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VALUING HEALTH-STATE: AN EQ-5D-5L VALUE SET FOR ETHIOPIANS

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This is to certify that the thesis prepared by Abraham Gebregziabiher Welie, entitled: “Health state valuation: An EQ-5D-5L value set for Ethiopians: A Population-Based Cross-Sectional Survey” and submitted in partial fulfillment of the requirements for the Degree of Master of Science in Pharmacoepidemiology and Social Pharmacy complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Abstract

Background: There is a growing interest in health technology assessment and economic evaluations in developing countries using measures such as EQ-5D-5L (European quality 5 dimension- 5 level). However, the main challenge is lack of local population value sets which are recommended in most countries as they reflect local preferences.

Objective: To obtain social preference and establish an EQ-5D-5L value set from the Ethiopian general population.

Methods: A sample reflecting urban, and rural population (n= 1,050) was recruited using stratified multi-stage quota sampling technique. Face-to-face, computer-assisted interviews using the EuroQol Portable Valuation Technology (EQ-PVT) software of composite time trade-off(c-TTO) and discrete choice experiments (DCE) were undertaken to elicit preference score. The feasibility of EQ-PVT was pilot tested in a sample of the population (n=110). A hybrid regression model combining c-TTO and DCE data was used to estimate the final value set.

Results: The pilot study revealed that the feasibility of EQ-PVT protocol was good and there were no special concerns with undertaking TTO task. The predicted value for the EQ-5D-5L ranged from -0.7186 to 1. The coefficients generated from a hybrid model were logically consistent. Anxiety/depression showed the most impact to utility decrement of 0.4578, and self-care influenced the least 0.2224. The maximum predicted value beyond full health was 0.9741 for the '11112' (health state of slight problem in anxiety/depression dimension).

Conclusions: This study established Ethiopian value set for EQ-5D-5L on the basis of c-TTO and DCE. It is expected to facilitate health economic evaluations, health-related quality of life research and to inform decision making in Ethiopia.

Keywords: Discrete choice experiment, EQ-5D-5L, Ethiopia, Health state valuation, Quality of life, Time trade-off, Utility.

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List of Abbreviations

AAU	Addis Ababa University
AIC	Akaike Information Criteria
BIC	Bayesian Information Criteria
BRHP	Butajira Rural Health Project
c-TTO	composite Time Trade-Off
CUA	Cost Utility Analysis
DCE	Discrete Choice Experiments
EQ-5D- 3L/5L	EuroQol five-dimensional three/five-level
EQ-PVT	EuroQol Portable Valuation Technology
EQ-VAS	European Quality Visual Analogue Scale
FMOH	Federal Ministry of Health
HRQoL	Health Related Quality of Life
HTA	Health Technology Assessment
NICE	National Institute for Health and Care Excellence
OLS	Ordinary Least Square
PROM	Patient reported out come
QALY	Quality Adjusted Life Year
QC	Quality Control
t-TTO	traditional Time Trade-Off.

1 INTRODUCTION

1.1 Background

Ethiopia is the second most populous country in Africa with unique cultural heritage, diverse population mix of ethnicity and religion (Karbo, 2013). The country remains largely with high morbidity and mortality burden due to communicable, non-communicable and other diseases (Misganaw *et al.*, 2017). These problems would lead to high economic and development challenges in the country. Over the last 25 years, the country has successfully put into service its strategy of expanding and re-establishes primary health care facilities. As a result, 16,440 health posts, 3,547 health centers and 311 hospitals have been constructed (HSDP-IV, 2014/2015).

In any healthcare system even during the best of economic climates, there will not be enough resources to meet all of society's healthcare needs. This problem is worsened by the expensiveness of technologically advanced equipment and facilities for delivering effective health care (Mehlman, 1986). As a result of this scarcity of resources, choices have to be made in healthcare about which health care technologies to fund. One way in which to inform these choices is to perform Health Technology Assessment (HTA) (Oortwijn, Mathijssen and Banta, 2010). One aspect of HTA is undertaking an economic evaluation (Rajan, Gutierrez-Ibarluezea and Moharra, 2011; Towse *et al.*, 2011; Attieh and Gagnon, 2012; Babigumira *et al.*, 2016). Although economic evaluation can be undertaken using natural outcomes such as life years saved, these are limited as they only capture one aspect of health, e.g. mortality. Quality adjusted life years (QALYs) are outcome measures that have been developed to mitigate such problems (Whitehead and Ali, 2010). QALYs combine life years (mortality) with a quality adjustment that reflects the health-related quality of life (morbidity) on a 0 (dead) to 1 (full health) utility scale (Whitehead and Ali, 2010; Greco, Lorgelly and Yamabhai, 2016). The quality adjustment relies on preferences for different health states derived

using scaling methods (techniques) such as time trade off (TTO) and standard gamble (SG) providing information on which health states are considered to have the largest burden (Bleichrodt and Johannesson, 1997; Wright *et al.*, 2009). Preference elicitation can be time consuming and costly if undertaken independently for each study, Therefore, indirect preference-based instruments such as EQ-5D have been developed. These measures include a descriptive system (e.g. EQ-5D has five dimensions with three or five levels of severity) as well as a tariff which can be applied to generate utility values. The tariff is based on a valuation in a representative sample of the community using TTO. For specific measurement applications, patients can complete the descriptive system and community derived tariffs are applied to generate the relevant utility values (van Reenen and Janssen, 2015). A number of countries have generated country specific value sets for the EQ-5D (Devlin *et al.*, 2014; Augustovski *et al.*, 2016; Xie *et al.*, 2016; Kim *et al.*, 2016; Shiroya *et al.*, 2016; Versteegh *et al.*, 2016; Luo *et al.*, 2017; Purba *et al.*, 2017; Ramos-Gon *et al.*, 2017; Ludwig *et al.*, 2018; Pattanaphesaj *et al.*, 2018) which is one of the most widely used measures in economic evaluation around the world and is recommended by decision-making bodies including the National Institute for Health and Care Excellence (NICE) in England and Wales, the Pharmaceutical Benefits Advisory Committee (PHARMAC) in New Zealand and other countries including Belgium, Columbia and Thailand (Brockis *et al.*, 2016; Angelis, Lange and Kanavos, 2018).

1.2 Statement of the Problem

Globally, countries with publicly financed health services struggle to provide universal health coverage and the process of deciding which healthcare technologies and interventions to invest in have become increasingly important. This problem is worst in developing countries as they have very limited healthcare budgets to deal with their demands (Chalkidoudou, Levine and Dillon, 2010). As a result, there is a growing interest in HTA in developing countries (Attieh and Gagnon, 2012). To undertake HTA economic evaluation is the main feature (Rajan, Gutierrez-Ibarluezea and Moharra, 2011; Towse *et al.*, 2011; Attieh and Gagnon, 2012; Babigumira *et al.*, 2016). Economic evaluations of health care technologies require decisions to be made under uncertainty and they necessitate a multidisciplinary process to evaluate the social, economic, organizational and ethical aspects (Rajan, Gutierrez-Ibarluezea and Moharra, 2011). However, it is important to recognize that these decisions happen throughout healthcare systems are based on country specific health state value. A number of countries have generated country specific value sets for the EQ-5D, which is one of the most widely used measures in economic evaluation (Devlin *et al.*, 2014; Augustovski *et al.*, 2016; Xie *et al.*, 2016; Kim *et al.*, 2016; Shirowa *et al.*, 2016; Versteegh *et al.*, 2016; Luo *et al.*, 2017; Purba *et al.*, 2017; Ramos-Gon *et al.*, 2017; Ludwig *et al.*, 2018; Pattanaphesaj *et al.*, 2018). Given the variation in culture, health and social care provision, preferences are likely to vary across different populations and it is therefore recommended that each country generate its own value set (van Reenen and Janssen, 2015).

The Ethiopian Federal Ministry of Health (FMOH) has introduced a public health insurance system and it aims to support health care financing with principle of HTA (Ali, 2014). The current practice of HTA for regulatory and formulary development is based on expert opinion and published HTA

studies from other countries (Babigumira *et al.*, 2016). Even though general population health state value is among the most important for HTA and context specific HTA are highly needed, local value sets are not available for Ethiopia.

1.3 Significance of the study

Health state valuation is important to detect and treat physical or psychological manifestations, and studies that assess health state valuation provide crucial information to do HTA and other health related decisions (Raine *et al.*, 2016). The main feature of HTA is doing economic evaluation which involves comparison of two or more interventions in terms of costs and outcomes in order to judge which is the most cost effective (Rajan, Gutierrez-Ibarluezea and Moharra, 2011; Towse *et al.*, 2011; Attieh and Gagnon, 2012; Babigumira *et al.*, 2016). Economic evaluation of health technologies needs a country specific health state value developed based on preference-based measures such as EQ-5D-5L (Norman *et al.*, 2009). To make the EQ-5D-5L optimally suited for local use, societal values reflecting preferences of one country population need to be attached to all 3,125 (i.e 5^5) health states in calculating quality-adjusted life years (QALYs) (Oppe *et al.*, 2014). This means to do HTA and economic evaluation studies based on preference-based measures, we should be able to obtain preference weights that reflect countries population norm, based on the preferences of country's general population. This is important as different countries have been found to value the same health states differently (van Reenen and Janssen, 2015). In the context of developing countries, the presence of local value sets could facilitate economic evaluation research and can improve the quality of regulatory, coverage and reimbursement policy decisions in individual and public healthcare (Oortwijn, Mathijssen and Banta, 2010; Mueller, Govender and Basu, 2011; Doaee *et al.*, 2013).

The aim of this study was to obtain social preferences and establish an EQ-5D-5L value set from Ethiopian general population; and would be the first step to perform HTA for making evidence-based policy decisions. The value set would facilitate health economic evaluations, health-related quality of life research and inform decision making in Ethiopia. Researchers, policy makers in the FMOH and academics are expected to use it frequently.

2 LITERATURE REVIEW

2.1 Health state valuation measurements

The World Health Organization (WHO) has defined health as: “*a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.*” This broad definition suggests that health can be about specific symptoms such as our ability to move or to be free from pain and it extends to all areas of our lives. Health of the population should be measured to identify the most important health domain problems (Brauer *et al.*, 2006).

Measurements of health can be objective (based on clinical outcomes) or subjective (based on the patient’s report of how they are feeling). Objective measurements are dependent on the presence or absence of externally provable effects of poor health. However, not every condition can be identified objectively and patients will often seek healthcare when they have specific symptoms which affect their daily activities, but that cannot be proved objectively. Subjective measures allow the assessment of such symptoms as well as what is important to patients (Johnston *et al.*, 2007).

Subjective measures can be condition specific (i.e. related only to health outcomes specific to a condition) or generic (i.e. covering symptoms and/or functioning areas that are important for health in general). A condition-specific measure is useful for comparing outcomes within a condition, for example, to compare different drugs for specific disease, as the measure focuses on the specific symptoms associated with this condition. However, to compare outcomes across different conditions, for example, to compare treatments for two different diseases, a generic measure is needed that focuses on broader outcomes. A generic measure can also be used to compare outcomes within a condition (Moretti *et al.*, 2005; Rowen *et al.*, 2012). A generic measure can be related to health i.e. HRQoL measures, or be broader than health, focusing on well-being or overall quality of

life measures focus on all aspects of quality of life (Jonathan *et al.*, 2012; Autumn *et al.*, 2016). HRQoL measures are useful when assessing the impact of conditions/interventions that directly relate to health (Velentgas *et al.*, 2013). EQ-5D-5L is a subjective, generic, HRQoL health state value measurement recommended by different decision-making bodies including the NICE in England and Wales, the PHARMAC in New Zealand and other countries to undertake economic evaluation (Brockis *et al.*, 2016; Angelis, Lange and Kanavos, 2018).

2.2 Evolution and application of EQ-5D

The EQ-5D was developed by a multi-disciplinary group of researchers in European countries. The researchers used their own expertise, together with a review of other generic HRQoL measures available at the time, to generate a core set of domains to reflect the most important concerns of patients themselves. After a number of revisions, it resulted in a five dimensional classification system each having three levels (van Reenen and Janssen, 2015). There are two versions of the measures; an older version called the EQ-5D-3L and a newer version called the EQ-5D-5L. The difference between the two versions is the number of response options in each dimension; the former has three levels while the latter has five (Oppe and Hout, 2017). Experience accumulated during the time of EQ-5D-3L led to the realization that there was a need for a new and more standardized approach to valuation. Valuation protocols used to value EQ-5D-3L have provided useful information about successful practices in health state valuation, but they were not sensitive enough (Oppe *et al.*, 2014; van Reenen and Janssen, 2015). The introduction of the EQ-5D-5L was considered to be an opportunity to cash in on these experiences and introduce a standardized valuation protocol, supporting best practices and promoting comparability of subsequent 5L valuation studies (Devlin and Krabbe, 2013). This formed the environment for systematic experimentation with valuation methods in the years around the introduction of the EQ-5D-5L and

subsequent decisions about the protocol for EQ-5D-5L valuation (Herdman *et al.*, 2011). This protocol has as major advancements that it is embedded in software to manage data collection efficiently.

Numerous valuation studies of this new protocol were conducted internationally with the aim of developing country-specific value set for EQ-5D-5L (Devlin *et al.*, 2014; Augustovski *et al.*, 2016; Kim *et al.*, 2016; Shiroya *et al.*, 2016; Versteegh *et al.*, 2016; Xie *et al.*, 2016; Luo *et al.*, 2017; Purba *et al.*, 2017; Ludwig *et al.*, 2018; Pattanaphesaj *et al.*, 2018). Studies showed that there is rareness of general health state valuation studies for EQ-5D-5L. Moreover, only thirteen studies reported a general population value set for EQ-5D-5L (van Reenen and Janssen, 2015). Most of these countries are high-income countries. None of lower middle and low-income countries have developed their own EQ-5D-5L utility weights. But lower middle and low-income countries make up the larger proportion of the world's population and have the greatest disease burden (WHO, 2016). There are many techniques to measure health state valuation of population for EQ-5D-5L, but the most commonly used techniques in the EQ-5D-5L valuation protocol are composite Time Trade-Off (c-TTO) and discrete choice experiment (DCE) (Devlin and Krabbe, 2013; Oppe *et al.*, 2014).

2.3 EQ-5D-5L Valuation protocol

Oppe *et al.*, (Oppe *et al.*, 2014, 2016) provide a detailed description of EQ-5D-5L valuation protocol. EQ-PVT is a data collection software uses separate PowerPoint files and it needs to different files for each data to collect. The EQ-PVT software protocol includes c-TTO and a DCE. c-TTO is a modified version of the traditional TTO (t-TTO) variant that was employed in the inspiring health state valuation study and most EQ-5D-3L valuation studies (Herdman *et al.*, 2011).

For the evaluation of health states that are considered to be better than dead, *c*-TTO offers respondents the traditional task comprising of a series of adaptive choices between x years in full health and 10 years in the disease state. In an iterative procedure, x is varied to identify the respondents' point of indifference where the health state value is given by $x/10$. When a respondent considers a health state to be worse than death, lead/lag-time TTO is used. Respondents then are offered a series of choices between x years in full health and a fixed life of 10 years in full health followed by 10 years in the target state. Like before, x is varied until indifference is reached and the health state is given by $(x-10)/10$ (Devlin *et al.*, 2011). On the other hand, DCE approach is increasingly used to assess preferences for health states because of the relative simplicity of the tasks and it comprises of pair wise comparisons of two EQ-5D-5L health states (Ryan and Gerard, 2003).

EQ-VT and EQ-PVT have their main characteristics in common; EQ-VT and EQ-PVT store the same data; TTO values and meta data required to generate quality reports and when EQ-PVT is used properly (with QC) the data is as good as EQ-VT data. EQ-PVT uses separate PowerPoint files for TTO, DCE and for any background questions. When a new type of data is collected it needs to open another file and insert relevant IDs in the relevant fields. EQ-VT is more users friendly, as all data is collected in one survey. EQ-VT works under Chrome or Mozilla; initially the data is saved in the cache memory of the browser. The interviewer uploads encrypted data to a server. EQ-PVT is based on PowerPoint and it works on Windows computers. The data are stored locally, and need to be shared with Principal investigator (PI) or EQ-PVT support team via email. Since EQ-VT data are stored on a central server, the EQ-VT support team has the opportunity to access the data and generate QC reports following an agreed code of conduct. EQ-VT has a QC tool embedded. With EQ-PVT it needs to run a short script to generate a similar report (in stata for instance).

2.4 Composite Time Trade-Off data

Following the first channel of EQ-5D-5L valuation studies, conducted in England, Netherland, China, Canada, and Spain, concerns were raised over observations of high rates of inconsistent responses, clustering of values, low values for mild states, and few worse than dead responses (Devlin *et al.*, 2014; Versteegh *et al.*, 2016). The valuation data of these problems was analyzed in depth. This was because of the EQ-VT software captures the entire path that is followed to reach a value. Oppe *et al.*, 2016 found that some interviewers systematically omitted explanation of the lead-time part of the *c*-TTO task and elicited no worse than dead values (Oppe *et al.*, 2016). Furthermore, in some interviews, very short time spent on explaining the *c*-TTO task and to obtain a single *c*-TTO value, which could reflect that respondents minimized effort and accelerated the *c*-TTO tasks by reducing the number of iterations. Since the iterative procedure requires a different number of steps to reach specific values, lack of effort in the task may partially account for the relatively low values for mild state, occurrence of these issues was found to vary across interviewers, suggesting that interviewer behavior had an effect on the tendency for respondents to use such short-cuts (Ramos-goñi *et al.*, 2017).

2.5 Discrete choice experiments data

The *c*-TTO task has been accompanied with a DCE task to collect additional information about health state values. The DCE task includes pair wise comparisons of two EQ-5D-5L health states. This implies that DCE values are derived on a latent scale and not suited to replace the *c*-TTO task as basis for value set generation. However, assuming that an individual's *c*-TTO and DCE responses both reflect the same underlying preferences for health and that DCE and TTO based value functions are the same up to a linear transformation ($\text{Beta}_{\text{TTO}} = \text{Theta} * \text{Beta}_{\text{DCE}}$), it may be considered to complement *c*-TTO data with DCE data (Devlin and Krabbe, 2013; Oppe *et al.*, 2014). This enables

a search for a common set of parameter values with a hybrid model that maximizes the likelihood of all observations collected in the *c*-TTO and DCE tasks (Ramos-Gon *et al.*, 2017). The valuation protocol provides no guidance on the basis for value set construction and decisions deviated. In Netherlands, Canada, South Korea, Uruguay, and China value algorithms were developed based on *c*-TTO data only (Augustovski *et al.*, 2016; Kim *et al.*, 2016; Versteegh *et al.*, 2016; Xie *et al.*, 2016; Luo *et al.*, 2017), while the hybrid model was adopted in Spain, England, Indonesia, German, and Thailand (Devlin *et al.*, 2014; Purba *et al.*, 2017; Ramos-Gon *et al.*, 2017; Ludwig *et al.*, 2018; Pattanaphesaj *et al.*, 2018). The two methods tend to agree on which dimensions of health were considered most important, and on the utility loss associated with each severity levels (Versteegh *et al.*, 2016).

