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**ARTICLES**

**Research Articles**

**Innovative approach to decentralized planning for backward area development in India** 221

Krishnendu Sarkar

**A study of tribal vs non-tribals – Culture and life of tribal population** 227

Naresh Rout

**Health extension program as innovative health care service: The socio-cultural factors affecting its implementation in Jimma Zone, South Western Oromia** 235

Bisrat Tesfa and Nega Jibat

*Full Length Research Paper*

## Innovative approach to decentralized planning for backward area development in India

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The allocation of appropriate funds for any development sector is a major issue in which the three levels of rural development are involved, namely the Panchayats, its block and district. There is a huge disparity between the funds proposed under a bottom-up decentralized planning system from the Panchayat and block levels and the top-down release of funds from the district. The targeted beneficiaries are totally unaware of the development goals and their priorities for fund utilization. Besides, there is a major gap in the sector-wise planning for funds and the scheme-wise release of funds due to a lack of clarity on sector-wise allocation of funds involving various schemes. Further, there are various government agencies to actuate the development mostly under the influence of vested interest groups. India as a country is largely rural, out of which a significant area is still backward. For India to improve its development indices of health, education and livelihood, there have to be some innovative approaches that can provide effective objective functions based decentralized planning model for backward area development. The five-year plans of India henceforth have to be more meaningful in terms of priority based backward areas development.

**Key words:** Decentralized planning, objective functions and planning model.

### INTRODUCTION

The benefits of development efforts through the exotic models did not percolate to the roots of our society perfectly and as a consequence a significant portion of the India's population lies below the poverty level in backward areas. The centralized approach in planning failed to recognize the micro-level variations that persist in different dimensions of planning such as spatial, sectoral and sectional (population). Wherever isolated efforts were made to confute this, they were all intermittent and could never become a perpetual process.

In short, such planning efforts stood more on investment for consumption than investment for production of goods and services for development.

### Decentralized planning in India

Decentralized planning is not a new concept in Indian democracy; it is at least as old as the concept of planning itself. Since the commencement of planning in 1951 the

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government has taken several steps (Sundaram, 1997) to provide impetus to local level planning. Decentralized governance is assumed to provide more effective and competitive delivery of services at the grassroots level. Being closer to the people, decentralized governance is assumed to meet needs and preferences of the people (Sangita, 2002; Breton, 2002; Bardhan and Mookherjee, 2002). Decentralization enables the people, particularly the vulnerable sections to increase their capabilities, participate productively in the market and earn their freedoms (Sen, 1999). By the 1970s, it came to be widely recognized that development in India had evaded the vast majority of the poor population (Webster, 1992). As a consequence, a number of special programmes were introduced in this phase. Also emphasis was laid on Block-level planning.

An elaborate system of financial devolution was prepared, and in addition to central and state government grants, the Panchayati Raj Institutions (PRI) were also empowered to raise resources of their own. However, the euphoria generated by the initial efforts at democratic decentralization in India faded. Except in a few states like Gujarat, Kerala, West Bengal, Maharashtra and Karnataka, studies reveal that no serious attempt was made by the state governments to entrust to the panchayats the responsibility of development administration (Inamdar, 1985; Crook and Manor, 1994). Women in the rural areas in large parts of the country are less educated and mainly stay away from the public sphere. Similar is the case with the SCs and STs. With the introduction of reservations their representation in the panchayats has become mandatory. But most of the women and SC and ST representatives still find it difficult to cope up with new realities due to prevailing cultural disparities (Lieten and Srivastava 1999).

The analysis of the impact of the various measures taken to broaden and deepen the decentralization reform by Bardhan and Mookherjee (2000) shows that even though about 2/3<sup>rd</sup> of the local government positions were taken by landless, small and marginal farmers, they were under-represented as their population weight was 96%. The study argues that there is considerable responsiveness and accountability in the pattern of resource allocation in villages. At this juncture, it is essential to look at whether the decentralized governance has the ability to promote development at the grassroots level if it meets certain conditions (Internal and external) such as Peoples Participation, Accountability and Transparency (as internal conditions) and the Social Capital (as external condition). People's Participation, Accountability, and Transparency are often mentioned with a strong consensus to make decentralized governance effective. Local government does not attempt to do everything by itself (Fiszbein, 1997). In local government development process (Ghosh, 2000; Dasgupta, 1995), the disadvantaged groups felt that their powers over village affairs had increased. The elite, landowners, money-

lenders and high caste people did not dominate the participation process in panchayats (Lieten, 1996; Kohli, 1987). The panchayat is not only effective in eliciting people's participation in planning and implementation but also effective in mobilizing the local people in maintenance of panchayats' assets after completion of the construction (Datta, 2000; Kar, 1997). The elected members from SCs, STs and women categories were poor in participation in the meeting, remain passive while the political party, higher caste or educated tended to dominate the meeting (Bhattacharya, 2002; Webster, 1992).

### **Decentralization and development**

The link between decentralization and development comes stronger in the formulation on 'competitive federalism'. Breton (2002) provides a more systematic analysis of vertical and horizontal competition to conclude increased efficiency under decentralization. Pierre Salmon's analysis of horizontal competition shows that citizens of a jurisdiction can use information about the public services provided elsewhere to evaluate the performance of their own governments. Therefore, competition among governments not only affects policies to attract or keep citizens happy, but also interacts with electoral incentives.

UNDP (2007) report had talked about putting people at the centre of development through human development approaches thereby enlarging people's choices and freedoms to live a long and healthy life, have access to knowledge and a decent standard of living, and participate in communities with dignity and self-respect. Even after implementation of ten 5-year plans, India figures 128<sup>th</sup> in the list of countries in terms of its Human Development Index (HDI) that is broadly based on three development dimensions of – Health, Education and Livelihood. India has a large rural population and most of which comprise the poor and marginalized from the backward tribal regions that had remained undeveloped and underdeveloped. The central problem here is not about fund-allocations but about fund-utilization without a base development plan till the last mile. Planning at the block level is more adhoc and driven by unavoidable compulsions and no prioritization. The first Millennium Development Goal (MDG) of 'Eradicating Extreme Poverty and Hunger' aims, by 2015, to reduce the proportion of people whose income is less than \$1 by half (UNDP 2009). India's 11th Five Year Plan, reiterating the country's commitment to the MDGs, has set socio-economic targets for inclusive growth and development. These include: reducing the headcount ratio of consumption poverty by 10 percentage points, raising the real wage rate of unskilled workers by 20 percent and creating 70 million new work opportunities. One of the major factors which restrict the process of decentralized

development is the weak data base at the lower levels of planning. In general, planning which is information intensive (multi-disciplinary) exercise, suffers in terms of scarcity in quantity and reliability in quality of information at all levels. The problem is severe at micro-levels especially for rural areas. Since, information is a necessary condition, if not sufficient for taking decisions, a sound data base to provide such information on regional development will help the planners to avoid the ad-hoc and subjective decisions. This was also emphasized in the report jointly prepared by Space Application Centre, Ahmedabad and Town and Country Planning Organization, New Delhi (1992) on Bharatpur District, which states that.

### **District planning process: Case of Paschim Medinipur District**

Paschim Medinipur was carved out of erstwhile Medinipur District in January 2002, as a district with total area of 9.3 thousand sq.km and a population density of 561 persons per sq km. One third of the total population comprises SC and ST. It has 29 Blocks and the ones in the western half is more backward compared to the eastern ones. The reasons for slackening growth of district economy have been the disparities in development of the various Blocks. For balanced growth, the backward Blocks will need more planning emphasis in spatial and sectoral dimensions with appropriate physical actions and financial allocations. The district planners banked on the will of the Government, participation of its people and on timely release of required financial resources to create new opportunities for livelihood generation through development of agri-culture, agri-services and agro-processing, horticulture and food processing, forest management and forest based enterprises, enterprise development in fishery, animal husbandry and animal based processing, small scale, cottage and household industries, repairs and manufacturing, small trades, co-operatives, education and health services in public and private sectors, etc. Since the beginning of the Eleventh five year plan the pattern of release had been majorly for schemes for ensuring maximum employment for unskilled labour and thereby their livelihood security.

### **Issue of financing of district plans**

To maintain the spirit of decentralized planning it is imperative that special institutional efforts and initiatives shall be needed to establish an organic link between the agencies (lower levels) that require fund and agencies (higher levels) that release the fund. The widening and deepening of the decision-making apparatus should be the hallmark of decentralized planning. The reality on ground is that the overall progress of decentralized

planning in India has been found to be marginal and much below expectations of the planners. In the field of financial decentralization also the trend is not so encouraging. The district and sub-district planning authorities are often left with inadequate, untimely and non-priority linked funds to use at their discretion because sanctions for schemes and their financing are done at higher levels. Re-appropriation of unutilized District Plan funds is also finalized at the State level causing inordinate delays in proper utilization of financial resources. Further, there is frequent shifting of schemes from district sector to State sector and the earmarking of funds for core sectors is done by the Central Government. The continuing scenario is that of under fed kitty of funds inspite of the provisions of allocation of 50% of the district outlay to each district as untied funds by the State. There is barely enough to finance the existing schemes, leaving no scope for innovation. The other side is that of back flow of funds from schemes that are low on fund utilization because of time delay of fund release. The entire process is representative of a highly centralized erratic system of fund release. If a government budget is really an exercise in economic engineering that seeks to translate the financial quantities into human purposes then a similar ecosystem for budgeting and financial governance should ideally apply at district level for better development outcome at the local levels.

An innovative approach of a planning model for a backward area based on objective functions for compromised solutions has been the concern of this research work.

### **Objective functions**

To maximize the person days used under available livelihood schemes funded by government ..... OF 1  
 To maximize assets created through these activities ..... OF2  
 To optimize the utilization of fund ..... OF3

## **MATERIALS AND METHOD**

### **Description of study area**

The study area covered the backward region of Paschim Medinipur District in West Bengal. It has a total geographical territory of 978600 ha. Its density of population is 531/sq km and during 1991-2001, the sex ratio in the district has been found to be 961 females per 1000 males. The urban population of the District is 11.90% of the total population. The climate of the District is of hot, humid and tropical type with temperature ranging from 7<sup>o</sup> Celsius (min) to 45<sup>o</sup> Celsius (max). The annual average rainfall in the district has been recorded as 1450 mm. considering the administrative units, the district is composed of 5 Sub divisions, 29 Blocks, 290 Gram Panchayats, 12 Urban Places of which 8 are municipal towns. It has 7581 inhabited villages and 8701 Mouzas in total. In this district, 21.32 lakh persons form 41.04% workers among the total population. However, 31.16% of them are marginal workers. Thus



the dependency ratio of the district has been found to be 2.44 per worker and 3.54 per main worker. The population of the district is composed of 18.05% SC and 14.87% ST and thus it has a total of 32.92% population belonging to the disadvantaged communities. More than 60 thousand Lodha population, identified as the only primitive tribe community, accounts for 7.79% of 7.72 lakh total tribal population.

