ADDIS ABABA UNIVERSITY
COLLEGE OF DEVELOPMENTAL STUDIES
CENTER FOR POPULATION STUDIES – REPRODUCTIVE HEALTH

PREDISPOSING, ENABLING, AND NEED FACTORS ASSOCIATED WITH SEXUAL AND REPRODUCTIVE HEALTH SERVICE UTILIZATION AMONG INTERNALLY DISPLACED WOMEN AND GIRLS: EVIDENCE FROM AMHARA REGION

By

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JUNE 2022

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF THE ADDIS ABABA UNIVERSITY IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN POPULATION STUDIES

October 2022,
Addis Ababa,
Ethiopia

DECLARATION

I, hereby declare that the thesis entitled **"*PREDISPOSING, ENABLING, AND NEED FACTORS ASSOCIATED WITH SEXUAL AND REPRODUCTIVE HEALTH SERVICE UTILIZATION AMONG INTERNALLY DISPLACED WOMEN AND GIRLS: EVIDENCE FROM AMHARA REGION*"** is my original work and has not been submitted earlier for the award of any academic degree or diploma. I also declare that no chapter of this thesis in the whole or part incorporated in this thesis from any earlier work done by others or myself. All sources of materials used for this thesis have been duly acknowledged. The participant's rights to anonymity and withdrawal from the study without prejudice are considered important ethical considerations in this research.

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ENDORSEMENT

This thesis has been submitted to Addis Ababa University, College of Development Studies, and Center for Population Studies for examination with my approval as a university supervisor.

Supervisor: Mr. Chalachew Arega

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Date: October 2022

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APPROVAL SHEET

This is to certify that **Bethelhem Fekade** has fulfilled the requirements prescribed for the MSc degree in the College of Development Studies, Addis Ababa University. The thesis entitled *"**PREDISPOSING, ENABLING, AND NEED FACTORS ASSOCIATED WITH SEXUAL AND REPRODUCTIVE HEALTH SERVICE UTILIZATION AMONG INTERNALLY DISPLACED WOMEN AND GIRLS: EVIDENCE FROM AMHARA REGION**"* was carried out under my supervision and evaluated and approved by examiners. No part of the thesis has been submitted for the award of any degree or diploma before this date. Ethical clearance was obtained from the Institutional Review Board (IRB) of the College of Development Studies, Addis Ababa University.

Approved by the examining board

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Chairman, Department Graduate Program Coordinator	Signature

DEDICATION

I dedicate this thesis paper to my late father, who passed few weeks after I completed this paper. A loving father who always taught me that education is a great tool to thrive and transform. I'm sure he is happy in heaven to see my small progress.

This thesis paper is mostly dedicated to all the countless displaced mothers, wives, and girls who lost their husbands, fathers, sons, and brothers during the Northern War. To all the women and girls who had unnecessarily sacrificed their loved ones, gone through physical and sexual abuse, forced to live in uncomfortable living conditions in the camp, their stories and suffering are far beyond what this paper can express. I wish all the displaced people a lifetime of mental peace.

ACKNOWLEDGMENT

I am deeply grateful to God for his blessings and grace throughout my journey.

I sincerely thank my incredible advisor, mentor, and friend, Mr. Chalachew Arega, for his invaluable guidance and advice during my thesis work. I would also like to thank my examiners, Professor Nigatu Regassa and Dr. Wondimeye Ashenafi, for their critical feedback, insightful suggestions, and consistent follow-up. I am incredibly thankful for the remarkable trust they both had shown me. I also owe a huge debt of gratitude to Mr. Tariku Dejene for his exceptional guidance on the step-by-step KoBo toolbox a mobile data collection tool, which significantly simplified the data collection and analysis process for this thesis. I would also like to sincerely thank the CPS non-academic staff, Selamina, and Elsa, for their consistent kindness and care throughout my studies.

I am grateful to Dr. Tesfaye Hurissa for his invaluable input on the Sexual and Reproductive Health aspects of my thesis. My sincere appreciation goes to Mr. Abduilhafiz Hassen at the Ethiopian Public Health Institute (EPHI) and Ato Abraham at the International Organization for Migration (IOM) Amhara region focal person for providing monthly status updates on Internally Displaced People (IDPs) in the Amhara region. Their support was crucial to this research.

I am especially grateful to the great people at the Federal Ministry of Health – Dr. Meseret Zelalem, Haregwoin Taddesse, and Eyob Getachew – for their responsiveness and for creating the essential link with Amhara Regional Health Bureau and Zonal Health Department experts. My deepest appreciation also extends to all the respondents and the key personnel who were interviewed despite their busy schedules, their time is the foundation of this work. This research would not have been possible without the dedication of the six female data collectors in Debrebirhan, Gondar, and Woldiya who undertook the significant task of this study.

Finally, and most importantly, I express my deepest gratitude to my unwavering support system: my parents, husband, siblings, and niblings. Their unconditional love and care throughout this entire journey have been my greatest source of strength.

ACRONYMS

ANC	Antenatal Care
ARDRMC	Amhara Region Disaster Risk Management Commission
CI	Confidence Interval
DPFSPO	Disaster Prevention Food Security Coordination Office
DPRM	Disaster Prevention and Risk Management Bureau of Amhara
EDHS	Ethiopian Demographic Health Survey
EPHI	Ethiopian Public Health Survey
FGD	Focus Group Discussion
FMOH	Federal Ministry of Health
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immune Deficiency Virus
IAWG	Inter-Agency Working Group
IDPs	Internally Displaced Persons
IDW	Internally Displaced Women
IPPF	International Planned Parenthood Federation
KII	Key Informant Interview
LARC	Long-Acting Reversible Contraception
MISP	Minimum Initial Service Package
MNS	Maternal and Newborn Service
NGO	Non-Governmental Organization
ODK	Open Data Kit
OR	Odds Ratio
PHEOC	Public Health Emergency Operation Center
PNC	Post Natal Care
RDRMB	Regional Disaster and Risk Management Bureau
RHS	Reproductive Health Service
RR	Reproductive Rights
SDG	Sustainable Development Goal
SPSS	Statistical Package for the Social Sciences
SRH	Sexual Reproductive Health
SRHS	Sexual Reproductive Health Service
STI	Sexually Transmitted Infections
UNFPA	United Nations Fund for Population
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs.
WHO	World Health Organization

ABSTRACT

Background: *Millions of people worldwide are displaced due to conflict and natural disasters. In Ethiopia's Amhara region, over two million people are Internally displaced (IDPs) due to the northern conflict, creating a critical gap in access to essential health services, including Sexual and Reproductive Health (SRH) services.*

Objective: *This study examines the factors influencing SRH service utilization including the levels, determinants, and challenges among IDPs in Amhara.*

Methods: *A cross-sectional study design employing quantitative (survey with 549 IDP women aged 15-49) and qualitative (FGDs and KIIs with service providers, government officials, and IDP youth) methods were used in DebreBirhan, Gondar, and Woldiya town.*

Results: *The study found significant associations between SRH utilization and education level, source of SRH information, household size, and preference for using health facilities. Qualitative findings revealed a gap between SRH policies and their implementation in IDP settings, with commodity shortages being a major constraint. It also revealed that inadequate attention was given to IDPs in general and for those who reside particularly in Gondar Camp.*

Recommendations: *This study recommends multisectoral collaboration to improve SRH service delivery, including disseminating information through various channels, establishing youth-friendly services in camps, and coordinating with stakeholders to ensure adequate SRH commodity availability.*

Keywords*: SRH, Women (aged 15-49), IDPs, Amhara region, northern war*

CHAPTER ONE
INTRODUCTION

Worldwide the growing insurgencies and other kinds of war, violence, and conflicts have left many people displaced in their own countries (Humanitarian Aid and Civil Protection, 2016). Due to the uncertainties in political, social, and economic circumstances in many countries, there are a substantial number of Internally displaced peoples (IDPs). Due to conflict and brutality, several people are displaced from place to place and from region to region. It is roughly estimated that close to two billion people worldwide are displaced, which is by far the highest number. According to the United Nations High Commissioner for Refugees (UNHCR), the number of forcibly displaced people has nearly doubled in the past two decades, with numbers remaining at a record high. (UNHCR, 2017). This indicates almost 68.5 million people worldwide are fleeing from their original residences. (UNOCHA, 2019).

In different parts of the world, IDPs are exposed to numerous health socio-economic, and cultural problems. In 2019, UNFPA estimated that out of a million people demanding humanitarian aid for reasons related to conflict and natural disasters, 35 million were women and girls aged 15–49 (UNFPA, 2019). Generally, people in these IDP camps face numerous health challenges (Olawale, 2015) including Sexual and Reproductive Health (SRH) challenges. Displaced women are in higher need of health care services, and they face health risks including Gender Violence (GBV) most noticed among adolescents and youth, lack of access to contraception, safe abortion services, and maternal health care services. Access to Sexual and Reproductive Health care Services (SRHS), including contraception and maternal care is recognized as part of the right to health (Galdos Silva, 2013).

SRH is a human right and, like all other human rights, applies to refugees, IDPs, and others living in fragile settings. (IAFM, 2018). Demanding humanitarian assistance has insufficient access to the SRH services to which they are entitled.