2.6 Whose values should be used?

There are different methods that can be used to collect preferences or values for different health states and different groups of people could be asked to provide these preferences. The choice of whose values to use is important as different groups will provide different values (Stamuli, 2011).

It is often argued that general population values should be used for most healthcare systems as they are the people who finance healthcare (e.g. as tax payers). The healthcare system is provided for the needs of the general population, and it can be argued that decisions about this system should be informed by what the general population want, particularly as they may become future patients. The general population, however, have not usually experienced the health states that they are asked to value, and their imagination of what it is like may not match the reality. In particular, they usually tend to focus on how bad the health state is initially, rather than thinking about what it is like to live in the health state in the longer term when they have adapted to the state and learnt to live with their

health problems. Also they rely on an accurate description of a health state as they are only valuing what is described (Stamuli, 2011; Oppe and Hout, 2017).

On the other hand, patients have a vested interest, as providing lower values to their own states mean a larger benefit can be gained from treatment. They may also have adapted to their current health state and may find it hard to imagine good health states or lowered their expectations about what good health states are like. Some methods used to collect values ask whether the patient would rather die than be in a certain health state and this may not be appropriate for patients valuing their own health (Stamuli, 2011).

The differences in values mean differences in the size of the benefit measured for economic evaluation, and therefore can impact on whether a new intervention is considered to be cost-effective. Usually, however, the general population of the country health state weights should be used to value health state (van Reenen and Janssen, 2015).

3 OBJECTIVE

3.1 General Objective

- To obtain social preference and establish an EQ-5D-5L value set from Ethiopian general population.

3.2 Specific Objectives

- To investigate feasibility of valuing the EQ-5D-5L using the EQ-PVT protocol in Ethiopia
- To establish the disutility value for each levels of the five health domains.
- To obtain social preference of Ethiopian general population based on both *c*-TTO and DCE data.
- To identify different important sorts of health problems of Ethiopian populations to the overall health related quality of life.

4 METHODS

4.1 Study area and period

This study was conducted in Addis Ababa City and nine rural kebeles of Butajira District, which is part of the Butajira Demographic Surveillance Site (DSS), located in Gurage Zone, in the Southern Nations, Nationalities and Peoples Regional State of Ethiopia. These study areas were selected because they reflect the urban and rural localities of the country. The populations of the areas covered are mixed in terms of ethnicity and culture. Data collection was carried out from March to May 2018.

Addis Ababa is the capital and biggest city of Ethiopia. It consists of a population of greater than 5 million. Because of its position as the capital of the nation all Ethiopian ethnic groups are represented in the city, the biggest groups incorporate the Amhara (55.08%), Gurage (19.00%), Oromo (17%), Tigray (6%), and Gamo (1.7%). In terms of religion most in the city are followers of Ethiopian Orthodox Christianity (75%), and Islam (18%) (Spaliviero , 2017).

Butajira district has an estimated area of 797 km², of which Butajira town covers approximately 9 km². The capital of the study District, Butajira Town is located 130 kms south of Addis Ababa. The Butajira Rural Health Project (BRHP) was initiated in 1986 with the intent of developing a continuous demographic surveillance system which would provide a baseline population and sampling frame for other health related activities that would be carried out in the area. The BRHP includes one urban and nine rural kebeles which were selected using probability proportionate to size from the 82 rural and four urban kebeles of Butajira Town, respectively. Amharic, the national language, is widely spoken in the area, and is also an important written language (Berhane and Byass, 2002).

4.2 Study design

Population-based, cross-sectional survey research design with assistance of EQ-PVT was employed.

4.3 Source and study population

The source population for this study was all Ethiopian adult general population greater than the age of 18. And the study population was the general adult population living in Addis Ababa and the selected rural kebeles of Butajira district

4.4 Sample size and sampling method

According to a multi-country pilot study, the recommended total sample size for using the EQ-PVT is 1,000 per country and the total number of health states included for c-TTO is 86 (based on monte Carlo simulation optimization algorithm) and 196 (based on Bayesian efficient design) pairs of health state valuation for DCE to represent the 3,125 health states derived from five dimension and five level of EQ-5D-5L) (Oppe *et al.*, 2016). The strategy of finding respondents during data collection was undertaken using personal networks of the supervisors' mediator between interviewers and the respondents, and only one person was interviewed from every household. A representative sample of 1,050 respondents was recruited based on multistage stratified quota sampling of geographic area/residence (urban/rural); gender (male/female); age group (18–24/24–54/55-64/>65 years); and religion (Christian/Islam/Others).

4.5 Eligibility Criteria

4.5.1 Inclusion criteria

Individuals: a) being 18+ years old; b) able to understand the task (judged by interviewer); and c) able to give informed consent.

4.5.2 Exclusion criteria

Individuals less than the age of 18 and presence of any illness or cognitive impairment that would interfere with the study task were excluded from the study.

4.6 Data collection and eliciting preferences methods

EQ-PVT was used to support computer aided data collection. EQ-PVT is a portable version of EQ-VT which allows preference data to be collected without requiring direct links to the EuroQol group software which is necessary for EQ-VT. It runs using similar algorithms to EQ-VT but these are executed via a program in PowerPoint. Data is stored on the computer and can then be uploaded to secure sites when internet links are available. EQ-PVT is therefore more practical in the context of developing countries where internet connections are not guaranteed.

The interviews were undertaken by 10 trained pharmacy post-graduate students who were given a three-day training course on the methodology and study procedures. The training material from the EuroQol group was translated into Amharic (annex-I) and it consisted of: (1) introduction of related concepts such as health-related quality of life and EQ-5D-5L as a generic questionnaire used to value health states, (2) explanation of the EQ-PVT protocol and interviewer instructions, (3) practice in groups and (4) pre-testing of the tools in selected population to ensure their understanding. During

the data collection, all data collectors travelled in one group to the study sites. Regular supervision was done on each data collection day by the trained principal investigators.

Interview consisted of a paper based and a computer assisted task. The paper-based task (annex-II) includes basic background questions, self-reported health measurement using the 5 item EQ-5D-5L instrument, and the companion visual analogue scale (VAS) of 0 (worst health) to 100 (best health). The computer assisted interview task includes a practice TTO task (involving the valuation of a mild, moderate, and severe health state; and other practices on better and worse health state than wheelchair which is tailored to the Ethiopian context); ten TTO tasks(annex-VII) and seven DCE tasks(annex-VI). There were 86 TTO health states in ten blocks with each block containing a range of health states across the range of severity from mild to severe as well as the worst health state (unable) in all dimensions (55555). There were seven DCE pairs in twenty-eight blocks; one block from TTO and DCE was assigned to each participants.

4.7 Pilot study

Feasibility of the valuation protocol for EQ-5D-5L valuation studies using the EQ-PVT was pilot tested in a sample of the population recruited from Addis Ababa. The pilot sample was recruited using national strata on age, gender and religion. The aim of the pilot was to investigate the feasibility of valuing the EQ-5D-5L using the EQ-PVT protocol in Ethiopia. Interviewers were instructed to assess feasibility in a broad sense, encompassing any consideration that could help the investigators to prepare for a full-scale 5L valuation study. In particular, they paid attention to the understanding of the tasks, level of engagement, acceptability of thinking/talking about death, and acceptability of EQ-5D-5L health states. Also, the concordance between *c*-TTO and DCE values was investigated.

Two interviewers who were trained in Rotterdam, the Netherlands completed 110 interviews in the pilot study. The quality control (QC) process was implemented to monitor their performance. One interviewer failed QC initially but the interviewer met the QC requirement after retraining. While strong interviewer effects were found in early rounds of data collection, interviewer performance was harmonized in later rounds. Based on this experience, training was provided to the full set of interviewers for the main study. The observed values were comparable to those obtained in other countries (Purba *et al.*, 2017; Ramos-goñi *et al.*, 2018). Acceptability of the tasks was good and there were no special concerns with thinking and talking about death. However, a frequently reported problem was that respondents found health states difficult to imagine. To resolve this issue, practice tasks were tailored to the local context. In a preliminary analysis of the data, a full consistent DCE model was obtained, but several inconsistencies were found in the TTO model involving level 2 and 3 in several dimensions. No major methodologic issues were identified for undertaking a valuation study using the EQ-PVT protocol in Ethiopia.

4.8 Quality Control

To ensure data quality, the quality control (QC) process employed using the EQ-PVT QC tool and syntax (annex- III, and IV) developed by the EuroQol group (Ramos-goñi *et al.*, 2018). The EuroQol group's expert and Ethiopia team organized Skype-based meetings every twenty interviews for the pilot study and every hundredth interview for the main study in order to discuss the QC reports with the EQ-PVT support team. The QC reports provided a number of statistics related to the quality of the data collected, differentiated by interviewer.

Criteria used to evaluate the quality of the interviews included the following:

- 1) Wheelchair time: when the duration of time an interviewer used to explain the 'wheelchair example' preceding the actual *c*-TTO tasks was less than 3 min.
- 2) Wheelchair lead-time: when the interviewer did not explain the worse than death element of the wheelchair example.
- 3) *c*-TTO duration: if completing the ten *c*-TTO tasks took less than 5 min.
- 4) Inconsistency: the value for state '55555' was not the lowest and it was at least 0.5 higher than that of the state with the lowest value.

If any of the four above-mentioned criteria were met/observed, the interview was 'flagged' as being of suspicious quality.

4.9 Data analysis and modeling

Statistical analysis was undertaken using the STATA 14.2 statistical package and specific syntax code(Annex-V) developed for this study. Descriptive statistics were used to summarize respondents' characteristics and responses to the *c*-TTO and DCE. For *c*-TTO, linear regression models (i.e. ordinary least square) were undertaken to estimate coefficients. The dependent variable in the *c*-TTO part of the model was defined as 1 minus the *c*-TTO observed values for a given health state to indicate disutility and therefore coefficients expressed the amount of utility decrements. DCE data were analyzed using likelihood function of a conditional logit distribution. In the DCE model, the dependent variable was a binary outcome 0/1 indicating the respondent's choice for each pair of EQ-5D-5L states. As the coefficients estimated from a conditional logit are expressed on a latent arbitrary utility scale, a rescaled parameter was used, which assumes that the *c*-TTO model coefficients are proportional to DCE model coefficients. The coefficients represented the utility decrements for the DCE rescaled model(Oppe and Hout, 2017). Modeling value sets, an innovative method developed by Ramos-Goñi *et al.*,(Ramos-goñi *et al.*, 2016), and a specific syntax code prepared for this study were used. Different types of models were produced using both types of data (*c*-TTO and DCE) and together to provide complementary evidence on preferences by taking into account the nature of preference data that are 'bounded' (censored); heterogeneity of respondents' views in health utilities; and heteroskedasticity of the error terms.

Continuous responses from *c*-TTO and dichotomous responses from DCE were combined in a single model using 'hyreg' command developed by Ramos Goñi *et al* (Ramos-goñi *et al.*, 2016) to undertake hybrid models. This command allows the continuous and dichotomous responses to have different distributions (logistic and normal), and have different independent variables to model

scaling terms. Since the variance of *c*-TTO data is not homogenous, a heteroskedasticity model was estimated in which *c*-TTO responses were censored at -1 .

The hybrid main effects with the 20 parameter model consisting of 4 dummies for each EQ-5D-5L dimensions was exploring using level 1 as the reference. Dummies were constructed to represent additional utility decrement of moving from one level to another. For instance, the mobility dimension was created 4 dummies slight problem in mobility (MO2) to unable (MO5) and the coefficient associated to MO2 indicated the utility decrement of moving from no problems (level 1) to slight problems (level 2), MO3 the additional utility decrement of moving from slight (level 2) to moderate (level 3) problems, and so on. Therefore, the overall decrement of moving from no to severe problems could be calculated as the sum of the coefficients of MO2 to MO5. The same set of dummy variables was defined for each of the remaining dimensions: self-care (SC), usual activities (UA), pain/discomfort (PD), and anxiety/depression (AD).

Some TTO data were excluded including data from: a) participants who gave all 10 health states the same value; and (b) participants who gave the worst state, 55555, a value that was no lower than the value they gave to the mildest health state in their block. Accordingly, nine participants were excluded. Two DCE data were excluded because of participants' ID overlap during data collection.

4.10 Evaluation of model performance

Model performance was evaluated using logical consistency of parameters, goodness of fit and significance level. Estimated coefficients are said to be logically consistent if estimated coefficients of the parameters were positive. Goodness of fit was assessed using the Akaike (AIC) and the

Bayesian information criteria (BIC). Finally, the level of significance was assessed based on p -value of the models. p – value less than 0.05 was considered as statistically significant.

4.11 Ethical considerations

Ethical approval was secured from Ethics Review (annex-IX) Committee of School of Pharmacy, Addis Ababa University and prior permission was sought from Demographic Health Surveillance site of BRHP office, Ethiopia. Written Informed consent was obtained from all study participants to confirm their willingness for participation after explaining the purpose of study.

4.12 Data security

The participants were assured about the confidentiality of their information obtained in the study by excluding any personal identifier in the data collection form

5 Results

5.1 Respondent characteristics

Ten interviewers completed 1050 interviews between March and May 2018. From participants who completed the interview, a total of 1041 response for TTO and 1048 for DCE task formed the sample for analysis. The characteristics of sample respondents were similar to the Ethiopian general population in terms of residence, age, gender, and religion (Table 5.1).

Table 5. 1. Background characteristics of the sample and general population

Characteristics	Study sample (N = 1050), n (%)	Ethiopian general population (%)*
Residence		
Urban	300 (28.57)	19.92
Rural	750(71.43)	80.08
Gender		
Female	503(47.90)	50.15
Male	547(52.10)	49.85
Age (in years)		
18-24	391(37.24)	36.00
25-54	575(54.76)	52.32
55-64	49(4.67)	6.91
65+	35(3.33)	5.20
Marital status		
Married	559(53.24)	NA
Unmarried	444(42.23)	NA
Divorced	22(2.10)	NA
Widowed	25(2.40)	NA
Education		
Can read and write(informal)	440(41.90)	NA
Primary school	173(16.48)	NA
Secondary school	265(25.33)	NA
Higher school	171(16.29)	NA
Employment status		
Employed or self-employed	693(66.0)	NA
Retired	30(2.86)	NA
Student	214(20.40)	NA
Looking after home or family	111(10.60)	NA
Other / none of the above	2(0.19)	NA
Experience of serious illness		
In self	142(13.52)	NA
In family	329(31.33)	NA
In self and in family	172(16.36)	NA
In caring for others	152(14.48)	NA
No	255(24.28)	NA
Religion		
Christian	679(64.67)	63.0
Muslim	368(35.05)	34.0
Others	3(0.29)	3.0

*Data obtained from the 2016 Ethiopian health survey(EDHSCSA, 2016); NA indicates not available

5.2 Self-Reported health problems

As depicted in Table 5.2, the highest proportion of health problems were reported mostly in the anxiety/depression dimension (43.6%) and least in the self-care dimension (6.7%). The mean self-reported EQ-5D-5L VAS score was 87.27 (SD=13.63).

Table 5.2: Self-reported health using the EQ-5D-5L descriptive system and the EQ-VAS

Parameters	EQ-5D-5L descriptive system with scores in %				
	Mobility	Self-care	Usual activities	Pain/discomfort	Anxiety/depression
No problems	88.19	93.43	83.33	58.09	56.38
Slight problems	7.61	4.70	11.43	27.43	33.71
Moderate problems	4	1.61	4.66	12	8.28
Severe problems	0.09	0.19	0.57	2.28	1.33
Unable/extreme problems	0.09	0.00	0.00	0.19	0.28
	Mean	SD	25th percentile	Median	75th percentile
VAS score	87.26	13.64	75.0	90.0	95.0

The overall distribution of observed TTO values of each interviewer and in total is shown in Figure 5.1. There is some evidence of clustering at key values on the graph (1 and -1). Health states were given a value of -1 (indicating that the respondents exhausted all of the lead time available to them) on 837 occasions (8.04% of all TTO observations). There are few observations between 0 and -0.5. Evidence of interviewer effects was observed, with different proportions of worse than dead values depending on which interviewer participants were interviewed by (Figure 5.1).



Figure 5. 1 Distribution of observed TTO values of every interviewer and in total

5.3 Modeling results

There were 837 (8.04%) left-censored *c*-TTO observations: when a respondent gave the lowest possible value (-1) for a health state in the *c*-TTO task. An ordinary least square (OLS) model was used for *c*-TTO observation data and most of the responses were logically consistent. The conditional logistic regression was used to model the DCE responses and since the responses of DCE data were on latent scale, the rescaled coefficients were used.

Table 5.3 shows that both sets of coefficients were in relative agreement; that is, in the disutility amount the most important dimensions were anxiety/depression and pain/discomfort; and the least important was self-care. The hybrid model parameters were logically consistent and all parameters except one parameter pain/discomfort level 3 (pd3) are statistically significant. It was in relative agreement with both *c*-TTO and DCE models. Anxiety/depression dimension influenced utility estimates the most, shown by disutility level five of 0.4578, and self-care influenced the least with disutility of level five 0.2224.

