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Screening for pelvic organ prolapsed without physical examination: Validation of the pelvic organ prolapse simple screening inventory (POPSSI)

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Acronyms

AA	Addis Ababa
CI	Confidence Interval
ETB	Ethiopian birr
GMH	Gandhi Memorial Hospital
OR	Odds ratio
POP	Pelvic Organ prolapse
POPSSI	Pelvic organ prolapse simple screening inventory
PFDI	pelvic floor disorder inventory
PPV	Positive predictive value
ROC	Receiver operating curve
SD	Standard Deviation
SPSS	Statistical package for social sciences
UVP	Uterovaginal prolapse
ZMH	Zewditu memorial hospital

INTRODUCTION

Pelvic organ prolapse occurs with descent of one or more pelvic structures: the uterine cervix or vaginal apex, anterior vagina (usually with bladder, cystocele), posterior vagina (usually with rectum, rectocele), or peritoneum of the cul-de-sac (usually with small intestine, enterocele).However, a specific definition of what constitutes clinically significant prolapse remains elusive[1].

POP results from relaxation of the pelvic floor muscle and is estimated to have a prevalence of 30-50% among women aged 50 and over[1]. Although mortality resulting from POP is not significant it has a huge impact on the daily activities of women afflicted by this condition, often disrupting and decreasing their quality of life[2].

POP and its complications impose a considerable economic burden on the person and it has been estimated that about 11% of women undergo surgery for POP before the age of 79 and with 29.2% require repeated surgery[3],[4],[5].

High parity is the single most important risk factor for prolapse in rich and poor women in both more and less developed countries[6].

Many women with pelvic floor disorder do not seek medical advice and this makes determining its incidence very difficult.

In 1996, International Continence Society defined a system of pelvic organ prolapse quantification (POP-Q) demonstrating high inter and intra observer reliability. It allows researchers to report findings in standardized, easily reproducible fashion. Prolapse in each segment is measured relative to the hymen, which is a fixed anatomic landmark that can be identified consistently. Accordingly, it is stage one when the leading prolapsed part is more than one centimeters above the hymenal ring; stage two when it is between one centimeter above and one centimeter below the hymenal ring; stage three when it is more than one centimeter below the hymenal ring but less than total vaginal length (TVL) minus two centimeters, and stage four if itis more than (TVL-2) cm below the hymenal ring [7].In Ethiopia, where access to obstetric care is very limited (institutional delivery being only 10 %) and the fertility rate is high (5.5 children per woman) little is known about the prevalence and risk factors for pelvic floor disorders.

There are few community -based studies conducted to determine the prevalence of pelvic organ prolapse. Requirement of a pelvic examination is a major hindrance for such studies and needs considerable time, resources and costs[8].

The common patient history remains a cornerstone in everyday practice, yet its diagnostic performance is essentially unexplored for many common conditions[9].

The aim of this study was to validate a short questionnaire that has the ability to discriminate between women with and without genital organ prolapse.

Objective

General objective

This objective of the present study wasto evaluate the validity of the PHQ-9, K-10, K-6 and SRQ-20 as screening tools for depression during pregnancy among Ethiopian women attending Butajira area health centers ANC clinics.

Specific objectives

Specific objectives of the study were

1) To evaluate criterion validity of the PHQ-9, K-10, k-6 and SRQ-20 against a gold standard.

2) To evaluate concurrent validity of the PHQ-9, K-10, K-6 and SRQ-20 with a measure of disability.

3) To estimate the point prevalence of depression in pregnant women attending ANC follow up in Butajira area health centres.

Hypothesis

The study will show that the PHQ-9, K-10, K-6 and SRQ-20 screening tools are valid instruments to screen for antenatal depression in Ethiopia.

Literature review

In low-income and middle-income countries, the prevalence of perinatal depression is somewhat higherthan in high-income countries (19, 20). Information drawn from scientific literature underlines, in HICs, between 3% and 16% of pregnant women fulfill the diagnostic criteria for unipolar major depression (21, 22). In specific populations, such as marginalized minority groups and unmarried teenagers, the prevalence of clinically relevant mood symptoms in pregnancy may be as high as 51%.In LMICs; the prevalence of antenatal depression is estimated to be 33% (23).

In a cross sectional study at two peri-urban health clinics in Dar es Salaam, Tanzania, it was found that there is a 39.5% prevalence of depression. Having a previous depressive episode (Odds Ratio 4.35, P<0.01), low (OR 2.18, P<0.01) or moderate (OR 1.86, P=0.04) satisfaction with ability to access basic needs, conflicts with the current partner (OR 1.89, P<0.01), or booking earlier for antenatal care (OR 1.87, P=0.02) were independent predictors of antenatal

depression in the logistic regression model; together explaining 21% of variance in depression scores (14).

Depressed mood in pregnancy was reported by 39% of mothers in peri-urban settlements, South Africa. Factors which were significantly associated with depressed mood at a $p < 0.05$ level included being single as opposed to being married or cohabiting with a partner, being unemployed, having a household income below 2000 rand per month, having less education, smoking, alcohol use, experiencing intimate partner violence in the previous year, receiving poorer social support from one's partner, mother and father, and receiving no financial support from the baby's father (1). Another study in rural South Africa, an area where there is high prevalence of HIV, showed a high numbers (47% confidence interval, CI: 37.2–56.3) of women met the criteria for a major depressive episode (MDE) (5).

In Nigeria, among pregnant woman who were interviewed during their late pregnancy, 8.3% women met the current (2 weeks) DSM-IV diagnosis of depressive disorder. The factors independently associated with depression included being single [odds ratio (OR)=16.67, 95% confidence interval (CI)=3.17-87.76], divorced/separated (OR=11.11, 95% CI=1.55-19.65), polygamous (OR=3.92, 95% CI=0.94-16.33), and having a previous history of stillbirth (OR=8.00, 95% CI=1.70-37.57) and perceived lack of social support (OR=6.08, 95% CI=1.42-26.04) (16).

A systematic review of papers covering nine LMICs found a weighted mean prevalence of common perinatal mental disorders in pregnant mothers to be 15.6% (95% CI: 15.4–15.9)(24). Another systematic review on pre- and postnatal psychological wellbeing in Africa showed prevalence rates of depression ranging between 4.3% and 17.4% during pregnancy, with a mean prevalence of 11.3% (95% CI 9.5%–13.1%) (25).

Methods

Study design

The study design was a cross sectional study to evaluate the criterion and concurrent validity of fourscreening instruments (PHQ-9, SRQ-20, K-10 and K-6) for depression in pregnant women in a primary care setting in Ethiopia.

Study setting

The study was conducted in three health centers in the Butajira Demographic Surveillance Site, southern Ethiopia,an area adjoining the PRIME Sodo site. These are Butajira, Enseno and Silte health centers. Pregnant women both from urban and rural areas attended the health centers.

Sampling

Study population

Reference populationswere all pregnant women who lived in the Butajira Demographic Surveillance Site. The source populations were pregnant women attending ANC follow up in Enseno, Butajira and Silte health centers.

Participant inclusion and exclusion criteria

A woman had to be pregnant and attend the health center for ANC visit to be included in the study. Potential participants were excluded from the study If were acutely unwell and neededemergency treatment, unable to converse in the official language of Ethiopia, Amharic, or unable to communicate for different reasons.All eligible pregnant women of any gestational age who came to ANC clinics at the health center were invited to participate in the study following their consultation with a health worker.

Sampling technique

Consecutive sampling technique was used; i.e.allpregnant womenwere included as they come until enough sample size was obtained.

Training

Two psychiatric nurses were given refresher training in administration of the criterion measure (MINI). The nurses were trained for two days previously by an Ethiopian psychiatrist, with emphasis on sociocultural factors affecting the presentation of depression in a rural Ethiopian setting. Extensive role play and observed piloting of the gold standard assessment and screening tools has already been carried out in a health center out-patient population. Inter-rater reliability has already been evaluated on 15 patients (half identified as having depression and half with no identified depression and agreement found to be excellent).

The screening instruments were administered by lay-interviewers, educated to the level of 10th grade (high school completers), who have been working as data collectors with the mental health research group for many years. Training was given until satisfactory level of rating proficiency was achieved. Inter-rater reliability has been assessed previously for the screening tools in 30 outpatient attendees of the Butajira hospital and was found to be very good.

Data collection procedure

After attending their ANC visit, the women were asked for consent. After giving informed consent,socio-demographic data together withthe test assessments (SRQ-20, PHQ-9 and K-10 (in which K-6was also extracted)) were administered by trained data collectors with extensive experience and the gold standard assessment (MINI)was administered by psychiatric nurses.Orders of administration of each of the test assessment interviews were randomized with resulting six different orders of administration. The psychiatric nurses conducting the criterion assessment interviews were blinded to the results of the screening tests, and vice versa.

Measures

Socio-demographic characteristics includedself-report of age, educational level, marital status,occupation, residential place and relative wealth. They were also asked for the gestational age of the current pregnancy in months and number of pregnancies they had previous to the current one. Data collectorscheaked for any problem/risk for the pregnancy from woman's integrated antenatal, labor, delivery, newborn and postnatal care card.

Depression screening scales

Self-Reporting Questionnaire, 20-item version (SRQ-20)

The SRQ-20 is a 20-item scale developed by the World Health Organization as a screening tool in primary care (26). The instrument establishes symptomatology in the preceding one month. It was previously translated into the national language of the country, Amharic, and validated in different settings in Ethiopia. We used the last validated version (27). Recommended cut-off score varies from setting to setting between 3/4 and 11/12 (26) but cluster around 7/8 (28). In Ethiopia, among convenience sample of postnatal and antenatal women optimal cut-off was 6/7 againstcomprehensive psychopathological rating scale (CPRS) case (27). All five questionnaires used are found in the Appendix 3.

Kessler 10-item scale (K-10)

This 10-item scale is a widely used tool to assess non-specific psychological distress in the previous one month (29). Each item is rated from 0 to 4, mainly based on the persistence of a specific symptom, from "none at all" to "all the time". The total score for the 10-item scale is 40 and the level of psychological distress ranges from minimal (score of 20 and above) to severe

distress (score of 30 and above).Both the 10- and 6-item versions were validated in Ethiopia, with the 10-item version showing superior validity (30). We used the validated Amharic (the official national language of Ethiopia) version of the K-10 in which K-6 was also extracted (30).