The SRH and reproductive rights of those in need of humanitarian assistance can only be realized by ensuring accountability (UNOCHA, 2020). Inadequate access to SRH services during emergencies contributes to unintended pregnancies, unsafe abortion, maternal morbidity and mortality, and increased incidence of sexually transmitted infections. (IAWG, 2019).

In the mid-1990 the global community began prioritizing the SRH needs of refugee and displaced populations. In 1995, more than 50 governments, United Nations (UN) agencies, and non-governmental organizations (NGOs) committed themselves to strengthening SRH in the fragile setting. One of the first activities of the new organization was to develop guidelines for providing reproductive health services for the IDP community. Importantly, A set of minimum reproductive health interventions as outlined in the manual. These minimum reproductive health interventions are to be put in place at the beginning of a humanitarian crisis and are known as the minimum initial service package (MISP). The minimal initial services package (MISP) was established to respond to the need for reproductive health at the beginning of the crisis and it has 6 building blocks that are set to be met in the fragile or humanitarian setting.

The Minimal Initial Services Package (MISP) was developed to respond to reproductive health desires at the onset of the IDP crisis and includes the following parameters. Preventing sexual violence, preventing the transmission of and reducing morbidity and mortality due to human immunodeficiency virus (HIV) and other STIs, preventing excess maternal and newborn morbidity and mortality, and preventing unintended pregnancies.

Despite efforts to enhance the availability and uptake of the (MISP), unmet SRH needs persist high and are mainly dire for adolescents and mothers affected by humanitarian emergencies (Fatusi A, 2016). Increasing access and utilization of SRH service outcomes among IDPs is critical. This study aims to explore and describe SRH interventions for IDPs to better inform the evidence-based interventions for improving SRH service outcomes. A stronger evidence base is needed to understand the context better.

1.1. SITUATION OVERVIEW

1.1.1 OVERVIEW OF IDPs IN AMHARA REGION

According to the Internal Displacement Monitoring Centre, there are slightly more than two million IDPs in Ethiopia at present, largely due to ethnic conflict, political instability, and scarce environmental resources. IDPs in Ethiopia have a significant unmet need for contraceptive services, including an unmet need for modern contraceptives nearly 50% (Gebrecherkos et al. 2018).

In early November 2020, the party that administers Tigray, the Tigray People Liberation Front (TPLF) attacked the Northern Command of Ethiopia's National Defense Force in Mekelle, Tigray region, prompting a military offensive conducted by the federal government of Ethiopia. Following this, conflict broke out in the Northern part of the country, and estimates show that the number of IDPs that were displaced because of the conflict is more than two million. (The Guardian, 2021). When conflict broke out in November 2020 in the Tigray region, it was not contained solely within the Tigray region it also spilled into the neighboring regions of Afar and Amhara. After the change of administration in Tigray at the end of June 2021, the conflict began to move south, and this is evident in the significant increase in IDPs. (IOM, 2021)

In the Amhara region, hundreds of thousands of people are displaced from their homes due to the northern regional conflict. As stated by the Amhara region Disaster Risk Management Commission report, it is estimated that the majority of IDPs are living within the host community in various conditions. There are also 13 collective IDP sites in different zones of the region.

Table 1: Displacement in the Amhara region monthly figure (PHEOC report, 2021-22)

Month	Total IDPs	Host Community	Collective sites
September 2021	1,144,397		
October 2021	2,250,274	2,109,602	140,672
November 2021	2,259,544	2,118,872	140,672
December 2021	2,356,587	2,202,085	154,502
January 2022	1,448,693	1,429,170	19,523
February 2022	1,119,810	1,084,305	35,505

A significant number of IDPs are also living in an open area that is not recognized nor protected by the local government as official IDP sites. (UNFPA HRP, 2021-2022). During the war, in November 2020 - 2021 more than 40 hospitals, 453 health centers, 1850 health posts, 4 blood banks, 2 Health science colleges, 465 private health facilities, and a total of 2,356,587 IDPs, and the majority >90% were in the host community. In November, where there was a huge need for 11,274,099 need humanitarian assistance (APHI report, 2021) Consequently, access to essential health services is a critical gap that requires urgent humanitarian intervention in liberated and occupied areas of the region.

A total of 674,492 clients have not used family planning services due to the conflict of which 18,885 pregnant women are escorted for unsafe abortion services that will cause a minimum of 756 maternal deaths. Similarly, 180,313 pregnant women missed maternity care across the continuum. As a result, at least 25,047 pregnant women and 10,819 neonates in war-affected zones are expected to suffer and probably would die. Besides, 38,045

mothers were not enrolled in the PMTCT service which resulted in 213 newborns acquiring HIV, and 881 exposed infants who discontinued the PMTCT service acquired HIV. Furthermore, 2341 clients who expected to use safe abortion and post-abortion services in war-affected zones didn't get the services. However, post-abortion care service users increased by 24.1% in South Gondar, 16% in Oromia special, 11% in the North Shewa zone, and 5.2% in South Wollo.

1.1.2. STATEMENT OF THE PROBLEM

SRH is important in all health delivery settings, especially in a crisis and fragile setting. Inadequate SRH service provision has been linked to unintended pregnancies, complications related to unsafe abortions, gender-based violence, obstetric emergencies, and increases in HIV and Sexually Transmitted Infections (STIs) (Singh et al, 2017) Obstetric emergencies, human immunodeficiency virus (HIV), sexually transmitted infections (STIs), and gender-based violence (GBV) are all significant contributors to morbidity and mortality in disaster settings (Bartlett et al. 2002, Gassler et al. 2004, Salama et al. 2004).

Women and girls are affected significantly in both sudden and slow-onset emergencies and face numerous SRH challenges in humanitarian crisis contexts. There are an estimated 26 million women and girls of reproductive age living in humanitarian crisis settings, all of whom need access to SRH information and services. (Casey SE, 2015). Access to family planning, SRH interventions, antenatal care, and services for sexual violence all remain low (UNHCR, 2019). Different studies have reported unfavorable reproductive outcomes following an internal displacement, including early pregnancy loss, premature delivery, stillbirths, delivery-related complications, and infertility.

Access and use of SRH services among young women in humanitarian settings are limited, even when services are available (Hindin, Kalamar, Thompson, Upadhyay, 2016). IDPs, specifically for unmarried youth SRH have not been given adequate attention. The health of this group of young people is most often overlooked in turbulent times of disaster and

conflict while they form the economic power of most families in the camp. (UNFPA, 2016). The existing research suggests that humanitarian crises may further exacerbate the risks related to poor SRH and limited service availability, especially for young women in these contexts (Askew et al, 2016, Barot. S, 2017).

According to WHO (2017), the progress seen in the sector is very little in advancing the evidence base for the effectiveness of SRH interventions, including the MISP, in crisis settings. A greater quantity and quality of more timely research is needed to determine the effectiveness of delivering SRH interventions in a variety of humanitarian crises. (WHO, 2017). The Existing empirical evidence clearly shows that forced migration and human mobility increase the vulnerability of girls and women to poor SRH outcomes such as lack of contraception use, high-risk sexual behaviours, STIs, and HIV/AIDS. (UNFPA, 2018).

IDPs in Ethiopia have a significant unmet need for contraceptive services, including an unmet need for modern contraceptives totaling nearly 50% (Gebrecherkos et al. 2018). This is a huge concern, as the inability to access modern contraceptives can lead to unplanned pregnancies, poor child spacing, unsafe abortions, and an increased prevalence of sexually transmitted infections. SGBV is also prevalent among IDPs in Ethiopia, leading to physical and mental health problems (Feseha and Gerbaba 2012). In a humanitarian setting, it is estimated that each year, 12 million women of reproductive age group give birth, unsafe abortion is also common, and close to 3.2 million are exposed to unsafe abortion among IDPs. (Singth, 2014).

Further, the situation at the camp coupled with mental health disorders can compound the risks for poor SRH outcomes and respectively impact SRH service use. Mental health disorders account for approximately 16% of the global burden of disease among young people aged 15–19 (WHO Factsheet, 2018). Young people living in fragile settings are at an even higher risk of developing mental health problems due to their living conditions (WHO fact sheet, 2018). These risks are further heightened among young women and girls because they are more likely to develop mental health problems.

Based on the Regional Disaster and Risk Management Bureau of Amhara (RDRMB) as of Feb 1, 2022, more than 1,119,810 IDPs are living in the Amhara region, of whom 35,505 (3.2%) are living in 22 collective sites. An additional 8,209,317 people need essential health services in war-affected areas. More than 40 hospitals, 453 health centers, and 1850 health posts were damaged and/or looted during the conflict. Consequently, access and utilization of essential health services is a critical gap that requires urgent attention.

As per the Amhara Regional Public Health Emergency Operation Center report, so far, a total of 2,806 pregnant women accessed antenatal care services for the first time (ANC 1) while 1,126 of them received the fourth ANC service. Besides, a total of 669 pregnant women gave birth at nearby health facilities and 631 of them have got PNC service. Also, 8,801 women accessed the modern contraceptive methods of their choice. Mental and psychosocial support is being delivered on a routine and campaign basis by psychiatrists and a total of 5144 received psychosocial support. Essential health service delivery is interrupted and affected. Besides more than 9,888 health workers are displaced.

