority of vCHPs stated that they were assigned the responsibility of providing most of the HEP packages to the community, it was only very limited types of HEP packages that were provided to the community. The most frequently stated HEP packages provided to the community were family planning, HIV/AIDS prevention, and treatment of illness. The specific services included provision of condom for contraception and HIV/AIDS prevention, provision of oral contraceptives and Depo-Provera injections, management of diarrhea with ORS, testing fever cases with RDTs, and provision of antimalarial drugs and analgesics. These services were reported each by only a quarter or less percent of vCHPs. Confirmation of services provided to the community was possible only among 56% of the vCHPs because the remaining vCHPs did not have registers where the services provide to the community are recorded. Among the vCHPs who had registers, the most commonly recorded services were growth monitoring, malaria treatment and environmental sanitation.

Model-family

- The most commonly used venue or approaches by vCHPs to educate or provide services to households were through house-to-house visits and community conversation. Majority (74%) of vCHPs on average visited at least four households per day, and 77% of vCHPs spent from 1 to 2 hours during each household visit. Moreover, 86% of vCHPs reported that they made 1 to 3 visits per month to each household assigned to them. Considering the number of households assigned, it was reasonable to visit each household no more than 1 to 3 times per month. The number of hours that vCHPs spent each day to undertake household visits and community conversations, and to provide other HEP activities was evenly distributed between 1 to 7 hours, which shows the lack of standardization of the work of vCHPs. Over the duration of their service as vCHPs, majority had formed model-family households, but about a quarter did not form model-families.

- The necessary supplies to provide the specific HEP services assigned to vCHPs such as condoms, contraceptive pills, and ORS were not available with majority of the vCHPs. Similarly, majority of the vCHPs were not equipped with the necessary HEP guidelines and manuals, and visual job aids.
- Majority (85.9%) of the vCHPs were regularly supervised by HEWs, and were supervised at least once over the three months preceding the survey. Moreover, a similar proportion of vCHPs participate in a regular review meeting with HEWs. About a third of vCHPs also attended refresher course over the year preceding the survey. Majority of vCHPs also feel that they were satisfied by the level of support they received from kebele administration, schools and HEWs.
- About a quarter of vCHPs received incentives in kind or cash, and majority of the vCHPs felt that some kind of incentives should be given for their service. Moreover, all vCHPs would like their contribution to be recognized. The best ways suggested by vCHPs to recognize their contribution include linking vCHPs to different government schemes meant to serve the poor and recognition by HEWs/HEP supervisors of high-performing vCHPs during review meetings.

- Although majority of vCHPs reported that the number of households assigned to them were about right, half of the vCHPs felt that the overall tasks and responsibilities assigned to them were too much. Moreover, 72.9% vCHPs indicated that the task and responsibilities assigned to them require more training than they received. Majority of vCHPs suggested that refreshment training and on-the-job support by HEWs and HEP supervisors as important mechanisms to improve their knowledge and skills.
- Almost all vCHPs stated that they have good relationship with households and feel well accepted by the community, and expressed satisfaction with their role as vCHPs. Although half of the vCHPs reported that they did not face constraints in performing their duties, the other half stated lack of interest and inaccessibility of households, workload, and inadequate skill and knowledge as constraints they faced while implementing the HEP services.

Characteristics of vCHPs

- Majority of the sampled vCHPs were from Tigray, Amhara, Oromia and SNNP regions. The reason was two fold – the number of kebeles sampled from these regions was larger, and vCHPs were available in most of the sampled kebeles since it has been a while since HEP has been implemented in these regions. Due to the small number of kebeles sampled and unavailability of vCHPs in majority of kebeles sampled, the number of vCHPs interviewed in Harari, Dire-Dawa, Benshangul-Gumuz, and Somali was very small. Thus, it was impossible to draw conclusions from these four regions and regional comparisons were done only among Tigray, Amhara Oromia and SNNP.
- Two-thirds of the vCHPs were between the ages of 25-39 years, and 85.7% were married. Majority (87.7%) of the vCHPs had completed at least one year of school, while 63.8% of the vCHPs had completed at least five years of formal education.

Recruitment and training of vCHPs

- Although it was not practiced widely, HEWs, district health office and community members were primarily involved in the selection and recruitment of candidates for vCHPs from the community. Acceptance by the community, being “socially active” and having interest to volunteer, a positive outlook and ability to read and write, and graduated as model-family were the most commonly used criteria during their selection. Previously working as a conventionally recognized community worker (e.g. CHWs/TBAs/CBRHA) was the least common used criterion.
- Nearly half of the vCHPs were trained for at least four days to become vCHPs, while the other half were trained for only one to three days, and the entire health extension package was covered during the training of majority (84.9%) of the vCHPs. Staff from the district health office and HEWs had mainly provided the training of vCHPs.