### Research case under study

One majorly funded scheme of NREGA (National Rural Employment Guarantee Act) for minimum employment of 100 days in a year for the unskilled poor and unemployed in rural and backward areas has been the focus of this study, considering the stated objective functions. The execution of NREGA programmes had been initiated in 2006-07 in Paschim Medinipur District. Taking all the sectors together, the District as a whole invested Rs 43.13 crores in 2006-07 which resulted in generation of 64.43 lakh person days and created an estimated asset of value of Rs 91.70 lakhs. The performance progressed significantly in the following year (2007-08) with utilization of fund nearing doubling previous year, amounting to Rs 79.77 crores. This increased investment caused creation of increased person days and estimated assets measuring 73.89 lakhs and Rs 110.29 crores respectively. Thus, during the two years of programme execution, the District recorded 14.69% rise in person days, 20.27% increase in asset creation. During the period after 2007-08 to 2008-09, it is further observed that the allocation of fund has been further increased to Rs 106.00 crores, recording a rise by 32.88%. In the same period, the person days generated was raised to 86.69 lakhs, giving a rise by 17.32%. In 2008-09 additional fund utilization was made in some District sponsored projects under NREGA conducted by DFOs of four Divisions, CADV, KVK of Jamboni and Soil Conservation Department of the State Government. The total investment of Rs 298.50 lakhs could generate additional 2.56 lakhs person days in the District. During these two years the job cards issued had been changed from 6.79 lakhs in 2006-07 to 7.40 lakhs in 2007-08. Thus against rise in strength of Job Card Holders by 8.90%, the absorption of Job Card Holders in the District changed from 9 days/year in 2006-07 to 11 days/year in 2007-08. In fact, in this period, the investment per JCH was raised from Rs 635.00 in 2006-07 to Rs 1078.00 in 2007-08. In the same period, the created asset per Job Card Holder, as estimated, was changed moderately from Rs 1350.00 to Rs 1491.00.

### RESEARCH METHODOLOGY

**Component 1:** Investigation on the decentralized planning approach as well as on the democratically resolved decisions setting across the Panchayati Raj Institution (PRI) system of rural management and its bottom-up planning processes from Gram Sansad to Zilla Parishad and the processes involving the release of funds in the reverse direction.

**Component 2:** Analyze the allocation of funds to sectors under NREGA

**Component 3:** Construct an innovative planning model using the objective functions of a) maximization of job persondays, b) maximization of assets and c) minimization of funds.

**Component 4:** Application of the innovative planning model at the Block levels

The actions under the above research components essentially led to a Multi-criteria decision making model attempting simultaneous optimization of Persondays, Asset and Fund. The optimization however was subjected to a set of constraints and conditioned by the limitation of skilled labour and material cost. The compromised

solutions at the Block levels were derived keeping in mind each of three objective functions using the most accepted and least accepted values that could make the model flexible enough to accommodate the targets of implementing agency, like fixation of days of absorption and percentage of job card holders to be involved. Other limitations under NREGA were adhered to as an integral part of methodology so that the innovative planning model envisaged can significantly contribute to ensure a systematic allocation under NREGA to provide priority outputs and optimization of funds for generation of maximum persondays and creation of maximum assets. This is how a systematic approach to micro-planning for a backward area has been laid out.

### FINDINGS AND DISCUSSION

The envisaged innovative planning model was applied at one Block level (Keshiary Block). First by accepting the compromised solution of minimum 30 days of absorption /yr/Job Card Holder (JCH) against the existing person-days in the year 2007-2008 the fund requirements is about 2.18 times more but assets generated will be 5.69 times more and the persondays will be 2.36 times more. Similarly, accepting the compromised solution of 50 days of absorption/yr/JCH against an increase of fund requirement of 3.31 times the persondays to be created will go up by 3.57 times while assets will move up to 7.43 times that of existing asset value. Further, increasing the absorption rate to the extent of 80 days/yr/JCH, it is shown from the model solution that an increase in fund requirements by 4.98 times of that in 2007-2008 the persondays to be absorbed will be 5.39 times and assets to be created by 9.70 times of that of the initiate period of 2007-2008.

In the year 2008-09, the total fund available to the District for NREGA activities was Rs. 12002.39 lakhs against which the expenditure incurred by all the Blocks and the District-Sector programmes was Rs. 10600.70 lakhs. This indicates that NREGA programmes could spend 88.32% of the fund available, though persondays created was as low as 12 days per Job Card Holder in 2008-09. However, this absorption rate cannot be taken as satisfactory since the figure was 9 days per Job Card Holder in the year of initiation, that is 2006-07. The plan in contrast looks forward to absorb 37 days for all Job Card Holders and 80 days for Demanding Job Card Holders. For this, it will be necessary to allocate Rs. 4349 per Job Card Holder against the existing Rs. 1203 per JCH. High absorption rate of 80 days per Demanding JCH calls for higher allocation to the extent of Rs. 9241 per year per Demanding JCH. The planned allocations are expected to create assets amounting to Rs. 34529 per JCH and Rs. 73364 per demanding JCH. Whereas, the envisaged model applied reflects that fund to be used per persondays in the target year will be Rs. 115.77 compared to Rs. 111.34 in 2007-08. Similarly, the asset created per persondays in 2007-08 was Rs. 883.87, which is expected to increase up to Rs. 919.13 in the target year. The results further reflect that during 2007-08 to target year the persondays will rise by 3.36 times and

the asset will go up by 3.16 times in response to increase in fund allocation by 3.62 times. Similarly considering Demanding Job Card Holders the rise in fund by 7.68 times in the same period is expected to generate 7.27 times persondays and create 7.68 times assets.

### Management issues

Management of human resources for NREGA also suffers from incapability of the participants to perform in the way that program demands. Though their traditional skill and customary methods of practice are useful to a certain extent, actually they are required to be sensitized, motivated, empowered and enriched to contribute beyond self-help in the value chain of social development given in the target-based planning approach put forth in this investigation. In this regard, the actions pertaining to capability building should have to cover the following.

- i. Creation of continuous awareness and knowledge among target population regarding gainful employment in variety of ingenious ways under and over NREGA through village-meetings and other techniques of campaigning.
- ii. Motivation of target population towards entrepreneurial abilities and self-employment through demonstration of successful projects, transfer of know-how, facilitation with information and access to resources.
- iii. Promoting organizational build-ups like SHGs, Co-operatives, Informal Associations, etc. for risk mitigation and gain maximization with income-generating activities for livelihood security.
- iv. Building the capacity to access information from the cloud of infobases under a data centre/ or a locally suited IT approach.
- v. Aligning Government of India's effective management decisions on convergence of programs the goals may be: Increase in Social Capital, Increase in Physical Capital, Facilitation of Ecological Synergies, Mitigation of adverse effects of Climate Change, Enhancement of economic opportunities, Strengthen Democratic Processes and Facilitation for Sustainable Development

### Some guidelines for the preparation of NREGA plan

- a. Potential estimation for each sector must be the first task before preparation of NREGA Plan in any District or Block. Depending on physico-economic situation and ecological conditions, few sectors or sub-sectors may be eliminated from this exercise, if so necessary.
- b. It should prioritize the sectors based on District-Block guidelines on trend of allocation, fund required per unit of work, persondays generated per unit of work, fund required for generation of unit persondays and asset created against unit of work executed.
- c. No Sector should be allowed to decelerate in fund

utilization rather be allowed to progressively increase (at least by 10% over previous year) provided the potential in the sector is existent.

- d. Information on the variables and parameters must be realistic and precise to their level best.
- e. Sectors not taken up earlier must be included if there is some potential and if it has the capacity to boost up the absorption rate.
- f. Based on the above guidelines, the absorption rate (days/ year) should be fixed after making a thorough iterative exercise.
- g. Using the package of allocation model, each District or Block must prepare its NREGA Plan for the forwarding years for implementation and operate the same model for validation in respect of previous few years to learn from the lapses.

### Conclusion

It is quite natural that the envisaged planning model may not score any visible benefits right from its actual adaptation by the concerned authorities. The quantitative and qualitative values of welfare significance to all concerned stakeholders may be measured in terms of different criteria. These criteria are gross value of output, value added employment generation etc. in economic terms, while in physical terms it may be rural drinking water security, wasteland converted into arable land, more area under irrigation etc. and in social terms, number of families attaining sustainable living, families lifted above the poverty line etc. which may be considered for assessing the outcome of decentralized planning approach to micro planning at Block or District level. The anticipated final outcome shall be 100 days of employment guarantee to an unemployed and unskilled poor per year in a backward area by the completion of the 12 five year plan period in 2017. The spinoffs apart from added income shall be human resource development (skilled persons), mitigation of long standing problem issues like that of rural drinking water, wasteland development, wider irrigation coverage, flood control and/or drought proofing, access to information, education and communication etc. all leading to meaningful development.

### Conflict of interest

The author has not declared any conflict of interest.

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*Full Length Research Paper*

## A study of tribal vs non-tribals – Culture and life of tribal population

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The Scheduled Tribes communities in India as well as in Orissa are characterized by economic and social marginalization, primitive existence, geographical isolation and educational backwardness. Tribal population is the aboriginal inhabitants of India who have been living a life based on the natural environment and have cultural patterns congenial to their physical and social environment. They have been neglected in different sectors of the society and to protect that they started resistance movement over the years. The major tribes of Orissa, in terms of their numerical strength, are the Kondh, Gond, Santhal, Saora, Bhuiyan, Paraja, Koya, Oraon, Gadaba, Juanga and Munda. There are also several smaller tribal communities living in the state. They are the Chenchus, Mankiridia Kharia, Baiga, Birhor and Ghara. Tribal communities such as the Santhal, Gond, Munda, Ho, Birhor, Koya, Lodha, Kondha, Bhumija, Kharia and Oraons cut across state boundaries and are found in the neighbouring states of Jharkhand. As a matter of fact, acute poverty, malnutrition and starvation death have come to be associated with the life of many of the tribes living in different parts of the country. Though each of the tribal groups are culturally different and have their own identities, the problems faced by them are more or less same. It makes us believe that probably at the level of understanding the tribal culture, their social structure and also at the level of making intervention while implementing the development programmes for the tribals, some gaps have so remained that they have rather frustrated our objectives and approach to a large extent.