Table 5. 3 Estimation results for c-TTO model, DCE rescaled model, and hybrid model

Independent variables of the model	c-TTO OLS model			DCE conditional logistic model rescaled			Hybrid model censored c-TTO values at -1 (final value set)		
	Coeff.	(SE)	p value	Coeff.	(SE)	p value	Coeff.	(SE)	p value
Mobility (MO)									
MO2	.0047	.0135	0.729	.4780	.0607	0.000	.0337	.0049	0.000
MO3	.0166	.0148	0.262	.1138	.0712	0.110	.0307	.0087	0.000
MO4	.1748	.0161	0.000	.9810	.0704	0.000	.1632	.0100	0.000
MO5	.1038	.0155	0.000	.7434	.0738	0.000	.1322	.0098	0.000
Self-care (SC)									
SC2	.0036	.0131	0.785	.2044	.0667	0.002	.0235	.0046	0.000
SC3	.0494	.0162	0.002	-.0024	.0738	0.974	.0160	.0078	0.042
SC4	.1189	.0154	0.000	.6849	.0775	0.000	.1024	.0093	0.000
SC5	.0826	.0133	0.000	.4234	.0732	0.000	.0804	.0091	0.000
Usual-activities (UA)									
UA2	.0188	.0139	0.176	.3470	.0629	0.000	.0323	.0049	0.000
UA3	.0441	.0142	0.002	-.0391	.0705	0.579	.0160	.0079	0.042
UA4	.1299	.0155	0.000	.5818	.0712	0.000	.1091	.0092	0.000
UA5	.0936	.0153	0.000	.6079	.0758	0.000	.1147	.0098	0.000
Pain/discomfort (PD)									
PD2	.0140	.0125	0.266	.4499	.0671	0.000	.0361	.0041	0.000
PD3	.0161	.0166	0.331	.1090	.0730	0.136	.0155	.0083	0.061
PD4	.2452	.0150	0.000	1.1358	.0765	0.000	.2187	.0099	0.000
PD5	.1421	.0163	0.000	.5689	.0760	0.000	.1361	.0107	0.000
Anxiety/depression(AD)									
AD2	.0111	.0139	0.428	.2718	.0701	0.000	.0259	.0041	0.000
AD3	.0381	.0151	0.012	.3516	.0715	0.000	.0589	.0077	0.000
AD4	.2322	.0145	0.000	1.1803	.0794	0.000	.2139	.0094	0.000
AD5	.1414	.0134	0.000	.8320	.0778	0.000	.1591	.0101	0.000
AIC	10587.058			6498.2987			14002.087		
BIC	10739.329			6650.1726			14336.808		

9578 continuous uncensored observations

837 continuous left-censored observations

0 continuous right-censored observations

0 continuous interval observations

7336 dichotomous observations

AIC Akaike information criteria, **BIC** Bayesian information criteria, **c-TTO** composite time trade-off, **DCE** discrete choice experiments, **SE** standard error.

The observed value of disutility ranged from -0.7186 for state 55555 to 0.974 for states 11112. Values for 11121 and 11122 were found to be 0.964 and 0.938, respectively. The mean observed value was negative for 10 out of 86 states that were included in the design. As shown in Table 5.2 and 5.3, the utility weight for each health state can be estimated as 1- the relevant decrement for each level of problem on each dimension.

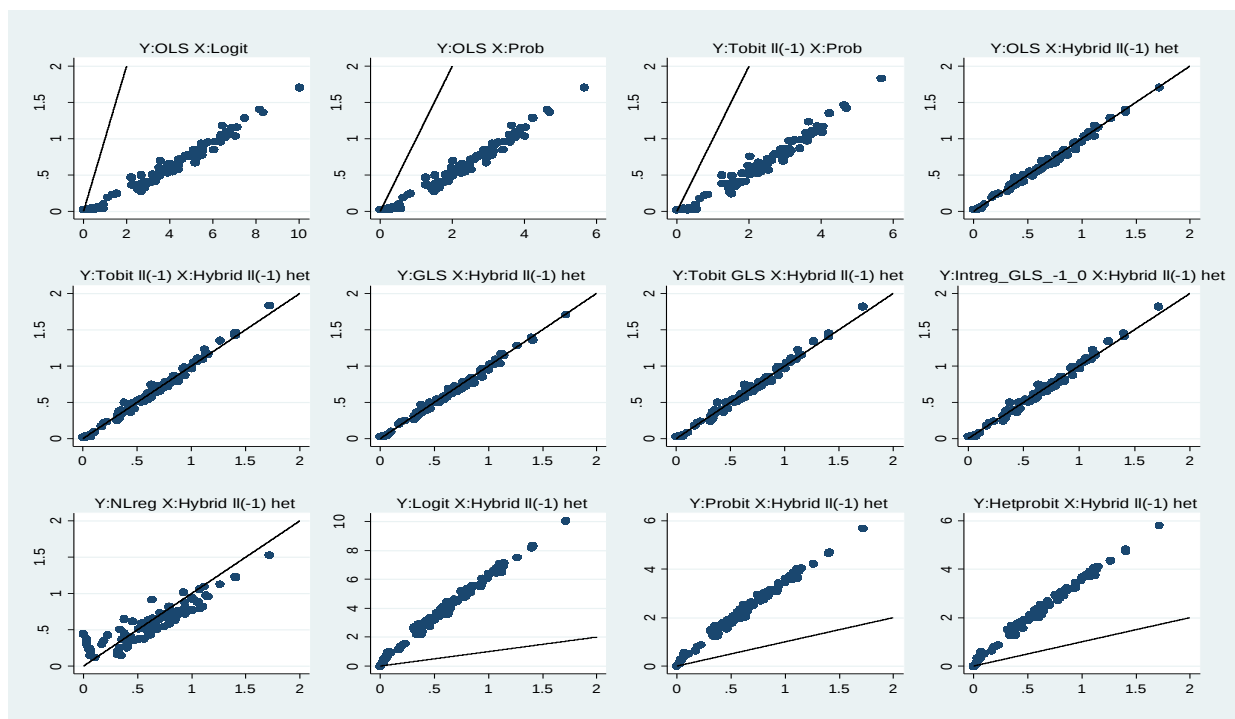


Figure 5. 2 A difference plots of Comparison of different models of *c*-TTO and DCE rescaled predicted utilities, of *c*-TTO and hybrid predicted utilities, DCE rescaled and hybrid predicted utilities respectively

***c*-TTO**, composite time trade-off, **DCE**, discrete choice experiment

The observed value shows in Table 5.4. Ranged from -0.7186 for state 55555 to 0.974 for states 11112, 11121 and 11122 were valued at 0.964 and 0.938 respectively. The mean observed value was negative for 10 out of 86 states that were included in the design.

Table 5. 4 Disutility values for selected 86 health states for estimated models of OLS, Tobit, and Hybrid-t

<i>Profile</i>	mean(OLS)	mean(Tobit)	mean(hybr~t)
11111	.0216731	.0180055	0
11112	.0327269	.0286182	.0258862
11121	.0356266	.0267339	.0360808
11122	.0466803	.0373466	.061967
11211	.040514	.0351763	.0323013
11212	.0515677	.045789	.0581875
11221	.0544675	.0439048	.0683821
11235	.4933803	.5067385	.5417304
11414	.4958518	.4931568	.4561322
11421	.2284441	.2206749	.1934742
11425	.6512174	.6660739	.6513085
12111	.0252472	.0204201	.0235125
12112	.0363009	.0310328	.0493987
12121	.0392007	.0291486	.0595932
12244	.6007571	.6021982	.6248715
12334	.3995998	.3931639	.4221454
12344	.6448146	.6503975	.6408695
12513	.3607886	.3760587	.3804511
12514	.5930318	.6192393	.5943766
12543	.6360964	.6594555	.6507699
13122	.099697	.0878979	.1014485
13224	.3888453	.3756664	.4066024
13313	.1867061	.1719567	.1725941
14113	.2427195	.2251285	.2267371
14554	1.178823	1.230344	1.119186
15151	.6936066	.7480208	.6287537
15411	.4689872	.4975358	.3797487
21111	.0263596	.0149771	.0337341
21112	.0374133	.0255898	.0596203
21121	.0403131	.0237056	.0698148
21315	.5120312	.5257463	.5398676
21334	.4007122	.3877209	.432367
21345	.787339	.8091431	.8101865
21444	.7758461	.7735252	.7601852
22434	.5342054	.5187063	.5649737
23152	.5078669	.520567	.5055001
23242	.3845787	.3767087	.4017219
23514	.6471608	.6643476	.6440797
24342	.5475479	.5434501	.5201623
24443	.7155313	.6994379	.6881835
24445	1.089187	1.106807	1.061204
24553	.9512662	.9841349	.9389949
25122	.3058633	.3199077	.3180563
25222	.3247042	.3370785	.3503577

<i>Profile</i>	mean(OLS)	mean(Tobit)	mean(hybr~t)
25331	.3738475	.3920999	.3559835
31514	.6107444	.6209894	.6353356
31524	.6246979	.6297178	.6714163
31525	.7661099	.7939065	.8305118
32314	.3907934	.3711655	.435022
32443	.5637773	.5399523	.6005095
33253	.5813723	.572348	.6274658
34155	1.055098	1.081088	1.070628
34232	.2748759	.2452101	.3161776
34244	.7903981	.7730415	.8077543
34515	.9240848	.9542713	.9363549
35143	.6218823	.6291862	.6419589
35245	1.014378	1.053726	1.047281
35311	.3603547	.3731298	.335126
35332	.4015015	.4099056	.4126071
35554	1.282678	1.351005	1.264089
42115	.6440573	.6472819	.708996
42321	.2981358	.2759815	.3355417
43315	.7563982	.7607887	.7732643
43514	.8385112	.8488387	.8379948
43542	.8435116	.8616378	.8354611
43555	1.39736	1.457453	1.403489
44125	.8263651	.8226889	.8634881
44345	1.150618	1.162727	1.146025
44553	1.142617	1.168626	1.13291
45133	.5514175	.5492505	.5864127
45144	1.028876	1.049665	1.019062
45233	.5702584	.5664214	.618714
45413	.714142	.7170283	.6922112
51152	.7499996	.7849331	.7921807
51451	.9317634	.9682613	.9236879
52215	.7666972	.794879	.8735442
52335	.8408477	.8692415	.9411371
52431	.5479937	.5524132	.5923969
52455	1.358111	1.416075	1.405035
53221	.40732	.406345	.4677597
53243	.7177923	.7190431	.7868111
53244	.9500356	.9622238	1.000737
53412	.5783969	.5849994	.5826573
54153	.9599923	.9814435	.9930317
54231	.5423713	.5423217	.5857161
54342	.8426973	.8583674	.8463244
55225	1.031573	1.086782	1.108468
55233	.6740575	.6968476	.7509609
55424	1.064138	1.099364	1.074464
55555	1.702639	1.822918	1.718609

6 Discussion

The study was conducted to obtain social preferences and to establish an EQ-5D-5L value set from the Ethiopian general population. To obtain values attached to 3125 EQ-5D-5L health states, 1,050 respondents were interviewed using the computer-assisted EQ-PVT protocol where both *c*-TTO and DCE were employed. A value set for the EQ-5D-5L has been reported based on the preferences of the Ethiopian general population. The socio-demographic characteristics of the respondents were similar to the general population with respect to geographic area/residence, gender, age group, and religion. This makes EQ-5D-5L suitable for health economic evaluations that will benefit the national health insurance system and HTA agencies. Such value sets would support uniformity and comparability in assessments of (PROMs), and to measure HRQOL across different patient groups.

A value set model has been generated based on *c*-TTO data and DCE data alone. Nonetheless, the final value set reported here is derived from a hybrid of both *c*-TTO and DCE data, because the two data provide different but complementary information about the views of the respondents. A hybrid model was also used by different studies (Devlin *et al.*, 2014; Shiroyiwa *et al.*, 2016; Purba *et al.*, 2017; Ramos-Gon *et al.*, 2017; Ludwig *et al.*, 2018;) to estimate the value set of EQ-5D-5L. The choice of the model reported in this paper reflects a number of researcher decrees about which model is best. The choice of a heteroskedasticity hybrid model as a final value set model for this research was based on three considerations. First, logical consistency of parameter; when the estimated coefficients magnitude values of logically worse health states are lower than those from logically better health states. Second, Goodness of fit: it was assessed using the AIC and BIC. Finally, the level of significance was assessed based on *p*-value (probability value) of the models; all dimensions are statistically significant except one parameter (pd3).

Similar to other countries such as the Netherlands (Versteegh *et al.*, 2016) and England (Devlin *et al.*, 2014), the preferences of the Ethiopian population suggest that anxiety/depression and pain/discomfort are the health problems that are most important. On the other hand, mobility is the most important dimensions in Indonesia (Purba *et al.*, 2017), Korea (Kim *et al.*, 2016) Japan (Shiroiwa *et al.*, 2016), Canada (Xie *et al.*, 2016), and Uruguay (Augustovski *et al.*, 2016). While problems with self-care and usual activity dimensions are less important, dimensions which has the smallest impact to the utility decrement varied by countries. In Ethiopia, the maximum predicted value beyond full health was 0.9741 for the '11112' state, while it was 11112 for Indonesia (utility = 0.921), 11211 (Purba *et al.*, 2017) and 12111 for England (utility = 0.950) (Devlin *et al.*, 2014), 11211 for China (utility = 0.955) (Luo *et al.*, 2017).

There were 837 (8.04%) left-censored *c*-TTO observations: when respondents gave the lowest possible value (-1) for a health state in the *c*-TTO task which is the highest as compared to other studies (Devlin *et al.*, 2014; Versteegh *et al.*, 2016; Luo *et al.*, 2017; Purba *et al.*, 2017; Ramos-goñi *et al.*, 2018) This study yields a utility value in the ranged of -0.7186 for state 55555 to 0.9741 for states 11112. Compared to other study used hybrid model, the worst health state had higher value than Indonesia (-0.865) (Purba *et al.*, 2017) but lower than English population (-0.285) (Devlin *et al.*, 2014).

This is the first study in Ethiopia as well as in East Africa to report a value set for the EQ-5D-5L. The strength of the study is that the data have been generated using a computer assisted EQ-PVT software; an international standardized protocol developed by EuroQol group. Furthermore, feasibility of valuing the EQ-5D-5L using the EQ-PVT protocol was investigated prior to the main study. The frequent QC meetings through Skype with EuroQol group team during the course of the study have strengthened the approach to high quality data. The data generated using this approach has resulted in a value set that can be used in Ethiopia.

Although the TTO data have good face validity, a potential limitation of the study is that there is evidence of largest cluster of values at 1(non-trading for mild health states). This was despite assessment of performance of interviewers and may suggest that in this context, participants are unwilling to trade-off time for what they consider to be mild states. There are also limitations in terms of differences in the distribution of background variables in the sample compared with the data provided by the Ethiopia National Bureau of Statistics. But these differences are small, and limited to some age groups and residence. The strategy of finding respondents during data collection in the rural area was undertaken using personal networks of the supervisor's mediator between interviewers and the respondents. In order to find respondents who fit into the pre-determined quota groups this recruitment way was preferred because these supervisors work for many years as supervisor and they are familiar with every respondent. A further investigation could be conducted to find out whether recruiting respondents via personal networks of supervisor's mediator between interviewers and/or respondents are not preferable or acceptable.

Ethiopia has nine major regions and two city administrations; however, respondents interviewed in this study were living in Addis Ababa city and Butajira rural area, Central Ethiopia. This might raise questions about the representativeness of the study sample. However, the data collection was focused in Addis Ababa city and Butajira rural areas of Gurage zone because these areas are the most mixed populous in terms of ethnicity and culture; and is main target of migration from all over Ethiopia (Berhane and Byass, 2002; Spaliviero M, 2017). The diversity of its residents in terms of culture helps to fulfil all the categories in our quota sampling in a feasible way.

7 Conclusions

Anxiety/Depression and Pain/Discomfort dimensions shows the highest disutility amount and they are the most important sorts of health problems of Ethiopian general population to the overall health related quality of life. This study established an Ethiopian value set for EQ-5D-5L on the basis of *c*-TTO and DCE from Ethiopian general population. It is expected to facilitate health economic evaluations, health-related quality of life researches and to inform health related decision making in Ethiopia.

8 Recommendations

- This study established an Ethiopian value set for EQ-5D-5L on the basis of *c*-TTO and DCE from Ethiopian general population, so researchers, policy makers in the FMOH and academics should use it for health economic evaluations, health-related quality of life researches and to inform decision making in Ethiopia.
- Amharic version of the instrument can be used to measure condition specific health status studies, clinical research, health-related quality of life researches and population surveys in Ethiopia.
- Health state valuation study should undertake using generic measurements in children and adolescents to inform health related decisions in children and adolescents.