Patient Health Questionnaire, 9 item version (PHQ-9)

The Patient Health Questionnaire (PHQ)is a brief self-report questionnaire designed as a screening tool for depression in primary care(31). The PHQ-9 has nine items and can be used to rate symptom severity and monitor change over time (32, 33). An additional question (10^{th} question) for the evaluation of the clinical significance of the experienced symptoms, can allow evaluation of DSM-IV depressive episode. The recommended cut-off score for major depressive disorder is of ≥10 (32),and in a meta-analysis was found to have acceptable diagnostic properties for detecting major depressive disorder for cut-off scores between eight and 11 (34). A threshold score of ≥10 had a sensitivity of 88% and a specificity of 88% for major depression (35).

Criterion measure of depression

The Mini-International Neuropsychiatric Interview (MINI)

The MINI is a brief diagnostic assessment scale that allows DSM-IV and ICD-10 diagnosis (36). It is modularized and each major diagnostic condition is represented by a module, for example, major depressive episode, mania/hypomania, psychotic disorders, etc. For this validation study, the module on major depressive episode was used. The skip rules were ignored and the raters were allowed to explore symptoms once the initial probe questions were asked to determine the presence of a symptom, its clinical significance and overall presence of MDE. Based on the principles of the MINI Plus, bereavement and organic exclusions were put in place.

Disability

WHO Disability Assessment Schedule

The full version (the 36-item) Disability Assessment Schedule, version 2, developed by the World Health Organization (WHODAS-II), was used to establish level of impairment associated with depression and other causes of mental distress. WHODAS assesses the level of disability and the number of days lost from work in the previous 30 days. The instrument is considered cross-culturally applicable (37). The Amharic version of the 36-item version, which was previously validated in Ethiopia (38), formed the basis of the current validation study.

Sample size

We used a formula for calculating sensitivity and specificity for single tests by Buderer (39): $n=[Z^2_{1-\alpha/2*} S_N \times (1-S_N)]/[L^2 \times Prevalence]$

Where***n*** = required sample size

$\boldsymbol{S_N}$ = anticipated sensitivity,

$\boldsymbol{\alpha}$ = size of the critical region ($1 - \boldsymbol{\alpha}$ is the confidence level),

$\boldsymbol{z}_{1-\alpha/2}$ = standard normal deviate corresponding to the specified size of the critical region (α), and

L = absolute precision desired on either side (half-width of the confidence interval) of sensitivity or specificity.

Using the following assumptions:

Desired sensitivity fixed at 80%

α=0.05

L=0.1

$Z^2_{1-\alpha/2=}3.84$

Prevalence=20%

Loss due to incomplete information or other reasons=3%

The required sample size was 316. This sample size allows the sensitivity estimate within the confidence limits of 75% and 84%.

Ethical considerations

Ethical permission was obtained from the Department of Psychiatry, College of Health Sciences, Addis Ababa University. All participants who were included gave written, informed consent before starting the interview. All pregnant women identified by the psychiatric nurses as suffering from MDEwere offered appropriate treatment and follow-up with the existing Butajira psychiatric service.All participants were given 30birr each as compensation for their time spent during the interviews.

Data analysis

Data was double entered by two data entry clerks and cleaned. We used STATA 11.0 for data analysis. Samples were categorized into cases of MDE and non-cases based on the gold standard (MINI) assessment. Optimal cut-off score was estimated at the cut-off score selected for maximum specificity not exceeding sensitivity. Sensitivity, specificity, percentage of correctly classified, positive and negative likelihood ratios and positive and negative predictive values were estimated for the optimal cut-off scores of each of the screening tests against the gold standard diagnosis of MDE. Sensitivity, specificity and positive predictive values were also estimated for different cut-off scores of thescreening tests against the gold standard diagnosis of MDE. To measure the overall predictive value of the instruments, Receiver operating characteristic (ROC) curve was plotted for each instrument and area under the ROC curve estimated. Internal consistency of each instrument was estimated using Cronbach's alpha (α). The degree of correlation between each screening instrument and WHODAS was measured using Spearman's rank correlation coefficient (Spearman's rho).

Results

Socio-demographic characteristics

Detail information on socio-demographic characteristics is presented on table 1. A total of 388 pregnant women were interviewed from three health centers (Butajira, Enseno and Silte). At the time of adequate sample interview (n=316), there were high number of participants from Silte health center and fewer from Enseno because of patient flow difference. Sowe were forced to include more women from Enseno health center into the study to have a more equivalent distribution of participants from the three health centers. Their age ranged from 15 to 40 years. Around 58% (n=224) were aged between 25 and 34 years. The majority of participants (56.3%; n=218), were illiterate. Only 40.4% (n=153) had attended formal education. Almost all (99.2%; n=385) were married. The majority of them (93.0%; n=361) were in monogamous and few (6.2%; n=24) were in polygamous marriages. Over half (57.5%; n= 223) resided in rural areas. The majority of the women were either housewives (62.9%; n= 242) or merchants (26.8%; n=103). More than half (59.3%; n=230) claimed they have similar wealth relative to others in their community while 36.9% (n=143) said less and 3.6% (n=14) said more. The gestational age of the pregnancy in participating women ranged from two to ten (already completed 9 months) months. For 30.0% (n=116) of women it was a first pregnancy and for the rest it ranged from the second to twelfth pregnancy.

Distribution of scores of screening instruments

The frequency distribution of scores was not normally distributed for all screening instruments, so median witn 25^{th} and 75^{th} percentiles were calculated instade of the mean. The results are shown in table 2.The median PHQ-9 score was two with 25^{th} and 75^{th} percentiles being zero and three respectively. For SRQ-20, the median score with 25^{th} and 75^{th} percentile were two, one and four respectively. K-10 had a median score of zero, with a 25^{th} and 75^{th} percentile being zero and two. In K-6 all the three scores were same, zero.

Prevalence of depression

The prevalence of Major Depressive Episode (MDE)in pregnant women attending ANC follow up using the gold standard measure was 3.9% (n=15). When cases in which organic causes cannot be definitely ruled out were included, the prevalence estimate increased to 4.4% (n=17).

Criterion validity of the screening instruments against a gold standard

PHQ-9

At optimal cutoff score of greater than or equal to four, PHQ-9 had a sensitivity of 86.7% and specificity of 80.4%. It had a positive predictive value (PPV) of 15.1% and negative predictive value (NPV) of 99.3%. ROC curve was plotted for each instrument to measure the overall predictive value of the instrument (see figure 1 and table 3). Area under the ROC curve was highest for PHQ-9,0.91 (95%CI=0.86-0.96), showing the performance of the instrument is excellent. Cronbach's α was 0.74, having good (acceptable) internal consistency. Comparison of criterion validity of each instruments at optimal cutoff scores are shown at table 4. Also sensitivity, specificity and positive predictive values of the four screening instruments at higher cut-off scores are presented on table 5.

SRQ-20

SRQ-20, at optimal cutoff score of greater than or equal to five, had a sensitivity of 80.0% and specificity of 79.6%. It had a PPV of 13.6% and NPV of 99.0%. Area under the ROC curve was 0.86 (95%CI=0.76-0.95), showing the performance of the instrument is good. Cronbach's α was calculated to be 0.84, the highest of all, having good internal consistency.

Kessler-10

K-10, at optimal cutoff score of greater than or equal to two, had a sensitivity of 93.3% and specificity of 69.4%. It had a PPV of 10.9% and NPV of 99.6%. Area under the ROC curve was 0.88 (95%CI=0.80-0.97), showing the performance of the instrument is good. Cronbach's α was calculated to be 0.79, having good internal consistency.

Kessler-6

K-6, at optimal cutoff score of greater than or equal to one, had a sensitivity of 86.7% and specificity of 80.8%. It has a PPV of 15.5% and NPV of 99.3%. Area under the ROC curve was 0.87 (95%CI=0.77-0.97), showing the performance of the instrument is good. Cronbach's α was calculated to be 0.78, having good (acceptable) internal consistency.

Concurrent validity of the screening instruments with a measure of disability (WHODAS II)

Spearman's rank correlation coefficient (Spearman's rho) is calculated to measure the degree of correlation instruments have with measure of disability i.e. WHODAS II. In all four instruments a positive correlation was found with rho p being 0.52 ($p<0.001$), 0.53 ($p<0.001$), 0.49 ($p<0.001$) and 0.43 ($p<0.001$) for PHQ-9, SRQ-20, K-10 and K-6 respectively.

Table 1: Description of the socio-demographic characteristics of participants (n= 388)

			Frequency(number)	percent
Age in years n= 387	15-19		23	5.9
	20-24		99	25.6
	25-29		132	34.1
	30-34		92	23.8
	35-39		39	10.1
	40-44		2	0.5
Literacy n= 387	Literate		169	43.7
	Illiterate		218	56.3
Education type n=379	Formal (Grades completed) n= 153	2-4	46	30.1
		5-8	67	43.8
		9-10	25	16.3
		>10	15	9.8
	Informal		22	5.8
	No education		204	53.8
Marital status	Married only wife		361	93.0
	Married 2nd or more		24	6.2
	Separated		2	0.5
	Single, never married		1	0.3

Residence place	Urban	165	42.5
	Rural	223	57.5
Occupation n= 385	House wife	242	62.9
	Farmer	17	4.4
	Merchant	103	26.8
	Government	10	2.6
	Student	1	0.3
	Daily laborer	7	1.8
	Unemployed	3	0.8
	other	2	0.5
Relative wealth	More	14	3.6
	Similar	230	59.3
	Less	143	36.9
	Not happy to respond	1	0.3
Gestational age in month n= 387	2-3	28	7.2
	4-6	135	34.9
	7-10	224	57.9
Number of previous pregnancies n= 387	0 (1st pregnancy)	116	30.0
	1-3	161	41.6
	4-6	93	24.0
	7-11	17	4.4

Prevalence of depression using the screening instruments

The prevalence of depression was 22.7% (n=88) by SRQ-20 with a cutoff score of greater than or equal to five. It was 22.2% (n=86) on PHQ-9 with a cutoff score of greater than or equal to four. When DSM-IV-TR criteria A of MDE are applied to PHQ-9, the prevalence significantly drops to 0.5% (n=2). Using K-10 and 6, prevalence is 33.0% (n=128) and 21.7% (n=84), with a cutoff score of greater than or equal to two and one respectively.