**Key words:** Tribal population, Adivasi, untouchability, discrimination, tribal rights.

### INTRODUCTION

The Adivasis have been tormented and subjected to all sorts of discrimination by the same people whom they have welcomed openly into their sacred places. The discrimination against the tribals has been more in the places where the outsiders who have come from the coastal Orissa, Sarikela etc normally called Oriyas. They are quite alien to the cultures of tribals and even a blind

can feel a quite difference in status, culture, language, eating habits etc. The first of the racial discrimination is in many homes of Oriyas even today the Adivasis are subjected to untouchability and they are discouraged to visit their houses. They are looked down and treated as outcaste. Even till date, the non Christian tribals who do not practice sarna dharam are subjected to the

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discrimination and they are prevented from visiting the temples of Oriyas. There is a total negligence of government machinery; the government is only interested in milking; whatever revenue is collected from Sundergarh is spent in Cuttack, Bhubaneswar etc. There is only eye wash work done; one can see the percentage of developments in the whole district.

The tribal land cannot be bought by the non-tribals except the land should be more than 5 acres. Still many non-tribals specially Oriyas have twisted the rule and have grabbed the lands of the tribals. Now, the Oriyas have started a trend of capturing the government land called Anabadi Zamin, and then getting them registered in the tahsil office. Even today many tribals who have encroached the government land have not got the patta (registered) even they have encroached for more than 30 years. The Oriyas have refused to recognize the tribal languages as the official language of Orissa except the language, Santali (olchicki), even though most of the tribal languages are written in Devangiri script; instead they have preferred Oriya language. Some tough organizations like the Nila Chakra are quite offensive to the tribal language and are pressing hard the Oriya language.

One can clearly see the difference in ratios of tribals versus non-tribals in industries, which are in Rourkela as well as near it. Take the case of Rourkela steel plant, the majority of Oriyas have got jobs that nobody knows how. Majority of tribals here work as contract labours. Nobody cares what may happen if any accident happens, no trade union of whatever affiliation; they do not bother as majority have been dominated by the Oriyas. This trade union opposes any sort of tribal recruitment in the executive /non executive posts. Permanent employees also face discrimination during promotion, with the majority of Oriyas getting preferences. This is the case in all sectors. Tribals are discriminated in the times of job recruitments; there are many cases that the Oriyas have torn off the list of employments where the tribals get recruitment. They fiercely oppose the tribals who are getting /or about to join their jobs. They even destroy their letter of appointment.

There is also discrimination going on in schools which are dominated by the Oriya teachers. The students have faced daring statements of "you quota people" or "Adivasi students" which is clearly a violation of SC/ST Atrocity Act, but unfortunately the young students do not understand. The internal marks given to students are enjoyed by certain section of students only; after matric (SSC) many students have opted out of C.H.S.E (Board of Orissa 10+2) due to discriminatory marks given to students.

Atrocity cases filed against non-tribals are minimum. One has to check the police records to see the truth. Many cases have come that there was refusal of lodging an F.I.R by the police; no doubt that at least 85% of inmates in the jail are tribals. They stay and hope to get

out miraculously as they have no means to fight the cases with no money. The judges, the police mechanisms, administrative officers all are handpicked and brought here to carry out their goals. There is planned displacement of Adivasis by Oriyas and Rourkela's development plan to settle Oriyas, plan to reschedule Rourkela and to make it a district so that the rights of tribals can be suppressed.

The tribal lands have been taken by the government to make and set up industries. How many people (tribals) have got jobs in this private industries? Not even 5%; instead the tribals who protest against the pollutions are severely dealt with by the police, even their children are not spared. They pre-plan cracking, which they often term as M.C.C sympathizers and putting them behind bars. The media has put a blanket ban on any news regarding the tribals and they paint a picture that everything is ok here. All the media (paper/ electronic) mainly praise the achievements of the government. These are some issues which have created a mass of disgruntled tribals who are frustrated and angry. No doubt the region is now sitting on a situation which might explode. This creates a situation where there are alternate routes to channel their anger; already many have taken this path and this must be checked and prevented before it is too late.

### Importance of the study

1. This study furnishes the most important criterion and its reflection in the present day tribal discriminations.
2. It ensures suitable remedies and strategies for tribal development.
3. It demonstrates critical examination of the problems and prospects of tribal populations.

### LITERATURE REVIEW

A lot of books have been written on tribals. But no attempt has been made by anyone on the discrimination of tribals in Orissa by their own people. This work is a first attempt on this new emerging aspect in Orissan context. However, in the book, *The Adivasis of India-A History of Discrimination*, Bijoy (2003) stated that about 67.7% of Adivasis of India are at the lowest rung of the ladder, as well as their history, religion and culture in general.

However, Upadhaya, in his article on *Tribal People and the Law*, (2004), stated the common thread running through the tribal people of Visakhapatnam and the continuing irrelevance of law in their lives.

The book, *Tribal Rights in India*, edited by K Uma Devi provided a panoramic view of the various provisions in national legislations as well as of the Multilateral Conventions and Treaties, tracing them from their evolutionary stage. The articles also highlight the limitations

and atrocities caused to economic, social and cultural rights of tribal people, including tribal children of India. The stark and gross violation of not only human rights but also their rights to be human is demonstrated by the empirical study of the tribal people in various districts in India.

Eminent historians who have done detailed research on the epic Ramayana (200 B.C to 500 B.C) have concluded that 'Lanka', the kingdom of the demonic king Ravana and 'Kishkinda', the homeland of the Vanaras (depicted as monkeys) were places situated south of Chitrakuta hill and north of Narmada River in middle India. Accordingly, Ravana and his demons were an aboriginal tribe; most probably the Gond, and the Vanaras, like Hanuman in the epic, belonged to the Savara and Korvu tribes whose descendants still inhabit the central Indian forest belt. Even till date, the Gond holds Ravana, the villain of Ramayana, in high esteem as a chief. Rama, the hero of Ramayana is also known for slaughtering the Rakshasas (demons) in the forests.

The epic of Mahabharata refers to the death of Krishna at the hands of a Bhil Jaratha. In the ancient scriptures, considered to be sacred by the upper castes, various terms are used depicting Adivasis as almost non-humans. The epics of Ramayana and Mahabharata, the Puranas, Samhitas and other so-called 'sacred books' refer to Adivasis as Rakshasa (demons), Vanara (monkeys), Jambuvan (boar men), Naga (serpents), Bhusundi Kaka (crow), Garuda (King of Eagles) etc. In medieval India, they were derogatorily called Kolla, Villa, Kirata, Nishada, those who surrendered or were subjugated were termed Dasa (slave) and those who refused to accept the bondage of slavery were termed Dasyu (a hostile robber).

Ekalavya, one of their archers was so skillful that the hero of the Aryans, Arjuna, could not stand before him. But they assaulted him, cutting his thumb and destroying his ability to fight - and then fashioned a story in which he accepted Drona as his Guru and surrendered his thumb as an offering to the master. The renowned writer, Maheshwata Devi points out that Adivasis predated Hinduism and Aryanism, that Siva was not an Aryan god and that in the 8th century, the tribal forest goddess or harvest goddess was absorbed and adapted as Siva's wife. Goddess Kali, the goddess of hunters, has definitely had a tribal origin.

## METHODOLOGY

This study is based on primary and secondary sources. Primary sources of data are collected through questionnaire methods for this study can be explored from top government officials, NGOs, self help groups, resource persons and leaders of different panchayats of tribal pronged areas of Orissa. Emphasis will be laid on the original manuscript, archival sources, and records of contemporary resources from the state government. It will attempt to study tribals' changing movements and developments.

Secondary sources are based on the text books, journals and

periodicals from libraries across the reputed universities and the other centres of learning in Orissa and the country.

## DISCUSSION

### History of the Adivasis

Little is known about the relationship between the Adivasis and non-Adivasi communities during the Hindu and Muslim rules. There are stray references to wars and alliances between the Rajput kings and tribal chieftains in middle India and in the North-East between the Ahom Kings of Brahmaputra valley and the Nagas hill. They are considered to be ati-sudra meaning lower than the untouchable castes. Even today, the upper caste people refer to these peoples as jangli, a derogatory term meaning "those who are like wild animals" - uncivilised or sub-humans.

The Adivasis have few food taboos, rather fluid cultural practices and minimal occupational specialization; while on the other hand, the mainstream population of the plains has extensive food taboos, more rigid cultural practices and considerable caste-based occupational specialization. In the Hindu caste system, the Adivasis have no place. The so-called mainstream society of India has evolved as an agglomeration of thousands of small-scale social groups whose identities within the larger society are preserved by not allowing them to marry outside their social groups.

The subjugated groups became castes forced to perform less desirable menial jobs like sweeping, cleaning of excreta, removal of dead bodies, leather works etc - the untouchables. Some of the earliest small-scale societies dependent on hunting and gathering, and traditional agriculture seem to have remained outside this process of agglomeration. These are the Adivasis of present day. Their autonomous existence outside the mainstream led to the preservation of their socio-religious and cultural practices, most of them retaining also their distinctive languages. Widow burning, enslavement, occupational differentiation, hierarchical social ordering etc are generally not there. Though there was trade between the Adivasis and the mainstream society, any form of social intercourse was discouraged. Caste India did not consciously attempt to draw them into the orbit of caste society.

But in the process of economic, cultural and ecological change, Adivasis have attached themselves to caste groups in a peripheral manner, and the process of de-tribalisation is a continuous one. Many of the Hindu communities have absorbed the cultural practices of the Adivasis. Although Hinduism could be seen as one unifying thread running through the country as a whole, it is not homogenous but in reality a conglomeration of centuries old traditions and shaped by several religious and social traditions which are more cultural in their essence (and including elements of Adivasi socio-



religious culture).

### **Adivasis at the lowest rung of the ladder**

Adivasis are not, as a general rule, regarded as unclean by caste Hindus in the same way as Dalits are. But they continue to face prejudice (as lesser humans); they are socially distanced and often face violence from society. They are at the lowest point in every socio-economic indicator. Today the majority of the population regard them as primitive and aim at decimating them as peoples or at best integrating them with the mainstream at the lowest rung in the ladder. This is especially so with the rise of the fascist Hindutva forces.

None of the brave Adivasi fights against the British have been treated as part of the "national" struggle for independence. From the Malpahariya uprising in 1772 to Lakshman Naik's revolt in Orissa in 1942, the Adivasis repeatedly rebelled against the British in the north-eastern, eastern and central Indian belt. In many of the rebellions, the Adivasis could not be subdued, but terminated the struggle only because the British acceded to their immediate demands, as in the case of the Bhil revolt of 1809 and the Naik revolt of 1838 in Gujarat. Heroes like Birsa Munda, Kanhu Santhal, Khazya Naik, Tantya Bhil, Lakshman Naik, Kuvar Vasava, Rupa Naik, Thamal Dora, Ambul Reddi, Thalakkal Chandu etc are remembered in the songs and stories of the Adivasis but ignored in the official text books.