Ethiopia has never experienced such a huge number of IDPs in one region due to conflict, in the recent history of the country, it has never happened in such magnitude Taking all the health burdens and urgencies into account, the Ministry of Health recently adopted an SRH toolkit for humanitarian settings. The toolkit includes key Minimum Initial Service Packages (MISP) for SRH that should be made available in all humanitarian contexts. To date, no comprehensive and rigorous research has been conducted to show the situation of SRH services in the conflict-affected. However, this research is presumed to provide valuable insight into MISP SRH service in fragile settings. Therefore, this research aimed at predisposing, enabling, and need factors associated with sexual reproductive health service utilization among internally displaced women and girls in the Amhara region.

1.2. RESEARCH OBJECTIVES

1.2.1. GENERAL OBJECTIVE

The major objective of the study is to examine the levels, determinants, and challenges of SRH service utilization among IDPs in the Amhara region.

1.2.2. SPECIFIC OBJECTIVES OF THE STUDY

This study is aiming to:

- Assess the levels of SRH service utilization among women of reproductive age in the IDP camps.
- Examine the key predictors of SRH utilization among women of reproductive age in the selected IDP centers.
- Explore policy/ administrative level gaps and facilitators to avail SRH services in the IDP setting.
- Identify the major challenges/ constraints of SRH services at the health facilities from service providers' and clients' perspectives.

1.3. RESEARCH QUESTIONS

- What is the level of utilization of SRH service?
- What are the major factors that influence the utilization of SRH services among IDPs living in the Amhara region?
- What are the gaps and challenges associated with the delivery of SRH services and assess policy, and resource implications to utilize SR services?

1.4. SIGNIFICANCE OF THE STUDY

Evidence shows that there are poor and inadequate SRH services in fragile settings and this has been linked with unplanned pregnancies, complications related to unsafe abortions, gender-based violence, and increases in HIV and sexually transmitted infections (STIs). (Singh NS, Aryasinghe S, Smith J, et al. 2018). In a humanitarian or fragile setting where IDPs are residing in need of SRH services, it is proven that there is a lack of substantial research to explore the need for SRH services and design-focused interventions to improve SRH outcomes among women of reproductive age groups in specific cultural contexts. (Casey SE, 2015)

This study aimed to explore the utilization of SRH utilization among IDPs in the Amhara region. The result of this research will contribute to the development of appropriate planning. The study will fill the current research/evidence gaps and identify the factors for SRH utilization in the conflict zones. The research will ease the implementation process for humanitarian and developmental organizations in the implementation of the Minimum Initial Standard Package (MISP) for SRH and help in designing tailored strategies. This will in turn enhance and improve the well-being of those IDPs in the region. Furthermore, the study will serve as reference material for those interested in the field of SRH service in a humanitarian setting. This study will have practical significance to shed light on further studies.

Understanding the SRH needs, and utilization patterns of internally displaced women and girls is crucial for humanitarian efforts. It allows aid organizations and governments to tailor their assistance programs effectively to address the specific needs of this vulnerable population. Researching the SRH utilization among internally displaced populations contributes to addressing health disparities. By identifying barriers to accessing SRH services, policymakers can work towards ensuring equitable access to healthcare services for all, regardless of displacement status. Findings from such a study can inform policy development and implementation.

Governments can use this data to create policies that prioritize the SRH needs of internally displaced women and girls, ensuring that they have access to essential services such as maternal healthcare, family planning, and sexual health education. Gender Equality and Women's Empowerment: Internally displaced women and girls often face heightened vulnerabilities, including increased risks of sexual violence and exploitation. Understanding their SRH utilization can help in designing interventions that promote gender equality, protect women's rights, and empower them to make informed decisions about their reproductive health.

There's often a lack of data on the SRH needs of internally displaced populations, particularly disaggregated data based on gender and age. This study can help fill this gap, providing valuable insights into the specific challenges faced by displaced women and girls and the factors influencing their SRH utilization.

1.5. DEFINITION OF TERMS

CONCEPTUAL DEFINITION OF TERMS

INTERNALLY DISPLACED PERSONS: These are people or groups of individuals who have been forced to leave their homes or places of habitual residence, and who have not crossed the international border (Displaced & Person, 2008)

MINIMUM INITIAL SERVICE PACKAGE (MISP): MISP for Sexual and Reproductive Health (SRH) in crises is a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis to prevent sexual violence, prevent the transmission of and reduce morbidity and mortality due to human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs), prevent excess maternal and newborn morbidity and mortality, prevent unintended pregnancies. (IAWG, 2018)

SERVICE AVAILABILITY - requires an adequate number of functioning healthcare facilities and services with trained medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive health services, including abortion services. adequate number of health care providers willing and able to provide such services should be always available in both public and private facilities and within reasonable geographical reach. (ESCR, 2016)

OPERATIONAL DEFINITION OF TERMS

SRH SERVICE UTILIZATION: this is measured by asking the respondent's history of utilizing one of MISP for SRH services which this study focused on (safe motherhood – ANC, PNC, DC, Abortion, FP, HIV and STI, GBV, and emotional health) during their stay at the host or collective sites.

SRH SERVICE ACCESSIBILITY: The term "accessibility" was used in this study to refer to geographical accessibility. IDPs who resided in the collective sites within a 1.6-kilometer

(1-mile) radius of the nearest SRH service center at the camp or adjacent health facilities were classed as having good geographical accessibility.

1.6. ETHICAL CONSIDERATIONS AND INSTITUTIONAL PERMISSION

Right to Choose: is fully the mandate of the IDPs to determine whether to be part of the study or not. The researcher developed a consent form, and the respondent gave verbal consent to be or not be part of the study.

Right to Safety: from the onset, the IDP setting is a very sensitive area where people get psychologically and emotionally challenged, therefore the researcher protects the right of the respondent's safety from any kind of harm. Especially, the GBV and emotional health section of the research triggered the respondents to experience stress, so the assigned data collector(s) automatically skipped such questions for the benefit of the respondent when the need arose.

Right to be informed: the researcher/ data collector informed the study participant of all aspects of the research tasks, such as letting the respondent know what is involved in the questionnaire, how long it will take, what will be done with the data, and we let respondent decide whether to participate in the research or not.

Confidentiality: the names of the respondents who participated in the survey are not revealed, the researcher rather uses codes to link the respondents to a questionnaire and stores the name-to-code linkage information separately from the questionnaire. When the results of the survey are shared with others, no individual's responses will ever be identified by name including quotes from FDG, or KII participants, rather the IDP site, age of the respondent, and the position of the key personnel are notified. The Researcher made sure the collectors and the names of participants were not discussed or revealed to anyone except to other survey staff, and their privacy and rights were well observed.

Ethical Clearance: The researcher secured ethical clearance from Addis Ababa University - Ethical Review Committee. Additional Letters of permission were obtained from the Ministry

of Health – MNCH Directorate, Amhara Region Public Health Emergency Operation Center (PHEO), North Shoa Zone, Gondar Health administration, and Woldiya.

1.7. ORGANIZATION OF THE RESEARCH

CHAP-1: INTRODUCTION: -This chapter contains the background of the study, a statement of the problem, basic research questions, the objectives of the study, the significance of the study, and the limitation/scope of the study.

CHAP-2: LITERATURE REVIEW: - This chapter deals with the literature review relevant to the study. It has a conceptual framework, theoretical review, and empirical review.

CHAP-3: RESEARCH METHODOLOGY: -Under this chapter, the type and design of research; the participants of the study; the sources of data; the data collection tools/instruments employed; the procedures of data collection; and the methods of data analysis are included.

CHAP-4: RESULTS AND DISCUSSION/Data presentation, analysis &interpretation: - This chapter summarizes the results/findings of the study and interprets and/or discusses the findings with extensive use of literature review.

CHAP-5: CONCLUSION AND RECOMMENDATION: -This chapter comprises conclusions and recommendations. The conclusions are drawn from chapter four of the study; the researcher also includes practical recommendations based on the conclusion of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1. LEVEL OF SEXUAL AND REPRODUCTIVE HEALTH (SRH) UTILIZATION AMONG INTERNALLY DISPLACED PERSONS (IDPS)

2.1.1 SRH UTILIZATION AMONG IDPs IN GLOBAL CONTEXT

Globally, the SRH needs of IDPs are often unmet, with significant disparities in access to services. Several studies have documented the disparities in SRH access and utilization between IDPs and non-displaced populations. Here are some key findings: Common barriers include disruptions in healthcare services, insecurity, lack of information, cultural stigma, and financial constraints (Kagee et al., 2018; Mberu et al., 2019). IDPs, particularly women, and girls, face a heightened risk of sexual violence and unintended pregnancy (Eberlein et al., 2017). This underscores the critical need for accessible SRH services, including emergency contraception and safe abortion services. Displacement can lead to mental health issues that can further hinder SRH service utilization (Fernando et al., 2020).

IDPs constitute a vulnerable population globally, facing numerous challenges including limited access to SRH services. The phenomenon of forced displacement due to conflicts, natural disasters, or other crises has been on the rise, exacerbating the already existing SRH disparities. According to the United Nations Refugee Agency (UNHCR), there were approximately 45.7 million IDPs worldwide by the end of 2020, with a significant portion being women and adolescents.