Table 2: Distribution of scores of screening instruments

Instrument	Median	25th percentile	75thpercentile
PHQ-9	2	0	3
SRQ-20	2	1	4
K-10	0	0	2
K-6	0	0	0

Figure 1: ROC curves for PHQ-9, SRQ-20, Kessler-10 and Kessler-6 against gold standard (MINI) diagnosis of MDE

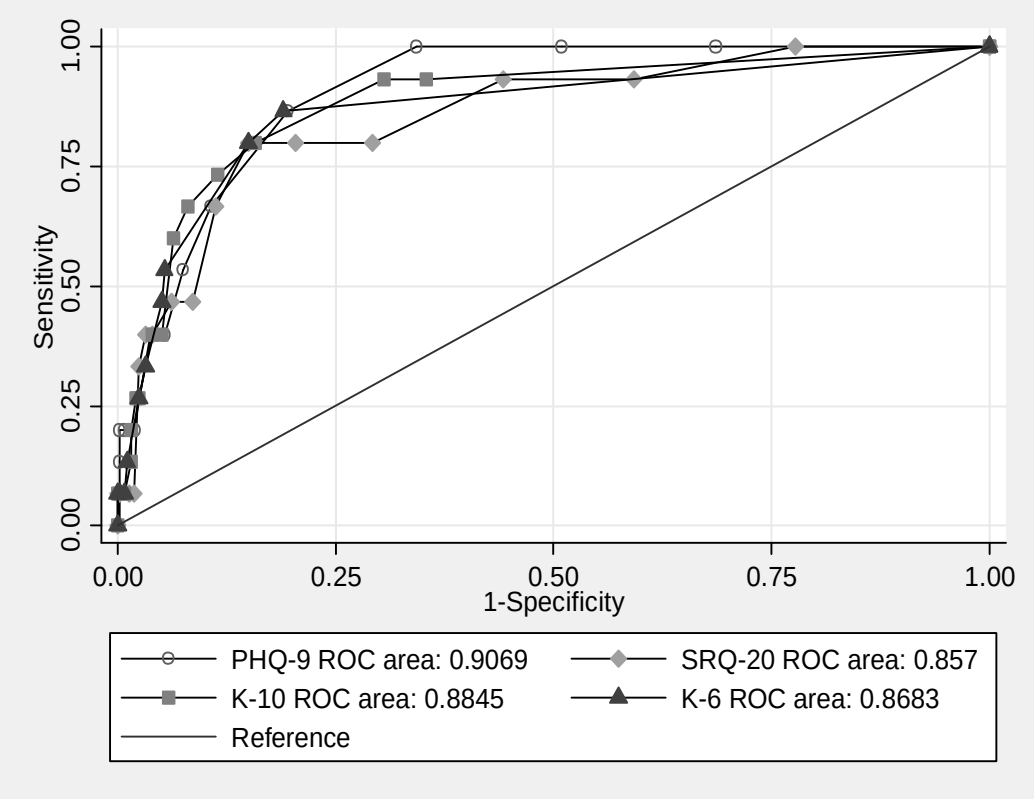

Table 3: Description of characteristics of the ROC curves

Instrument	ROC area	95% confidence interval
PHQ-9	0.91	0.86-0.96
SRQ-20	0.86	0.76-0.95
K-10	0.88	0.80-0.97
K-6	0.87	0.77-0.97

Table 4: Comparison of Criterion validity of PHQ-9, SRQ-20, Kessler-10 and Kessler-6 at optimal cut-off scores against gold standard (MINI) diagnosis of MDE

Instrument	Optimal Cutoff >=	Sensitivity %	Specificity %	Correctly classified %	LR+	LR-	PPV %	NPV %	Cronbach's α
PHQ-9	4	86.7	80.4	80.7	4.43	0.17	15.1	99.3	0.74
SRQ-20	5	80.0	79.6	79.6	3.93	0.25	13.6	99.0	0.84
K-10	2	93.3	69.4	70.4	3.05	0.10	10.9	99.6	0.79
K-6	1	86.7	80.9	81.2	4.55	0.16	15.5	99.3	0.78

Table 5: Sensitivity, specificity and positive predictive values of PHQ-9, SRQ-20, Kessler-10 and Kessler-6 at higher cut-off scores

Instrument	Cut-off (≥)	Sensitivity (%)	Specificity (%)	PPV (%)
PHQ-9	6	53.3	92.5	22.4
	7	40.0	94.6	23.3
SRQ-20	9	46.7	93.8	23.5
	10	40.0	96.0	28.8
K-10	8	40.0	96.0	28.8
	9	26.7	97.6	31.0
K-6	3	53.3	94.6	28.8
	4	46.7	94.9	28.1

Discussion

In this study of the criterion validity of brief depression screening scales in antenatal clinics in Ethiopia, the four scales (PHQ-9, SRQ-20, K-6 and 10) all showed very good criterion validity as dimensional scales, PHQ-9 showing better criterion validity than the rest. However positive predictive value was low which limits their clinical applicability. While all instruments have an acceptable to good internal consistency, SRQ-20 had the highest result, and all four instruments showed positive correlation with WHODAS II.

Strengths of the study include having a large sample size (n=388) which gives it a higher power. Most validation studies have a fewer sample size (30, 40, 41). Pregnant women were included consecutively into the sample and participants both from urban and rural areas were included ensuring the representativeness. We also used instruments that were previously translated into the national language (Amharic) and validated in different settings. Our data collectors were with extensive data collection experience and data collectors and psychiatric nurses were given refresher training on administration of screening tests and MINI. Inter-rater reliability was already evaluated and was found to be excellent. In order to eliminate order effect, orders of administration of each of the screening tests were randomized. MINIwas administered to all participants to avoid selection bias. Data collectors and psychiatric nurses were blinded to the results of criterion assessment and screening instruments.

There is no gold standard instrument for detection of depression in pregnancy. MINI is an acceptable gold standard for validation studies. It is a semi-structured instrument,as psychiatric nurses were allowed to ask additional questions to be certain about the presence of a symptom. One limitation could be use of psychiatric nurses. Using psychiatrists would have been the best alternative as our findings are heavily reliant upon the quality of the gold

standard diagnosis, but was not feasible. We also used only the depression section on MINI so were not able to assess other common mental disorders (CMD). High scores may have relationship with CMD other than depression. Restricting diagnoses to depression has a risk of missing other CMD which might have a significant proportion.

The prevalence of depression in pregnant women in primary health care settings in our study (3.9%)is much lower than what has been reported in other studies and systematic reviews (17, 24, 25, 42). We would have expected it to be higher than community samples but the result was to the contrary. One explanation for this could be because of use of screening instruments having lower PPV, which led to many false positives. But all cannot be explained this since using the same diagnostic instrument (MINI), the prevalence of depressionin Nigeria in the third trimester ranged from 8.3-17.4% (16, 43) and in Morocco in first, second and third trimester was found to be 17.4%, 16.0% and 15.7% respectively (44). However in a previous community study done in Ethiopia, if the same SRQ-20 cut-off (≥ 5) had been used, we would have CMD estimated prevalence of 18.6% (18). This is lower than the prevalence of MDE by SRQ-20 in the current study (22.7%).

When we see the case detection properties of the screening instruments, all were found to be highly accurate. This finding is similar to other studies done in general primary care settings (30, 40, and 45). Similar findings are reported in postnatal women in Ethiopia using K-10 and 6 (30). The area under the ROC curve (AUC) was above 0.85 for all instruments, highest being for PHQ-9. The relatively good performance of PHQ-9 may be attributable to the fact that it contains DSM-IV-TR criteria A symptoms of MDE. The fact that SRQ-20 and Kessler included anxiety symptoms might have contributed partly to the relatively lower performance, but the same reason might make them preferable in primary health care population because of the mixed depression/anxiety/somatic presentation of cases.

To use the instruments in clinical setting, an optimal balance between sensitivity and PPV is important. Minimum of 50% for both sensitivity and PPV is mandatory for an acceptable instrument (45). But in all of the instruments, it was difficult to set that cut-off score because it was not possible to get a higher PPV without sensitivity being significantly compromised. Thus none of the instruments have higher sensitivity at an acceptable PPV.

The cut-off scores are much lower than what was reported in other studies and also from the recommended thresholds (26, 27, 28, 34, 35). We normally would have expected it to be higher because pregnancy by itself can have symptoms (change in energy level, appetite and sleep) mimicking symptomatology of MDE, but was not the case in our study. Generally, lower cut-off score means that the women had a high threshold for reporting symptoms.The Kessler-10 and

6 cut-off scores in our study areimplausibleand difficult to explain whyas a score of one on Kessler scale means scoring positive on only a single symptom a little of the time.

Conclusion

The study shows that there is little difference between PHQ-9, SRQ-20, K-10 & 6 in their criterion validity as dimensional scales, all showed good discriminating ability in relation to MINI and have a positive correlation with WHODAS II. Previously recommended thresholds for the PHQ-9 and SRQ-20 resulted in many undetected major depressive disorders. In addition, all are poorly suited to be used as a screening instrument in clinical settings because of low PPV, only can be used in selected occasions. If used at all in clinical settings, has to be combined with mental health professional assessment of positives to reduce false positives.

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Declaration of interest

None.

Reference

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Appendix

1. Participants' Information Sheet

የጥናት ተሳታፊዎች መረጃ ቅፅ

Detecting depression

በዚህ የጥናት እንዲሳተፉ ተጋብዘዋል፡፡ ተሳትፎዎት በፍላጎት ላይ ብቻ የተመሰረተ መሆን አለበት፣ በጥናቱ ላለመሳተፍ ከመረጡ የሚያስከትለው ችግር የለም፡፡ በጥናቱ ለመሳተፍ ከመወሰንዎ በፊት ጥናቱ ለምን እንደሚሰራና የእርስዎ ተሳትፎ ምን እንደሚያካትት መረዳቱ አስፈላጊ ነው፡፡ እባክዎ ከዚህ በታች የተሰጡ መረጃዎችን በጥንቃቄ ያዳምጡ፡፡ ግልጽ ያልሆነ ነገር ካለና የበለጠ መረጃ ከፈለጉ ሊጠይቁን ይችላሉ፡፡

<u>የምርምሩ አላማ</u>

የዚህ ጥናት አላማ የድብርት ህመም መለኪያ መሣሪያዎች በነፍሰ ጡር እናቶች ላይየድብርት ህመምን እንደሚለኩ ማጥናት ነው፡፡

<u>በጥናቱ እንዲሳተፉ የሚመረጡት እነማን ናቸው</u>

ከላይ በተጠቀሰው ርእስ ላይ መረጃ ሊሰጡን እንደሚችሉ የምናስባቸው ለእርግዘና ክትትል ወደ ጤና ጣቢያ የሚመጡ ነፍሰ ጡር እናቶችን ቃለ መጠይቅ እናደርግላቸዋለን፡፡

<u>በጥናቱ ለመሳተፍ ቢስማሙ ምን ይደረጋል</u>፡፡

ከመረጃ ሰብሳቢዎቻችን አንዱ በጤና ጣቢያ ውስጥ የመጡበትን ምርመራ ካደረጉ (ከጨረሱ) በሁዋላ አንዳንድ ጥያቄዎች ይቀርብሎታል ፡፡ ቃለ መጠይቁ ወደ አርባ ደቂቃ ገደማ ይወስዳል፡፡ ለጊዜዎ ማካካሻ 30ብርከፍያ ይኖረዋል፡፡

<u>በጥናቱ መሳተፍ ምን ጉዳት ይኖረዋል</u>?