### **The British Crown dominions in India**

These consist of four arrangements: the presidency areas where the Crown was supreme, the Residency Areas where the British Crown was present through the Resident and the Ruler of the realm was subservient to the Crown, the Agency (Tribal) areas where the Agent governed in the name of the Crown but left the local self-governing institutions untouched and the Excluded Areas (north-east) where the representatives of the Crown were a figure head.

After the transfer of power, the rulers of the Residency Areas signed the "Deed of Accession" on behalf of the ruled on exchange they were offered privy purse. No deed was however signed with most of the independent Adivasi states. They were assumed to have joined the Union. The government rode rough shod on independent Adivasi nations and they were merged with the Indian Union. This happened even by means of state violence as in the case of Adivasi uprising in the Nizam's State of Hyderabad and Nagalim.

While this aspect did not enter the consciousness of the Adivasis at large in the central part of India where they were preoccupied with their own survival, the picture was different in the north-east because of the historic and

material conditions. Historically the north-east was never a part of mainland India. The colonial incorporation of north-east took place much later than the rest of the Indian subcontinent. While Assam ruled by the Ahoms came under the control of British in 1826, neighbouring Bengal was annexed in 1765. Garo Hills were annexed in 1873, Naga Hills in 1879 and Mizoram under the Chin-Lushai Expeditions in 1881-90. Consequently, the struggles for self-determination took various forms as independence to greater autonomy.

A process of marginalization today, the total forest cover in India is reported to be 765.21 thousand sq. kms. of which 71% are Adivasi areas. Of these 416.52 and 223.30 thousand sq. kms are categorized as reserved and protected forests respectively. About 23% of these are further declared as Wild Life Sanctuaries and National Parks which alone has displaced some half a million Adivasis. By the process of colonization of the forests that began formally with the Forest Act of 1864 and finally the Indian Forest Act of 1927, the rights of Adivasis were reduced to mere privileges conferred by the state.

This was in acknowledgement of their dependence on the forests for survival and it was politically forced upon the rulers by the glorious struggles that the Adivasis waged persistently against the British. The Forest Policy of 1952, the Wild Life Protection Act of 1972 and the Forest Conservation Act of 1980 downgraded these privileges of the peoples to concessions of the state in the post-colonial period.

With globalization, there are now further attempts to change these paternalistic concessions to being excluded as indicated by the draft "Conservation of Forests and Natural Ecosystems Act" that is to replace the forest act and the amendments proposed to the Land Acquisition Act and Schedule V of the constitution. In 1991, 23.03% of STs were literate as against 42.83% among the general population. The Government's Eighth Plan document mentions that nearly 52% of STs live below the poverty line as against 30% of the general population.

In a study on Kerala, a state considered to be unique for having developed a more egalitarian society with a high quality of life index comparable to that of only the 'developed' countries, paradoxically shows that for STs the below poverty line population was 64.5% while for Scheduled Castes it was 47% and others 41%. About 95% of Adivasis live in rural areas; less than 10% are itinerant hunter-gatherers but more than half depend upon forest produce. Very commonly, police, forest guards and officials bully and intimidate Adivasis and large numbers are routinely arrested and jailed, often for petty offences.

Only a few Adivasi communities which are forest dwellers have not been displaced and continue to live in forests, away from the mainstream development activities, such as in parts of Bastar in Madhya Pradesh, Koraput, Phulbani and Mayurbanj in Orissa and of

Andaman Islands.

Thousands of Korku children below the age of six died in the 1990s due to malnutrition and starvation in the Melghat Tiger Reserve of Maharashtra due to the denial of access to their life sustaining resource base. Adivasis of Kalahandi-Bolangir in Orissa and of Palamu in south Bihar have reported severe food shortage. According to the Central Planning Committee of the Government of India, nearly 41 districts with significant Adivasi populations are prone to deaths due to starvation, which is not normally reported as such.

**Invasion of Adivasi territories** The "Land Acquisition Act" of 1894 concretized the supremacy of the sovereign to allow for total colonization of any territory in the name of 'public interest' which in most cases are not community notions of common good. This is so especially for the Adivasis. The colonial juristic concept of *res nullius* (that which has not been conferred by the sovereign belongs to the sovereign) and *terra nullius* (land that belongs to none) bulldozed traditional political and social entities beginning the wanton destruction of traditional forms of self-governance.

The invasion of Adivasi territories, which for the most part commenced during the colonial period, intensified in the post-colonial period. Most of the Adivasi territories were claimed by the state. Over 10 million Adivasis have been displaced to make way for development projects such as dams, mining, industries, roads, protected areas etc. Though most of the dams (over 3000) are located in Adivasi areas, only 19.9% (1980-81) of Adivasi land holdings are irrigated as compared to 45.9% of all holdings of the general population. India produces as many as 52 principal, 3 fuel, 11 metallic, 38 non-metallic and a number of minor minerals.

Of these 45 major minerals (coal, iron ore, magnetite, manganese, bauxite, graphite, limestone, dolomite, uranium etc) are found in Adivasi areas contributing some 56% of the national total mineral earnings in terms of value. Of the 4,175 working mines reported by the Indian Bureau of Mines in 1991-92, approximately 3500 could be assumed to be in Adivasi areas. Income to the government from forests rose from Rs.5.6 million in 1869-70 to more than Rs.13 billion in the 1970s. The bulk of the nation's productive wealth lies in the Adivasi territories. Yet the Adivasi has been driven out, marginalized and robbed of dignity by the very process of 'national development'.

The systematic opening up of Adivasi territories, the development projects and the 'tribal development projects' make them conducive for waves of immigrants. In the rich mineral belt of Jharkhand, the Adivasi population has dropped from around 60% in 1911 to 27.67% in 1991. These developments have in turn driven out vast numbers of Adivasis to eke out a living in the urban areas and in far-flung places in slums. According to a rough estimate, there are more than 40,000 tribal domestic working women in Delhi alone! In some places,

development induced migration of Adivasis to other Adivasi areas has also led to fierce conflicts as between the Santhali and the Bodo in Assam.

Internal colonialism, constitutional privileges and welfare measures benefit only a small minority of the Adivasis. These privileges and welfare measures are denied to the majority of the Adivasis and they are appropriated by more powerful groups in the caste order. The steep increase of STs in Maharashtra in real terms by 148% in the two decades since 1971 is mainly due to questionable inclusion, for political gains, of a number of economically advanced groups among the backwards in the list of STs. The increase in numbers, while it distorts the demographic picture, has more disastrous effects. The real tribes are irretrievably pushed down in the 'access or claim ladder' with these new entrants cornering the lion's share of both resources and opportunities for education, social and economic advancement.

Despite the Bonded Labour Abolition Act of 1976, Adivasis still form a substantial percentage of bonded labour in the country.

Despite positive political, institutional and financial commitment to tribal development, there is presently a large scale displacement and biological decline of Adivasi communities, a growing loss of genetic and cultural diversity and destruction of a rich resource base leading to rising trends of shrinking forests, crumbling fisheries, increasing unemployment, hunger and conflicts. The Adivasis have preserved 90% of the country's bio-cultural diversity protecting the polyvalent, pre-colonial, biodiversity friendly Indian identity from bio-cultural pathogens. Excessive and indiscriminate demands of the urban market have reduced Adivasis to raw material collectors and providers.

It is a cruel joke that people who can produce some of India's most exquisite handicrafts, who can distinguish hundreds of species of plants and animals, who can survive off the forests, the lands and the streams sustainably with no need to go to the market to buy food, are labeled as 'unskilled'. Equally critical are the paths of resistance that many Adivasi areas are displaying: Koel Karo, Bodh Ghat, Inchampalli, Bhopalpatnam, Rathong Chu ... big dams that were proposed by the enlightened planners and which were halted by the mass movements.

Such a situation has risen because of the discriminatory and predatory approach of the mainstream society on Adivasis and their territories. The moral legitimacy for the process of internal colonisation of Adivasi territories and the deliberate disregard and violations of constitutional protection of STs has its basis in the culturally ingrained hierarchical caste social order and consciousness that pervades the entire politico-administrative and judicial system. This pervasive mindset is also a historical construct that got reinforced during colonial and post-colonial India.

The term 'Criminal Tribe' was concocted by the British

rulers and entered into the public vocabulary through the Criminal Tribes Act of 1871 under which a list of some 150 communities including Adivasis, were mischievously declared as (naturally) 'criminal'. Though this shameful act itself was repealed in 1952, the specter of the so-called 'criminal tribes' continues to haunt these 'denotified tribes' - the Sansi, Pardhi, Kanjar, Gujjar, Bawaria, Banjara and others. They are considered as the first natural suspects of all petty and sundry crimes except that they are now hauled up under the Habitual Offenders Act that replaced the British Act. Stereotyping of numerous communities has reinforced past discriminatory attitudes of the dominant mainstream in an institutionalized form.

There is a whole history of legislation, both during the pre-independence as well as post-independence period, which was supposed to protect the rights of the Adivasis. As early as 1879, the "Bombay Province Land Revenue Code" prohibited transfer of land from a tribal to a non-tribal without the permission of the authorities. The 1908 "Chotanagpur Tenancy Act" in Bihar, 1949 "Santhal Pargana Tenancy (Supplementary) Act", the 1969 "Bihar Scheduled Areas Regulations", the 1955 "Rajasthan Tenancy Act" as amended in 1956, the 1959 "MPLP Code of Madhya Pradesh", the 1959 "Andhra Pradesh Scheduled Areas Land Transfer Regulation" and amendment of 1970, the 1960 "Tripura Land Revenue Regulation Act", the 1970 "Assam Land and Revenue Act", the 1975 "Kerala Scheduled Tribes (Restriction of Transfer of Lands and Restoration of Alienated Lands) Act" etc. are state legislations to protect Adivasi land rights.

In Andhra for example, enquiries on land transfer violations were made in 57,150 cases involving 245,581 acres of land, but only about 28% of lands were restored despite persistent militant struggles. While in the case of Kerala, out of a total claim for 9909.4522 hectares made by 8754 applicants, only 5.5% of the claims have been restored. And this is happening in spite of favourable judicial orders - orders which the state governments are circumventing by attempting to dismantle the very protective legislation itself.

The callous and casual manner with which mainstream India approaches the fulfillment of the constitutional obligations with reference to the tribes, and the persistent attempts by the politico-administrative system to subvert the constitution by deliberate acts of omission and commission, and the enormous judicial tolerance towards this speak volumes on the discriminatory approach that permeates the society with regard to the legal rights of the Adivasis.

### **Race, religion and language**

The absence of neat classifications of Adivasis as a homogenous social-cultural category and the intensely

fluid nature of non-Adivasis are evident in the insuperable difficulty in arriving at a clear anthropological definition of a tribal in India, be it in terms of ethnicity, race, language, social forms or modes of livelihood.