Research on SRH utilization among IDPs on a global scale reveals multifaceted barriers hindering access to essential services. Studies by Roberts et al. (2018) and Smith and Johnson

(2020) highlight the pressing need for targeted interventions to address SRH disparities among IDPs globally. Initiatives focusing on community-based healthcare delivery, comprehensive sexual education and the provision of culturally sensitive services have shown promising results in enhancing SRH utilization rates among displaced populations. These barriers include but are not limited to a lack of adequate healthcare infrastructure in displacement camps or settlements, and limited availability of trained healthcare personnel, particularly those specialized in SRH. Socio-cultural norms and stigmas surrounding SRH, inhibit open discussions and seeking care.

2.1.2. SRH UTILIZATION AMONG IDPs IN SUB-SAHARAN AFRICA CONTEXT

The challenges of SRH access for IDPs are particularly pronounced in Sub-Saharan Africa, where pre-existing healthcare system weaknesses are often exacerbated by displacement crises. Many Sub-Saharan African countries face resource constraints, limiting their capacity to expand and adapt healthcare services for IDPs (Mberu et al., 2019).

In Sub-Saharan Africa, adolescents face significant SRH challenges, including limited access to youth-friendly services. A systematic review identified structural barriers such as negative attitudes of health workers and individual barriers like lack of knowledge among youth regarding SRH services. Facilitators of service utilization included community outreaches and health education, suggesting the need for targeted interventions focusing on educating youth and training health workers (Ninsiima, Chiumia, & Ndejjo, 2021).

In Sub-Saharan Africa, the challenges surrounding SRH utilization among IDPs are exacerbated by a combination of socio-economic, political, and cultural factors. The region hosts a significant proportion of the world's IDP population, with countries such as South Sudan, Nigeria, and the Democratic Republic of Congo experiencing protracted conflicts leading to large-scale displacement. Gender-based inequalities can further limit access to SRH services for displaced women and girls.

High prevalence of sexual violence and exploitation, leads to increased risks of unintended pregnancies, sexually transmitted infections (STIs), and psychological trauma. Gender inequalities exacerbate disparities in access to SRH services, particularly affecting women and girls. (Eberlein et al., 2017). Ongoing conflicts and violence in some regions can create additional barriers to accessing SRH services, limited access to comprehensive SRH education and services due to low literacy rates, and cultural taboos surrounding sexuality. (Kagee et al., 2018).

2.1.2. SRH UTILIZATION AMONG IDPs IN ETHIOPIA CONTEXT

Ethiopia, like many countries in Sub-Saharan Africa, grapples with the complex intersection of displacement and SRH disparities. The country hosts a significant number of IDPs, primarily driven by internal conflicts, natural disasters, and environmental degradation. (O'Connell et al., 2022). Ethiopia experiences frequent internal displacement due to conflict, drought, and other factors. Studies reveal different challenges for IDPs regarding SRH. Displaced communities often lack access to basic healthcare facilities, making SRH services even more scarce (Abebe et al., 2020).

A qualitative process evaluation in Ethiopia's Somali region highlighted the importance of strong partnerships, local stakeholder engagement, and alignment with national priorities to effectively address SRH service needs within IDP communities. However, challenges such as fragile security conditions, retention of trained providers, and barriers to sexual and gender-based violence services hinder improvements in SRH service access among IDPs. Inadequate infrastructure and resources in displacement settings, hinder the provision of essential SRH services (O'Connell et al., 2022).

Cultural taboos and traditional beliefs can discourage IDPs from seeking SRH services, particularly those related to family planning or sexual violence. Cultural norms and traditional practices influencing SRH behaviors and preferences among displaced populations. (Beyene

et al., 2018). Integration of SRH services within the broader healthcare framework for IDPs, leading to fragmented care delivery. While humanitarian organizations play a crucial role in providing SRH services to IDPs, their capacity can be overwhelmed during large-scale displacement events (Abebe et al., 2020). Efforts by governmental and non-governmental organizations to address these challenges have been notable, with initiatives such as the Health Extension Program and community-based health interventions aiming to improve SRH outcomes among IDPs in Ethiopia. However, sustained commitment and investment are required to ensure equitable access to SRH services for all displaced populations in the country. (Beyene et al., 2018).

Addressing SRH disparities among IDPs globally, in Sub-Saharan Africa and Ethiopia, requires a comprehensive approach that considers the complex interplay of socio-economic, political, and cultural factors. Efforts to improve access to SRH services must be context-specific, gender-sensitive, and community-driven to effectively meet the needs of displaced women and girls and ensure their SRH services are upheld.

Efforts to address these challenges have been underway, with initiatives such as the Minimum Initial Service Package (MISP) for SRH in Humanitarian Settings being implemented across the region. However, gaps persist in translating policies into tangible improvements in SRH outcomes for IDPs in Sub-Saharan Africa.

2.3. MINIMUM INITIAL SERVICE PACKAGE (MISP) FOR SRH SERVICES IN IDP SETTINGS

The Minimum Initial Service Package (MISP) for SRH in crises is a sequence of vital, lifesaving actions essential to respond to the SRH wants of pretentious populations at the onset of a fragile crisis to avoid sexual violence, avert the spread of and decrease morbidity and mortality due to human immunodeficiency virus (HIV) and other Sexually Transmitted

Infections (STIs), prevent excess maternal and newborn morbidity and mortality and prevent unplanned pregnancies. (IAWG, 2018). MISP was recognized to act in response to the need for reproductive health at the beginning of the crises and it has 6 building blocks that are set to be encountered in the fragile or IDP setting.

These are: recognizing an entity to execute and lead MISP, avoiding gender-based violence and recognizing an organization to lead MISP at the onset, inhibiting sexual violence from taking place, and if happens improving the system for survivors and casualties. Reduce the mortality and morbidity rate due to HIV and STI and maternal and newborn, unplanned pregnancy the final goal of MISP is to incorporate comprehensive SRH service into primary health care. Even though efforts have been made to benefit the MISP at the onset the unmet SRH need continues very high. (Fatusi A., 2016)

MISP for SRH services includes preclusion of unplanned gestations and it is defined as a pregnancy that happened when no children were required or that occurred prior than desired. (Santelli J, et al., 2003). MISP is a standard package of services that should be put into effect at the onset of a crisis. That includes maternal health including Antenatal Care (ANC), Delivery Care (DC) and Postnatal Care, Family Planning, HIV/STI, Gender-Based Violence (GBV), Psychosocial support, and Abortion Care. (IAWG, 2020).

Gender-based violence can happen at any point in a person's life, in times of normal circumstances or unpredictability. Armed conflict and emergencies can significantly decline a society's capacity to defend women and girls from GBV. Intimate partner violence is also exacerbated in a crisis setting. Sexual violence is also used as a tool of welfare to strengthen the military force. Girls and women may be involuntarily forced to trade sex foodstuff donations and other supplies they need to survive. In some places, they are married off early or insistently, to safeguard or care for their families. (UNICEF GBV in emergencies, 2017)

In all stages of the conflict, women and girls remain at high risk of sexual violence, physical violence, and various forms of exploitation, including sex trafficking as different research also revealed. (Ward J, 2002). In armed conflict-affected situations, women and girls are often survivors of violent conflict directly and of violence perpetrated by people they know, including their husbands, boyfriends, other family members, or unknown rebel forces. (Gupta et al 2012).

The context in which any disaster occurs affects the psychological morbidity and its outcomes, as well as personal factors such as exposure to traumatic events, social support, and resilience (Bonanno et al, 2017). Mental health following natural or manmade disasters is mostly psychosocial and depends upon manifold factors, including poor socio-economic status, lack of family members and community or neighbor support, and increased violence because both man-made and natural disasters can cause socioeconomic denial by the destruction of houses and trades and loss of employment opportunities. These adverse events affect the reproductive health of women. Socio-economic withdrawal is associated with the poor reproductive health of women and numerous chronic diseases, including mental health disorders. (WHO, 2005)

Having had an abortion, abnormal vaginal discharge, genital ulcers or whether participants had ever heard about STDs, and having heard about contraceptives were significant risk factors for depression and anxiety (Anwar et al, 2011). Women who had abortions were two to three times more at risk of depression and anxiety compared to those who did not have an abortion in emergency settings. Women who had no or difficult access to health facilities were six to seven times at greater risk of depression and anxiety compared to those who had easy access to health facilities. women who were separated from any family member were seven times more likely to have difficult access to health facilities compared with women who had easy access to health facilities. (Anwar et. al 2011).

2.4. EMPIRICAL REVIEW

FACTORS THAT INFLUENCE SRH SERVICE UTILIZATION AMONG IDPs

Several factors influence the utilization of SRH services among Internally Displaced women and girls. These factors are often multifaceted and interlinked, reflecting the complex challenges faced by displaced populations. Displacement often disrupts existing healthcare systems, making it difficult for IDPs to access basic services, including SRH care (Kagee et al., 2018). IDPs often experience economic hardship, making it difficult to afford user fees or transportation costs associated with SRH services (Mberu et al., 2019).

Awareness about available SRH services and culturally appropriate information is limited and can create barriers to utilization. Displacement can lead to anxiety, depression, and other mental health challenges, further hindering help-seeking behaviors for SRH needs. (Fernando et al., 2020). Fear of violence and insecurity in displacement settings can restrict movement and limit access to healthcare facilities (Eberlein et al., 2017).