በቃለመጠይቁ መሳተፍ የሚያስከትለው ችግር የለም፡፡ እርስዎ በጥያቄዎቹ ደስተኛ ካልሆኑ መልስ ይሰጡ ዘንድ አይገደዱም፡፡ ቃለ መጠይቁም ዕዚሁ ላይ መቆም ይችላል፡፡የጊዜ ጫናውን ለማሳጠር እንሞክራለን፡፡

የሚገኘው መረጃ በኢትዮጵያም ሆነ በሌሎች ሀገሮች ያለውን የአእምሮ ጤና አገልግሎት እንደሚያሻሽለው ተስፋ እናደረጋለን፡፡

<u>በሰጡን ቅድመ መረጃ ምን እናደርግበታለን?</u>

ጥያቄዎቹ የእርስዎን ስም እንዲሁም ማንነት አያካትቱም፡፡ ስለዚህ ከፕሮጀክቱ አስተባባሪዎች እና የፕሮጀክቱ የመረጃ ሰራተኞች ውጪ ማንም ሌላ ሰው መረጃው የእርስዎ ስለመሆኑ የሚያውቀው አይኖርም ፡፡

የመረጃ ሰነዶቹን በሚቆለፉ መሳቢያ / መደርደርያ / እናስቀምጣለን፡፡ከጥናቱ ማለቅ በኋላ የሰጡን መረጃ ሌሎች ተመራማሪዎች ይጠቀሙበት ይሆናል፡፡ ግን በማንኛውም መንገድ መረጃ የሰጠውን ሰው መለየት እናዳይችሉ ይደረጋል፡፡

<u>ዋና አጥኚዎች</u>

ዶ/ር ሻርሎት ሃንሎን እና ዶ/ር ግርማይ መድህን፡፡ ሊያገኙን ከፈለጉ የቡታጅራ ፕሮጀክት ቢሮ ስልክ ቁጥር 046 ዘ15 ዘ5 95 በመጠቀም በስራ ቀኖች በሥራ ሰአት ሊደውሉልን ይችላሉ ፡፡

በጥናቱ መሳተፍ የእርስዎ ውሳኔ ጉዳይ ይሆናል፡፡ በጥናቱ ላለመሳተፍ ከወሰኑ በማንኛውም ሰአት ምክንያት መስጠት ሳይጠበቅብዎት በነጻነት ተሳትፎውን ማቋረጥ ይችላሉ፡፡

ይህ ጥናት በማንኛውም መንገድ ጉዳት ካደረሰብዎት የአ.አ ዩኒቨርሲቲ የህክምና ፋኩልቲ የስነምግባር (ኢቲክስ) ተቋማዊ የክለሳ ቦርድን ከዚህ በታች በተጠቀሰው አድራሻ ማነጋገር ይችላሉ፡፡

- ስልክ ቁጥር 0ዘ15-553 87 34

<u>ማስታወሻ</u>

ወደ መጨረሻ ሪፖርትነት እስኪቀየር ድረስ በፊለጉት ሰአት መረጃዎን ከፕሮጀክቱ ሊያወጡ ይችላሉ፡፡

በጥናቱ ለመሳተፍ ከወሰኑ ይህን የመረጃ ቅጽ ይሰጥዎትና ስምምነት ግን በፊርማ እንዲያረጋግጡ ይጠየቃሉ፡፡

የመረጃ ወረቀቱን ካነበቡ እና ወይም ስለምርምሩ የተሰጠውን መግለጫ ካዳመጡ በኋላ እባክዎን ይህን **የፈቃደኝነት መግለጫ** ቅጽ ይሙሉ::

የአ.አ.ዩ የምርምር ስነ-ምግባር ኮሚቴ መለያ ቁጥር .....

በዚህ ምርምር ለመሳተፍ ስላሰቡ እናመሰግናለን:: በምርምሩ ለመሳተፍ ከመወሰንዎ በፊት ምርምሩን የሚመራው ሰው ስለፕሮጀክቱ ማብራሪያ ሊሰጥዎ ይገባል:: እባክዎ ከመረጃው ወረቀት ወይም ከተደረገልዎት ገለጻ የመነጨ ጥያቄ ካለዎት በምርምሩ ለመሳተፍ ከመወሰንዎ በፊት ጥናቱን የሚያካሂደውን ግለሰብ ይጠይቁ:: በእጅዎ ይኖር ዘንድ እና በፈለጉ ጊዜ እንዲያመሳክሩበት የዚህ የስምምነት ቅጽ ግልባጭ ይሰጥዎታል::

በማንኛውም ጊዜ በምርምሩ ላለመሳተፍ ከወሰንኩኝ ለምርምሩ ለሚያካሂዱት ወይም ወኪሎቻቸው ማሳወቅ እንደምችልና ምንም ምክንያት ሳላቀርብ ከምርምሩ እራሴን ላገል እንደምችል ተረድቻለሁ:: ከዚህም ባሻገር ጥናቱ እስኪታተም ድረስ የሰጠሁትን ቅጽ መረጃዎች ማውጣት እንደምችል ተረድቻለሁ::

የሰጠሁት የግል መረጃ ለተገለፀልኝ አላማ ጥቅም ላይ ይውል ዘንድ ተስማምቻለሁ::

የሰጡን መረጃ እንደ ሪፖርት ይታተማል:: የሚሰጡን መረጃ ሚስጥራዊነት እንደሚጠበቅና ከሚወጡትም ሪፖርቶች ማንነቶንለማወቅ እንደማይቻል ልናረጋግጥ እንወዳለን::

የምርመራ ቡድኑ ቅድመ መረጃውን ለወደፊት ምርምር ሊጠቀም እንደሚችል እስማማለሁ::

2. Participant consent form

የተሳታፊዎች የፈቃደኝነት መግለጫ ቅፅ

<u>የተሳታፊው መግለጫ</u>

እኔ _____

_____

ከላይ የተጠቀሰው የምርምር ፕሮጀክት በበቂ ሁኔታ ተብራርቶልኝ በጥናቱ ለመሳተፍ ተስማምቻለሁ:: ከላይ የተጻፉትን ማሳሰቢያዎች እና ስለፕሮጀክቱ የሚገልጽ የመረጃ ወረቀት አንብቤ ጥናቱ የሚያካትተውን ተረድቻለሁ::

ፊርማ _____ ቀን _____

<u>የምስክር ቃል</u>(ተሳታፊው ያልተማረ ከሆነ)

እኔ_____

_____

ከላይ የተጠቀሰው የምርምር ፕሮጀክት በበቂ ሁኔታ ለ _____ ተብራርቶላቸው በምርምሩ ለመሳተፍ ተስማምተዋል፡፡ ከላይ የተጻፉ ማሳሰቢያዎች እና ስለፕሮጀክቱ የሚገልጽ የመረጃ ወረቀት የተነበበላቸው ሲሆን ጥናቱ የሚያካትታቸውንም ጉዳዮች ተረድተዋል፡፡

ፊርማ _____ ቀን _____

<u>የቃለ መጠይቅ አቅራቢ ቃል፡-</u>

እኔ_____ የጥናቱን ምንነት የሚፈልጋቸውን ነገሮችና በጥናቱ መሳተፍ ሊያከትል የሚችለውን ጉዳዮች ለተሳታፊው በጥንቃቄ አብራርቻለሁ፡፡

ፊርማ _____ ቀን _____

3. Questionnaires

3.1. Socio-demographic data

መጠይቁ የተሞላበት ቀን	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]
የተጠያቂው ቁጥር	[ ][ ][ ][ ]
የጠያቂው ቁጥር	[ ][ ][ ]
የታዩበት የጤና ጣቢያ ስም	

የግለሰቡ መረጃ **በቅድሚያ ስለእርስዎ አጠቃላይ መረጃ እጠይቃለሁ። በአብዛኛው ማወቅ የምፈልገው አሁን ስላሉበት ሁኔታ ነው።**				
101	እድሜዎትስንትነው?	**[ ] [ ]**		AGE
102	ማንበብና መጻፍ ይችላሉ?	አችላለሁ	***1***	LIT
		አልችልም	***2***	
103	ምን አይነት ትምህርት ተምረዋል?	ምንም አልተማሩም	***1***	EDUTYPE
		መደበኛ ያልሆነ ትምህርት	***2***	
		መደበኛ ትምህርት	***3***	
		መልስ መስጠት አልፈለጉም	***99***	
104	የጥያቄ 102 መልስመደበኛትምህርትከሆነስንተኛክፍልአጠናቅቀዋል?	[ ][ ] ክፍል		EDUGRAD
105	የጋብቻ ሁኔታ (በአሁኑ ወቅት የትዳር ሁኔታ እንዴት ነው?)	ያገባ፣ ብቸኛ ሚስት	1	MARISTAT
		ያገባ፣ ሁለትና ከዚያ በላይ ሚስት	2	
		የተፋቱ	3	
		የተለያዩ (ከባል ጋር በጥል የተለያዩ)	4	
		ባል የሞተባቸው	5	
		ያላገቡ	6	
106	**የመኖሪያ ቦታ** (የሚኖሩት ቀበሌ ከተማ ነው ወይስ ገጠር?)	ከተማ	0	RES
		ገጠር	1	
107	**ስራ** (ገቢ የሚያገኙበት ስራዎ ምንድነዉ?)	የቤት እመቤት	1	EMP
		አርሶ አደር	2	
		ነጋዴ	3	
		ተማሪ	4	
		የመንግስት ሰራተኛ	5	
		የቀን ስራ (የጉልበት ሰራተኛ)	6	