Duties and responsibilities of vCHPs

- Model-family training, provision of prevention and promotion education at community level, and provision of services to any household in the neighborhoods were reported by majority of vCHPs as the duties and responsibilities assigned to them. Only a quarter of the vCHPs stated that they planning, implementation, and monitoring of HEP services at kebele level along with HEWs as their responsibility. However, the HEP implementation manual describes that vCHPs

should plan, implement and monitor applicable work plans with HEWs, and the low percentage of vCHPs identifying the overall support for the HEWs as part of their job description suggests low comprehension of expected duties. With regard to specific HEP packages, majority of vCHPs stated that they were assigned to provide services on most of the HEP packages. The most frequently stated responsibilities among the environmental sanitation hygiene packages were construction of sanitary latrine, waste management, personal hygiene and water safety measures. HIV/AIDS and malaria prevention and control were the most frequently stated infection prevention packages, while family planning and vaccination were among the most frequently stated maternal and child health service packages. The least widely stated HEP packages as their responsibility were first aid, adolescent reproductive health, and tuberculosis prevention and control. This trend could have been influenced by the training and orientation given by HEWs because similar trend was observed from the HEW performance study.

- Majority of vCHPs were assigned at least 20 households to education and provide services, which is in line with Ethiopia HEP implementation guideline. The HEP implementation manual recommends that each vCHPs need to be assigned from 20 to 50 households. However, there were some vCHPs who were assigned less than 20 households or more than 60 households, which were mainly reported in Amhara and Oromia.

Execution of HEP activities

- Although majority of vCHPs stated that they were assigned the responsibility of providing most of the HEP packages to the community, it was only very limited types of HEP packages that were provided to the community. The most frequently stated HEP packages provided to the community were family planning, HIV/AIDS prevention, and treatment of illness. The specific services included provision of condom for contraception and HIV/AIDS prevention, provision of oral contraceptives and Depo-Provera injections, management of diarrhea with ORS, testing fever cases with RDTs, and provision of antimalarial drugs and analgesics. These services were reported each by only a quarter or less percent of vCHPs. Confirmation of services provided to the community was possible only among 56% of the vCHPs because the remaining vCHPs did not have registers where the services provide to the community are recorded. Among the vCHPs who had registers, the most commonly recorded services were growth monitoring, malaria treatment and environmental sanitation.
- The most commonly used venue or approaches by vCHPs to educate or provide services to households were through house-to-house visits and community conversation. Majority (74%) of vCHPs on average visited at least four households per day, and 77% of vCHPs spent from 1 to 2 hours during each household visit. Moreover, 86% of vCHPs reported that they made 1 to 3 visits per month to each household assigned to them. Considering the number of households assigned, it was reasonable to visit each household no more than 1 to 3 times per month. The number of hours that vCHPs spent each day to undertake household visits and community conversations, and to provide other HEP activities was evenly distributed between 1 to 7 hours, which shows the lack of standardization of the work of vCHPs. Over the duration of their service as vCHPs, majority had formed model-family households, but about a quarter did not form model-families.

- The necessary supplies to provide the specific HEP services assigned to vCHPs such as condoms, contraceptive pills, and ORS were not available with majority of the vCHPs. Similarly, majority of the vCHPs were not equipped with the necessary HEP guidelines and manuals, and visual job aids.

In-service training and support

- Majority (85.9%) of the vCHPs were regularly supervised by HEWs, and were supervised at least once over the three months preceding the survey. Moreover, a similar proportion of vCHPs participate in a regular review meeting with HEWs. About a third of vCHPs also attended refresher course over the year preceding the survey. Majority of vCHPs also feel that they were satisfied by the level of support they received from kebele administration, schools and HEWs.
- About a quarter of vCHPs received incentives in kind or cash, and majority of the vCHPs felt that some kind of incentives should be given for their service. Moreover, all vCHPs would like their contribution to be recognized. The best ways suggested by vCHPs to recognize their contribution include linking vCHPs to different government schemes meant to serve the poor and recognition by HEWs/HEP supervisors of high-performing vCHPs during review meetings.

Perception and satisfaction

- Although majority of vCHPs reported that the number of households assigned to them were about right, half of the vCHPs felt that the overall tasks and responsibilities assigned to them were too much. Moreover, 72.9% vCHPs indicated that the task and responsibilities assigned to them require more training than they received. Majority of vCHPs suggested that refreshment training and on-the-job support by HEWs and HEP supervisors as important mechanisms to improve their knowledge and skills.
- Almost all vCHPs stated that they have good relationship with households and feel well accepted by the community, and expressed satisfaction with their role as vCHPs. Although half of the vCHPs reported that they did not face constraints in performing their duties, the other half stated lack of interest and inaccessibility of households, workload, and inadequate skill and knowledge as constraints they faced while implementing the HEP services.

Recommendation

- There is a need to standardize the recruitment and selection criteria of candidate for vCHPs and the duration and content of pre-service vCHPs training.