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Annex- I: Interviewer protocol Amharic version

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የጥናቱ ተሳታፊዎች ምላሽ የተለያየ ሊሆን ይችላል። አንድንድ ተሳታፊዎች ከሌሎች በተሻለ የጥናቱን ይዘትና ክንውኖች ቶሎ የመረዳት ችሎታ ይኖራቸዋል።

የጥናቱ ጠያቂ ሊያደርጋቸው የሚገቡ አራት አንኳር ክንውኖች አሉ

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 - ከሞት የተሻለ ሁኔታ ተብሎ የተቀመጡ ክንውኖችን ማስረዳት
 - ከሞት የባሰ ሁኔታ ተብሎ የተቀመጡ ክንውኖችን ማስረዳት
 - የቁልፍ ሀ እና ለ ጥቅምን ማብራራት
 - የቁልፍ ሀ እና ለ ጥቅም ተመሳሳይ መሆኑን ማብራራት
 - ከጥያቄው ባሻገር ያለውን ሙሉ ሃሳብ ማስረዳት። የቱኛው ይሻላል? ህይወት ሀ ወይም ህይወት ለ
 - የጥያቄው ተሳታፊ ሊያስታውሳቸው የሚገባው በክንውኑ ስር የሚጠቃለሉ እሳቤዎችን ማብራራት
 - ተሳታፊው ሞትን ላይመርጥ ይችላል
 - ስለ አንድ የሆነ የጤና ሁኔታ ሲታሰብ ያን የጤና ሁኔታ የተሻለ ሊያደርግ የሚችል ሕክምና እንደሌለ ማወቅ ይገባል (ለምሳሌ፡ የሕመም ማስታገሻ) የጤና ሁኔታው የሚኖረው ልክ በሰማያዊው ሳጥን ውስጥ ተገልጾ እንደተቀመጠው ይሆናል።
 - በመላሹ የእድሜ ዘመን ሕመሙ ምንም ዓይነት ሕክምና እና መድሃኒት አይገኝለትም።

2. ለእያንዳንዱ ጥያቄ የጥናቱ ተሳታፊ የ ኢ.ኪው-5ዲ-5ኤል የጤና ሁኔታውን ድምፁን ከፍ አድርጎ እንዲያነብ ማድረግ። ተጠያቂው ሰው ከአንዱ ወደ ሌላው ጥያቄ ሲሸጋገር ከቀድሞው የተለየ የጤና ሁኔታ እንደቀረበ መረዳቱን ማረጋገጥ ያስፈልጋል።

3. መላሹ በትክክል ክንውኑን መረዳቱን እርግጠኛ መሆን ያስፈልጋል

4. ይህ ጥናት አስቸጋሪ እንደመሆኑ መላሹ ተስማምቶት ጥናቱን እየመለሰ መሆኑን እርግጠኛ መሆን ያስፈልጋል። ትዕግስት በእጅጉ አስፈላጊ ነው።

በመቀጠል ለጠያቂዎች የቀረበው መመሪያ የሚያተኩረው በጥናቱ ወቅት ጠያቂዎች ለጥናቱ ተሳታፊዎች (መላሾች) መስጠት ስላለባቸው የቃል መመሪያዎች ነው። ይህ ሰነድ በሌሎች የጥናቱ ክፍሎች ላይ መረጃ አይሰጥም። ለምሳሌ፡- የጥናቱን ገለፃ ስለማቅረብ፣ ለጥናቱ የሚደረግ ስምምነትን ስለመፈረምና ሌሎች - እነዚህ በስነ-ምግባር መመዘኛዎች ላይ በመመርኮዝ ከአንድ ሃገር ወደ ሌላ ሃገር ልዩነት ይኖራቸዋል። በእያንዳንዱ ሁኔታ እነዚህ ሁኔታዎች በአግባቡ እየተከናወኑ መሆናቸውን ማረጋገጥ የጥናቱ ባለቤት ኃላፊነት ይሆናል።

በቀጣዮቹ ገጾች ላይ ጠያቂው ሊያከናውናቸው የሚገቡ መመሪያዎች በስተግራ በኩል ተዘርዝረው ይገኛሉ። እነዚህ ለመላሾች መነበብ የለባቸውም።

ለመላሾች የተሰጡ መመሪያዎች በገጾቹ በስተቀኝ በኩል የተቀመጡ ሲሆን በደማቅና ስላሽ ፅሁፍ ሆነው በድርብ ጥቅስ ምልክት ውስጥ ተካተዋል። እነዚህን ለመላሾች ድምፅን ከፍ አድርጎ መነበብ አለባቸው።

ማስታወሻ: መላሹ በማንኛውም ጊዜ ጥናቱን ለማቋረጥ ቢፈልግ (በማንኛውም ምክኒያት) ፣ በኢ.ኪ.ወ.ፒ.ቪ.ቲ መተግበሪያ ላይ የምትገኘውን የ 'Log out' (ውጣ) ምልክት በመጫን መውጣት ያስፈልጋል። መተግበሪያውን ሙሉ በሙሉ አይዝጉት። ከአንድ መጠይቅ 'Log out' (ውጣ) የሚለውን መጫን ከጥናቱ የተሰበሰቡ ማንኛቸውንም የ ቲ.ቲ.አ. እና ዲ.ሲ.ኢ. መረጃዎችን እንደሚያጠፋ ይገንዘቡ።

1. ትውውቅ

1.1 እንኳን ደህና መጡ እና ትውውቅ

ከክፍል 1 — 4 ላሉት ላፕቶፑ በእርስዎ እጅ መሆን አለበት። ይህም ማለት ለመላሹ የሚያስፈልገውን መረጃ እርሶ ይሰጣሉ ማለት ነው። መላሹ መቀመጡንና ሁለታችሁም የላፕቶፑን ስክሪን በትክክል ማየት መቻላችሁን ማረጋገጥ ያስፈልጋል።

ለመላሹ በስክሪን ላይ የቀረበውን ትውውቅ ያንብቡ (በምስል 1 ላይ ተመልክቷል)

ምስል 1: ትውውቅ

በጤና ላይ ያሉ አመለካከቶች

በዚህ ጥናት ላይ ለመሳተፍ ስለተስማሙ እናመሰግናለን

ይህ ጥናት በጤና ዘርፉ ላይ መሻሻሎችን ለማምጣት እየተካሄደ ያለ ጥናት ነው። እንደ እርስዎ ያሉ የሰፊው ማህበረሰብ አባላት በዚህ ጥናት ላይ ድጋፋቸውን እንዲያሳዩ ያስፈልጋል። እነኚህ ጥያቄዎች ስለ ሕመምና ጤንነት ያልዎትን የተለያዩ አመለካከቶች የሚዳስሱ ናቸው።

በሕይወትዎ አጋጥመዎት ስላሉ አሊያም ስላላጋጠመዎት የጤና ሁኔታዎች እንዲያስቡ ይደረጋሉ። ትክክል ወይም ስህተት የሆነ (የሚባል) መልስ የለም። እርስዎ የሚያስቡትን ብቻ ያመለክቱ።

ከቀድሞ ልምድ በመነሳት ይህ ጥናት ከ ሰላሳ (30) እስከ አርባ አምስት (45) ደቂቃ ሊፈጅ ይችላል። የጥያቄዎቹ ይዘት ካልተስማማዎት በማንኛውም ሰዓት ጥናቱን ማቆም ይችላሉ። በጥናቱ ላይ የሚሰጥዎቸው መልሶች በፍፁም ምስጢራዊነት የሚጠበቁ ይሆናሉ።

ለመጀመር ዝግጁ ነዎት?

 ቀዳሚ

ቀጣይ 

መላሹን ለማሟላቱ ጥያቄዎች ያሰናዱት። የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ እና የልምምድ የጤና ሁኔታዎችን ይጠቀሙ።

መላሹ ጥያቄዎች ካሉት እንዲጠይቅ እድሉን ይስጡት። መላሹ ዝግጁ እስከሚሆን ድረስ ጥያቄዎትን አይጀምሩ።

“በቅድሚያ ስለ ግል ጤንነትዎ እና ስለ እርስዎ ሌሎች ቀላል ጥያቄዎች፤ እንደ እድሜ እና የቀድሞ የህመም ሁኔታ ያሉ” ጥያቄዎች ይጠየቃሉ። በመቀጠል የተለያዩ የጤና ሁኔታዎችን መረዳት እንዲችሉ የሚረዳ ዓይነት ምሳሌ ይመለከታሉ። ይህን ምሳሌ በጋራ የምንመለከተው ሲሆን ቀጥለው እንዲያደርጉ ስለሚጠበቅብዎት ክንውን በቂ የሆነ

መረዳት እንዲኖርዎ ያግዛል። ከዚህ በኋላም ሶስት ተከታታይ የልምምድ ጥያቄዎች እንመለከታለን። እነኚህም ያልዎትን መረዳት ይበልጥ ለማጠናከርና በጥናቱ ላይ የተካተቱ የጤና ሁኔታዎች ክብደት እንዲያውቁ ይረዳዎታል።”

“ጥያቄ አለዎት ወይንስ እንጀምር?”

1.2 የማሟሟቂያ ጥያቄዎች

ለመላሹ ስለ ማማሟሟቂያ ጥያቄዎቹ መመሪያ ይስጡ

- አምስት በግል የሚገለፁ የጤና ጥያቄዎች
- በግል የሚገለፅ የጤና ደረጃ
- የመላሹ ድህረ ታሪክ ጥያቄዎች

በዚህ የጥናቱ ደረጃ ላይ ላጥቶቹን እርስዎ ይዘው ቢጠይቁ ይበልጥ ይመችዎታል።

መላሹ “ፅኑ ሕመም” ማለት ምን ማለት እንደሆነ ቢጠይቅዎ ፅኑ ሕመም ማለት እንደራሱ የጥናቱ ተሳታፊ አረዳድ ማለት መሆኑን ይግለፁለት።

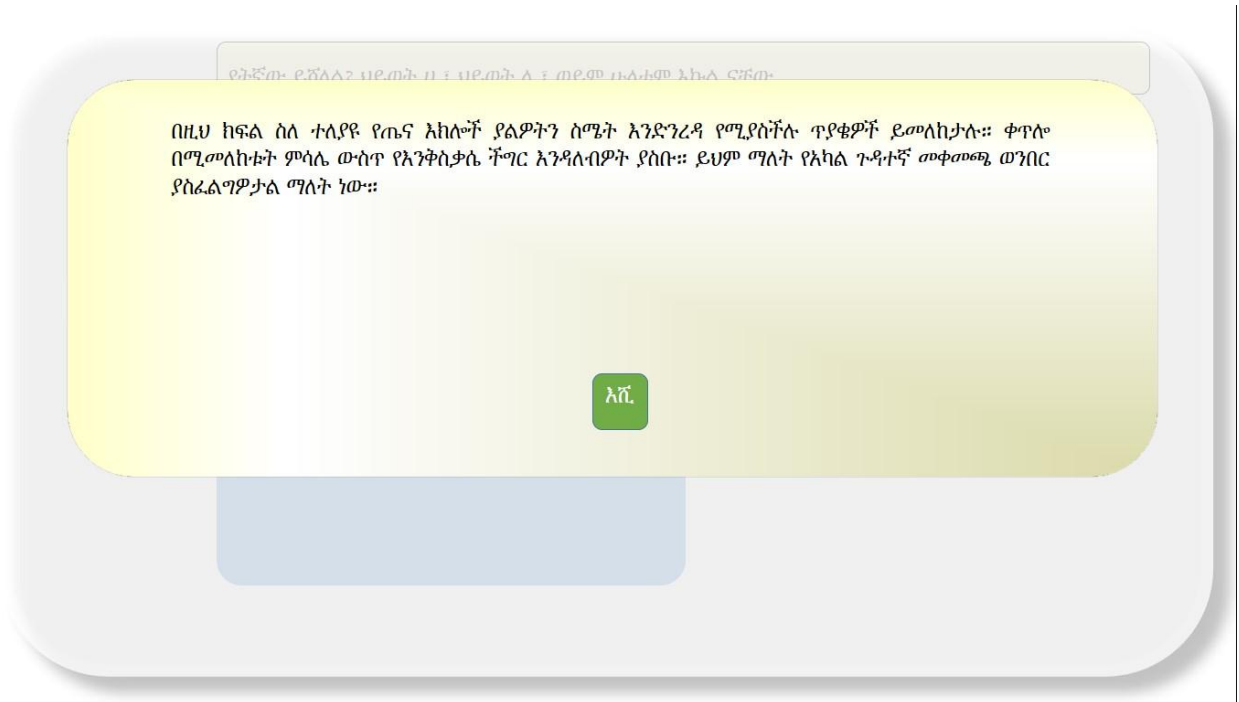
“አሁን ስለ እርስዎና ስለ ጤንነትዎ አንዳንድ ጥያቄዎች እጠይቅዎታለሁ።”

2. ታይም ትሬድ ኦፍ (ቲ.ቲ.ኦ.) የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፡ ትውውቅ

ከክፍል 2 — 4 ላሉት ላፕቶፕ በእርስዎ እጅ መሆን አለበት።

በስክሪን ላይ የተመለከተውን የ ቲ.ቲ.ኦ ትውውቅ ለመላሹ ያንብቡለት (በምስል ሁለት ላይ ተመልክቷል)

ምስል 2፡ የ ቲ.ቲ.ኦ. ትውውቅ



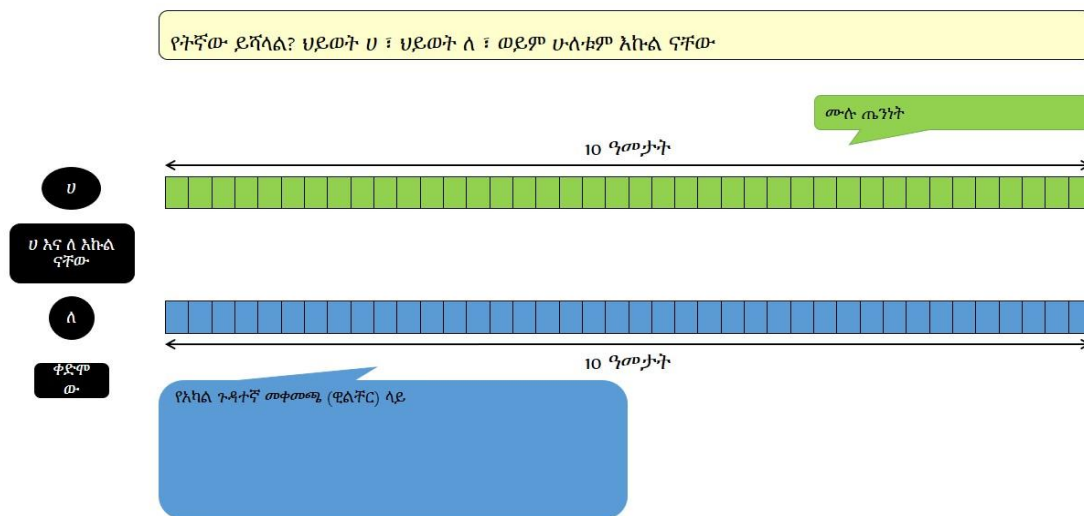
መላሹን ለአካል ጉዳተኛው ወንበር ምሳሌ ያሰናዱት

“በሚከተሉት ጥያቄዎች በሙሉ ጤንነት እና በተወሰነ የጤና እክል መካከል እንዲያወዳድሩ ይጠየቃሉ። በዚህ አብረን በምንመለከተው ምሳሌ ውስጥ የጤና እክሎቹ ከሕመም ጋር ይያያዛሉ - በሌላ አገላለፅ ለመንቀሳቀስ የአካል ጉዳተኛ ወንበር ያስፈልግዎታል።”

2.1 የስክሪኑን ይዘቶች ማስተዋወቅ

የሚታየው የስክሪኑ ይዘቶች ከምስል ሶስት “ክንውኑ ይህን ይመስላል” ጋር አንድ ዓይነት መሆኑን ያረጋግጡ

ምስል 3: የ ቲ.ቲ.ኦ. የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፤ ሕይወት $U = 10$ ዓመታት



ለመላሹ አሁን ያለበት የቱ ጋር እንደሆነ በምስሉ (በመለኪያው) በስተግራ በኩል ያሳዩ

ለሕይወት U አረንጓዴው መለኪያ ላይ ያመልክቱ። መላሹ ሙሉ ጤንነት ማለት ምን ማለት እንደሆነ ከጠየቀ፤ ሙሉ ጤንነት ማለት እንደራሱ የጥናቱ ተሳታፊ አረዳድ ማለት መሆኑን ይግለፁለት።

ለሕይወት A ወደ ሰማያዊ መለኪያ ያመልክቱ

“የሁሉም መለኪያዎች የግራ ጥግ የአሁኑን ጊዜ ይወክላል።”

“ይህ አረንጓዴ መለኪያ ሕይወት U ብለን የምንጠራውን ያሳያል። በሕይወት U ውስጥ፤ ከአሁን ጀምሮ ለ 10 ዓመታት ያህል ይኖራሉ። በእነዚህ 10 ዓመታት ውስጥ ሙሉ

ጤንነት ይኖርዎታል። ከአስር ዓመታት በኋላ ይሞታሉ።”

“ይህ ሰማያዊ መለኪያ ሕይወት ለ ብለን የምንጠራውን ያሳያል። በሕይወት ለ ውስጥ

በቢጫ ሳጥኑ ውስጥ ወዳለው ጥያቄ ያመላክቱ

እንዲሁ ለ 10 ዓመታት ያህል ይኖራሉ። ነገር ግን በነዚህ 10 ዓመታት ውስጥ የመንቀሳቀስ ችግር ይኖርብዎታል - ይህም ማለት ለመንቀሳቀስ የአካል ጉዳተኛ ወንበር ያስፈልግዎታል ማለት ነው።”

“እንደ እርስዎ ላለ ሰው በሕይወት ሀ እና በሕይወት ለ መካከል መምረጥ ምን ሊመስል እንደሚችል ያስቡ። የቴኛውን ይመርጣሉ? ምርጫው በሕይወት ሀ ማለትም 10 ዓመታትን በሙሉ ጤንነት በመኖርና ሕይወት ለ ማለትም 10 ዓመታትን ከእንቅስቃሴ ችግር ጋር በመኖር መካከል ነው።”

መላሹ ሕይወት ለ ከመረጠ ወይም ደግሞ ሕይወት ሀ እና ሕይወት ለ እኩል ናቸው ብሎ ካሰበ ከሁለቱ ቁልፎች አንዱን እንዲጫን ይዘዙ። ካልሆነ ወደ ታች እንዲቀጥል ይግለፁ።

2.2 የ ሀ ቁልፍ ሲነካ ምን እንደሚከሰት ያሳዩ

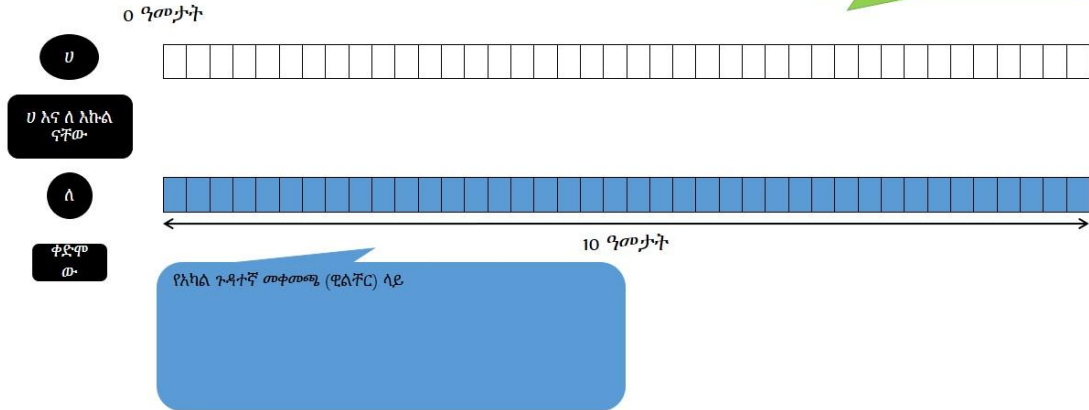
ሕይወት ሀ ለመምረጥ እንዴት የ ሀ ቁልፍን በመጫን መምረጥ እንዳለባቸው ያሳዩ። የስክሪኑ ይዘቶች ከምስል አራት ጋር አንድ ዓይነት መሆኑን ያረጋግጡ።

ምስል 4: ቲ.ቲ.ኦ. የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፤ ሕይወት ሀ = 0 ዓመት

“የ ሀ ቁልፍን ከተጫኑ በኋላ ኮምፒዩተሩ ምርጫዎት ላይ በመመስረት በጥቂቱ ለየት ያለ ጥያቄ ይቀርብልዎታል።”

የትኛው ይሻላል? ህይወት ሀ ፣ ህይወት ለ ፣ ወይም ሁሉም እኩል ናቸው

ሙሉ ጤንነት



ለሕይወት ሀ ወደ ባዶው መለኪያ ያመላክቱ

“በድጋሚ በሕይወት ሀ እና ሕይወት ለ መካከል እንዲመርጡ ይጠየቃሉ። ነገር ግን በአሁኑ አማራጮች ዜሮ ዓመት በሕይወት ሀ (ማለትም አሁን መሞት) ...”