		ስራ አጥ	7	
		ሌላ_____	8	
108	በቀበሌዎ ውስጥ ካሉ ሰዎች ጋር ራስዎን ሲያወዳድሩ ያለዎት ሃብት እኩል ነው፤ ይበልጣል፤ ወይንስ ያንሳል ብለው ይገምታሉ?	ያነሰ	1	RELWEAL
		የበዛ	2	
		ተመሳሳይ	3	
		አላውቅም /አላስታውስም	88	
		መልስ መስጠት አልፈለጉም	99	
109	የስንት ወር እርጉዝ ነዎት?	[ ] [ ] ወር		GEST
110	ያሁኑ እርግዝናዎ የመጀመሪያ ነው?	አዎ	1	PRIMIP
		አይደለም	2	
የ109 መልስ አይደለም ከሆነ ወደ 110 ይለፉ				
111	ከዚህ በፊት ስንት ጊዜ አርግዘዋል?	[ ] [ ]		PREVPR

3.2. Patient health questionnaire -9-item version (PHQ-9)

PHQ-9 **<u>ማስታወሻ</u>**፡አልፎአልፎብቻ (2-6 ቀናት)፣በዛላለጊዜ (7-11 ቀናት)፣ከሞላ ጎደል በየቀኑ (12-14 ቀናት)መሆኑንይግለፁ፡፡				**Code**
ላለፉት ሁለት ሳምንታት ከነዚህ ከምዘረዝራቸው ችግሮች ውስጥ፤ የትኞቹ ደርስውብዎት (በየትኞቹ ተቸግረው) እንደነበር እጠይቅዎታለሁ።				
1.	የእለትተእለትተግባርዎንለማከናወን (ለመስራት) ያለዎት ተነሳሽነት ወይም ፍላጎት በጣም ቀንሶ ነበር?	አዎ	1	PHLI
		የለም	0	

	መልሱአዎከሆነበሁለቱሳምንታትዉስጥለምንያህልጊዜተሰማዎት?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
2.	የመከፋት፣ የመደበት ወይም ተስፋ የመቁረጥ ስሜት ይሰማዎት ነበር?	አዎ	1	PHFS
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተሰማዎት?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
3.1	እንቅልፍ አልወስድ ብሎዎት ወይም በደንብ መተኛት አቅትቶዎት ይቸገሩ ነበር?	አዎ	1	PHIS
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተቸገሩ?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
3.2	እንቅልፍ በዝቶብዎት ይቸገሩ ነበር?	አዎ	1	PHOS
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተቸገሩ?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
4.	የድካም ወይም የአቅም ማነስ ስሜት ይሰማዎት ነበር?	አዎ	1	PHLE
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተሰማዎት?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
5.1	የምግብ ፍላጎትዎ ቀንሶ ነበር?	አዎ	1	PHLR
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ቀንሶ ነበር?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
5.2	የምግብ ፍላጎትዎ ከተለመደው በላይ ጨምሮ ነበር?	አዎ	1	PHLA
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ጨምሮ ነበር?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
6.	ራስዎን የመጥላት ወይም ዋጋ የለኝም የማለት ወይም ራሴንም ሆነ ቤተሰቤን አሳዝኛለሁ የሚል ስሜት ተሰምቶዎት ነበር?	አዎ	1	PHFH
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተሰማዎት?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
7.	በሚሰሩት ስራ ላይ ሃሳብዎን ለመሰብሰብ/ትኩረት መስጠት አስቸግርዎት ነበር? (ለምሳሌ፣ ከሰዎች ጋር ሲጨዋወቱ ትኩረት ሰጥቶ ማዳመጥ?)	አዎ	1	PHDC
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተቸግረው ነበር?	አልፎአልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
8.1	ለሌሎች ሰዎች እስከሚታወቅ ድረስ በእንቅስቃሴዎ ወይም በንግግርዎ በጣም ቀስ ብለው ነበር?	አዎ	1	PHDT
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተቸግረው ነበር?	አልፎ አልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	

		ከሞላ ጎደል በየቀኑ	3	
8.2	ለሌሎች ሰዎች እስከሚታወቅ ድረስ መረጋጋት አቅቶዎት፣ አንድ ቦታ አርፎ መቀመጥ ወይም መቆም እስከማይችሉ ሆነው ነበር?	አዎ	1	PHDS
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተቸግረው ነበር?	አልፎ አልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
9.	ከምኖር ብሞት ይሻላል ብለው አስበው ወይም ራስዎን በሆነ መንገድ ሊጎዱ አስበው ነበር?	አዎ	1	PHWD
		የለም	0	
	መልሱ አዎ ከሆነ በሁለቱ ሳምንታት ዉስጥ ለምን ያህል ጊዜ ተሰምቶዎት ነበር?	አልፎ አልፎ ብቻ	1	
		በዛ ላለ ጊዜ	2	
		ከሞላ ጎደል በየቀኑ	3	
10.	ከተዘረዘሩት ችግሮች ለአንዳቸውም አዎ የሚል መልስ ከተሰጠ የሚከተለውን ይጠይቁ። በእነዚህ ችግሮች ምክንያት ስራዎን ለመስራት፣ የቤት ሓላፊነትዎን ለመወጣት ወይም ከሰዎች ጋር ተስማምተው ለመኖር ምን ያህል አስቸጋሪ ሆኖብዎት ነበር?	በጭራሽ አልተቸገርኩም	1	PHDR
		በመጠኑ ተቸግሬ ነበር	0	
		በጣም ተቸግሬ ነበር	1	
		እጅግ በጣም ተቸግሬ ነበር	2	

3.3. Kessler 10-item scale (k-10)

ኬስለር 10

አሁን ደግሞ ባለፈው አንድ ወር ስለነበረዎት ስሜት እጠይቅዎታለሁ፡፡ ለእያንዳንዱ ጥያቄ አምስት ምርጫዎች ይቀርብልዎታል፤ አንዱን ብቻ ይምረጡ፡፡

<u>ለጠያቂ ማስታወሻ</u>**፡ ተጠያቂው ማብራሪያ ካስፈለጋቸው፡ እምብዛም (2-7 ቀናት) አልፎ አልፎ ብቻ (8-15 ቀናት)፣ በዛ ላለ ጊዜ (16-24 ቀናት)&ሁልጊዜ (ከ25 ቀናት በላይ) መሆኑን ይግለፁ፡፡**

ተ.ቁ	ጥያቄ	ነጥብ		
1.	ባለፉት 30 ቀናት ውስጥ የመደበር (የመተከዝ) ስሜትይሰማዎት ነበር?	አዎ	1	KTIRED
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
2.	ባለፉት 30 ቀናት ውስጥ በጣም ከመደበትዎ (ከመከፋትዎ) የተነሳ ምንም ነገር ሊያስደስትዎ ያልቻለበት ወቅትነበር?	አዎ	1	KNERV
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
3.	ባለፉት 30 ቀናት ውስጥ የመረበሽ ስሜት ይሰማዎት ነበር?	አዎ	1	KNERC
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
4.	ባለፉት 30 ቀናት ውስጥ ውስጥዎ እጅግ ከመረበሹ የተነሳ ምንም ነገር ሊያረጋጋዎት	አዎ	1	KHOPE

	ያልቻለበት ወቅትነበር?	የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
5.	ባለፉት 30 ቀናት ውስጥ እረፍት የማጣት ወይም የመቁነጥነጥ ስሜት ይሰማዎት ነበር?	አዎ	1	KREST
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
6.	ባለፉት 30 ቀናት ውስጥ እጅግ ከመቁነጥነጥዎ የተነሳ አንድ ቦታ አርፎ መቀመጥ ያልቻሉበት ወቅት ነበር?	አዎ	1	KPROB
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
7.	ባለፉት 30 ቀናት ውስጥ <u>ለምንም አልጠቅምም (ዋጋ የለኝም) የሚል ስሜት</u> ይሰማዎት ነበር?	አዎ	1	KDEPR
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
8.	ባለፉት 30 ቀናት ውስጥ ምንም ሳይሰሩ ይደክምዎት ነበር?	አዎ	1	KEFFO
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
9.	ባለፉት 30 ቀናት ውስጥ ተስፋ የመቁረጥ ስሜት ይሰማዎት ነበር?	አዎ	1	KCHEE
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	
10.	ባለፉት 30 ቀናት ውስጥ ሁሉንም ነገር የግድዎን ያደርጉ ነበር? *(ለምሳሌ መናገር፣ መነሳት፣ መሄድ፣ የመሳሰሉትን)*	አዎ	1	KWOTH
		የለም	0	
	<u>መልሱ አዎ ከሆነ፤</u> በአንድ ወር ዉስጥ ለምን ያህል ጊዜይሰማዎት ነበር?	እምብዛም	1	
		አልፎ አልፎ ብቻ	2	
		በዛ ላለ ጊዜ	3	
		ሁልጊዜ	4	

3.4. Self-Reporting Questionnaire 20-item version (SRQ-20)

1	ባለፉት 30 ቀናት ብዙ ጊዜ ራስ ምታት ያምዎታል?	አዎን	1	SRHA
		የለም	0	
2	ባለፉት 30 ቀናት የምግብ ፍላጎትዎ ቀንሷል?	አዎን	1	SRAP