2.4.1. PREDISPOSING FACTORS

2.4.1.1. KNOWLEDGE OF SRH SERVICES

Limited knowledge of available Sexual and Reproductive Health (SRH) services is a major barrier for internally displaced women and girls (IDPs) in accessing the care they need. This lack of awareness can be attributed to various factors, including disruptions in healthcare systems, limited access to culturally appropriate information, and social stigma surrounding SRH issues (Fernando et al., 2020; Mberu et al., 2019). Knowledge of SRH services plays a crucial role in determining the utilization of these services among internally displaced women and girls.

A comprehensive understanding of available SRH services, including family planning, maternal health care, and prevention and treatment of sexually transmitted infections (STIs), is essential for informed decision-making and access to appropriate care in humanitarian settings. (IAWG, 2020)

Internally displaced populations often face significant challenges in accessing SRH information and services due to various barriers, including limited educational opportunities, cultural norms, and disruptions in healthcare systems. Inadequate knowledge about SRH issues can lead to misconceptions, fears, and hesitation in seeking care, exacerbating existing health disparities among displaced women and girls. (IRC, 2020). Increasing knowledge of SRH services among internally displaced women and girls correlates positively with improved health outcomes, including reduced rates of unintended pregnancies, maternal mortality, and STIs. (MSF, 2018)

2.4.1.2. LEVEL OF EDUCATION AND SRH UTILIZATION

The level of education is a potential factor influencing sexual and reproductive health (SRH) service utilization among internally displaced persons (IDPs). Studies suggest that IDPs with higher education may be more likely to utilize SRH services compared to those with lower education levels. Education can equip individuals with knowledge about SRH issues, services available, and their importance. This awareness can empower IDPs to seek out and utilize these services. (Assefa, D., et al 2013). Higher education can improve communication skills, making it easier for IDPs to discuss sensitive SRH topics with healthcare providers. (Beyene,et al 2022)

2.4.1.3. CULTURAL NORMS, RELIGIOUS BELIEFS, AND SRH SERVICE UTILIZATION

There is a significant difference in different cultures when it comes to psychological and social features. For any program to be effective the social and cultural aspects should be considered (Ocholla, 2003). There is a tradition of early motherhood in different cultures of Africa dictates the sexuality of teenagers as a matter of social and marital status and not as a matter

of age. The decision on the use of SRH and the use of family planning services is highly affected by cultural perspectives (Ibid).

Certain cultural practices may discourage open communication about sexuality or family planning methods (Ahmed et al., 2016). According to Kaida et al, Culture significantly influences the attitude of men and women in SRH utilization. Men's culture and religious background also highly influence their attitude toward FP and reproductive health (Ibid). This indicates that culture directly influences the members of society by molding them to act according to traditions that have existed for generations.

The cultural stigma surrounding SRH topics can prevent IDPs from seeking out services, fearing judgment or social exclusion (Mbizvo et al., 2017). Religious leaders can hold significant sway within IDP communities. Their pronouncements on SRH can significantly impact service utilization (Ibid). SRH services that are sensitive to cultural and religious beliefs are more likely to be utilized by IDPs (Ahmed et al., 2016). Training healthcare providers to be culturally competent can improve communication and build trust with IDPs (George et al., 2019). Engaging with community leaders and religious figures can help promote positive messages about SRH and encourage service utilization (Mbizvo et al., 2017).

2.4.1.4. AREA OF RESIDENCE – IDP CAMP AND SRH SERVICE UTILIZATION

Internally displaced women and girls (IDWGs) residing in camps face unique challenges in accessing essential services, including SRH services. The specific location of their residence – the IDP camp – can significantly impact their service utilization. Fear of violence or harassment while traveling to and from service locations within or outside the camp can deter IDWGs from seeking services (Moser & McGregor, 2019). Limited access to information about available services within the camp or nearby can be a major barrier, particularly for women with limited mobility (Murshed & McGregor, 2017).

Long distances to service locations, lack of transportation options, or inconvenient service hours can create significant obstacles for IDWGs (Funk et al., 2018). Poor sanitation facilities within the camp can lead to hygiene concerns and limit access to private spaces needed for utilizing certain SRH services (Moser & McGregor, 2019).

Providing SRH services directly within the camp or nearby can significantly improve access for IDWGs (Funk et al., 2018). Creating safe spaces within service locations, ensuring privacy, and having female healthcare providers can encourage utilization (Murshed & McGregor, 2017). Raising awareness about available services through community outreach programs and involving female camp leaders can promote service utilization (Funk et al., 2018).

2.4.1.5. WOMEN DECISION-MAKING POWER AND SRH SERVICE UTILIZATION

In many cultures, patriarchal norms limit women's control over their sexuality and healthcare decisions (George et al., 2019). This can restrict their ability to seek out or utilize SRH services without permission from husbands, fathers, or other male family members. Studies show that in many developing countries, the male often dominates in making important decisions in the family including reproduction, family size, and contraceptive use. If the wife wants to use contraception, she may not be able to use it or may be forced to discontinue the method, if the husband disapproves of contraception (Drennam, M, 1998).

Economic dependence on male partners can limit women's ability to access services due to financial constraints or fear of disapproval if they spend money on themselves (Moser & McGregor, 2019). When women have greater control over their finances and decision-making, they are more likely to seek out SRH services to meet their needs (Ibid). Programs that equip women with negotiation and communication skills can empower them to discuss SRH with their partners and make informed decisions jointly (George et al., 2019).

In traditional rural areas of Ethiopia, men hold considerable influence over family dynamics, including decisions to use family planning. One study by the Population Council in rural Ethiopia found husbands' influence over the use of modern family planning. The study further demonstrates that the attitudes of husbands are extremely influential in FP decision-making, possibly more influential than the characteristics of the woman (Annabel Erulkar, 2007). In another study, the World Bank found that only (23.6%) of women in Ethiopia make decisions to use contraception on their own (World Bank, 2005).

2.4.2. ENABLING FACTORS

2.4.2.1. POLICIES AND GUIDELINES ON SRH SERVICE UTILIZATION

Inter-agency Framework for Reproductive Health in Humanitarian Settings (IAF) is a globally recognized framework by UNFPA, UNHCR, UNICEF, WHO, and others that outlines key principles for ensuring SRH services in humanitarian emergencies, including for IDPs (Inter-Agency Working Group for Reproductive Health in Humanitarian Settings, 2010). The framework was developed by a consortium of NGOs, these guidelines provide a practical framework for integrating SRH into humanitarian response plans (Sexual Violence Working Group, 2010).

The National Health Sector Transformation Plan (HSTP) national policy framework prioritizes improving access to quality healthcare, including SRH services, for all Ethiopians. The HSTP acknowledges the specific needs of vulnerable populations like IDPs and outlines strategies for reaching them. (Federal Ministry of Health, Ethiopia, 2015). Defining essential SRH services to be provided, establishing mobile clinics, or integrating services into existing facilities and training service providers on IDP-specific SRH needs are important points that the 5-year HSTP plan considered.

While the existing policies and guidelines demonstrate a commitment to improving SRH service utilization for IDPs, challenges remain in terms of national and regional readiness. Limited funding and human resources can hinder the effective implementation of policies (Moser & McGregor, 2019). Insufficient monitoring and evaluation systems make it difficult to assess the impact of policies and identify gaps (Funk et al., 2018). National guidelines may need to be adapted to specific regional contexts and cultural practices within IDP communities (George et al., 2019).

2.4.2.2. RESOURCE ALLOCATION FOR IDPs AND SRH SERVICES UTILIZATION

Limited resources can prevent IDPs from affording service fees, transportation costs, or necessary supplies like menstrual hygiene products (Funk et al., 2018). Allocating resources for fee waivers, subsidized services, or cash transfers empowers IDPs to overcome these financial barriers and prioritize SRH care. Insufficient funding can hinder the deployment of qualified healthcare providers, the establishment of clinics, and the procurement of essential commodities like contraceptives and medications (Moser & McGregor, 2019). Strategic resource allocation allows for improved service availability within IDP camps and host communities.

Adequate resource allocation allows for investments in equipment, training for healthcare providers, and maintaining a consistent supply of essential commodities, ultimately leading to better quality SRH services (George et al., 2019). Resources can be directed toward community outreach programs that raise awareness about SRH services, address stigma, and encourage service utilization among IDPs (Funk et al., 2018). Regular assessments to identify specific service gaps and resource needs within IDP communities are crucial for effective resource allocation (Murshed & McGregor, 2017). Prioritizing resource allocation towards essential SRH services and ensuring efficient use of funds is vital (Moser & McGregor, 2019). Collaboration between government agencies, humanitarian organizations, and local communities can ensure resources are used effectively and address context-specific needs (George et al., 2019).

2.4.2.3. STAKEHOLDERS COLLABORATION AND SRH SERVICE UTILIZATION AMONG IDPs.

Governments, developmental partners (e.g., NGOs, UN agencies), and the private sector can combine resources to address funding gaps and ensure consistent availability of SRH services and commodities (Harvey, 2017). Governments offer policy frameworks and local knowledge, developmental partners provide technical expertise and service delivery experience, and the private sector contributes innovative solutions and logistical capacity (Preuss, 2018). Collaboration can facilitate outreach programs, mobile clinics, and culturally sensitive service delivery models to overcome barriers faced by IDP populations (Murshed & McGregor, 2017).