ለሕይወት ለ ወደ ሰማያዊው መለኪያ ያመላክቱ

“... ወይም ደግሞ ከአሁን ጀምሮ ለ 10 ዓመታት ያህል በአካል ጉዳተኛ ወንበር ላይ መኖር”

እንደ አስፈላጊነቱ ተጨማሪ ማብራርያ ይስጡ

“አሁን ከመሞት ይልቅ አስር ዓመታትን በአካል ጉዳተኛ ወንበር ላይ መኖር ይሻላል ብለው ካሰቡ፤ ሕይወት ለ ይመርጣሉ ማለት ነው።”

መላሹ ስለ ሕይወት ሀ ማለትም አሁን መሞት በሚለው አገላለፅ ግራ የመጋባት ምልክት ከታየበት በሌላ አማራጭ የቃላት አጠቃቀም ለማስረዳት ይሞክሩ። ምሳሌ፡- በሕይወት ለ ላይ በተጠቀሰው የኑሮ ሁኔታ ከመኖር ይልቅ መሞት ትመርጣለህ?

“ለ10 ዓመታት ያህል በአካል ጉዳተኛ ወንበር ላይ ሆኖ ከመኖር ይልቅ አሁን መሞት ይሻለኛል ብለው ካሰቡ (መሞት ከመረጡ) ሕይወት ሀ ይመርጣሉ”

“የቱን ሕይወት ይመርጣሉ?”

መላሹ ጥያቄዎቹን ለይቶ ለመምረጥ የራሱን/ሷን ውሳኔ ይወስን/ትወስን

ሀ. መላሹ ሕይወት ሀ ከመረጠ (0 ዓመት) ፣ ወደ ክፍል 4 “የታይም ትሬድ ኦፍ (ቲ.ቲ.ኦ.) በአካል ጉዳተኛ ወንበር ላይ መሆን ምሳሌ፡ ከሞት የባሉ የተባሉ ሁኔታዎች (WTD)” በመሄድ በቅድሚያ ከሞት የባሰ የጤና ሁኔታ ክንውኖችን ያብራሩ

ለ. መላሹ ሕይወት ለ ከመረጠ ፣ ወደ ክፍል 3 “የታይም ትሬድ ኦፍ (ቲ.ቲ.ኦ.) በአካል ጉዳተኛ ወንበር ላይ መሆን ምሳሌ፡ ከሞት የተሻለ የተባለ ሁኔታዎች (BTD)” በመሄድ በቅድሚያ ከሞት የተሻለ የጤና ሁኔታ ክንውኖችን ያብራሩ።

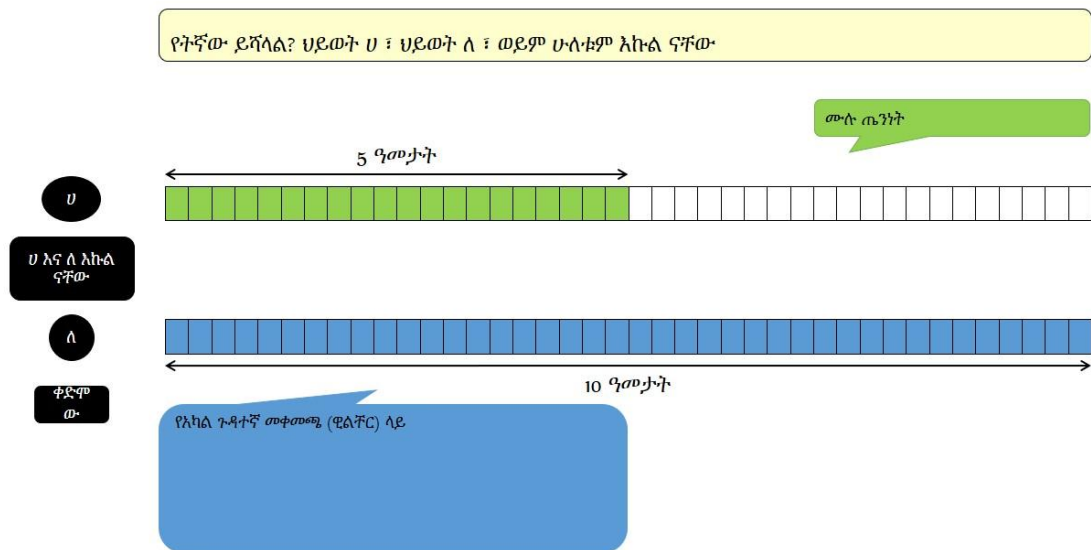
በክፍል 3 ወይም ክፍል 4 ያሉ መመሪያዎችን በመከተል መላሹ በአካል ጉዳተኛ መቀመጫ ወንበር ላይ ስለ መኖር በሚኖሩ ጥያቄዎች ዙርያ ወደ ውሳኔ እንዲያመራ ይርዱት። በኮምፒውተር ስክሪክ ላይ የማረጋገጫ መልእክቱን ካገኙ በኋላ መላሹ በቀድሞው ጥያቄ ላይ በአካል ጉዳተኛ ወንበር ላይ ሆኖ መኖር ይሻላል የሚል ውሳኔ ከነበረው፤ ከዛ የባሰ የሚባል የጤና ሁኔታ ምሳሌ ያቅርቡለት በተቃራኒው ደግሞ ሞት ይሻላል ብሎ መርጦ ከሆነ ከቀድሞው በአካል ጉዳተኛ ወንበር ላይ ከመቀመጥ የተሻለ የጤና ሁኔታ አማራጭ ያቅርቡለት።

3. ታይም ትሬድ ኦፍ (ቲ.ቲ.ኦ.) የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፡ ከሞት የተሻለ የጤና ሁኔታዎች (BTD)

3.1 የ ለ ቁልፍ ሲነካ ምን እንደሚከሰት ያሳዩ

ሕይወት ለ ለመምረጥ እንዴት የ ለ ቁልፍን በመጫን መምረጥ እንዳለባቸው ያሳዩ። “የ ሀ ቁልፍን ከተጫኑ በኋላ ኮምፒውተር ምርጫዎት ላይ በመመስረት በጥቂቱ ለየት የስክሪኩ ይዘቶች ከምስል አምስት ጋር አንድ ያለ ጥያቄ ይቀርብልዎታል።” ዓይነት መሆኑን ያረጋግጡ።

ምስል 5: ቲ.ቲ.ኦ. የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፤ ሕይወት ሀ = 5 ዓመታት



ለሕይወት ለ ወደ ሰማያዊው መለኪያ
ያመላክቱ፤

“አሁን ረዘም ላለ ጊዜ ማለትም ለ 10
ዓመታት ያህል በአካል ጉዳተኛ ወንበር
ላይ በመኖርና...”

ለሕይወት ሀ ወደ አረንጓዴው መለኪያ ጥግ
ያመላክቱ፤

“አጠር ላለ ጊዜ ማለትም ለ 5 ዓመታት ያህል
በሙሉ ጤንነት በመኖር መካከል ምርጫ
ቀርቦልዎታል።”

3.2 ታይም ትሬድ ኦፍ (ቲ.ቲ.ኦ.) የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፡- ከሞት የባሉ የጤና ሁኔታዎች (WTD)

ሕይወት ሀ ሲመርጥ ምን እንደሚከሰት ለመላሹ
ያሳዩ

የውጤት ደረጃዎችን በግልፅ ያሳዩ (በሕይወት ሀ
ያሉ ከ 0 እስከ 10 ዓመታት ድረስ)

ሕይወት ለ ሲመርጥ ምን እንደሚከሰት ለመላሹ
ያሳዩ። እነዚህ የተለያዩ በተደጋጋሚ የሚያጋጥሙ

መላሹ በትክክል ተረድቶት ከሆነ በማረጋገጥና አስፈላጊ ሆኖ ሲገኝ ተጨማሪ ማብራሪያ በመስጠት ይርዱት።

ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸው ወደሚለው የአማራጭ ቁልፍ ያመላክቱ።

መላሹ ምርጫውን ለማስቀመጥ በሚያደርገው ሂደት የሚያደርገውን የቁልፎች እንቅስቃሴዎች በአግባቡ መረዳቱን ያረጋግጡ።

አስፈላጊ ሆኖ ከተገኘ፤ የአማራጭ ቁልፎችን በመንካት በሕይወት ሀ ውስጥ ያለው የጊዜ ርዝማኔ እንዴት እንደሚለዋወጥ በማሳየት ተጨማሪ ማብራሪያ ይስጡ።

በአካል ጉዳተኛ ወንበሩ ምሳሌ ላይ መላሹ የራሱን ውሳኔ ያኑር። ሕይወት ሀ እና ሕይወት ለ እኩል ናቸው የሚለውን ቁልፍ በመንካት እና የማረጋገጫ መልእክት የሚያቀርበው ሳጥን ውስጥ ላለው መልእክት መስማማትዎን የሚያሳየውን ቁልፍ በመጫን ይቀጥሉ።

“ልክ እንደ ቀድሞው ሁሉ ሕይወት ሀ ይሻላል ብለው ካመኑ የ ሀ ቁልፍን ይጫኑ። ይህ አማራጭ በሕይወት ሀ ውስጥ ያለውን የሙሉ ጤንነት የጊዜ መጠን ያሳጥራል።”

4. ታይም ትሬድ ኦፍ (ቲ.ቲ.ኤ.) የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፦ ከሞት የባሉ የጤና ሁኔታዎች (WTD)

4.1 ከሞት የባሉ የሚባሉ የጤና ሁኔታዎችን ያስተዋውቁ

“ሕይወት ለ ይሻላል ብለህ የምታስብ ከሆነ ልክ እንደ ቀድሞው ሁሉ የ ለ ቁልፍን በመጫን ምረጥ።”

“ምርጫዎትን በሚያደርጉበት በእያንዳንዱ ጊዜ በሕይወት ሀ ውስጥ ያለው የጊዜ ርዝማኔ ይለዋወጣል። ይህም የሚሆነው የ ‘ሀ’ እና ለ ሕይወት እኩል ናቸው’ የሚለውን ምርጫ እስኪመርጡ ድረስ ይሆናል።”

“ይህ ምርጫዎ የሚወሰነው የሚመርጡት የጤና ሁኔታ ምን ያህል ጥሩ ወይም መጥፎ ነው ብለው በሚያስቡት ልክ ይሆናል። እናም ለተለያዩ ሰዎች የተለያየ ይሆናል። በመሆኑም ትክክል ወይም ስህተት የሚባል መልስ የለም።”

“የሚፈልጉት አማራጭ ላይ ሲደርሱ ‘ሕይወት ሀ’ እና ለ ከሞላ ጎደል ተመሳሳይ ናቸው’ የሚለውን ቁልፍ ይጫኑ። በዚህም ጊዜ ምርጫዎ ትክክል ስለመሆኑ እንዲያረጋግጡ የሚጠይቅ መልእክት የያዘ መስኮት በስክሪኑ ላይ ይታይዎታል። ይህን አረጋግጠው ሲያበቁ አንድ ጥያቄ አጠናቀዋል ማለት ነው ስለዚህ ሌላ የጤና ሁኔታ ላይ የሚያትት ጥያቄ ይቀርብልዎታል።”

“እዚህ ላይ የሰዎች ምርጫ የሚወሰነው በአካል ጉዳተኛ ወንበር ሆኖ ስለመኖር ባላቸው አመለካከት ላይ ይሆናል ማለት ነው። ከዚህ ባሻገር ረጅም እድሜ ለመኖር በሚሰጡት ዋጋም የሚወሰን ይሆናል። ያስታውሱ - ትክክል የሆነ ወይም ስህተት የሚባል መልስ የለም ይልቁንም የእርስዎን አመለካከት ለማወቅ ነው።”

“ምርጫዎትን በሚያደርጉበት በእያንዳንዱ ጊዜ በሕይወት ሀ ውስጥ ያለው የጊዜ ርዝማኔ ይቀንሳል ወይም ይጨምራል። የ ሀ ቁልፍን በሚጫኑበት ወቅት በሕይወት ሀ ውስጥ ያለው ጊዜ ይቀንሳል። የ ለ ቁልፍን ሲጫኑ ደግሞ የሕይወት ሀ የጊዜ ርዝማኔ ይጨምራል። ቁልፎቹን በሚጫኑበት ወቅት በአንድ ጊዜ የሚለዋወጠው የጊዜ መጠን እስከ 5 ዓመት ሊደርስ ይችላል። ቆይቶ በሚቀርብልዎት ጥያቄዎች ውስጥ ግን በጊዜ መካከል ያለው ለውጥ እስከ 6 ወር ሊያጥር ይችላል።”

ለመላሹ ከሞት ለባሱ የጤና ሁኔታዎች ገለፃ ያዘጋጁ።

[መላሹ ከሞት የባሰ የጤና ሁኔታን አልመረጠም ብሎ በማሰብ] “እስካሁን ባየኔው መሰረት አሁን ከመሞት ይልቅ ለ10 ዓመታት ያህል በአካል ጉዳተኛ ወንበር ላይ መኖርን ይመርጣሉ።”

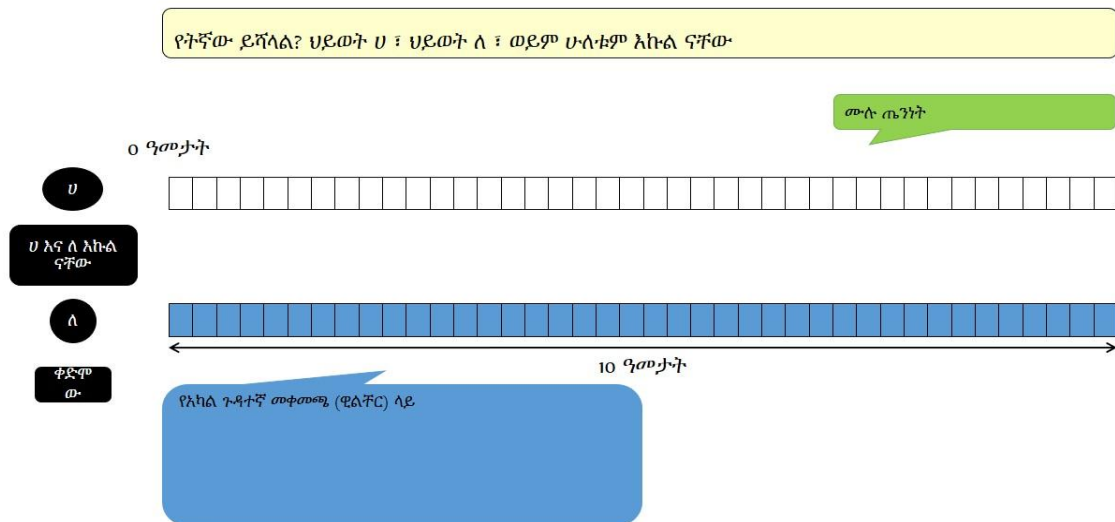
“በቀጣይ የተለያዩ የጤና ሁኔታዎችን እንዲያስቡ ይጠየቃሉ። ከነዚህ መካከል የተወሰኑት መካከለኛ ችግርን ያካትታሉ; ከፊሎቹ ደግሞ በእጅጉ መጥፎ የሚባል የጤና ሁኔታን ያካተቱ ይሆናሉ።”

“አሁን በእጅጉ የከፋ ነው የተባለውን የጤና ሁኔታ ላስረዳዎት እፈልጋለሁ። ምናልባት በዚህ የጤና ሁኔታ ለ10 ዓመታት ከመኖር ይልቅ ሞትን መምረጥ ሊፈልጉ ይችላሉ።”

“በዚህ ወቅት የ ሀ ቁልፍን ይጫናሉ። ምክኒያቱም በዚህ እጅግ በከፋ የጤና ሁኔታ ውስጥ ከመኖር ይልቅ ሕይወት ሀ ይመርጣሉ።”

በቀጣዩ ምስል ላይ እንደተመለከተው የ ሀ ቁልፍን በመጫን እንዴት የሕይወት ሀ የጊዜ ርዝማኔ 0 ማድረግ እንደሚችል ለመላሹ ያሳዩ።

ምስል 6: ቲ.ቲ.ኦ. የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፤ ሕይወት ሀ = 0 ዓመታት



እንደ አስፈላጊነቱ ተጨማሪ ማብራሪያ ይስጡ።

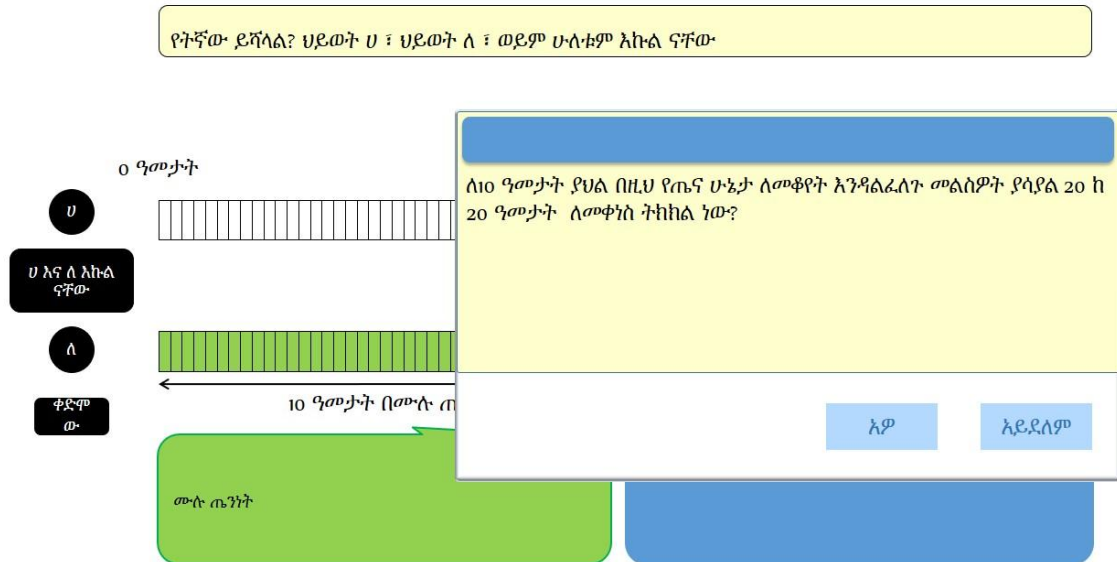
መላሹ ለመቀጠል ዝግጁ ከሆነ፤ የ ሀ ቁልፍን አንድ ጊዜ ይጫኑ። ይህ ድርጊት ልክ በምስል 7 ላይ