		የለም	0	
3	ባለፉት 30 ቀናት የእንቅልፍ ችግር አለብዎት?	አዎን	1	SRIS
		የለም	0	
4	ባለፉት 30 ቀናት በቀላሉ<ይደነግጣሉ (ይበረግጋሉ)?	አዎን	1	SRFR
		የለም	0	
5	ባለፉት 30 ቀናትእጅዎ ይንቀጠቀጣል?	አዎን	1	SRTR
		የለም	0	
6	ባለፉት 30 ቀናት መረበሽ፣ መጠበብ ወይም በሚረባውም በማይረባውም ሐሳብ ይበዛብዎታል?	አዎን	1	SRWO
		የለም	0	
7	ባለፉት 30 ቀናት ምግብ ከበሉ በኃላ ሆድዎን ይከብድዎታል (ሆድዎን ይነፋዎታል)?	አዎን	1	SRID
		የለም	0	
8	ባለፉት 30 ቀናት በትክክል ማሰብ ይቸግርዎታል (ሀሳብዎ እየተዘራረቀ ያስቸግርዎታል)?	አዎን	1	SRDT
		የለም	0	
9	ባለፉት 30 ቀናት ደስታ የማጣት ስሜት አለዎት?	አዎን	1	SRSA
		የለም	0	
10	ባለፉት 30 ቀናት ከወትሮው በላይ ያስለቅስዎታል?	አዎን	1	SRWC
		የለም	0	
11	ባለፉት 30 ቀናት በየቀኑ በሚሠሯቸው ሥራዎች መደሰት ይቸግርዎታል?	አዎን	1	SRLH
		የለም	0	
12	ባለፉት 30 ቀናት በእለት ተእለት ጉዳይዎ (ተግባርዎ) ላይ ውሳኔ መወሰን ያስቸግርዎታል?	አዎን	1	SRPDM
		የለም	0	
13	ባለፉት 30 ቀናት የእለት ተእለትሥራዎችተበድሏል(ተስተጓጉሏል)?	አዎን	1	SRDFW
		የለም	0	
14	ባለፉት 30 ቀናትበእለትተእለትኑሮላይ ጠቃሚ አስተዋጽኦ (ተሳትፎ)ማበርከትአልቻልኩምይላሉ?	አዎን	1	SRSCO
		የለም	0	
15	ባለፉት 30 ቀናትለተለያዩ ነገሮች የነበረዎት ፍላጎት/ስሜት/ጠፍቷል?	አዎን	1	SRWS
		የለም	0	
16	ባለፉት 30 ቀናት የማልጠቅመ ወይም ዋጋ ቢስ ነኝ ብለው ያስባሉ<?	አዎን	1	SRFWL
		የለም	0	
17	ባለፉት 30 ቀናት ውስጥ፤ ራስዎትን የማጥፋት ሐሳብ መጥቶብዎት ያውቃል?	አዎን	1	SRWTD
		የለም	0	
18	ባለፉት 30 ቀናት ሁልጊዜ ድካም ይሰማዎታል?	አዎን	1	SRFTIR
		የለም	0	
19	ባለፉት 30 ቀናት ሆድዎ ይረበሻል (ሆድዎ ውስጥ ያለመመቸት ስሜት ይሰማዎታል)?	አዎን	1	SRFDIS
		የለም	0	
20	ባለፉት 30 ቀናት በቀላሉ ይደክማሉ?	አዎን	1	SREGR
		የለም	0	

3.5. Mini-International Neuropsychiatric Interview (MINI)

መጠይቁ የተሞላበት ቀን	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]
የተጠያቂው ቁጥር	[ ][ ][ ][ ]
የተጠያቂው ስም	
የተጠያቂው ዕድሜ	[ ][ ]
የተጠያቂው ቀበሌ	

መጠይቁ የተሞላበት ቀን	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]
የተጠያቂው ቁጥር	[ ][ ][ ][ ]
የተጠያቂው ዕድሜ	[ ][ ]
የተጠያቂው ቀበሌ	

M.I.N.I

<u>የመጠይቁ የአሞላል መመሪያ (RATING INSTRUCTIONS)</u>፤

ሁሉም ጥያቄዎች መመለስ ይኖርባቸዋል፡፡ <u>የለም ወይም አዎን የሚለውን አማራጭ አክብቡ፡፡</u> ምላሹን ለመመላት የሙያ ግምገማችሁንም ተጠቀሙ፡፡ አስፈላጊ ሆኖ ሲገኝ፤ ምላሹ ትክክለኛ መሆኑን ለማረጋገጥ ምሳሌ እንዲሰጥ ጠይቁ፡፡ ህመምተኛው ያልተረዷቸው ነገሮች ካሉ ማብራሪያ እንዲጠይቁ አበረታቱ፡፡

ጠያቂ ባለሙያዎች፤ እያንዳንዱ <u>የጥያቄ ክፍል</u> በትክክል መመለሱን ማረጋገጥ ይኖርባቸዋል (ለምሳሌ፤ ምልክቱ ምን ያህል ጊዜ እንደቆየ፤ ድግግሞሹ፤የህመሙ ብርታት፤ እንዲሁም አማራጮች)

<u>በሌላ ህመም ሳቢያ ወይም በመጠጥ እና በእፅ ምክንያት የተከሰተ የአእምሮ ህመም ምልክት፤ በ M.I.N.I.ላይ መሞላት የለበትም፡፡</u>

A.የአባች ድባቴ ህመም ክስተት

ማስታወሻ፤ <u>የለም ወይም አዎን የሚለውን አማራጭ አክብቡ።።</u>

A1	a.	ላለፉት ሁለት ተከታታይ ሳምንታት የመደበር ወይም የማዘን (የመከፋት) ስሜት ነበረዎት ወይ?	የለም	አዎን
		A1 ሀ አዎን ከሆነb.ን ጠይቁ፤ ***A1 ሀየለም ከሆነ***ወደ A2እለፉ		
	b.	የቀኑን አብዛኛውን ጊዜ እና ከሞላ ጎደል በየእለቱይህ የመደበር ወይም የማዘን (የመከፋት) ስሜት ነበረወይ?	የለም	አዎን
A2		ላለፉት ሁለት ሳምንታት አብዛኛውን ጊዜ ለብዙ ነገሮች ፍላጎት ማጣት ወይም በፊት ያስደስትዎት ለነበሩት ነገሮች ስሜት ማጣት ነበረዎት?	የለም	አዎን
		*A1*b. *ወይም A2 መልስ አዎን ነው?*	የለም	አዎን

A3		**ባለፉት ሁለት ሳምንታት**		
a	a.1	ከሞላ ጎደል በየቀኑ የምግብ ፍላጎትዎ ከወትሮው ቀንሶ ነበር?	የለም	አዎን
	a.2	ከሞላ ጎደል በየቀኑ የምግብ ፍላጎትዎ ከወትሮው ጨምሮ ነበር?	የለም	አዎን
	a.3	ሆን ብለው ሳይሞክሩ ክብደትዎ ቀንሶ ነበር (ከሰውነት ክብደት ቢያንስ አምስት ከመቶ ያህሉን መቀነስ)?	የለም	አዎን
	a.4	ሆን ብለው ሳይሞክሩ ክብደትዎ ጨምሮ ነበር (ከሰውነት ክብደት ቢያንስ አምስት ከመቶ ያህል)?	የለም	አዎን
b	b.1	ከሞላ ጎደል በየቀኑ እንቅልፍ እንቢ ብሎዎት ነበር? (ማለትም፤እንቅልፍ አልዎስድ ማለት፤ ሌሊት መንቃት/የእንቅልፍ መቆራረጥ/፤ ጠዋት ማልዶ መንቃት)	የለም	አዎን
	b.2	ከሞላ ጎደል በየቀኑ እንቅልፍ እየበዛብዎት ተቸግረው ነበር?	የለም	አዎን
c	c.1	ከሞላ ጎደል በየቀኑ ንግግርዎ ወይም እንቅስቃሴዎ	የለም	አዎን

		ከተለመደው በላይ ቀስ ብሎ ነበር?			
	c.2	ከሞላ ጎደል በየቀኑ መቅበጥበጥ፤ አርፎ አለመቀመጥ እና እረፍት ማጣት ነበረዎት?	የለም	አዎን	
d		ከሞላ ጎደል በየቀኑ ድካምና ጉልበት ማነስ ነበረዎት?	የለም	አዎን	
e		ከሞላ ጎደል በየቀኑ ዋጋ ቢስነት፣ የበታችነት ወይም የጥፋተኝነት ስሜት ይሰማዎት ነበር?	የለም	አዎን	
		A3e አዎን ከሆነ ምሳሌ ይጠይቁ። *ምሳሌው ከእውነት የራቀ ሃሳብ (delusional idea) ይመስላል?* *0 የለም 1 አዎን*			
f		ከሞላ ጎደል በየቀኑ ሃሳብዎት እየተበተነ ወይም ዉሳኔ ላይ ለመድረስ እየተቸገሩ ነበር?	የለም	አዎን	
g		በተደጋጋሚ ራስዎትን ለመጉዳት አስበው፣ ራስዎትን ለማጥፋት ስሜት አድሮብዎት ወይም ሞቼ ባረፍኩት ብለው ያውቃሉ?	የለም	አዎን	
n		*ከተለመደው በላይ ወይም በትንሹም በትልቁም እየተበሳጨ ተቸግረዋል?*	የለም	አዎን	New item
A4		*3 ወይም ከዛ በላይ የሆኑ የA3 ጥያቄዎች አዎን የሚል መልስ ተሰጥቷቸዋል? (ወይምA1 ወይምA2የለም የሚል መልስ ከተሰጣቸው ፤4 የA3 ጥያቄዎች አዎን የሚል መልስ ተሰጥቷቸዋል?)* *<u>ማስታወሻ</u>፡ a.1.-a.4.=1, b.1.-b.2.=1, c.1.-c.2.=1 (ለእያንዳንዳቸው አንዳንድ ነጥብ ብቻ ይሰጥ)*	የለም	አዎን	

<u>ማስታወሻ</u>፤ ለ A4መልሱ የለም ከሆነ፤ ወደ መጠይቅ B እለፉ።።

A5. የነበረዎት የመደበት ስሜት በኑሮዎ ላይ ጫና ፈጠረብዎት? ወይም በስራዎ፣በማህበራዊ ህይወትዎ እንዲሁም በሌላ መልኩ ያለዎትን ኃላፊነት እንዳይወጡ አደረገዎት ወይ?	የለም	አዎን
A6.1. የሚወዱትን ሰው በሞት አጥተዋል?	የለም	አዎን

A6.1.a. ለጥያቄ A6.1. መልሳቸው አዎን ከሆነ፤ "የሚወዱትን ሰው በሞት ከተለዩ ስንት ጊዜ ሆነው?" ብለው ይጠይቁ:: [ ][ ] ወራት።።

A6.2. <u>ለጥያቄ A6.1. መልሳቸው አዎ ከሆነ</u>፤ የሚከተለውን ጥያቄ አቅርቡ።።

ከላይ የተዘረዘሩት ምልክቶች ሙሉ በሙሉ፤ የሚወዱትን ሰው በሞት ከማጣት የተነሳ የመጡ ናቸው? ከሆነስ እነዚህ ምልክቶች፣ በክብደታቸው፣ በእለት ተእለት ተግባርዎት እና ኑሮዎት ላይ ባደረሱት መስተጓጓል፤ እንዲሁም ከጊዜው ርዝመት አንጻር ከሌሎች ሃዘን ከደረሰባቸው ሰዎች ጋር ሲወዳደር ጋር ተመሳሳይነት አለው?