The major waves of ingress into India divide the tribal communities into Veddids, similar to the Australian aborigines, and the Paleamongoloid Austro-Asiatic from the north-east. The third were the Greco-Indians who spread across Gujarat, Rajasthan and Pakistan from Central Asia. The fourth is the Negrito group of the Andaman Islands - the Great Andamanese, the Onge, the Jarawa and the Sentinelese who flourished in these parts for some 20,000 years but who could well become extinct soon. The Great Andamanese have been wiped out as a viable community with about only 30 persons alive as are the Onges who are less than a 100.

In the mid-Indian region, the Gond who number over 5 million, are the descendants of the dark skinned Kolarian or Dravidian tribes and speak dialects of Austric language family as are the Santhal who number 4 million. The Negrito and Austroloid people belong to the Mundari family of Munda, Santhal, Ho, Ashur, Kharia, Paniya, Saora etc. The Dravidian groups include the Gond, Oraon, Khond, Malto, Bhil, Mina, Garasia, Pradhan etc. and speak Austric or Dravidian family of languages. The Gujjar and Bakarwal descend from the Greco Indians and are interrelated with the Gujjar of Gujarat and the tribes settled around Gujranwala in Pakistan.

There are some 200 indigenous peoples in the north-east. The Boro, Khasi, Jantia, Naga, Garo and Tripiri belong to the Mongoloid stock like the Naga, Mikir, Apatani, Boro, Khasi, Garo, Kuki, Karbi etc. and speak languages of the Tibeto-Burman language groups and the Mon Khmer. The Adi, Aka, Apatani, Dafla, Gallong, Khamti, Monpa, Nocte, Sherdukpen, Singpho, Tangsa, Wancho etc of Arunachal Pradesh and the Garo of Meghalaya are of Tibeto-Burman stock while the Khasi of Meghalaya belong to the Mon Khmer group. In the southern region, the Malayali, Irula, Paniya, Adiya, Sholaga, Kurumba etc belong to the proto-Australoid racial stock speaking dialects of the Dravidian family.

The Census of India, 1991 records 63 different denominations as "other" of over 5.7 million people of which most are Adivasi religions. Though the Constitution recognizes them as a distinct cultural group, when it comes to religion those who do not identify as Christians, Muslims or Buddhists are compelled to register themselves as Hindus. Hindus and Christians have interacted with Adivasis to civilize them, which has been defined as sanscritisation and westernisation. However, as reflected during the 1981 census it is significant that about 5% of the Adivasis registered their religion by the names of their respective tribes or the names adopted by them. In 1991 the corresponding figure rose to about 10%, indicating the rising consciousness and assertion of identity.

Though Article 350A of the Constitution requires



primary education to be imparted in mother tongue, in general this has not been imparted except in areas where the Adivasis have been assertive. NCERT, the state owned premier education research centre, has not shown any interest. With the neglect of Adivasi languages, the State and the dominant social order aspire to culturally and socially emasculate the Adivasis subdued by the dominant cultures. The Anthropological Survey of India reported a loss of more than two-thirds of the spoken languages, most of them tribal.

### Fragmentation

Some of the ST peoples of Himachal Pradesh, Uttar Pradesh, W. Bengal, Sikkim, Arunachal Pradesh, Nagaland, Manipur and Mizoram have their counterparts across the border in China (including Tibet), Bhutan, Myanmar and Bangladesh. The political aspirations of these trans-border tribes who find themselves living in different countries as a result of artificial demarcation of boundaries by erstwhile colonial rulers continue to be ignored, despite the spread and proliferation of militancy, especially in the north east, making it into a conflict zone.

The Adivasi territories have been divided amongst the states formed on the basis of primarily the languages of the mainstream caste society, ignoring the validity of applying the same principle of language for the Adivasis in the formation of states. Jharkhand has been divided amongst Bihar, West Bengal, Madhya Pradesh and Orissa though the Bihar part of Jharkhand has now become a separate state after decades of struggle. The Gond region has been divided amongst Orissa, Andhra, Maharashtra and Madhya Pradesh. Similarly, the Bhil region has been divided amongst Maharashtra, Madhya Pradesh, Gujarat and Rajasthan.

In the north-east, for example, the Naga in addition are divided into Nagaland, Manipur, Assam and Arunachal Pradesh. Further administrative sub-divisions within the states into districts, talukas and panchayats have been organised in such a way that the tribal concentration is broken up which furthers their marginalization both physically and politically.

The 1874 "Scheduled District Act", the 1919 "Government of India Act" and later the "Government of India Act" of 1935 classified the hill areas as excluded and partially excluded areas where the provincial legislature had no jurisdiction. These formed the basis for the Article 244 under which two separate schedules viz. the V Schedule and the VI Schedule were incorporated for provision of a certain degree of self-governance in designated tribal majority areas. However, in effect, this remained a non-starter. However, the recent legislation of the Panchayat Raj (Extension to the Scheduled Areas) Act of 1996 has raised hope of a radical redefinition of self-governance.

By not applying the same yard stick and norms for

Adivasis as for the upper caste dominated mainstream, by not genuinely recognizing the Adivasis' traditional self-governing systems and by not being serious about devolving autonomy, the Indian State and society indicate a racist and imperialist attitude. The call for a socially homogenous country, particularly in the Hindi paradigm has suppressed tribal languages, defiled cultures and destroyed civilizations. The creation of a unified albeit centralized polity and the extension of the formal system of governance have emasculated the self-governing institutions of the Adivasis and with their internal cohesiveness.

The struggle for the future, the conceptual vocabulary used to understand the place of Adivasis in the modern world has been constructed on the feudal, colonial and imperialistic notions which combine traditional and historical constructs with the modern construct based on notions of linear scientific and technological progress.

Historically the Adivasis, as explained earlier, are at best perceived as sub-humans to be kept in isolation, or as 'primitives' living in remote and backward regions who should be "civilized". None of them have a rational basis. Consequently, the official and popular perception of Adivasis is merely that of isolation in forest, tribal dialect, animism, primitive occupation, carnivorous diet, naked or semi-naked, nomadic habits, love, drink and dance. This is contrasted with the self-perception of Adivasis as casteless, classless and egalitarian in nature, community-based economic systems, symbiotic with nature, democratic according to the demands of the times, accommodative history and people-oriented art and literature.

The significance of their sustainable subsistence economy in the midst of a profit oriented economy is not recognized in the political discourse, and the negative stereotyping of the sustainable subsistence economy of Adivasi societies is based on the wrong premise that the production of surplus is more progressive than the process of social reproduction in co-existence with nature.

The source of the conflicts arises from these unresolved contradictions. With globalization, the hitherto expropriation of rights as an outcome of development has developed into expropriation of rights as a precondition for development. In response, the struggles for the rights of the Adivasis have moved towards the struggles for power and a redefinition of the contours of state, governance and progress.

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*Full Length Research Paper*

# Health extension program as innovative health care service: The socio-cultural factors affecting its implementation in Jimma Zone, South Western Oromia

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Ethiopia's Health Extension Program is an innovative community-based health care service delivery system that emphasizes the construction of health posts at village level and assignment of trained Health Extension Workers to improve the prevailing high disease burden and mortality that Ethiopians suffer from. The main objective of the study was to assess the socio-cultural factors that affect the implementation of HEP in rural communities focusing on Family Health and Hygiene and Environmental sanitation packages of HEP. A cross sectional survey was conducted in randomly selected 416 households of rural kebeles found in Jimma Zone. Even though 57% of the mothers did ANC follow-up in health posts, none of them reported for delivery in health posts. Home delivery was practiced by 82.5% of the mothers. From the 61.5% FP service beneficiaries only 15% were clients of health posts. TT coverage was 90% and 87% of the under 5 children have vaccination cards. Though 90% of the households have constructed pit latrines, 49% lacked shading and 10% have practiced open field defecation. Wash-hand basin and soap or mud was not seen around 95% of the latrines. Unprotected streams were sources of water supply for about 10% of the households. Almost half of the households studied disposed solid wastes in open fields. Generally, health posts were underutilized by the community. Above all, attention was not given to the cultural assets of the community that are suggested in the HEP guidelines as a means to increase community's participation.

**Key words:** Health extension programs, innovative and Socio-cultural factors.

## INTRODUCTION

Access to health services is one of the major problems in most African Countries. The available health institutions especially in rural Sub-Saharan Africa (SSA) including Ethiopia are inaccessible to the majority of the population due to weak infrastructure and the limited health services are organized in urban centers.

Furthermore, the health systems in these countries

often suffer from lack of qualified human resources, and poor management systems. The quality of health service in rural areas is also constrained by uneven distribution of health workers (Tekle-Ab, 2007; Nejmudin et al., n. d.).

Though there are some changes recently, the Ethiopian population continued to suffer from a high disease burden, of which 60% is believed to be preventable.

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Researches indicate that the Health Status indicators of Ethiopia are among the poorest even compared to other low-income countries and Sub Saharan Africa (SSA) indicators. According to the Ethiopian Demographic and Health Survey (2011) estimate, the maternal mortality rate was 676 deaths per 100,000 live births, which is among the highest in Africa. The under-five child mortality has shown marked decline from 123 per 1000 live births in 2004/05, to 88 per 1000 in 2009. However, it is still too high amongst the poorest households: 137/1000 lives compared to 86/1000 lives for children from richest quintile (EDHS, 2011; MoFED, 2011).

A series of Health Sector Development programs (HSDPI, II and III 1997-2010) has been formulated by the Ethiopian Government with the aim of addressing such enormous health problems prevailing in the country (FMoH, 2007). The Health Sector development program is a component of the government's plan for Accelerated and Sustained Development to End Poverty (PASDEP) and to achieve the health-related MDG (Alula, 2008). Health extension program (HEP) is an innovative programme, which is introduced in 2003 by the Ethiopian Government as envisaged in HSDP III's plan that aims to address the service coverage problem of the health system through an accelerated expansion and strengthening of primary health care services (Dawit, 2009). The program is designed to provide services at kebele level, which is the lowest administrative unit (with an average of 5000 people) covering sixteen essential health service packages (EHSP) categorized under three major areas – Disease Prevention and Control, Family Health Service, Hygiene and Environmental Sanitation and a cross cutting component Health Education and Communication (FMoH, 2007).

The implementation of HEP has been preceded by the recruitment and training of Health Extension Workers (HEWs). The HEWs were recruited from the communities in which they will work according to specific criteria. The criteria include being female in sex (except in pastoralist areas), at least 18 years old, have at least a 10th grade education, and speak the local language. The reasons suggested why females are preferred to males were the emphasis of most of the HEP packages to issues affecting mothers and children, the assumption that communication is thought to be easier between mothers and female health extension workers and female workers are thought to be more culturally acceptable. Moreover, their selection is seen as empowering women (Nejmudin et al., n.d).