እንደተመለከተው ከሞት የባሱ ስለተባሉት የጤና ሁኔታዎች የሚያትተው የ ቲ.ቲ.ኦ. ክፍል የሚያስጀምር የማረጋገጫ መልእክት የያዘ መስኮት በኮምፒውተርዎት ስክሪን ላይ እንዲታይ ያደርጋል።

“አሁን በሕይወት ሀ ምንም ዓመታትን ባለመኖርና (ማለትም አሁን በመሞትና) በሕይወት ለ ውስጥ ባለው የጤና ሁኔታ ለ 10 ዓመታት በመኖር መካከል አማራጭ ይኖርዎታል ማለት ነው።”

“በሕይወት ለ ውስጥ የተዘረዘሩት የጤና ችግሮች እጅግ የከፉ ናቸው ብለው ካሰቡ በሕይወት ለ ውስጥ ለ10 ዓመታት ያህል ከመኖር ይልቅ አሁን መሞትን ሊመርጡ ይችላሉ። በዚህ ጊዜ የ ሀ ቁልፍን ይጫኑ።”

ምስል 7: ከሞት የባሉ የጤና ሁኔታዎች ገላጭ ዕሁፍ



በምስል 7 ላይ እንደተመለከተው ከሞት የባሉ ለተባሉ የጤና ሁኔታዎች ገላጭ ዕሁፉን ለመላሹ ያንብቡለት። መላሹ መጠይቁን ለመቀጠል ዝግጁ ሲሆን በኮምፒውተር ስክሪን ላይ የመጣውን የማረጋገጫ ዕሁፍ በመዝጋት ይቀጥሉ።

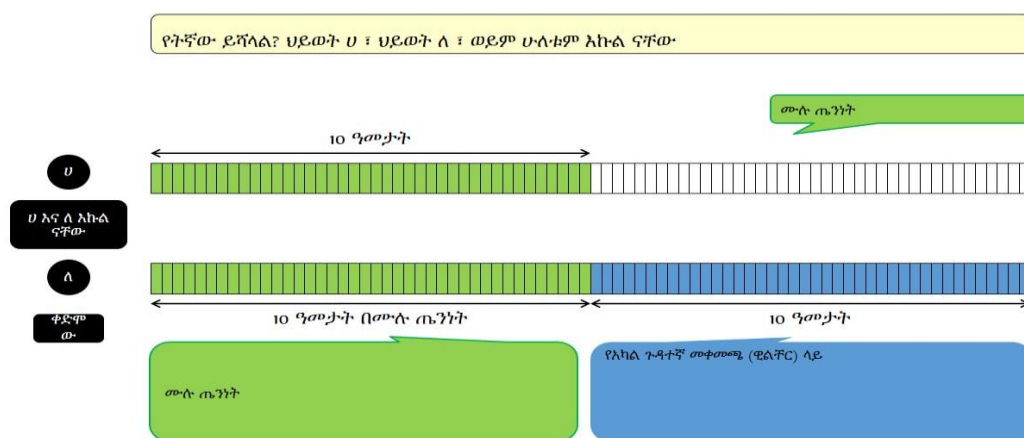
4.2 የስክሪን ይዘቶች ያስተዋውቁ

በስክሪኩ ላይ ያሉት እያንዳንዳቸው ይዘቶች ከምስል 8 ጋር አንድ ዓይነት መሆኑን ያረጋግጣሉ።

ክንውኑ እንዴት እንደተቀየረ ያብራሩ።

“አሁን በጥቂቱ ለየት ያሉ ጥያቄዎችን ይጠየቃሉ። አሁንም የሚመርጡት በሕይወት ሀ እና ሕይወት ለ መካከል ሲሆን በሰማያዊው መለኪያ ላይ ያለው የሕይወት ለ አማራጭ ልክ በቀድሞው የጤና ሁኔታ ውስጥ 10 ዓመታትን ማሳለፍን ይወክላል። ነገር ግን ከቀድሞው የሚለየው በዚህኛው ላይ የጤና እክሎች ያሉበት ህይወት የሚጀምረው ቀድሞ 10 ዓመታትን በሙሉ ጤንነት ካሳለፉ በኋላ ይሆናል። ሕይወት ለ በአጠቃላይ ለ20 ዓመታት ይቆያል ማለት ነው።”

ምስል 8: ቲ.ቲ.አ. የአካል ጉዳተኛ መቀመጫ ወንበር ምሳሌ፡ ሕይወት ሀ = 10 ዓመታት ከሞት የባለ የጤና ሁኔታ



ለሕይወት ሀ ወደ መለኪያው መሃከለኛ ክፍል ያመላክቱ።

“ሕይወት ሀ አሁን ተቀይሯል። ሕይወት ሀ ለ10 ዓመታት ያህል ይቆያል። ስለዚህ በሕይወት ሀ ለ10 ዓመታት ያህል በመቆየት መካከልና...”

“ለ20 ዓመታት ያህል በሕይወት ለ መኖር። ከዚህም ውስጥ አስሩን ዓመታት በሙሉ ጤንነት ሲሆን ቀጥሎም ሌሎች አስር ዓመታትን በአካል ጉዳተኛ ወንበር ላይና ከሌሎች ችግሮች ጋር መኖር ነው።”

“አሁን የቱን ሕይወት ይመርጣሉ? ሕይወት ሀ ወይስ ሕይወት ለ?”

ለሕይወት ለ ወደ መለኪያው ያመላክቱ።

4.3 ታይም ትሬድ ኦፍ (ቲ.ቲ.ኤ.) ክንውን ከሞት ለባሉ ሁኔታዎች

መላሹ ሕይወት ሀ ሲመርጥ ምን እንደሚከሰት በግልፅ ያሳዩ። የአመራረጥ ሂደቱን የሚያሳየውን ቅደም ተከተል ያሳዩ (በሕይወት ሀ ውስጥ ከ 0 እስከ 10 ዓመት)

አማራጩን ያብራሩ።

ምላሹን ካገኙ በኋላ በትክክል መረዳቱን አሁንም ያረጋግጡ እንደ አስፈላጊነቱም ተጨማሪ ማብራሪያ ይስጡ።

ልክ እንደቀድሞው ሁሉ መላሹ ምርጫው ላይ እስኪደርስ ድረስ የቀድሞውን ሂደት ያከናውኑ። ከዚያም ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸው ወደሚለው አማራጭ ይጠቁሙ።

“ልክ እንደ ቀድሞው ሁሉ የ ሀ ቁልፍን በሚጫኑበት ወቅት ሕይወት ሀ ለውጥ አሳይቷል።

4.4 ተጨማሪ መረጃ

ስህተት ቢፈፀም ምን መደረግ እንዳለበት ያብራሩ

አሁን ሕይወት ሀ 5 ዓመታትን ብቻ ይቆያል እናም ጥያቄው በድጋሚ የትኛውን ሕይወት ይመርጣሉ የሚለው ይሆናል። የሚኖረው አማራጭ በሕይወት ሀ ውስጥ 5 ዓመታትን በሙሉ ጤንነት መኖርና በሕይወት ለ ውስጥ 10 ዓመታትን በሙሉ ጤንነት ኖሮ ከዛ በኋላ ያሉ 10 ዓመታትን በአካል ጉዳተኛ ወንበር ላይ ሆኖ መኖር”

“በሕይወት ሀ ውስጥ ሙሉ 5 ዓመታትን በሙሉ ጤንነት መኖር ይችላሉ። ሕይወት ለ ደግሞ ረዘም ላለ ጊዜ ማለትም ለ 10 ዓመታት ያህል በሙሉ ጤንነት እንዲኖሩ አማራጭ ያቀረበልዎት ቢሆንም ሌሎች ተጨማሪ ዓመታትን በተጓደለ ጤንነት መኖር ይኖርብዎታል። በእርግጥ አሁን ጥያቄው 10 ዓመታትን በሙሉ ጤንነት ውስጥ መኖር ቀጣዮቹን 10 ዓመታት በተጓደለ ጤንነት ለመኖር እንዲፈልጉ ያደርግዎታል ወይስ በተጓደለ የጤና ሁኔታ ተጨማሪ 10 ዓመታትን ከመኖር ይልቅ 5 ዓመታትን ቀንሶ ለ 5 ዓመታት ያህል ብቻ በሙሉ ጤንነት እንዲኖሩ ያደርግዎታል የሚለው ነው። ልክ በሕይወት ሀ ውስጥ እንዳለው ማለት ነው።”

“ምርጫዎችን በሚያደርጉበት በእያንዳንዱ ጊዜ በሕይወት ሀ ውስጥ ያለው የጊዜ ርዝማኔ ይቀያየራል። ይህም የሚሆነው ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል እኩል ናቸው የሚለውን ውሳኔ እስኪመርጡ ድረስ ይሆናል። የትኛውን ይመርጣሉ?”

“አሁን ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸው ብለው የሚያስቡበት ላይ ደርሰዋል ስለዚህ ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል እኩል ናቸው የሚለውን ቁልፍ በመጫን ይምረጡ። መልስዎችን እንዲያረጋግጡ የሚጠይቅ ጥያቄ መስኮት በኮምፒውተር ስክሪን ላይ ይቀርብልዎታል። በመስማማት ወደ ቀጣዩ የጤና ሁኔታ ይሄዳሉ።”

“አንድ ስህተት ቢፈፀም - ለምሳሌ ምርጫዎት ሕይወት ለ ሆኖ ሳለ የ ሀ ቁልፍን ቢጫኑ - ለእኔ ይንገሩኝ። የሚፈልጉትን ምርጫዎን በድጋሚ አስተካክለው መቀጠል ስለሚችሉ እንደ አዲስ መጀመር አይጠበቅብዎትም።”

“በስህተት ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል እኩል ናቸው የሚለውን አማራጭ ቁልፍ በስህተት ከተጫኑ የማረጋገጫ መልእክት በሚያቀርበው መስኮት ላይ አልስማማም በማለት ወደ ኋላ መመለስ ይችላሉ።”

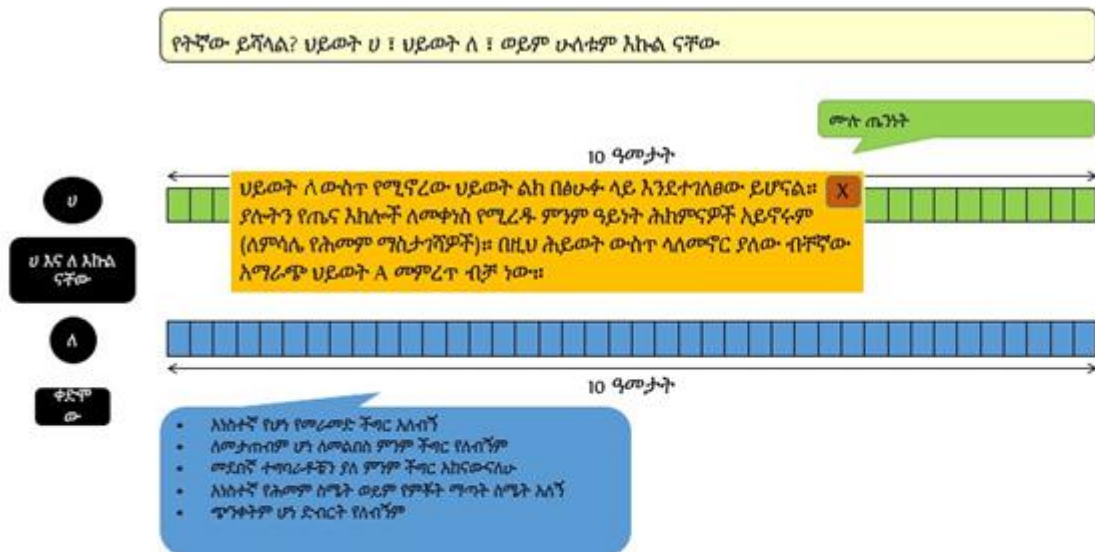
ዋና ዋና የሆኑ ምናባዊ ክንውኖችን ለመላሹ ያብራሩ (ምስል 9)

“ከመጀመራችን በፊት በተጨማሪ ላብራራልዎት የምፈልገው አንድ ጉዳይ አለ።”

“ስለ እነኚህ ጥያቄዎች ሲያስቡ ሁልጊዜ በሁለት አማራጮች መካከል መምረጥ ይችላሉ። ሕይወት ሀ እና ሕይወት ለ ብቻ። ሕይወት ለ ሲያስቡ በሰማያዊው መለኪያ ላይ እንዴት እንደተገለፀ ብቻ ያስቡ።”

“ሕይወት ለ ልክ እንደተገለፀው ብቻ መኖር እንደሚቻል ያስቡ። የጤና ሁኔታዎችን ለማሻሻል የሚጠቅሙ ማንኛውም ሕክምናዎች እንደሌሉ ይወቁ። እነኚህን የጤና እክሎች ለማስወገድ ያለው ብቸኛ አማራጭ ሕይወት ሀ መምረጥ ብቻ ነው። በሕይወት ሀ ውስጥ ሙሉ ጤንነት ማለት እርስዎ ሙሉ ጤንነት ነው ብለው የሚያስቡት ነው።”

ምስል 9: የ ቲ.ቲ.ኦ. ክንውንን የሚያብራሩ ገላጭ ፅሁፍ



5. የልምምድ ሁኔታዎች

5.1 የመጀመሪያ የልምምድ ሁኔታ (ቀላል)

ለመላሹ ላፕቶፑን ይስጡ።

የመጀመሪያውን የ ቲ.ቲ.ኦ. ክንውን ለመላሹ ያብራሩ።

በሰማያዊው መለኪያ ውስጥ ወደ ተመለከተው የጤና ሁኔታ ያመላክቱ።

መላሹ የጤና ሁኔታውን መግለጫ በጥንቃቄ እንዳይበዘዘ ያረጋግጡ። የጤና ሁኔታውን ማንበብ ካልቻለ (ለምሳሌ በእይታ ችግር ምክኒያት ሊሆን ይችላል) ያንብቡለት።

ምርጫውን እስኪወስን ድረስ ጊዜ ሊሰጡት ይገባል።

መላሹ ሕይወት ሀ ከመረጠ አሊያም ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸው ብሎ ከመረጠ ካሉት አማራጮች መካከል አንዱን እንዲጫን ይገለፁ። ይህ ካልሆነ ወደ ታች ይቀጥል

መላሹ የመጠይቁን የ ቲ.ቲ.ኦ. ክፍል በራሱ እንዲያጠናቅቅ ያድርጉ። በዚህ መሃል አማራጭ የሚቀመጥባቸው የቁልፎች አጣቃቀም ላይ ብቻ እርዳታ ያድርጉለት።

መላሹ የ ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸውን ቁልፍ ሲጫንና ለማረጋገጫ መልእክቱን መልስ ሰጥቶ ሲያበቃ አንድ የጤና

ሁኔታ ለማጠናቀቁ ምስጋና በማቅረብ ሌላ የጤና ሁኔታ እንዲያስተናግድ ይገለፁ።

“ይህ ጥያቄ ቀድሞ ከተመለከቱት የአካል ጉዳተኛ ወንበር ላይ ኑሮ ምሳሌ ጋር ተመሳሳይ ነው። ለየት የሚል የጤና ሁኔታው ብቻ ነው።”

“ጥናቱን ስንጀምር ስለ እርስዎ የጤና ሁኔታ የጠየቅክዎትን 5 ጥያቄዎች ያስታውሷቸዋል። እዚህ ጋር የተገለፀው የጤና ሁኔታ ምናልባትም አንድ ግለሰብ እነኚያን ጥያቄዎች ቢጠየቅ መልሶበት ሊሆን የሚችልበት መንገድ ሊሆን ይችላል። መግለጫውን ሊያነቡልኝ ይችላሉ?”

“ልክ እንደ የአካል ጉዳተኛ መቀመጫ ወንበሩ ምሳሌ ጥያቄው የቱን እንደሚመርጡ እየጠየቅዎት ነው። በሕይወት ሀ ውስጥ 10 ዓመታትን በሙሉ ጤንነት ከዛ በኋላ ሞት ወይም ደግሞ በሕይወት ለ 10 ዓመታትን በሰማያዊው መለኪያ እንደተመለከተው የጤና ሁኔታ እና ከዛ ሞት ። እባክዎትን ለሕይወት ሀ የ ሀ ቁልፍን በመጫን እና ለሕይወት ለ እንዲሁ የ ለ ቁልፍን በመጫን ይምረጡ።”

“አሁን ሕይወት ሀ አሁኑኑ መሞት ነው። የቱ ይሻላል ብለው ያስባሉ? ሕይወት ሀ ወይስ ሕይወት ለ?”

“ባጣም ጥሩ! የመጀመሪያውን ተግባራዊ የጤና ሁኔታ አጠናቀዋል።”

በሰማያዊው ሳጥን ውስጥ ወደ ተቀመጠው አዲሱ የጤና ሁኔታ ያመላክቱ። መላሹ አዲስ የጤና ሁኔታ ሊመለከት እንደሆነ ካስተዋለ በኋላ እንዲቀጥል ማረጋገጫ የሚሰጥበት መልእክት ላይ መልስ እንዲሰጥ ጊዜ ይስጡት።

5.2 ሁለተኛ የልምምድ ሁኔታ (ከባድ)

ለመላሹ ሁለኛውን የ ቲ.ቲ.ኦ. ክንውን ያብራሩ።

አዲሱን የጤና ሁኔታ ማብራሪያ በጥንቃቄ እንዳነበበ ያረጋግጡ።

ነገር ግን እንደሚመለከቱት ከቀድሞው በእጅጉ የባሰ ነው።”

“እያንዳንዱ የሚመለከቱት የጤና ሁኔታ የተለያየ ነው። የጤና ሁኔታውን ገላጮች በጥንቃቄ በማንበብ በዛ ዓይነት የጤና ሁኔታ ውስጥ መኖር ምን ሊመስል እንደሚችል ያስቡ። በእያንዳንዱ ሁኔታ የተለያዩ የጤና እክሎች ያሉበት አዲስ ሕይወት ይቀርብልዎታል፤ የጤና እክሎችን ድምፅዎትን ከፍ አድርገው እንዲያነቧቸው እጠይቅዎታለሁ። በዚህ መንገድ የጤና ሁኔታውን በትክክል ተረድተዉት እንደሆነ አረጋግጣለሁ። እባክዎትን አሁን ድምፅዎትን ከፍ አድርገው ሊያነቡልኝ ይችላሉ?”