Partnerships between governments and the private sector can leverage private sector expertise in supply chain management and service delivery models to increase access to SRH commodities (Chemon et al., 2019). Collaboration with local communities, including community health workers and faith-based organizations, can address cultural sensitivities, promote trust, and encourage SRH service utilization (George et al., 2019). Training programs for healthcare providers, including community health workers can enhance service quality and cultural competency within IDP settings (Funk et al., 2018). Establishing clear guidelines and monitoring systems is crucial to ensure ethical practices and quality service delivery within partnerships (Chemon et al., 2019).

Prioritization and sustainability: Partnerships need clear goals that prioritize IDPs' needs and develop strategies for the long-term sustainability of SRH service delivery beyond the immediate response phase (Harvey, 2017).

2.4.2.3. WOMEN EMPOWERMENT AND SRH SERVICE UTILIZATION

Support networks of women within IDP camps can provide a safe space for sharing information, encouraging service utilization, and challenging harmful gender norms (Funk et al., 2018). Programs that equip women with negotiation and communication skills can empower them to discuss SRH with their partners and make informed decisions jointly

(George et al., 2019). Programs that empower women economically can increase their decision-making power regarding SRH. When women have greater control over their finances and healthcare decisions, they are more likely to seek out SRH services to meet their needs (Moser & McGregor, 2019). Empowerment programs that equip women with SRH information and communication skills can enable them to discuss these topics openly with partners and healthcare providers (George et al., 2019).

Empowerment fosters self-confidence and the ability to navigate complex healthcare systems, overcoming potential hesitation or stigma surrounding SRH services (Funk et al., 2018). Programs that provide women with economic opportunities can increase their financial independence and decision-making power regarding SRH (Moser & McGregor, 2019). Women's empowerment is a critical strategy to improve SRH service utilization among IDPs. By increasing decision-making power, knowledge, and self-efficacy, empowerment programs can equip women to overcome barriers and access essential healthcare services.

2.4.2.3. ECONOMIC EMPOWERMENT AND SRH SERVICE UTILIZATION

Limited financial resources can prevent IDPs from paying for transportation to service locations, user fees associated with services, or necessary supplies like menstrual hygiene products (Funk et al., 2018). Financial dependence on partners or family members can limit women's control over healthcare decisions (Moser & McGregor, 2019). Programs that provide IDPs, particularly women, with income-generating opportunities or vocational training can improve their financial security and decision-making power regarding SRH (Moser & McGregor, 2019).

Direct cash transfers can empower IDPs to prioritize spending on essential healthcare services, including SRH (Funk et al., 2018). Studies suggest that economic empowerment programs can lead to a rise in the utilization of SRH services like antenatal care, family planning, and HIV testing among IDPs (Moser & McGregor, 2019)

2.4.3. NEED FACTOR

2.4.3.1. AVAILABILITY OF SERVICES, PROVIDERS, AND COMMODITIES

Providing SRH services directly within IDP camps or nearby can significantly improve access and utilization (Murshed & McGregor, 2017). Creating safe and private spaces within service locations with female healthcare providers can encourage women and girls to utilize SRH services (George et al., 2019). Lack of essential SRH commodities like contraceptives, hygiene products, or medications can significantly hinder service provision and discourage IDPs from seeking care (Moser & McGregor, 2019). Limited availability of diagnostic equipment for conditions like sexually transmitted infections (STIs) or pregnancy complications can restrict the scope of available services (Funk et al., 2018). Ensuring culturally appropriate commodities, such as menstrual hygiene products, is crucial for promoting service utilization (George et al., 2019).

Limited funding and logistical challenges can hinder the availability of both health services and essential commodities and equipment (Moser & McGregor, 2019). Competing needs within IDP settings may lead to prioritizing other necessities over investments in SRH services and resources (Funk et al., 2018). Regular assessments to identify specific service gaps and commodity needs within IDP communities are crucial (Murshed & McGregor, 2017). Utilizing mobile clinics or outreach programs can overcome geographic barriers and bring services closer to IDP populations (George et al., 2019). Strengthening supply chain management systems can ensure the consistent availability of essential commodities within IDP settings (Moser & McGregor, 2019).

Instability and insecurity within IDP settings can deter some healthcare professionals from working in these environments (Funk et al., 2018). Community Health Providers (CHPs), often recruited from within IDP communities, can bridge the gap between the limited availability of formal healthcare providers and the health needs of the population (George et al., 2019). CHPs often share cultural backgrounds and languages with IDPs, fostering trust and promoting service utilization (Murshed & McGregor, 2017).

CHPs can play a crucial role in outreach programs, raising awareness about available services and encouraging IDPs to seek care (Funk et al., 2018). Effective collaboration between service providers at the facility and CHPs is essential to optimize healthcare delivery in IDP settings (George et al., 2019). Providing training and ongoing support to CHPs can equip them with the skills and resources to handle basic healthcare needs and make appropriate referrals to formal providers for complex cases (Murshed & McGregor, 2017). Formal healthcare providers diagnose and treat complex medical conditions, while CHPs provide basic care, education, and social support (Funk et al., 2018).

Developing incentive programs for healthcare professionals to work in IDP camps can improve availability (Moser & McGregor, 2019). Investing in training and capacity building for CHPs within IDP communities can strengthen the healthcare workforce (George et al., 2019). Fostering clear communication channels between CHPs and formal service providers ensures timely referrals and efficient service delivery (Funk et al., 2018). The availability of health services, commodities, and equipment are crucial factors influencing SRH service utilization among IDPs. Addressing resource constraints, prioritizing SRH needs, and implementing innovative service delivery models are essential to ensure IDPs access these vital healthcare services.

2.4.3.2. ACCESSIBILITY OF SRH SERVICES

Distance to service locations, insufficient transportation options, or inconvenient service hours can create significant obstacles for IDPs seeking SRH services (Funk et al., 2018). IDP camps often face shortages of qualified healthcare providers, essential commodities, and equipment, hindering access to SRH services (Funk et al., 2018). Difficulties reaching service locations due to long distances, poor infrastructure, or lack of transportation can be major barriers (Moser & McGregor, 2019). Safety issues within or around IDP camps, particularly for women and girls, can limit their ability to access SRH services freely (George et al., 2019).

One of the challenges for host community fees, transportation costs, or hidden costs associated with SRH services can be a burden for IDPs with limited financial resources (Funk et al., 2018). IDPs may face discrimination or stigma from healthcare providers or community members, hindering their willingness to seek SRH services (Moser & McGregor, 2019). Limited awareness about available SRH services within the host community can be a barrier for IDPs, particularly those with language or cultural differences (George et al., 2019).

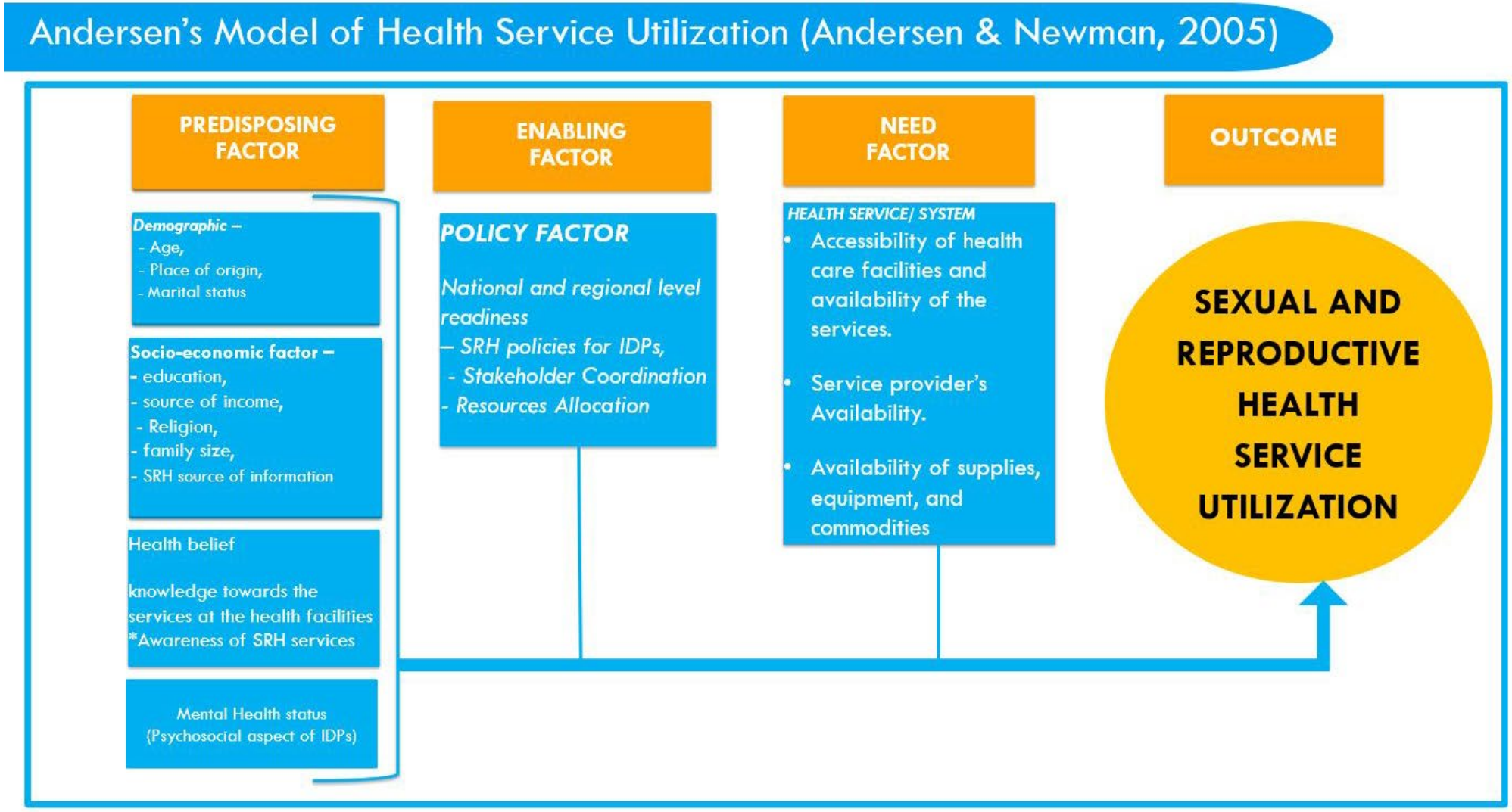
Establishing SRH services directly within IDP camps or nearby can significantly improve access and utilization (Murshed & McGregor, 2017). Utilizing mobile clinics or outreach programs can overcome geographical barriers and bring services closer to IDPs in host communities (Funk et al., 2018). Integrating IDPs into existing healthcare systems within the host community can improve accessibility but requires addressing potential discrimination and ensuring cultural sensitivity (Moser & McGregor, 2019). Collaborating with community leaders and healthcare providers in both IDP centers and host communities can raise awareness, address stigma, and promote service utilization (George et al., 2019). Implementing fee waivers or subsidized services for IDPs can help overcome financial barriers to accessing SRH services (Funk et al., 2018).