<u>ለጠያቂው፡</u> ይህ ከሆነ ግለሰቡ ያላቸው አግባብ ያለው ሃዘን (uncomplicated bereavement) ነው።። አግባብ ያለው ሃዘን (uncomplicated bereavement) አለመሆኑን አረጋግጠዋል?

የለም አዎን

A7. a. እነዚህ ምልክቶች ከመጀመራቸው በፊት የሚወስዷቸው መድሃኒቶች ወይም

ለሱስ የሚዳርጉ እጾች ይወስዱ ነበር?

የለም አዎን

b. እነዚህ ምልክቶች ከመጀመራቸው በፊት ዘወትር ከሚጎስዱት በላይ አልኮል

ወይም ጫት ይጠቀሙ ነበር?

የለም አዎን

c. እነዚህ ምልክቶች ልክ ከመጀመራቸው በፊት አካላዊ ህመም ነበረዎት?

የለም አዎን

<u>በጠያቂው አስተያየት፡-</u> የድባቴ ህመሙ ከላይ ከተጠቀሱት ምክንያቶች በአንዱ የመጣ ሊሆን ይችላል ብለው ያምናሉ? አስፈላጊ ከሆነ ሌሎች ተጨማሪ የማብራሪያ ጥያቄዎችን ይጠይቁ።።

A7*(ማጠቃለያ) ድባተቴው ከሌላ በሽታ የመጣ(organic) እንዳልሆነ ተረጋግጧል?*

የለም አዎን አጠራጣሪ ነው

A8. *የA7(ማጠቃለያ) መልስ አዎ ወይም አጠራጣሪ ከሆነ <u>አዎን ይምረጡ</u>።።*

የለምአዎን
የአባች ድባቴ ህመም ክስተት

A9. *A7c. መልስ አዎን ከሆነና፡ የA7(ማጠቃለያ) መልስየለም ከሆነ <u>አዎን ይ</u>*

የለምአዎን
ከአካላዊ ህመም የተነሳ የስሜት መታወክ

A10. *A7a ወይምb መልስ አዎን ከሆነና፡ የA7 (ማጠቃለያ) መልስ የለም ከሆነ አዎን <u>ይምረጡ</u>።።*

የለምአዎን
በሱስ አስያዥ ንጥረ ነገሮች የተነሳ የስሜት መታወክ

A10 PAST: ከአሁን በፊት ተመሳሳይ የሆነ የድባቴ ህመም አጋጥሞዎት ያውቃል?

የለም አዎን

ቅደም ተከተል

A11. በመጀመሪያ የድባቴ ህመም ምልክቶች ሲጀምርዎ ዕድሜዎ ስንት ነበር?[ ][ ] ዓመት

A12. በእድሜዎ ሁሉ እነደዚህ አይነት የድባቴ ህመም ስንት ጊዜ ተመላልሶብዎታል? [ ][ ] ጊዜ

A13. ተመሳሳይ ወይም ተቃራኒ የሚመስል በሽታ ያለበት ወይም ለአእምሮ መታወክ መደሃኒት የሚጠቀም ዘመድ አለዎት? **የለም አዎን**

B.

1. እስካሁን ስለድባቴ ወይም ስለመተከዝ ስሜቶች አነጋግሬዎታለሁ።። ከዚህ ውጭ የሆነ የሚነግሩኝ የአእምሮ መታወክ ወይም ጭንቀት አለ?

<u>ማስታወሻ</u>፡ briefly explore anxiety symptoms and describe the symptoms and the likely diagnosis

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2. ሐኪም ወይም አዋቂ አላወቅልኝም የሚሉት ህመም አለ?

<u>ማስታወሻ</u>፡ briefly explore somatoform symptoms and describe the symptoms and the likely diagnosis

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3.6. WHO Disability Assessment Schedule, version 2 (WHODAS II)

<u>መግቢያ</u>

<u>ለጠያቂ ማስታወሻ</u>፡**ካርድ ቁጥር ነን ለተጠያቂ ስጥ እና የሚከተለውን ማብራሪያ ስጥ።**

ይህ ቃለመጠይቅ ሰዎች በጤና እክል ምክንያት ስለሚኖራቸው ችግር ይሆናል።

የጤናእክል ስል በሽታ ወይም ህመም፣ ሌሎች ለአጭር ወይም ለረዥም ጊዜ የሚቆዩ የጤና ችግሮች፣ ጉዳቶች፣ የአእምሮ ወይም የመንፈስ መታወክ እንዲሁም ከመጠጥ እና ከዕጽ ጋር የተናኙ ችግሮችን ይሆናል።

ቃለመጠይቁን ሲመልሱ ሁሉንም የጤና ችግርዎን እንዲያስቡ እፈልጋለሁ።

<u>ለጠያቂ ማስታወሻ</u>፡ **ካርድ ቁጥር ነን አመልክት** ወይም ለተጠያቂዉ አንብብእና የሚከተለውንማብራሪያ ስጥ።

<u>"አንድን ተግባር ለማከናወንመቸገር"</u>ማለት፤

ስራውን ለማከናወን ተጨማሪ ጥረትሲያስፈልግ

ስራውን ማከናወን አለመመቸት ወይም የህመምስሜት ሲፈጥር

ስራውን ለማከናወን ብዙ ጊዜ ሲፈጅ

ስራዉን ለማከናወን ቀድሞ ከሚሰሩበት ሌላ መንገድለመጠቀም ሲገደዱ ማለት ነው፡፡ እንግዲህ አንድን ተግባር ለማከናወን ስለሚገጥምዎት ችግር ስጠይቆትእነዚህን እያሰቡ መልስ ይስጡ፡፡

<u>ለጠያቂ ማስታወሻ</u>፡ለተጠያቂዉየሚከተለውን ተጨማሪ ማብራሪያ ስጥ፡፡

ጥያቄዎቹን ሲመልሱ የያለፉትን 30 ቀነቀት እያስታወሱ ይሁን። እንዲሁም እነዚህን ጥያቄዎች ሲመልሱ በአማካይ ባለፉት 30 ቀናት <u>ብዙ ጊዜ</u> የሚያከናውኑትን ስራ ለመፈፀም ምን ያህል ችግር ይገጥምዎት እንደነበር እያሰቡ ይሁን።

ካርድ ቁጥር 2ን ለመላሹ ስጥና ድምፅህን ከፍ አድርገህ መስፈርቶቹን አንብብላቸው። በመቀጠልም የሚከተለውን ተጨማሪ ማብራሪያ ስጥ፡፡

ጥያቄዎቹን ሲመልሱ እነዚህን 5 የችግር ወይም የእክል ደረጃዎች ይጠቀሙ፣

1. ምንም ችግር የለም2. አነስተኛ ችግር3.መካከለኛ ችግር 4.ከፍተኛ ችግር 5.በጣም ከፍተኛ ችግር ወይምፈጽሞ መስራት አለመቻል።

ለጠያቂ ማስታወሻ፤ መጠይቁ እስኪጠናቀቅ ድረስ ካርድ ቁጥር 1እና ካርድ ቁጥር 2 ለመላሹ እንደሚታዩ መሆን አለባቸው።

የመረዳት ብቃት

ለጠያቂ ማስታወሻ፤ ለመላሹ **ካርድ ቁጥር 1እና ካርድ ቁጥር 2 አሳይ።**

ነገሮችን ሰለ**መረዳት**እና ከሰዎች ጋር ያለዎትን መግባባት በተመለከተ አንዳንድ ጥያቄዎች አቀርብልዎታለሁ።

ጥያቄዎቹን ሲመልሱ ከላይ የጠቀስኩልዎትን 5ቱን የችግር ወይም የእክል ደረጃዎች ይጠቀሙ፣ እነዚህም፣

ምንም ችግር የለም2.አነስተኛ ችግር 3.መካከለኛ ችግር 4. ከፍተኛ ችግር5.በጣም ከፍተኛ ችግር ወይምፈጽሞ መስራት አለመቻል

ባለፉት 30 ቀናት		ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D1.1	በሚሰሩት ሥራ ላይ ሀሳብዎንለጥቂትጊዜ (ለ10 ደቂቃ)ያህልመሰብሰብ ይቸገሩነበር?	1	2	3	4	5
D1.2	አስፈላጊ የሆኑ ነገሮችን አስታዉሰዉለማድረግይቸገሩነበር?	1	2	3	4	5
D1.3	በእለት ተእለት ህይወትዎ ውስጥ የሚገጥሙችግሮችንመንስኤለማወቅእናመፍትሄ ለመፈለግ ይቸገሩነበር?	1	2	3	4	5
D1.4	አዲስ ነገር ወይምሥራ ለመማር ይቸገሩነበር? (ለምሳሌየእርሻስራ፣ባልትና፣የእጅስራ፣የሞባይልአጠቃቀምወዘተ . . .)	1	2	3	4	5
D1.5	በአጠቃላይ ሰዎች የሚሉትን መረዳት ይቸገሩነበር?	1	2	3	4	5
D1.6	ከሰዎች ጋር ንግግርጀምሮመጨረስይቸገሩነበር?	1	2	3	4	5

2.<u>እንቅስቃሴ</u>

<u>ለመላሹ</u> ካርድ ቁጥር 1እና ካርድ ቁጥር 2 አሳይ።

አሁን ከእንቅስቃሴ ጋር ስለሚያያዙ ችግሮች እጠይቅዎታለሁ።

	ባለፉት 30 ቀናት	ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D2.1	ረዘም ላለ ጊዜ መቆም ምን ያህል ይቸግሮት ነበር? ለምሳሌ ግማሽሰአት	1	2	3	4	5
D2.2	<u>ከተቀመጡበት ለመነሳት</u>ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D2.3	<u>እቤትዎ ውስጥ መዘዋወር</u> ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D2.4	<u>ከቤትዎ ለመውጣት</u> ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D2.5	<u>ረዘም ያለ ርቀት ለመጓዝ</u> ምን ያህል ይቸግሮት ነበር? ለምሳሌ የሩብሰአትመንገድ (1ኪ.ሜትር)	1	2	3	4	5

3 . እራስን መንከባከብ<u>**ወይም መጠበቅ**</u>

አሁን እራስዎን ለመንከባከብ የሚገጥምዎትን ችግር እጠይቆታለሁ።

	ባለፉት 30 ቀናት	ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D3.1	<u>ሰውነትዎን መታጠብ</u> ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D3.2	<u>ልብስዎትንለመልበስ</u> ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D3.3	<u>ምግብለመመገብ</u> ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D3.4	<u>ያለሰዉብቻዎትንለተወሰኑ</u> ቀናት መቆየት <u>ምን ያህል ይቸግሮት ነበር?</u>	1	2	3	4	5