መላሹ የመጠይቁን የ ቲ.ቲ.ኦ. ክፍል በራሱ እንዲያጠናቅቅ ያድርጉ። በዚህ መሃል አማራጭ የሚቀመጥባቸው የቁልፎች አጣቃቀም ላይ ብቻ እርዳታ ያድርጉለት።

“አዲሱ የጤና ሁኔታ ከቀድሞው የጤና ሁኔታ ጋር በተወሰነ መልኩ ተመሳሳይ ሊሆን ይችላል። አምስት የጤና ገላጮችን በመጠቀም የተብራራ ነው

5.3 ሶስተኛ የልምምድ ሁኔታ (መሃከለኛ)

ለሁሉም የ ቲ.ቲ.ኦ. ክንውኖች እነኚህን ያስታውሱ

- የመላሹን ቀልብ ወደ ተለወጠው የጤና ሁኔታ ያምጡ
- መላሹ የጤና ሁኔታውን ድምፁን ከፍ አድርጎ እንዲያነበው ይጠይቁ
- ጠቃሚ ሆኖ ከታየው መላሹ ያሰበውን ሃሳብ ድምፁን ከፍ አድርጎ እንዲለው ያበረታቱት

ይህ የመጨረሻው የልምምድ ሁኔታ ነው። እባክዎ ድምፅዎን ከፍ አድርገው ያንብቡት።

በዚህ የጤና ሁኔታ መኖርን ያስቡት። ለአንዳንድ ሰዎች እነኚህን የጤና ችግሮች ማሰብ ምናልባት ከባድ ሊሆን ይችላል። እንዴት አንድ ሰው ቆሞ የመንቀሳቀስ ችግር ሳይኖርበት እራሱን የማልበስ የመታጠብና የእለት ተእለት ተግባራቱን ማከናወን ይሳነዋል? ይሉ ይሆናል። ለማንኛውም ይህንን የጤና ሁኔታ ለማሰብ የቻሉትን ያህል ይሞክሩ። ለምሳሌ አንድ ሰው ሁለቱም እጆቹ በአንድ ምክንያት ከጥቅም ውጪ ቢሆኑ ይህ ሁኔታ ሰውየውን ልብሶቹን ከማጠብ እራሱን ከማልበስ እና የእለት ተእለት ተግባራቶቹን ከማከናወን ሊያግደው ይችላል ነገር ግን ቆሞ ከመንቀሳቀስ ሳያግደው

ህመም እንዲሁም ጭንቀትና ድብርት ላያስከትልበት ይችላል ብለው ያስቡ።

5.4 መመሪያዎቹ ግልፅ እንደሆኑ ማረጋገጫ

መላሹ መመሪያዎቹን በአግባቡ መረዳቱን በማረጋገጥ እንደ አስፈላጊነቱ ተጨማሪ ማብራርያ ይስጡ።

ለመላሹ ላጥቶቹን ይስጡ። ላጥቶቹን ይዞ በራሱ መስራቱ የቲ.ቲ.ኦ. ክፍሉን በደንብ ለመልመድ ጠቃሚ ይሆናል ብለው ካሰቡ ይህን እንዲያደርግ ያበረታቱት።

አለዚያ መላሹ የሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸው የሚለውን ቁልፍ እንዲጫን ይጠይቁት። ይህ መላሹ ዋጋ ወደሚሰጠው የመጀመሪያው የጤና ሁኔታ የሚወስደውን

ምስል 10: የመጀመሪያው የቲ.ቲ.ኦ. ክንውን

መለእክት ያዘለ መስኮት እንዲቀርብ ያደርገዋል። (በምስል 10 ላይ እንደተመለከተው)

“ስለ 10 የተለያዩ የጤና ሁኔታዎች ጥያቄዎችን ይጠየቃሉ። እባክዎትን እያንዳንዱን የጤና ሁኔታ በደንብ በማጤን መልስዎትን ይወስኑ። አዲስ የጤና ሁኔታ በሚቀርብልዎት ወቅት ጥያቄዎችን ከመመለስዎ በፊት የጤና ሁኔታውን እንዲያነቡት እጠይቅዎታለሁ።”

“ያስታውሱ - ትክክል ወይም ስህተት የሆነ/የሚባል መልስ የለም። የእኛ ፍላጎት የእርስዎን አመለካከት ማወቅ ብቻ ነው።”

የሕክምና ደረጃዎን ለማረጋገጥ ይጠቀሙ።

ይህ የልምምድ ክፍል መጨረሻ ነው። በመቀጠል ከተመረጠው መደዳ ውስጥ ጥያቄዎች ይጠየቃሉ

እሺ

- መደበኛ ተግባራትን ለማከናወን አልቸልም
- የሕመም ስሜትም ሆነ የምችት ማጣት ስሜት የለኝም
- እጅግ ከባድ ጭንቀት ወይም ድብርት አለብኝ

6. ለ 10 የ ኢ.ኪ.ው.-5ዲ-5ኤል የጤና ሁኔታዎች የታይም ትሬድ ኦፍ (ቲ.ቲ.ኦ.) ክንውኖች

6.1 የመጀመሪያ እና ቀጣይ ክንውኖች

ለሁሉም የ ቲ.ቲ.ኦ. ክንውኖች እነዚህን ያስታውሱ

- የመላሹን ቀልብ ወደ ተለወጠው የጤና ሁኔታ ያምጡ
- መላሹ የጤና ሁኔታውን ድምፁን ከፍ አድርጎ እንዲያነበው ይጠይቁ
- ጠቃሚ ሆኖ ከታየው መላሹ ያሰበውን ሃሳብ ድምፁን ከፍ አድርጎ እንዲለው ያበረታቱት

ይህ የመጨረሻው የልምምድ ሁኔታ ነው። እባክዎ ድምፅዎን ከፍ አድርገው ያንብቡት።

6.2 ግብረ መልስ ጥያቄዎች

የአስሩን የ ቲ.ቲ.ኦ. ክንውን መጠናቀቅ ተከትሎ ቀሪዎቹን የ ቲ.ቲ.ኦ. ግብረ መልስ ጥያቄዎች መላሹ እንዲያጠናቅቃቸው ይተገባ።

“በተጠየቁቸው ጥያቄዎች ላይ አስተያየት ካልዎት እንቀበላለን።”

7. የ ቲ.ቲ.አ. ክንውኖቹን ምላሾች ለማረጋገጥ የተዘጋጀ የ ግብረ መልስ ሞጁል

7.1 የግብረ መልስ ሞጁል

የስክሪኑን ይዘቶች ለመላሹ ያሳዩ። በምስል 11 ላይ ምሳሌ ተሰጥቷል።

“እዚህ ጋር አስሩን ቀደም ሲል ያየሃቸውን የጤና ሁኔታዎች ትመለከታለህ። የጤና ሁኔታዎቹ የተቀመጡት ምርጫዎትን ሲያደርጉ የሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል እኩል ናቸው ብለው ሲያስቀምጡ በሕይወት ሀ ውስጥ ባለው የጊዜ ርዝማኔ ልክ ነው።”

“የተሻሉ ናቸው ብለው ጥቂት ጊዜ ብቻ ቀንሰው እርስዎ ያስቀጧቸው የጤና ሁኔታዎች በላይኛው የስክሪኖ ክፍል ላይ ተቀምጠዋል። የከፉ ናቸው ብለው ረጅም ዓመታትን ቀንሰው በመጥፎ የፈረጁቸው የጤና ሁኔታዎች ደግሞ በታችኛው የስክሪኖ ክፍል ላይ ተቀምጠዋል። እኩል የጊዜ ርዝመት የቀነሱላቸው የጤና ሁኔታዎች ደግሞ ጎን ለጎን ተቀምጠው ያገኛቸዋል።”

“ጥቁር ሰማያዊ ቀለም ያላቸው ሳጥኖች ውስጥ የሚያገኛቸው የጤና ሁኔታዎች ከሞት የባሉ ብለው የፈረጁቸው የጤና ሁኔታዎች ናቸው።”

ምስል 11: የግብረ መልስ ሞጁል ምሳሌ

ከ ላይ የተሻለ የጤና ሁኔታ

*የመራመድ ችግር የለብኝም *ለመታጠብም ሆነ ለመልበስ ምንም ችግር የለብኝም *መደበኛ ተግባራቶቼን ለማከናወን ለነክተኛ ችግር ሌለብኝ *ለነክተኛ የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *ጭንቀትም ሆነ ድብርት የለብኝም 1	*የመራመድ ችግር የለብኝም *ለመታጠብም ሆነ ለመልበስ ለነክተኛ የሆነ ችግር ሌለብኝ *መደበኛ ተግባራቶቼን ያለ ምንም ችግር ለከናወናለሁ *የሕመም ስሜትም ሆነ የምቶት ማጣት ስሜት የለኝም *ጭንቀትም ሆነ ድብርት የለብኝም 1	*የመራመድ ችግር የለብኝም *ለመታጠብም ሆነ ለመልበስ ምንም ችግር የለብኝም *መደበኛ ተግባራቶቼን ለማከናወን ለነክተኛ ችግር ሌለብኝ *መጠነኛ የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *ጭንቀትም ሆነ ድብርት የለብኝም 2	*ምንም መራመድ ሊልኝልኝም *ለመታጠብም ሆነ ለመልበስ ከፍተኛ የሆነ ችግር ሌለብኝ *መደበኛ ተግባራቶቼን ለማከናወን ለነክተኛ ችግር ሌለብኝ *መጠነኛ የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *ጭንቀትም ሆነ ድብርት የለብኝም 3
*ምንም መራመድ ሊልኝልኝም *ለመታጠብም ሆነ ለመልበስ ምንም ችግር የለብኝም *መደበኛ ተግባራቶቼን ለማከናወን ከፍተኛ ችግር ሌለብኝ *የከፋ የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *ጭንቀትም ሆነ ድብርት የለብኝም 4	*መጠነኛ የሆነ የመራመድ ችግር ሌለብኝ *ለመታጠብም ሆነ ለመልበስ ከፍተኛ የሆነ ችግር ሌለብኝ *መደበኛ ተግባራቶቼን ለማከናወን ሊልኝልኝም *የሕመም ስሜትም ሆነ የምቶት ማጣት ስሜት የለኝም *እጅግ ከባድ ጭንቀት ወይም ድብርት ሌለብኝ 5	*የመራመድ ችግር የለብኝም *ለመታጠብም ሆነ ለመልበስ ለነክተኛ የሆነ ችግር ሌለብኝ *መደበኛ ተግባራቶቼን ለማከናወን ሊልኝልኝም *የሕመም ስሜትም ሆነ የምቶት ማጣት ስሜት የለኝም *ከባድ ጭንቀት ወይም ድብርት ሌለብኝ 6	*መጠነኛ የሆነ የመራመድ ችግር ሌለብኝ *ፊላ ልታጠብም ሆነ ልለብስ ሊልኝልኝም *መደበኛ ተግባራቶቼን ለማከናወን ሊልኝልኝም *የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *እጅግ ከባድ ጭንቀት ወይም ድብርት ሌለብኝ 7
*ከባድ የሆነ የመራመድ ችግር ሌለብኝ *ፊላ ልታጠብም ሆነ ልለብስ ሊልኝልኝም *መደበኛ ተግባራቶቼን ያለ ምንም ችግር ለከናወናለሁ *ከባድ የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *ከባድ ጭንቀት ወይም ድብርት ሌለብኝ 8	*ምንም መራመድ ሊልኝልኝም *ፊላ ልታጠብም ሆነ ልለብስ ሊልኝልኝም *መደበኛ ተግባራቶቼን ለማከናወን ሊልኝልኝም *የከፋ የሕመም ስሜት ወይም የምቶት ማጣት ስሜት ሌለኝ *እጅግ ከባድ ጭንቀት ወይም ድብርት ሌለብኝ 9		

ከ ታች የከፋ የጤና ሁኔታ

የጤና ሁኔታዎቼ በትክክለኛው ቅደም ተከተል መቀመጣቸውን ይጠይቁ።

መላሹ ያሰበውን እንዲናገርና ምርጫውን የመቀየር ዕቅድ ካለው ለምን ሊቀይር እንዳሰበ ምክኒያቱን ይጠይቁ።

በደረጃ አሰጣጡ ሂደት ላይ ከሚከተሉት መካከል አንዱን ከተመለከቱ፡

- የከፋ የጤና ሁኔታዎች ከላይ ከተቀመጡ (የተሻለ ዋጋ ከተሰጣቸው) ከሌሎች የጤና ሁኔታዎች አንፃር
- ከባድ የሆኑ የጤና ሁኔታዎች ከላይ ከተቀመጡ (የተሻለ ዋጋ ከተሰጣቸው) ከቀላል የጤና ሁኔታዎች አንፃር
- ብዙ የጤና ሁኔታዎች በእኩል ደረጃ ላይ ከተመደቡ

በዚህ ጊዜ ከመላሹ ጋር በአንድ ላይ በመሆን የደረጃ አሰጣጡን በድጋሚ ማየት ያስፈልጋል። ይህን ሲያደርጉ የእያንዳንዱን የጤና ሁኔታ ከእሱ እኩል ከተቀመጠው የጤና ሁኔታ አንፃር የተሰጠውን ደረጃ ማመዛዘን ያስፈልጋል። ጥያቄ ውስጥ የገባው የጤና

ሁኔታ በእርግጥም ከጎኑ ከላይ ወይም ከስሩ ከተቀመጠው የጤና ሁኔታ አንፃር የተሻለ የከፋ ወይም እኩል መሆኑን መላሹን በድጋሚ በመጠየቅ እንዲያረጋግጥልዎ ያድርጉ።

“ለመልስዎች በሰጠው ፍቺ/አተረጓጎም ደስተኛ መሆንዎን ማወቅ እንፈልጋለን። እባክዎትን ውጤት አሰጣጥዎን በጥንቃቄ ያስቡ። በጤና ሁኔታዎቹ ዙርያ መልሶችዎን ለማስተካከል ሃሳቡ አለዎት? መልስዎት አዎ ከሆነ እባክዎትን የትክክለኛውን የጤና ሁኔታ ሳጥን ይጫኑ።”

7.2 የአስተያየት ሳጥን

መላሹ የግብረ መልስ ሞጁልን ሞልቶ ሲጨርስ በፅሁፍ መፃፍያ ሳጥኑ ውስጥ አስተያየቱን አስቀምጦ እንዲያልፍ ይፈለጋል። ሆኖም ይህ ግዴታ አይደለም። መላሹ 'የደረጃ ቅደም ተከተልን አሳይ' የሚለውን ቁልፍ በመጫን ወደ ደረጃ አሰጣጥ ሂደቱ መመለስ ይችላል። ነገር ግን በእዚህ ደረጃ ላይ የጤና ሁኔታዎችን መምረጥ ወይም አለመምረጥ አይችልም።

8. የተለየ ምርጫ ሙከራ (ዲ.ሲ.ኢ.) ከንውኖች ለ 7 ጥንድ የጤና ሁኔታዎች

8.1 ትውውቅ

የስክሪኑ ይዘቶች ከምስል 12 ጋር ተመሳሳይ እንደሆኑ ያረጋግጡ። ለመላሹ የስክሪን ላይ የዲ.ሲ.ኢ. ትውውቅ መልእክቱን ያንብቡለት።

“አሁን 7 የተለያዩ መልክ ያላቸው ጥያቄዎች ይጠየቃሉ።”

ምስል 12: የ ዲ.ሲ.ኢ. ትውውቅ

በዚህ ክፍል ስለ ተለያዩ የጤና አከላኛ ያልዎትን ስሜት እንድንረዳ የሚያስችሉ ጥያቄዎች ይመለከታሉ። በሚቀጥለው ምሳሌ ውስጥ ከሁለት የጤና ሁኔታዎች መካከል ይመርጣሉ። ሀ እና ለ

እሺ

ሀ

ለ

የ ዲ.ሲ.ኢ. ክንውኑን ያስተዋውቁ

“ጥያቄዎቹ እስካሁን ካዩአቸው ጥያቄዎች ይለያሉ። አሁንም የሚመርጡት በሕይወት ሀ እና በሕይወት ለ መካከል ቢሆንም ነገር ግን በአሁኑ ላይ ሀ እና ለ እንደ ቀድሞው የተወሰነ የጊዜ ርዝማኔ ያላቸው አማራጮች ሳይሆኑ ሁለት የተለያዩ የጤና ሁኔታዎች ብቻ ናቸው። እንደ ቀድሞው ሁሉ የጤና ሁኔታዎቹ አምስት ገላጮችን የሚያካትት ነው።”

የሁለቱም የጤና ሁኔታዎችን መግለጫ በጥንቃቄ ማንበብ ጠቀሜታ ላይ ያተኮሩ።

“እያንዳንዱ የሚቀርብልህ ጥንድ ጥያቄ ለየት ያለ ይሆናል። ሁለቱንም ገላጮች በአግባቡ ማንበብህን እርግጠኛ ሁን እንዳንት ያለ ሰው በዚህ ዓይነት የጤና ሁኔታ ውስጥ ቢኖር ምን ይመስላል። ለእያንዳንዱ ጥንድ የጤና ሁኔታ የቱኛው ይሻላል ብለው እንደሚያስቡ ማወቅ እንፈልጋለን።”

8.2 የመጀመሪያና ቀጣይ ክንውኖች

መላሹን ሁለቱንም የጤና ሁኔታዎች ድምፁን ከፍ አድርጎ እንዲያነባቸው ይጠይቁ።

“ሁለት የተለያዩ የጤና ሁኔታዎች እዚህ ጋር ይታያሉ። እባክዎትን ሁለቱንም መግለጫዎች ድምፅዎትን ከፍ አድርገው ያንብቧቸው።”

መላሹ የራሱን ውሳኔ እንዲወስን እድል ይስጡት።

“የቱ ጤና ይሻላል ብለው ያስባሉ ሀ ወይስ ለ? እባክዎትን መልስዎትን በትክክለኛው ጥቁር ቁልፍ ላይ በመጫን ያመላክቱ።”