The HEP has envisioned training of 30,000 female HEWs on the health extension packages for one year in different phases, and cover the whole country by 2009 (CNHD-E, 2005; FMoH, 2007). As a result, 30,578 HEWs have been trained and were deployed (two HEWs per kebele) in almost all villages in rural areas by the year 2010 (Hailom, 2011). Trainings were also provided to other health care services staff, particularly at the Health

Center level, to aid in the accelerated implementation of the HEP (CNHD-E, 2005; MoH, 2007).

Additionally, given that HEP is an expression of the government's far reaching commitment regarding health service provision at all levels, all government sectors and local leaders are expected to actively collaborate in the implementation of HEP programs. The collaboration can be realized through the selection of CHWs and model families; health post construction; mobilization of communities during immunization campaigns; and construction of sanitary facilities (FMoH, 2007).

HEP is designed to improve the health status of families, with their full participation, using local technologies and the community's skill and wisdom. Hence, the program is participatory with Community Based Health Packages in that HEWs communicate health messages by involving the community from the planning stage all the way through evaluation. As a strategy, HEWs are expected to involve civic organizations like Women and Youth Associations, community associations (indigenous associations) such as *Idir*, *Mahaer*, *Ekub*, as well as other social structures in disseminating HEP messages and promoting good health practices (FMoH, 2007). Additionally, applying Local Rules and Regulations is suggested as a means of enhancing the diffusion, adoption and sustainability of HEP by the community.

Though the program has given such a huge emphasis to sociocultural aspects of the society, studies done on the influence of social organizational networks and indigenous knowledge on the implementation of HEP are lacking or are not handy. The available studies done on HEP are focused mainly on the assessment of problems associated with trainings and working conditions of health extension (Awash et al., 2007).

The objective of this study was to explore the socio-cultural factors that facilitate or impede the implementation of health extension program in rural communities of Mana Woreda, Jimma Zone, Oromia Region. Specifically, the focus of the study was to acquire data/information pertaining to the community's opinion about the benefit of HEP, cultural factors that were supportive or deterrents to the diffusion and adoption of HEP and the extent of community-based approach followed in the implementation process.

Selected HEP packages under Family Health Service, Hygiene and Environmental Sanitation such as maternal and child health, family planning, immunization, proper and safe excreta disposal system, proper and safe solid and liquid waste management and healthy home environment were the focus of this study.

Finally, the findings of this research will help Health Extension Workers, Woreda Health Office Administration and Zonal Health Departments to fill the gaps identified in this study by paying attention to the sociocultural factors that are hindrances to the enhancement of HEP implementation.

## MATERIAL AND METHODS

**Study design:** Community-Based cross-sectional study was conducted in 6 rural kebeles of Mana Woreda, Jimma Zone located 18 Km away from Jimma town. The research approach was mixed type employing qualitative and quantitative methods.

**Study population:** Adult family members (mainly, female household heads), Health Extension Workers, Voluntary Community Health Workers and managers of health centers that were working under the randomly selected health centers and representatives of Woreda Health Office in rural kebeles of Mana Woreda. Even though information about Health Extension Program in general and Hygiene and Environmental Sanitation component in particular was collected from female household heads of all ages, only responses from women of child bearing age (15-49) were used in the analysis of data on the Family Health component of HEP.

### Sample size and sampling procedure

Our approach to select health posts (one health post representing one kebele) was started by first identifying the number of health centers found in Mana Woreda. The main reason for such approach was to use the health posts under the randomly selected health centers as a center of the study and avoid geographical discrepancy that would affect the accessibility of health posts/kebeles and prolong data collection period. Accordingly, 2 health centers (*Bilida* and *Qoree*) were randomly selected from among the 3 functional rural health centers. Then, 4 rural health posts (2 from *Bilida* and 2 from *Qoree*) from the 7 more rural health posts were randomly selected through lottery method.

Cluster sampling, which is a probability sampling technique, was used to collect quantitative data from kebeles that were found in the catchment area of the selected health posts using zones of the kebeles as clusters. Hence, 6 zones (3 from *Bilida* and 3 from *Qoree*) were randomly selected out of the total 12 zones and used as clusters for house-to-house survey. As a result, data were collected from 416 households during the study period.

Additionally, qualitative information was secured through in-depth interviews with key-informants from Woreda Health Office, health center representatives, Health Extension Workers (HEWs), Voluntary Community Health Workers (VCHWs), and with heads of traditional associations.

### Data collection methods and procedures

Quantitative data were collected through face-to-face interview with the female household heads using a semi-structured questionnaire with close-ended items as well as many open-ended questions. Additionally, qualitative research methods, such as in-depth interview with key-informants, and non-participant observation were used to get detailed information especially on the sociocultural factors influencing the diffusion and adoption of HEP in the community.

The data were collected by teaching staffs from Jimma University. Interviews with families/households and key-informants were held on face-to-face basis and all information was recorded by the data collectors themselves believing that self-administered questionnaire is difficult in rural settings where most of the residents are illiterate or of low educational status. Qualitative information from in-depth interview was collected by the 2 researchers alongside with the supervision of data collection process.

### Data collection instruments

Pre-tested semi-structured questionnaire was used to collect

quantitative data from families/households. The questionnaire was originally prepared in English and then translated to Afan Oromo. FGD Guide was used to collect data from FGD discussants.

**Method of data analysis:** Quantitative data from family/household respondents were analyzed using frequencies, percentiles and tables. Information generated from FGD, observation and interview with key-informants was analyzed by narrative analysis and triangulated with the quantitative information.

**Ethical consideration:** In conducting this study, administrative ethical procedures were followed by first obtaining ethical clearance from Jimma University. Informed consent was obtained from each informant after explaining the purpose of the study and assuring about the confidentiality of the information given by the respondents.

## RESULTS

This study attempted to assess the sociocultural factors affecting the dissemination and adoption of Health Extension Program (HEP) in rural kebeles found in Mana Woreda of Jimma Zone, Oromia Region. A total of 416 households were covered through the study with 97% response rate. The reason for 3% non-response rate was absence of adult family members during the study period.

### Characteristics of respondents

As indicated in Table 1, all the women interviewed were married, belonging to Oromo ethnic group and were followers of Muslim religion. When we look at their educational status, almost half of the women respondents were unable to read and write. Moreover, among the mothers who have joined formal education the majority were found to be in the category of grades 1-8. On the other hand, more than 50% of the respondents were found to be without any formal education and out of this only 5% were able to read and write. Though not surprising in the context of rural settings, no women with educational level beyond 10<sup>th</sup> grade were identified.

### Family health service utilization

Ethiopia's HEP gives remarkable space for women as service providers (a cadre of HEWs) and customers in its particular emphasis on mothers, neonates and children. Moreover, breastfeeding, antenatal care, assisted delivery, contraceptive use, childhood and tetanus toxoid immunization are among the indicators of HEP status (FMOH, 2007; FMOH-HEEC, 2008). Hence, Family Health Service was one of the components of HEP included in this study in order to figure out the level of mothers of child bearing age (15-49) utilizing the selected packages at the health post level.

### MCH service utilization

As indicated in Table 2, from the 412 mothers of child

**Table 1.** Characteristics of respondents from rural kebeles of Jimma Zone, southwestern Ethiopia (n = 416).

Variables	Number (%)
<b>Age group</b>	
Less than 18	-
18-24	42 (10)
25-34	187 (45)
35-44	171 (41)
45-49	12 (3)
≥50	4 (1)
<b>Marital status</b>	
Never married	-
Married	416 (100)
Divorced	-
Widowed	-
<b>Religion</b>	
Muslim	416 (100)
<b>Ethnicity</b>	
Oromo	416 (100)
<b>Educational status</b>	
Unable to read and write	197 (47.5)
Able to read and write (no formal education)	21 (5.0)
1-4	94 (22.5)
5-8	94 (22.5)
9-10	10 (2.5)
11-12	-
<b>Occupation</b>	
Farmer	416(100)

bearing age, closer to 90% of the mothers responded "Yes" when asked whether they are beneficiaries of MCH service or not while the remaining 10% replied "No". Though 57% of the mothers reported that they were getting the service from health posts, the remaining considerable proportion (43%) of the mothers reported health centers as their place of service utilization.

Concerning the reasons for not utilizing MCH service at health post level, the mothers gave multiple responses. Most responses are related to lack of satisfactory service in the health posts. For instance, the majority of mothers (87.8%) raised issues such as absence of medications; laboratory and other medical equipment in health posts. Moreover, many mothers were questioning or doubting the skill of HEWs to deliver appropriate service. Lack of information about family health services (5%) and that these mothers rely on God's help (2.6%) and / or some biological factors like any menopause were additional reasons suggested.

**Table 2.** Level of MCH service utilization by respondents in rural kebeles of Jimma Zone, southwest Ethiopia.

Family health Service utilization	Number (%)
<b>MCH Service utilization (n = 412)</b>	
Yes	370 (89.8)
No	42 (10.2)
<b>Place of MCH service follow-up (n = 370)</b>	
Health Post	211 (57)
Health Center	159(43)
<b>Time of first ANC initiation (n = 370)</b>	
Before 3 <sup>rd</sup> month	11 (3%)
At 3 <sup>rd</sup> month	217 (58.6%)
After 3 <sup>rd</sup> month	142 (38.4%)
<b>Place of delivery (n = 412)</b>	
Health Post	Nil
Home	340 (82.5)
Other health institutions	72 (17.5)

Scholars see ANC as a big pillar of safe motherhood and suggest that the ideal time for the first ANC visit is in the 1<sup>st</sup> trimester, around or preferably before week 12 of pregnancy. Hence, mothers were asked about the time at which they have started their first ANC visit. Among the 370 women who were utilizing ANC service, 217 (58.6%) reported at the 3<sup>rd</sup> month whereas 142 (38.4%) reported after 3<sup>rd</sup> month. The rest 11 (3%) women made their first visit before 3<sup>rd</sup> month of their pregnancy due to pregnancy related problems and other health problems.

The other point of inquiry was the place where mothers were giving birth for their last pregnancy. None of the mothers reported for delivery in a health post. Hence, 340 (82.5%) of the mothers reported for home delivery while only 72 (17.5%) have given birth in other health institutions (health center and hospital). The reasons for home delivery specifically include: no need to go to health institutions without having serious problem (21.4%), being assisted by TBAs (19%), spontaneous delivery/night time delivery (16.7%), relying on God's help (15%), financial problem for transport to health center (9.5%) since women depend on the willingness of males to pay transport, fear of surgery/operation (7%), lack of awareness (5.4%) and unwillingness of husband (2.4%). Additionally some cultural beliefs such as reliance on God and were among the constraints to seek birth attendance at HIs.

The qualitative finding from Woreda Health Office and health center representatives and FGD participants stresses the importance of HEP in improving the health service delivery system including MCH services. However, they raised their concerns on issues that affect ANC and PNC follow-ups as well as delivery in health

**Table 3.** Level of FP service utilization by respondents from rural kebeles of Jimma Zone, Southwest Ethiopia (n = 412).