2.5. CONCEPTUAL FRAMEWORK

This research utilized Andersen's Model of Health Service Utilization (Andersen & Newman, 2005) to examine the utilization of sexual and reproductive health services among the IDPs. The researcher amended the model to the SRH utilization context. Andersen's Model is a conceptual behavioral model that shows a systems perspective to enable investigation of the client's health and provider-related variables associated with the existing policies and resource allocations.

It states that the use of health care services utilization is influenced by three dynamic determinants. These are ***predisposing factors***, ***enabling factors***, and ***Need factors***. ***Predisposing factors*** are characteristics such as age, residence, marital status, education, religion, source of information, and knowledge of the health care system. ***Enabling characteristics*** in terms of policy factors include resource allocation, facility readiness, health policy, health system organization management, and collaboration with stakeholders. (Rebman, 2005). ***Need factors*** include the availability and accessibility of facilities, supplies, medical equipment, and social support. According to this model, untimely access to healthcare services may lead to adverse health outcomes. The combined influence of these factors determines the likelihood of an individual utilizing health services. A strong predisposing factor coupled with a high need and enabling resources will likely lead to service utilization. Conversely, weak predisposing factors, low perceived need, and limited enabling resources will likely lead to lower utilization. Therefore, Andersen's Model emphasizes the cumulative effect of these factors. Based on the literature review the following concepts have been identified and summarized in the conceptual framework below.

Figure 1 : Conceptual Framework Anderson's Model of Health Service Utilization



CHAPTER THREE
MATERIALS AND METHODS

3.1. **RESEARCH DESIGN/ APPROACH** - The research design employed for this study is cross-sectional and qualitative. The researcher used a cross-sectional study design to examine the utilization of SRH services. The study focused on the utilization of SRH services to gather information and the interrelationship of variables through a structured standardized CDC questionnaire was used.

For qualitative thematic analysis, the method was used to analyze the data collected from the field. Both Focus Group Discussion (FGD) and Key Informant Interview (KII) were conducted to understand service providers' perspectives on service availability and accessibility, resource allocation, coordination, and readiness of the facility. The semi-structured qualitative guide facilitates the discussion with married and unmarried women, service providers, and government officials from the Federal Ministry of Health (FMOH), Ethiopian Public Health Institute (EPHI), and Amhara Regional Health Bureau (ARHB) humanitarian and emergency focal person to address the objective of the study.

*3.2.*STUDY VARIABLES*:*

3.2.1. Dependent Variable: the dependent variable is SRH service utilization. (this is measured by asking the respondent's history of utilizing one of MISP for SRH services which this study focused on (safe motherhood – ANC, PNC, DC, Abortion, FP, HIV and STI, GBV, and emotional health) during their stay at the host or collective sites.) A scoring system is used to evaluate service utilization. Each respondent receives a score based on the number of utilized services out of 5 offered by MISP. 100% utilization (all 5 services), 80% utilization (4 out of 5 services), 60% utilization (3 out of 5 services), 40% utilization (2 out of 5 services), and 20% utilization (1 out of 5 services).

3.2.2. Independent variable: the independent variables which are related to the dependent variables are divided into four categories.

Demographic variable • Age, • marital status • place of origin • Residence • Regular Income • Household size Socio-economic variables Education • Religion • Source of income • Source of SRH information, • Facility availability, • Mental health status	Policy variable • SRH policies for IDPs, • resource allocation, • stakeholder coordination	Health System • Availability of the services and accessibility of the health care facilities, • service providers availability, • availability of supplies, commodities, and equipment.

3.3. STUDY CRITERIA

Inclusion Criteria

Participants must:

- Internally displaced women between the age of 15 - 49
- Identify as IDPs in collective sites,
- IDPs who gave consent.

Exclusion Criteria

- Excluded participants are those with critical illness or mentally unstable.

3.4. STUDY POPULATION

The Amhara region has witnessed ongoing displacement due to intensifying conflicts with a neighboring region. Displaced individuals have sought shelter in nearby towns, with the current study focusing on those residing within collective sites. To ensure representativeness, a lottery method was employed to randomly select three collective sites for data collection. The research encompassed towns within the Amhara region, specifically North Shoa (Gondar

City), and North Wollo (Woldiya).

S/ No	Zone	Collective site	Host community	Total IDPs	%
1	West Gojjam	0	251286	251286	22.4
2	North Wollo	1057	172742	187092	16.7
3	North Gondar	8038	171361	179399	16.0
4	Wag-Himra	335	115578	115913	10.4
5	North Shewa	12,120	81514	84315	7.5
6	South Gondar	401	69379	69780	6.2
7	Wolkayt-Tegedie	0	65540	65540	5.9
8	Awi	0	45461	45461	4.1
9	South Wollo	4695	22220	26915	2.4
10	East Gojjam	0	24120	24120	2.2
11	Bahir Dar	0	23935	23935	2.1
12	Oromo Zone	0	16270	16270	1.5
13	Central Gondar	2590	13431	16021	1.4
14	Gondar City	1930	10346	12523	1.1
15	West Gondar	118	1122	1240	0.1
	Grand Total	**35,505**	**1,084,305**	**1,119,810**	**100**

Table: Distribution of IDPs in the Amhara region, northern Ethiopia, Feb 01/2022 (Source: Regional DRMC)

3.4.1. **Target population:** Internally displaced women aged 15-49 years residing in any IDP camp within the Amhara region.

3.4.2.***Source Population****:* All Internally Displaced Persons (IDPs) residing in the Amhara region.

3.4.3.***Study Population:*** Internally displaced women and girls aged 15-49 years residing in collective sites located in Debrebirhan, Gondar, and Woldiya towns within the Amhara region.

3.4.4. ***Study subject:*** The women who were selected and participated in the actual study (n = 547)

3.4.5. ***Study units:*** Reproductive-aged women living in the selected IDP camps.

For the qualitative research, the study participants were service providers at the camp and adjacent health center, MNCH focal persons at the health facilities, IDP focal persons at Zonal Health departments, and Humanitarian and Emergency for SRH coordinators at the Federal and Regional levels.

3.5. SAMPLING TECHNIQUES

3.5.1. **Sample Size:** In the IDP settings women and adolescents are extremely affected in the IDP settings, the sample size needs to have a minimum number of women to support a good estimation of the parameters of the population. It is in this respect that the following Cochran's formula is used to estimate the sample size.

$$n = \frac{Z^2 pq}{L^2}$$

$$= \frac{Z^2 P(1-P)}{L^2}$$

Where;

n = the desired sample size

Z = the standard normal deviation at the required CI set at 95% (1.96) –

P = proportion of interest in the percentage of IDPs who receive SRH services in the IDP sites = 0.5

q= probability of not happening (pop estimated not to have the characteristics being measured (q=1-P)

L= precision of the estimate **–** 5% (0.05) Estimated non-response rate = 10 %.

Multi-stage sampling design effect = 1.3

The design effect was computed using the formula: $f = 1 + \rho(m - 1)$, where f is the design effect, ρ is the intra-class correlation and m is the average number of sample respondents per small cluster within a single IDP center. Given that ρ=0.05 and m=7, the design effect yields 1.30.