በእያንዳንዱ አዲስ ጥንድ የጤና ሁኔታዎች በሚቀርብበት ጊዜ መላሹ ድምፁን ከፍ አድርጎ እንዲያነባቸው ይጠይቁ። ከዛም የ ዲ.ሲ.ኢ. ክንውኑ እስከሚያልቅ ድረስ መላሹ በራሱ ይስራ።

8.3 የግብረ መልስ ጥያቄዎች

የመጨረሻውን የ ዲ.ሲ.ኢ. ክንውን (ሰባተኛ) ማለቅ ተከትሎ መላሹ ሶስቱን የ ዲ.ሲ.ኢ. ግብረ መልስ ጥያቄዎች በራሱ እንዲጨርስ ያድርጉ።

“አሁንም በድጋሚ በመለሷቸው ጥያቄዎች ላይ ያልዎትን አስተያየት እንቀበላለን።”

8.4 የአስተያየት ሳጥን

መላሹ ፈቃደኛ ከሆነ በፅሁፍ ሳጥኑ ውስጥ አስተያየት እንዲያኖር ይጠይቁ። ይህ ግዴታ አይደለም።

9. ክንውኖችን ማገባደድ

9.1 የአስተያየት ሳጥን

መላሹ ፈቃደኛ ከሆነ በፅሁፍ ሳጥኑ ውስጥ አስተያየት እንዲያኖር ይጠይቁ። ይህ ግዴታ አይደለም።

9.2 መደበኛ መጠይቅ

መሰረታዊው መጠይቅ ከተጠናቀቀ በኋላ መደበኛውን መጠይቅ በመክፈት ስለ መላሹ ተጨማሪ የድህረ ታሪክ መረጃዎችን መሰብሰብዎን አይርሱ።

የኪይ ቦርድ አቋራጮች ለቲ.ቲ.አ. ክንውን

የ ቲ.ቲ.አ. እና የ ዲ.ሲ.አ. ክንውኖችን በማውዝ ብቻ በመጠቀም ማጠናቀቅ ይቻላል። ነገር ግን ምናልባት መላሹ ማውዝ መጠቀም ባይመቸው እነኚህ ቀጥሎ የተዘረዘሩት የኪይ ቦርድ አቋራጮችን እንደ አማራጭ መጠቀም ይቻላል።

ድርጊት	ቁልፍ
“ሀ” መምረጥ	A
“ለ” መምረጥ	B
“ሀ እና ለ ከሞላ ጎደል ተመሳሳይ ናቸውን መምረጥ” (ቲ.ቲ.አ. ብቻ)	s
የእርዳታ መልዕክት መስኮትን መዝጋት	x
ጥያቄውን ወደ ነበረበት መመለስ (ቲ.ቲ.አ. ብቻ)	r

ቀስቃሾች

በማንኛውም ሰዓት ከተቻለ የጥናቱ ተሳታፊ ክንውኖቹን በራሱ ያድርግ። ሆኖም አንዳንድ ጊዜ ቀጥለው በቀረቡት ምክኒያቶች ጣልቃ መግባትና እገዛ ማድረግ አስፈላጊ ሊሆን ይችላል።

1. በሕይወት ሀ ውስጥ ያለው ጊዜ 10 ዓመታትን በሙሉ ጤንነት ሆኖ ሳለ መላሹ ሕይወት ሀ አይመርጥም

መላሹ ይህን ለምን እንዳደረገ ይጠይቁት

- በአረዳድ ችግር ምክኒያት ነበር?
- ጥናቱን ቶሎ ጨርሰው ለመሄድ ፈልገው ነው?

አስፈላጊ ከሆነ ማብራርያ ይስጡ - ለምሳሌ መልሳቸው ሙሉ ጤነኛ ከመሆን ይልቅ ሕመምተኛ መሆን ይሻላል ወይም ደግሞ ለ 10 ዓመታት ያህል እየታመመ መኖርና ለ 10 ዓመታት ያህል በሙሉ ጤንነት መኖር እኩል ናቸው። የጥናቱ ተሳታፊ የሚፈለገው መረጃ ሙሉ በሙሉ ግልፅ እንደሆነላቸው ሲረዱ ብቻ ጥናቱን ለመቀጠል በድጋሚ መጠየቅ ይችላሉ።

2. መላሹ በቋሚነት ሙሉ ዓመትን ብቻ ለምርጫ ሲጠቀም

መላሹ ከዓመት በታች የሆነ የጊዜ ርዝመት ለአማራጭ መጠቀም እንደሚችል ያስታውሱት (ለምሳሌ - 9 ዓመት ከ6 ወራት መምረጥ ይችላሉ)

3. መላሹ ከሞት ለተሻሉ እና ከሞት ለባሉ ሁኔታዎች መሃከል የሚደረገው ምርጫ ላይ አማራጮችን ለማቀዳየር ሲቸገር ስናይ

መጠይቁ ከሞት ለባሉ የጤና ሁኔታዎች በሚቀየርበት በእያንዳንዱ ጊዜ መላሹ በትክክል ለውጥ መኖሩን መረዳቱን ማረጋገጥ ያስፈልጋል። ክፍል አራትን እንደ መመሪያ በመጠቀም አስፈላጊ ከሆነ ተጨማሪ ማብራሪያ ይስጡ።

- መላሹ የጤና ሁኔታው ከሞት የባለ አይደለም ብሎ የሚያምን ከሆነ የ ለ ቁልፍን መጫን ወደ መደበኛው የ ቲ.ቲ.ኦ. ፎርማት በመመለስ ከሞት የተሻሉ ወደሚባሉት የጤና ሁኔታዎች ይመልሰዋል።
- መላሹ በሁለቱ ፎርማቶች መካከል እየተመላለሰ ከተቸገረ (ማለትም ከሞት በተሻሉ የጤና ሁኔታዎች ውስጥ ሕይወት ሀ በመምረጥና ከሞት በባሉ ሁኔታዎች ውስጥ ሕይወት ለ) በመምረጥ መካከል ግራ ተጋብቶ ከሆነ ክንውኑን ለማጠናቀቅ ሀ እና ለ ከሞላ ጎደል ተመሳሳይ ናቸው በመጫን እንዲወጣ ማድረግ ወይም ደግሞ የጤና ሁኔታው ከሞት የተሻለ ወይም የባለ መሆኑን በመጠየቅ እና የሚሰጠው መልስ ላይ በመመርኮዝ የትኛውን ፎርማት መጠቀም እንዳለበት መግለፅ

4. መላሹ ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸው ብሎ የሚያስብበት ነጥብ ላይ መድረስ ሲያቅተው

ከስድስት ወራት በታች ለሆነ የጊዜ ርዝማኔ መተግበሪያው አማራጮች የሉትም። በመሆኑም መላሾች በዚህ አጋጣሚ ሲቸገሩ ሊታዩ ይችላሉ። በዚህን ጊዜ ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል እኩል ናቸው ቁልፍን በመጫን ወደ ቀጣዩ ክንውን መሄድ እንዳለበት ለመላሹ ማስረዳት።

5. ሕይወት ሀ ውስጥ ያለው የጊዜ ርዝማኔ ዜሮ ዓመት ሲሆን መላሹ ሕይወት ሀ እና ሕይወት ለ ከሞላ ጎደል ተመሳሳይ ናቸውን ይመርጣል (በብዛት በአንድ ቲ.ቲ.ኦ. ክንውን ውስጥ የሁለተኛው ድርጊት)

መላሹ በትክክል ለ10 ዓመታት በዚህ የጤና ሁኔታ ውስጥ ከመኖር ይልቅ አሁን መሞትን መርጦ እንደሆነ ምርጫውን ያደረገው በሚገባ ያረጋግጡ። ለ10 ዓመታት በዚህ የጤና ሁኔታ ውስጥ ከመኖር ይልቅ አሁን መሞትን የሚመርጥ ከሆነ የ ሀ ቁልፍን ይጫን እና ከሞት የባሉ የጤና ሁኔታዎችን ፎርማት ይጠቀም። የማረጋገጫ መልእክት የያዘ መስኮት በኮምፒውተር ስክሪኑ ላይ ይቀርባል።

Annex-II: Paper based questionnaire



የፋርማኮ ኢፒዲሞሎጂ እና ሶሻል ፋርማሲ ትምህርት ክፍል

እንደምናውቀው በአሁኑ ጊዜ በቂ የሆነ በጀት የለም። በመሆኑም ያለውን በጀት በአግባቡ በ ዋና ዋና የሆኑ የህዝቡ የጤና ችግሮች ላይ ቢውል በጣም ጠቃሚ ነው። ስለዚህ ይህ ጥናት የኢትዮጵያ ህዝብ በተለያዩ የጤና እክሎች ላይ ያለውን እይታ ለመመልከት የተዘጋጀ ነው። በመቀጠል የተለያዩ የጤና እክሎችን/ሁኔታዎችን እንዲመለከቱ ይጠየቃል። እናም የትኛው የጤና ሁኔታ እንደሚሻል ይመርጣል። እንዲያደርጉ የምንጠይቅዎ ይህንን ይመስላል

✦ በመጀመሪያ ዛሬ ያልዎት የጤና ሁኔታ እንዴት እንደሆነ እንጠይቅዎታለን። ይህም በመቀጠል የሚቀርብልዎትን ጥያቄዎች ምን እንደሚመስሉ ለማወቅ ይረዳዎታል። ዛሬ ያልዎትን የጤና ሁኔታ ከ 0 (የከፋ የጤና ሁኔታ) እስከ 100 (በጣም ጥሩ የጤና ሁኔታ) መለኪያ ላይ እንዲያስቀምጡ ይጠየቃል።

✦ በመቀጠል እርስዎን የሚገልፁ አምስት የጤና ሁኔታዎች በሚሰጥዎት መለኪያ የት ላይ እንደሚያስቀምጡት እንዲያመለክቱ ይጠየቃል።

✦ በመጨረሻም ከሁለቱ የተለያዩ የጤና ሁኔታዎች መካከል እንዲመርጡ ይጠየቃል።

ጥቂቶቹ የጤና ሁኔታዎች አዲስ ሊሆኑብዎት ይችላሉ። ለምሳሌ ያህል አንድ ሰው መራመድ እየቻለ ነገር ግን እራሱን ማልበስ ወይም መታጠብ ይሳነዋል፤ አንድ ሰው ሕመም ወይም የምችት ማጣት ስሜት ሳይኖረው የአልጋ ቁራኛ ይሆናል ወ.ዘ.ተ... የሚሉ ሁኔታዎች ሊያጋጥሙዎት ይችላሉ። እርስዎ የሚጠበቅብዎት እነኚህ ሁኔታዎች ተከስተው ቢሆን ብለው በምናብዎ በማሰብ ጥያቄዎቹን መመለስ ነው።

በአንዳንድ ሁኔታዎች ላይ በተገለፀው የጤና ሁኔታ ከመኖር ይልቅ ወዲያውኑ መሞትን ሊመርጡ ይችላሉ። በመቀጠል ወዲያውኑ ከመሞት እና በተገለፀው የጤና ሁኔታ ለተወሰኑ ዓመታት ኖረው የተቀሩትን በሙሉ ጤንነት መኖር መካከል እንዲመርጡ ይጠየቃል። መጠይቁ በሚካሄድበት ወቅት እነዚህ አሰራሮች በጠያቂው ይብራሩልዎታል።

ይህ ጥናት ጊዜ እንደሚወስድና ጊዜዎትን እንደሚሻማብዎት እናውቃለን። ለሚያደርጉልን ትብብር አስቀድመን በእጅጉ እናመሰግናለን። እርስዎ የሚሰጡን መረጃ የሀገሪቷን የጤና አሰጣጥ ስርዓት እና የበጀት አጠቃቀም ምን መምሰል እንዳለበት ለመወሰን እንደሚረዳ ተስፋ እናደርጋለን። እናመሰግናለን!

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት? አዎ ☐ አይደለሁም ☐

ፈቃደኛ መሆንዎትን ካረጋገጡ ቃለ መጠይቁን ይጀምሩ

- የጥናቱ ተሳታፊ መለያ ቁጥር_____
- ቲ.ቲ.አ ቁጥር_____
- ዲ.ሲ.ኢ. ቁጥር_____

እርስዎን በተመለከተ አጠቃላይ መጠይቅ	መልስ
1. እድሜ	_____ ዓመት
2. ጾታ	☐ ወንድ ☐ ሴት
3. የጋብቻ ሁኔታ	☐ ያላገባ/ች ☐ ያገባ/ች ☐ አግብቶ/ታ የፈታ/ች ☐ የትዳር ንደኛን በሞት ያጣ/ች
4. የትምህርት ደረጃ	☐ አማርኛ ቋንቋ ማንበብ የሚችል/የምትችል ☐ አንደኛ ደረጃ ትምህርት (ከ 1ኛ-8ኛ ክፍል) ☐ ሁለተኛ ደረጃ/መሰናዶ ትምህርት (ከ 9ኛ-12ኛ ክፍል) ☐ ከፍተኛ ትምህርት (ሰርተፍኬት፣ ዲፕሎማ፣ የመጀመሪያ ዲግሪና ከዚያ በላይ)
5. የስራ ቅጥር ሁኔታ	☐ ተቀጣሪ / የግል ስራ ☐ ጡረተኛ ☐ ተማሪ ☐ የቤት እመቤት ☐ ሌሎች፣ይግለፁ _____
6. ከዚህ በፊት በጽኑ የመታመም አጋጣሚ	☐ በራስ ☐ በቤተሰብ ☐ ሌሎችን በማስታመም ☐ የለም
7. ሃይማኖት	☐ ክርስትያን ☐ ሙስሊም ☐ ሌሎች፣ይግለፁ _____

እንቅስቃሴ

- የመራመድ ችግር የለብኝም ☐
- አነስተኛ የሆነ የመራመድ ችግር አለብኝ ☐
- መጠነኛ የሆነ የመራመድ ችግር አለብኝ ☐
- ከባድ የሆነ የመራመድ ችግር አለብኝ ☐
- ምንም መራመድ አልችልም ☐

ራስን መንከባከብ

- ለመታጠብም ሆነ ለመልበስ ምንም ችግር የለብኝም ☐
- ለመታጠብም ሆነ ለመልበስ አነስተኛ የሆነ ችግር አለብኝ ☐
- ለመታጠብም ሆነ ለመልበስ መጠነኛ ችግር አለብኝ ☐
- ለመታጠብም ሆነ ለመልበስ ከፍተኛ የሆነ ችግር አለብኝ ☐
- ራሴ ልታጠብም ሆነ ልለብስ አልችልም ☐
- መደበኛ ተግባራት (ለምሳሌ፦ ስራ፣ ትምህርት፣ የቤት ውስጥ ስራ፣ ቤተሰባዊ ወይም የእረፍት ጊዜ ተግባራት)**
- መደበኛ ተግባራቶቼን ያለ ምንም ችግር አከናውናለሁ ☐
- መደበኛ ተግባራቶቼን ለማከናወን አነስተኛ ችግር አለብኝ ☐
- መደበኛ ተግባራቶቼን ለማከናወን መጠነኛ ችግር አለብኝ ☐
- መደበኛ ተግባራቶቼን ለማከናወን ከፍተኛ ችግር አለብኝ ☐
- መደበኛ ተግባራቶቼን ለማከናወን አልችልም ☐

የሕመም ስሜት/ምቹት ማጣት

- የሕመም ስሜትም ሆነ የምቹት ማጣት ስሜት የለኝም ☐
- አነስተኛ የሕመም ስሜት ወይም የምቹት ማጣት ስሜት አለኝ ☐
- መጠነኛ የሕመም ስሜት ወይም የምቹት ማጣት ስሜት አለኝ ☐
- ከባድ የሕመም ስሜት ወይም የምቹት ማጣት ስሜት አለኝ ☐
- የከፋ የሕመም ስሜት ወይም የምቹት ማጣት ስሜት አለኝ ☐

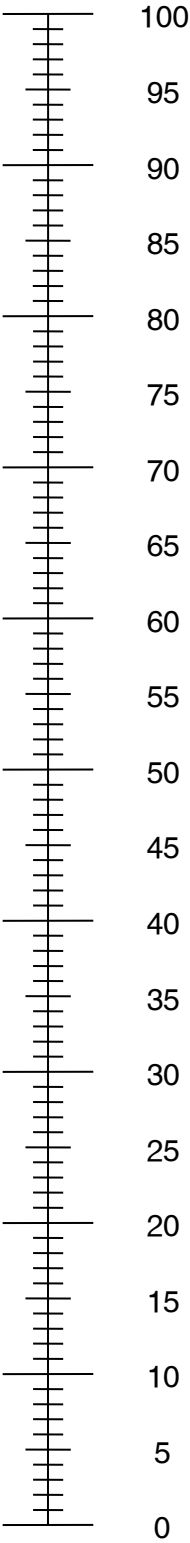
ጭንቀት/ድብርት

- ጭንቀትም ሆነ ድብርት የለብኝም ☐
- አነስተኛ ጭንቀት ወይም ድብርት አለብኝ ☐
- መጠነኛ ጭንቀት ወይም ድብርት አለብኝ ☐
- ከባድ ጭንቀት ወይም ድብርት አለብኝ ☐
- እጅግ ከባድ ጭንቀት ወይም ድብርት አለብኝ ☐

- ዛሬ የጤና ሁኔታዎ ምን ያህል ጥሩ ወይም መጥፎ መሆኑን ለማወቅ እንፈልጋለን፡፡
- መለኪያው ከ0 እስከ 100 ድረስ ቁጥሮች አሉት፡፡
- 100 ማለት ሊኖርዎ የሚችለው በጣም ጥሩው የጤና ሁኔታ ነው።
0 ማለት ሊኖርዎ የሚችለው በጣም መጥፎው የጤና ሁኔታ ነው።
- በመለኪያው ላይ ዛሬ ጤንነትዎ ያለበትን ሁኔታ ለማሳየት የ “X” ምልክት ያድርጉ፡፡
- አሁን፣ ከስር ባለው ሳፕን ውስጥ በመለኪያው ላይ ምልክት ያደረጉበትን ቁጥር ይጻፉ፡፡

የዛሬ ጤንነትዎ =

ሊኖርዎ የሚችለው በጣም
ጥሩው የጤና ሁኔታ



ሊኖርዎ የሚችለው በጣም
መጥፎው የጤና ሁኔታ