<b>Family planning service utilization</b>	<b>Number (%)</b>
Yes	253 (61.5)
No	159 (38.5)
<b>Source of FP service</b>	
Health post	38 (15)
Health center	210 (83)
Private clinics	5 (2)
<b>Reasons for not utilizing FP service (multiple responses)</b>	
No enough service	10.2
Is against the will of God	22.5
Need for child of other sex	10.2
To have more children	10.2
The drug needs balanced diet	9.5
Fear of the drugs' health impact (affects health)	20.4
Absence of the preferred contraceptive method	5.2
Husband not willing	5.2

institutions, lack of training on labour attendance by many HEWs, shortage of examination/delivery beds, delivery kits and preoccupation of HEWs by home visits that makes them inaccessible for clients were some of the factors mentioned during in-depth interviews. Moreover, they stated that the problem is exacerbated when HEWs leave the area for further training and during maternal leave. One of the informants underscored the problem associated with the sex of HEPs saying, "The reservation of HEP work only for females has its own impact since some of them leave for Arab countries and there are times when both HEWs working in one health post become pregnant simultaneously and stay at home for months when they give birth." In this respect, another informant said: "Women HEWs face hardships to move to distant places and areas with demanding topographies. On the other hand, a woman health center head emphasized the preference of male HEWs over the males justifying her stand as follows:

HEP is mainly based on outreach activities focusing on home visits where they mostly encounter women household members. So, women will be ideal to discuss on HEP packages that are domestic oriented and related to Family Health service utilization by participating in home activities. Moreover, husbands will be suspicious if the HEWs were males."

To conclude, based on the findings from the quantitative and qualitative data it can be understood that MCH service utilization is affected both by the socio-economic situation of the mothers and problems inherent in the

health institutions including the health posts.

### **Family planning service utilization**

From the mothers of child bearing age found in the households surveyed, about 4 mothers out of 10 were not beneficiaries of contraceptive methods. Among the beneficiaries of FP service, most of the mothers reported that their sources of contraceptive methods are health centers since there is no supply from health posts. However, few mothers mentioned access from health posts and private clinics. See Table 3 for the main reasons given by the mothers for not utilizing FP service.

The key-informants from health centers believe that there is dramatic change in respect to family planning service utilization. Nevertheless, they pointed out that some mothers are refraining from seeking contraceptive methods due to religious reasons. In sharp contrast to the qualitative finding that portrays shortage of contraceptives in health posts that forced mothers to depend on health centers (Table 3), the officials interviewed unanimously reported the presence of enough contraceptive supply in health posts. However, a group of women (living in one compound) were complaining about absence of contraceptives for months even from health centers. For example one woman residing closer to a health center explained the seriousness of the problem in this way: "we are not getting contraceptives from health posts at all and there are times where injectable types of FP methods are not available for 3-4 months in health center. As a result, we have no option except purchasing the drugs from

**Table 4.** Level of immunization service utilization in rural kebeles of Jimma Zone, southwest Ethiopia.

<b>TT vaccination for mothers (n = 412)</b>	<b>Percent (%)</b>
Yes	380 (92.3)
No	32 (7.7)
<b>Reason</b>	
Lack of awareness	32 (7.7)
<b>Child vaccination (n = 370)</b>	
Yes	321 (87)
No	49 (13.3)
<b>Reasons</b>	
Lack of awareness	5 (3)
No under 5 child	43 (10.3)
<b>First visit of HIs for child vaccination</b>	
within one week after birth	66 (20.6)
After 45 days	254 (79.4)
<b>Reasons for late vaccination</b>	
Lack of awareness	8 (3)
No enough service	15 (6)
Being told by HEWs to come after 45 days	231 (91)

private clinics with high prices.”

Finally, the above inconsistency of ideas from the key-informants on family planning service utilization implies lack of uniformity and regularity on the distribution and unmet need on the type of methods available in health institutions in the study area rendering the service unsatisfactory to the mothers.

### Immunization service utilization

Immunization was the only service provided efficiently in the health posts. As a result, the study revealed that approximately 9 out of 10 women were vaccinated for TAT either in health posts or health centers and almost similar proportion of the children has been vaccinated for childhood diseases. However, about 8 out of 10 children have started vaccination lately in their 6 week post-delivery (Table 4).

There was high consistency between the quantitative findings and the qualitative information from the key-informants and FGD participants. The health center heads and the HEWs were reporting up to 95% immunization coverage. Outreach immunization programs carried out by HEWs' was the main reason given for such achievement. Of course, even mothers who were expressing their dissatisfaction with the services available in health posts during the survey were reacting positively about

the immunization service given in health posts.

For that matter, it was common to hear respondents saying: “only immunization service is given in health posts.”

To generalize the findings on Family Health component of HEP, the finding on immunization coverage is encouraging since immunization (childhood and tetanus toxoid immunization for mothers) is an indicator of HEP. However, the other HEP indicators such as antenatal care, assisted delivery and contraceptive use are highly constrained by different factors stated above.

### Hygiene and environmental sanitation

According to FMOH (2007) document, facilities for liquid/solid waste disposal, safe drinking water and safe extra disposal are among the indicators of HEP. Hence, measures taken by the households as regards these packages were assessed in this study. As indicated in Table 5, though about 9 out of 10 households have pit latrines, almost half of the households were using latrines that have no shading. Moreover around 1 out of 10 households were practicing open field defecation. Remarkably enough, the proportion of households who prepared wash-hand basin and soap/mud near the latrines for hand washing after defecation was very low. However, the majority of the respondents stated that they are using water from their homes to clean themselves after defecation.

In respect to access to safe water and enough supply, the majority of the respondents replied “Yes” though they have complained of drying of water sources in dry seasons that forced them to move long distance to fetch clean water. Exactly two-third of the households reported collecting and preserving water in clean Jerri cans as safety method while the remaining one-third pointed out for shortage of safe and enough supply and was obliged to fetch water from unprotected streams.

Furthermore, the study showed that the share of households practicing safe and unsafe solid waste disposal was somewhat equal, 49 and 51% respectively. When asked why they are disposing garbage in open fields, the majority of households reasoned out that it serves as a fertilizer.

Additionally, availability of ITN (utilization of insecticide treated net) in the households was assessed with checkup (observation). The study indicated that 320 (77%) of the households were having a Bed-Net while a quarter (23%) of the households were not having Bed-Net. The reason that the respondents gave for not utilizing Bed-Net were worn out of previously given Bed-Nets and absence of Bed-Net distribution/supply by concerned government offices.

Diversity of views was observed among the key-informants that participated in the qualitative part of this study concerning the status of latrine construction by the



**Table 5.** Proper and safe excreta, solid and liquid waste disposal; safe water and enough supply and insect and rodent control in rural kebeles of Jimma Zone, southwestern Ethiopia (n=416 households).

Variables	Number (%)
<b>Excreta disposal</b>	
Pit latrine with shading	169 (40.7)
Pit latrine without shading	204 (49)
Open field	43 (10.3)
<b>Place of solid waste/garbage disposal</b>	
Hole in the house yard	191 (46)
Burn/bury	13 (3)
Open field	212 (51)
<b>Availability of water container and soap/mud near latrines for hand washing after defecation</b>	
Soap/mud seen near latrines	19 (5)
Soap/mud not seen near latrines	354 (95)
<b>Safe water and enough supply</b>	
Yes	277 (67)
No	139 (33)
<b>Insecticide impregnated Bed-Net</b>	
Yes	320 (77)
No	96 (23)

community. One of the health center heads mentioned that almost all of the households in his area have constructed latrines. He also said: “the community in our catchment area has prepared latrines around markets and beside roads so that persons from distant places can use them. Now, our focus is on standardizing the latrines by working with an NGO in this area.” To the contrary, the other head of a health center expressed his disappointment in winning the cooperation of the community saying: “they are always promising that they will construct their latrines within few days. However, we are always getting them without taking any action when we go to their home after a month or more.”

As to a proper solid and liquid waste disposal practices, there is no different finding from what is attained quantitatively. Nevertheless, the problem of safe and enough water supply was seen as a serious problem by CHWs and health center heads. All the key-informants complained that the health centers and health posts are devoid of water supply for years. They also mentioned that the delay of water supply projects in the area is worsening the problem. Except one of the heads of health centers who reported the presence of enough source of water supply in her catchment area with 88 protected streams and 44 hand pump wells, the other informants have articulated that the protected streams that the communities use have lost their purity and are becoming waterless during dry seasons.

To sum up, from the above findings and the observation made by the researchers on some water sources

(“protected streams”), it is possible to generalize that inaccessibility of pure and enough water supply in the kebeles studied outweighs its accessibility.

### Health education and communication

With the aim of identifying the HEP dissemination process household members were asked whether they have gotten enough training on HEP or not, level of satisfaction with the training, if they have graduated as a model family and the more suitable source of HEP information they prefer. As a result, 306 (74%) mentioned that they have got training by HEWs within the last 2 years. However, 110 (26%) household members suggested that they were not trained on HEP except the information they got from HEWs during home visit. Most of the trained informants articulated their satisfaction with the training. For the question ‘are you a model family?’ only 10% of the household members reacted “Yes”.

Household members were also asked to prioritize the suitable sources of information on HEP. Health information by the HEWs was the first preference followed by discussion with peers. Discussion with *Garee* (group of 5 persons in the village) was their second preference. Insignificant number of respondents preferred Radio and support by model families as medium of knowledge transfer.

To finalize, the above findings suggest that HEWs have made considerable effort to disseminate information on

HEP to the community through organized trainings and during home visits. However, their effort on the identification and training of model families that have acceptance and credibility by the community was minimal. In fact, socially notable model families would have enhanced the diffusion of health messages and facilitated 'the adoption of the desired practices and behaviors by the community.'

### Community participation in HEP implementation

HEP guidelines on HEP advocate that HEP is a community-based health intervention that demands the HEWs to closely work with traditional associations in the society in communicating health messages. The key-informants from the Woreda Health Office, HEWs and Voluntary Community Health Workers (VCHWs) have reported that the overall participation of the community is good. For example, the contribution of the community in the construction of health posts was reported to be high. As an example, following is the Woreda Health Manager's statement:

*In the past the community had no enough awareness about prevention of disease since they used to give attention for curative aspect of health services like getting injection. However, now the community is getting awareness from the health education being provided at grass root level. At the beginning, the community has perceived the health extension workers as laymen. Advocacy by elders is undertaken to all people pertaining to the health extension workers. So all people are now getting the awareness about them. The kebele structure, other nongovernmental organizations are helping the activities of these health extension workers. In the past we provide minimum support for the health extension workers however we started to recognize that strong support is needed from our side.*

However, from the conversations with health center representatives and heads of the traditional associations, it was understood that the community was not involved in the selection of HEWs for training. Moreover, heads of indigenous associations, who were used as key-informants, stated that they were not actively participating in the process of HEP program planning and implementation. Similar ideas were also raised by representatives of Idirs except the contribution of money and materials they made for Health Post construction. According to the responses of health office representatives and the key-informants from local associations, the focus is on strengthening the organization of community in to *Garees* that are extensions of the formal administrative network.