4. ከሰዎች ጋር መግባባት

አሁን ከሰዎች ጋር ለመግባባት የሚኖሮትን ችግር እጠይቆታለሁ። ያስታውሱ በጤና መታወክ ምክንያት የተፈጠሩ ችግሮችን ብቻ ነው የምጠይቀው። ይህም ማለት:- በሽታ ወይም ህመም፣ ሌሎች ለአጭር ወይም ረዘም ጊዜ የሚቆዩ የጤና ችግሮች፣ ጉዳቶች፣ የአእምሮ ወይም የመንፈስ መታወክ እንዲሁም ከመጠጥ እና ከዕጽ ጋር የተገናኙ ችግሮችን ይሆናል።

ካርድ ቁጥር 1እና ካርድ ቁጥር 2 አሳይ/አንብብ።						
	ባለፉት 30 ቀናት	ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D4.1	ከማያውቋቸው ሰዎች ጋር ተግባብቶጉዳይመፈጸምምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D4.2	በጓደኝነት መቆየት ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D4.3	ቅርብ ከሆኑ ሰዎች ጋር ተግባብቶመኖርምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D4.4	አዲስ ጓደኝነትመጀመርምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D4.5	ወሲባዊ ግንኙነት ማድረግምን ያህል ይቸግሮት ነበር?	1	2	3	4	5

5. የኑሮ እንቅስቃሴ

5(ነ) የቤት ውስጥ ሥራዎች

የሚከተሉት ጥያቄዎች እቤትዎ ውስጥ ስላሎት እንቅስቃሴ እንዲሁም አብረዎት የሚኖሩ ወይም ቅርብ የሆኑ ሰዎችን ስለመንከባከብ ይሆናል። ስራዎቹ ምግበ ማብሰል፣ ፅዳት፣ ሱቅ ወይም ገበያ መሄድ እንዲሁም ሌሎች ሰዎችን መንከባከብ እና ንብረትዎን መጠበቅ ናቸው።

ካርድ ቁጥር 1እና ካርድ ቁጥር 2 አሳይ/አንብብ።						
ባለፉት 30 ቀናት የሚከተሉትን ማድረግ ምን ያህል ይቸግሮት ነበር?		ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D5.1	የቤት ውስጥ ሃላፊነቶችን መወጣት ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D5.2	ቅድሚያየሚሰጧቸዉንየቤት ውስጥ ሥራዎች በደንብ መስራት ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D5.3	መስራት ያለብዎትን የቤት ውስጥ ሥራዎች በሙሉ ሰርቶለመጨረስምን	1	2	3	4	5

	ያህል ይቸግሮት ነበር?					
D5.4	የቤት ውስጥ ሥራዎን በሚፈለገው ፍጥነት ለመስራት ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5

ከD5.1 – D5.4 ውስጥ የችግሩደረጃከምንም በላይ (ከ በላይ) ምላሽ የተሰጠበት ካለ የሚከተሉትን ጠይቅ።

D5.01	ባለፉት 30 ቀናት በጤናዎ ችግር የተነሳ ለስንት ቀናት የቤት ውስጥ ሥራዎን መስራት ቀነሱ ወይም ሙሉ ለሙሉ ሳይሰሩቀሩ?	የቀናት ብዛት ይመዝግቡ _____ ቀናት

መላሹ ሠራተኛ (በክፍያ፣ በነፃ፣ በግል የሚሰራ ከሆነ) ወይም ተማሪ ከሆነ
ከD5.5 –D5.10 ያለዉንሙላ። ካልሆነ ግን ወደ D6.1እለፍ።

5(2) ስራ ወይም ትምህርት

አሁን ስለሥራዎ ወይም ስለትምህርትዎ እጠይቅዎታለሁ።

ካርድ ቁጥር 1እና ካርድ ቁጥር 2 አሳይ/አንብብ።

ባለፉት 30 ቀናት		ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D5.5	የዕለት ተዕለት ሥራዎን ወይምትምህርትዎንለማከናወንምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D5.6	ቅድሚያየሚሰጡትንሥራወይምትምህርትበደንብመስራትምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D5.7	መስራት ያለብዎትን ሥራ ወይምትምህርትበሙሉ ሰርቶለመጨረስምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D5.8	ሥራወይምትምህርትዎንበሚፈለገው ፍጥነት ለመስራት ምን ያህል ይቸግሮት ነበር?	1	2	3	4	5

D5.9	በጤናዎ ምክንያት ከሚጠበቅብዎወይምከወትሮደረጃዎዝቅብለዉእንዲሰሩ ተገደዋል?	የለም	1
		አዎን	2
D5.10	በጤናዎ ምክንያት ገቢዎ ቀንሷል?	የለም	1
		አዎን	2

ከD5.5 – D5.8 ውስጥ የችግሩደረጃከምንም በላይ (ከ በላይ) ምላሽ (ምላሾች) የተሰጠበት ካለ የሚከተሉትን ጠይቅ።

D5.02	ባለፉት 30 ቀናት በጤናዎ ችግር የተነሳ ለማማሸ ቀንወይምከዚያበላይ ሥራ ሳይሰሩየቀሩትለምንያህልቀናትነበር?	የቀናት ብዛት ይመዝግቡ _____ ቀናት

ማህበራዊ ተሳትፎ

አሁን በህበረተሰብ ውስጥ ለለዎት ተሳትፎ እንዲሁም የጤና ችግር በራስዎ እና በቤተሰብዎ ላይ ስላስከተለው ችግር እጠይቅዎታለሁ። አንዳንዶቹ ችግሮች ከ30 ቀናት በላይ የቆዩ ሊሆኑ ይችላሉ:: ሆኖም ግን፣ የሚከተሉትን ጥያቄዎች ሲመልሱ እባክዎ ባለፉት 30 ቀናት ላይ ብቻ ያተኩሩ። እነዚህን ጥያቄዎች ሲመልሱ ስለጤናዎ ችግር እያሰቡ እንዲሆን በድጋሚ አሳስብዎታለሁ።

ካርድ ቁጥር 1እና ካርድ ቁጥር 2 አሳይ።						
	ባለፉት 30 ቀናት	ምንም	አነስተኛ	መካከለኛ	ከፍተኛ	በጣም ከፍተኛ
D6.1	በማህበራዊእንቅስቃሴ ውስጥ (ለምሳሌ:- ዓመት በዓል፣ ድግስ፣ ለቅሶ፣እድር፣ሊቃ..ወዘተ) ልክ እንደሌላው ሰውመሳተፍምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D6.2	በአካባቢዎባሉ መሰናክሎችና ምቹያልሆኑሁኔታዎችምክንያትምን ያህል ይቸግሮት ነበር?	1	2	3	4	5
D6.3	ሰዎች ባላቸው መጥፎ (አሉታዊ) አመለካከትና ተገቢያልሆኑድርጊቶችየተነሳ ክብርዎተጠብቆልዎትለመኖር ምን ያህል ተቸገሩ?	1	2	3	4	5
D6.4	በጤናዎመታወክወይምየጤናዎመታወክባስከተለዉችግርምክንያት ምን ያህል ጊዜአጥፍተዋል?	1	2	3	4	5
D6.5	በጤናዎ ችግርምክንያት መንፈስዎ ምን ያህል ተረብሿል?	1	2	3	4	5
D6.6	የጤናችግርዎየእርስዎንናየቤተሰብዎን ሀብትእናንብረትምን ያህል አራቆተ?	1	2	3	4	5
D6.7	በእርስዎ የጤና ችግር ምክንያት ቤተሰንዎ ምን ያህል ተቸግሯል?	1	2	3	4	5
D6.8	ራስዎትንችለዉለመዝናናት ወይም ለመደሰት ለመዝናናትወይም ለመደሰት ሲሉነገሮችንማድረግምን ያህል ይከብድዎታል?	1	2	3	4	5
H1	በአጠቃላይ ባለፉት 30 ቀናት ዉስጥ እነዚህ ችግሮች ለምን ያህል ቀናት ነበሩ?			የቀናት ብዛት ይግለፁ_____		

H2	ባለፉት 30 ቀናት ዉስጥ፣ በማንኛዉም የጤና ችግር ምክንያት፣ የተለመደ ስራ ወይም እንቅስቃሴዎትን ሙሉ በሙሉ ማድረግ ያልቻሉት ለምን ያህል ቀናት ነበር?	የቀናት ብዛት ይግለፁ_____
H3	ባለፉት 30 ቀናት ዉስጥ፣ በማንኛዉም የጤና ችግር ምክንያት፣ ሙሉ በሙሉ ምንም ስራ መስራት ያልቻሉባቸዉን ቀናት ሳይጨምር፣ የተለመደ ስራ ወይም እንቅስቃሴዎትን ለመቀነስ የተገደዱባቸዉ ምን ያህል ቀናት ነበሩ?	የቀናት ብዛት ይግለፁ_____

ካርድ ቁጥር 1

የጤና ችግሮች

በሽታ ህመም ወይም ሌላ የጤና ችግር

ጉዳቶች

የአእምሮ ወይም የመንፈስ መታወክ

ከመጠጥ (አልኮል) ጋር ተገናኙ ችግሮች

ከዕጽ ጋር የተያያዙ ችግሮች

"<u>አንድን ተግባር ለማከናወን መቸገር</u>" ማለት፤

ስራውን ለማከናወን ተጨማሪ ጥረት ሲያስፈልግ

ስራውን ማከናወን አለመመቸት ወይም የህመም ስሜት ሲፈጥር

ስራውን ለማከናወን ብዙ ጊዜ ሲፈጅ

ስራዉን ለማከናወን ወድሞ ከሚሰሩበት ሌላመንገድ ለመጠቀም ሲገደዱ ማለት ነው::

ካርድ ቁጥር 2

5 -- በጣም ከፍተኛ

4 -- ከፍተኛ

3 -- መካከለኛ

2 -- አነስተኛ

1 -- ምንም

3.7. To be filled from FMOH integrated antenatal, labor, delivery, newborn and postnatal care card

ጠያቂውከመዝገብላይየሚሞላው				
1	እርግዝናውላይየተለየችግርአለ?	አለ	1	HIGHRISK
		የለም	2	