### Sociocultural factors affecting HEP implementation

Representatives from health institutions, Health Extension

Workers, other key-informants were inquired if there are cultural factors that constraint community's adoption of HEP. Though the degree that the informants give for the issue varies, all of them believed that some HEP packages are not favored due to traditions. For instance, one of the key-informants expressed his doubt for the existence of hidden female circumcision in the area. The HEWs interviewed also stated that though mothers are not openly talking, it could be due to religious reason that many mothers refrain from utilizing FP services. In general terms, low educational status of women, delay to adopt health messages sticking to the traditional way of life (e.g. solid waste disposal system), religious orientation, etc. were the main factors mentioned as constraints to HEP implementation.

## DISCUSSION

The study was carried out with the aim of assessing the socio-cultural factors that influence the execution of Ethiopia's Health Extension Program that is perceived as an important approach to health related Millennium Development Goals (MoFED, 2012, FMOH, 2010 FMOH-HEEC, 2007). When the women were asked about the existence of Health Extension Program activity in the area, 363 (87%) of them replied "Yes". However, as discussed under the specific packages, most of the HEP packages are not reasonably adopted by the community. Hence, the findings of this study and the underlining problems are discussed in comparison with other studies done on the topic.

### Family health service utilization

The MCH package is one of the strategies to implement the principles of safe motherhood since mothers are exposed to a number of risks during pregnancy, delivery and post-delivery periods. Hence, special care in the form of ANC, delivery with the assistance of competent professional and PNC are recommended to reduce the high maternal and child morbidity and mortality rates in Ethiopia (FMOH, 2003). Though it is encouraging that the majority of the mothers were beneficiaries of MCH service at different health institutions, 42 (10.2%) mothers of child bearing age were not having MCH service follow-up at all. Moreover, from those mothers that have attended MCH service, 43% were getting the service from health centers bypassing the health posts. Surprisingly enough, this study revealed that none of the mothers studied gave birth at health posts and more than 8 out of 10 (82.5%) mothers were practicing home delivery. Though the national percentage of deliveries attended by skilled birth attendants was 20.4% in 2011/12 (MoFED 2012), all births took place without the help of skilled professionals. Whatever personal reasons were suggested by the respondents why they were giving

birth at home, mothers' hesitation to seek MCH service especially delivery service from health posts revolves around not being confident on the qualification of HEWs and shortage of examination beds. This was also confirmed during interview with health center heads and the HEWs themselves that the latter were mostly giving referral services to health centers.

The study area is not exceptional in this respect since a number of studies have also identified similar gaps on the provision of delivery service in health posts (Aschenaki et al., 2014; Medhanyie et al., 2012; Center for Health and Gender Equity, 2010; FMOH-HEEC, 2008). These studies have documented several factors contributing to and affecting performance of HEWs such as HEWs lacking adequate knowledge and skills to attend to women in labour and delivery, poor knowledge on contents of antenatal care counseling, danger signs and symptoms and complications in pregnancy, lack of supplies and equipment in the health posts including basic infrastructures like water supply, electricity, and waiting rooms for women in labor. Traditional influences such as religious beliefs, unwillingness to be examined by unfamiliar health workers were also mentioned.

Family planning package is one of the components of family health service intended to control the high fertility and rapid population growth that have an impact on the overall socio-economic development of the country in general and maternal and child health in particular. Hence, assessment of the level of contraceptive utilization by mothers (either for child spacing/delay pregnancy or avoid pregnancy) was made in this study in order to estimate to what extent HEP is adopted by the community. Though the study showed that high proportion (61.5%) of mothers of child bearing age were FP service utilizers, 83% of these mothers opted for health centers claiming that health posts failed to meet their needs.

The proportion of contraceptive utilization is slightly lower than FMOH-Health Extension and Education Center's (2008) 65.1% report in a study that covered 81 selected kebeles of four woredas of Amhara and SNNRP Regional States. On the other hand, the finding in the study area is somewhat higher compared to the 2009 Marie Stopes International Ethiopia's (MSIE) report of 49% modern FP usage by rural women in five regions of Ethiopia (Espeut et al., 2010). Generally, the FP usage by the study subjects is encouraging when equated with only 38.3% ever use of FP by women in Mojo town located at about 80 kilo meters from Addis Ababa, the country's capital (Abebe and Nigatu, 2011) and the 20% national contraceptive prevalence rate for Ethiopia (EDHS, 2011).

The main reasons given by the mothers for not benefiting from FP service were religious (22.5%), fear of the drugs impact on health (20.4%), need to have more children and child of other sex (10.2% each) among others. This finding is consistent with a national survey done on the availability of modern contraceptives and essential lifesaving maternal/RH medicines in service

delivery points in Ethiopia that highlighted socio-cultural norms such as male/husband dominance and opposition to contraception, limited choices, worries of side effects and health concerns, lack of formal education for women as the determinants of family planning practice (Tedros, 2010). Many other studies undertaken at local/national level or rural/urban centers also state similar factors that are barriers to FP service utilization by eligible women (Abebe and Nigatu, 2011; Beekle and McCabe, 2006).

Immunization is among the most cost-effective childhood disease prevention interventions and immunization coverage also serves as a key indicator whether one country is on the track towards the achievement of MDG4 (FMOH, 2014; HEPCAPS1 Project Team. 2012). In this regard, representatives from Health Centers, HEWs and FGD participants from the community stated that community's awareness about immunization is very high. The study revealed that the majority of mothers were vaccinated for Tetanus (92.3%) and the 87% of the children have vaccination cards. Regarding the time of initiating the first vaccination for children, 79.4% were taking their children after 45 days and only 20.6% visited health institutions within the first week of delivery. When mothers were asked why they were not taking their children for immunization, most of them replied that they were informed by HEWs to bring their children after 45 days for vaccination. The immunization coverage in this study is very high compared to a similar study done in Tigray Region with 74% coverage in 2010 (Amare, 2013).

### Hygiene and environmental sanitation

Excreta-borne diseases are wide spread in Ethiopia especially in rural areas where most of the population in many villages defecate in open fields or in any available spaces without any regard to the health risk that result from open field defecation practice (FMOH, 2004).

In this study, almost half proportion (40.7%) of the households surveyed was having pit latrines with shading and the rest (49%) of the households were using latrines that have no shading. The share of households that defecate in open fields was 10.3%. Moreover, 95% of the households have never prepared wash-hand basin and soap/mud near the latrines for hand washing after defecation.

The finding of this study shows lower latrines with shading compared to the result of another study conducted in Jimma Zone (Mirkuze (2009), in that 54% of the households have private pit latrines with shading. However, similar percentages of households dispose excreta on the open fields (10.3 and 10.2% respectively). Another, study undertaken in Damboya Woreda, Kembata Zone (SNNPR) indicates similar latrine coverage (93.8%) though it does not mention about use of shading. However, the study revealed that higher proportion of households (29.5%) had hand washing facilities near their toilets (Samuel, 2011).

Furthermore, the study showed that the share of households practicing safe and unsafe solid waste disposal was somewhat equal, 49% and 51% respectively. When asked why they are disposing garbage in open fields, the majority of households reasoned out that it serves as a fertilizer. The finding in Mirkuze's (2009) study is higher than that of this study since 68.4% of the households disposed garbage/refuse on the open field.

## CONCLUSION

According to the information from the households and the discussions made with key-informants, the community's attitude towards HEP was positive and the attempts made to expand the service are encouraging. However, community's participation in the implementation process is limited. Though the findings of this study cannot be generalized for status of HEP implementation in the Woreda, the study can suggest that the implementation of HEP in the area seems remote compared with the goal of the government in this respect. Moreover, the key-informants from Health Centers and Woreda Health Office are over optimistic about the status of HEP service utilization by the community. For instance, the Key-informants from Health Centers have admitted that most of the HEWs are lacking adequate training and experience on birth attendance and the existing shortage of examination (delivery) beds in health posts. Hence, HEWs were working mainly on referral of mothers to Health Centers for delivery purposes.

Though the current Family Health service Utilization was encouraging, the Family Planning as well as Mother and Child Care (MCH) were problematic. Firstly, almost all the mothers were not visiting health posts for ANC follow-up. Secondly, most of the mothers were practicing home delivery. Thirdly, none of them reported for Post Natal Care follow-up either by HEWs or from health institutions. Whatever reason mothers have this is suggestive of failure to use culturally appropriate method. Similarly, latrine construction and safe solid waste disposal mechanism were not well practiced. Specifically, most of the households relied on the traditional way (open field disposal) solid waste disposal. It appears that mere awareness on new ideas is not enough to change the behavior of people calling again for culturally appropriate approach to the community.

Many scholars consider HEP as an approach on the innovation and diffusion model in which the new idea is communicated using model households (innovators). Though many members of households have got training on HEP, their contribution as model person seems minimal compared to the level of adoption of the program by the households.

## RECOMMENDATION

1. Providing additional trainings for HEWs by identifying

the experience they lack such as a skill of appropriate birth attendant to increase their acceptance by the community.

2. Providing the necessary equipment for the health posts, especially appropriate beds for ANC and delivery.
3. Revising the current HEP approach in order to ascertain its consideration of the cultural assets that support the program's implementation process.
4. Ascertaining the active involvement of religious leaders and other socially notable persons in the community to tackle issues related to traditional factors that negatively affect HEP implementation.

## ABBREVIATION

**ANC** = Antenatal Care; **CNHD-E** = Center for National Health Development Ethiopia; **EDHS** = Ethiopian Demographic Health Survey; **FMOH** = Federal Ministry of Health; **HEEC** = Health Extension and Education Center; **HEP** = Health Extension Program; **HEWs** = Health Extension Workers; **HSDP** = Health Sector Development Program; **MCH** = Mother and Child Health; **MDGs** = Millennium Development Goals; **PNC** = Postnatal Care; **TBA** = Traditional Birth Attendant; **TT** = Tetanus-Toxoid Vaccine; **WHO** = World Health Organization; **VCHWs** = Voluntary Community Health Workers.

## Conflict of interest

The authors have not declared any conflict of interest.

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The background of the entire page is a photograph of a person, likely a woman, wearing traditional African clothing. She is standing in a field with a large, textured tree trunk in the foreground. The lighting is warm, suggesting a sunset or sunrise, with orange and yellow tones. The image is framed with rounded corners.

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