Sample Size (n) = $\frac{(1.96)2\times0.5(1-0.5)}{(0.05)2} *1.3$

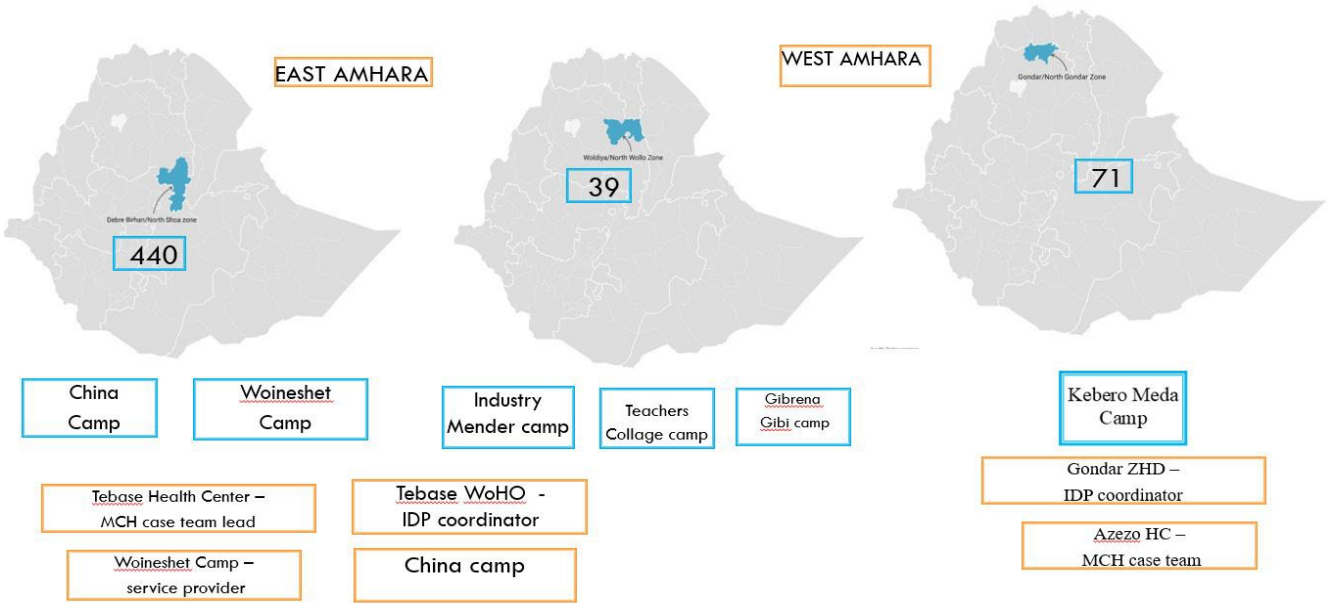
n= 384*1.3=499.20

Non response rate = 499.20*10/100

=499.20+49.92

= 549

Debre Birhan	12,021.00	0.80	440
Gondar	1,930.00	0.13	71
Woldiya	1,057.00	0.07	39
	15,008.00		**549**



3.6. SAMPLING PROCEDURE

The researcher used probability sampling, specifically systematic sampling techniques with the list of women in the RH group and identified women to be included in the study. The steps used were the total number of IDPs living in each camp – DebreBirhan (12,120), Gondar (1930), and Woldiya (1057) – as per Amhara Public Health Institute data – February 2022. The average family size of IDPs in the selected camp is 5 and the total of women in RH was calculated:

Debrbirhan = 12,120/5 = 2424

Gondar = 1930/5 = 386

Woldiya = 1057/5 = 211

After the total population was calculated

N = (DB) = 2424 N=(GON) = 386 N= (WOL) = 211

The sample size for each IDP camp:

Debrebirhan = 440

Gondar = 71

Woldiya = 39

To determine the sample size of each woman

Debre birhan

$i = \frac{N}{n} = 2424/440 = \mathbf{6}$

Gondar

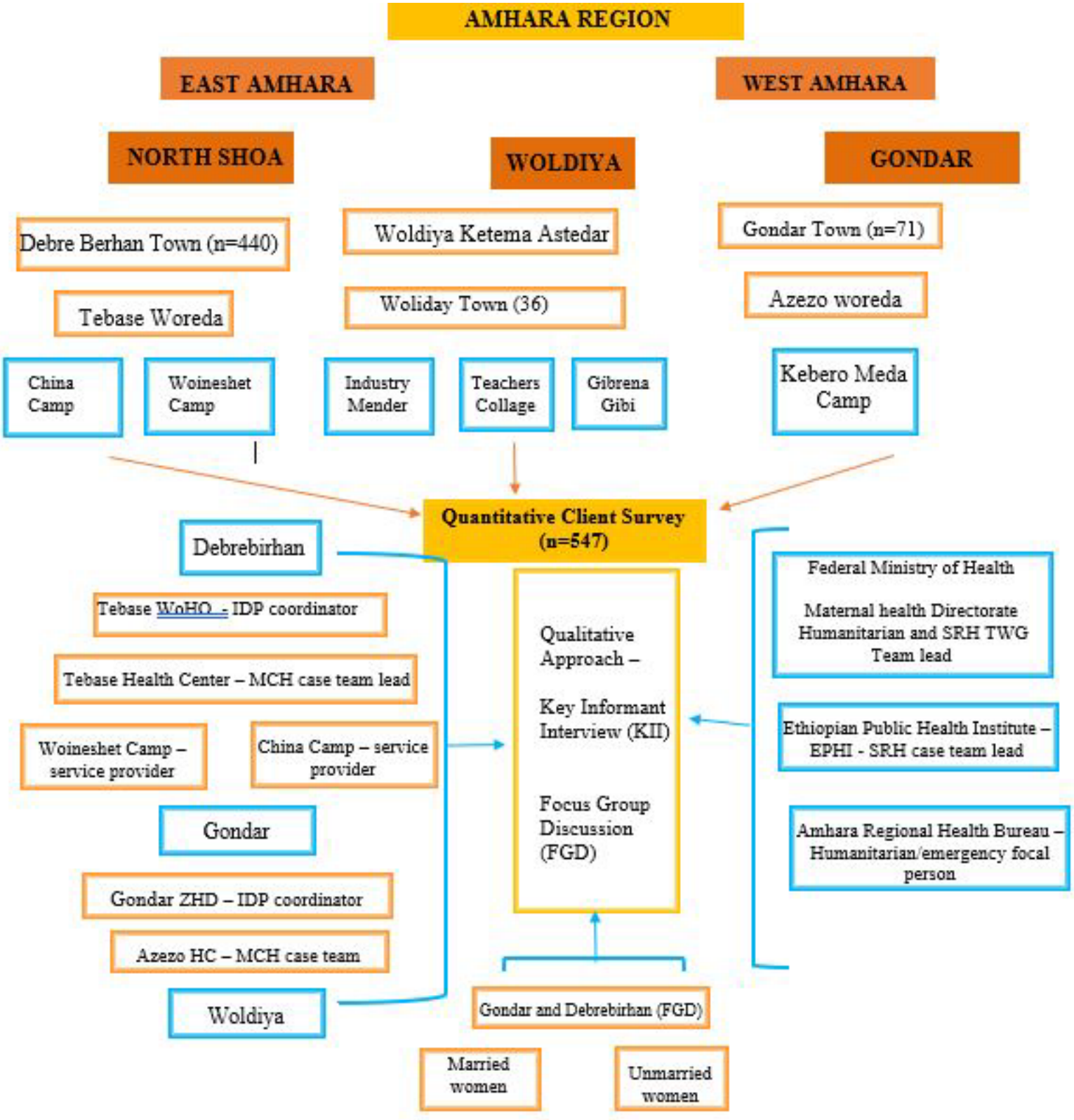
$i = \frac{N}{n} = 386/71 = \mathbf{5}$

**** Woldiya***

$i = \frac{N}{n} = 211/39 = \mathbf{5}$

The sampling K was selected randomly by the lottery method between numbers 1 and i. K depends on the camp, which is every 6 for Debrebirhan and every 5 women for Gondar and Woldiya. The successive woman for the inclusion was selected by moving the interval K+I, K+2i, K+3i… until the required sample for each camp was reached. (Graphic, 2014).

3.7. SAMPLING FRAME



3.8. DATA COLLECTION METHOD

Primary data was collected from a sample of the target group using a cross-sectional survey. A structured questionnaire was adopted from CDC survey forms for conflict-affected people. The survey form was translated into Amharic and interviews were conducted in Amharic.

3.8.1. Electronic data collection and data quality

Quantitative data was collected using Open Data Kit (ODK) software. The ODK was designed to include conditionality rules for skip patterns. Depending on the internet connectivity in the sites the data was uploaded daily to the database. The supervisor in the region monitors to ensure the procedure to strictly adhered to and checks completeness and inconsistency.

3.8.2.Data collectors' recruitment

Female data collectors with ample data collection experience and with health backgrounds were recruited. For Gondar data collection, 2 female data collectors were deployed from Gondar town, and for Debrebirhan 4 data collectors were taken from Addis Ababa whereas for Woldiya, 1 data collector was deployed from Debre Sina town. The data collectors were given a half-day training/orientation on the study method, field procedure, a detailed review of the data collection instrument, and the use of electronic data collection.

3.8.3. ***Pre-testing tool –*** the researcher went to Debrebirhan and collected data from 10

3.8.4. samples of Internally Displaced Women (IDW) collected electronically. The questionnaires were coded, and pilot tested for validity and reliability, and necessary corrections were taken.

3.8.5. Data collection instruments:

IDP client Survey form: the researcher used the CDC structure interview guide, for conflict-affected women. The guide was adopted and modified to a country context. Respondents were asked about the MISP components utilization – safe motherhood, HIV and STI, Family planning, GBV, and Emotional health but this structured toolkit lacks the abortion questionnaire, therefore abortion pieces will be embraced from eDHS.

Service provider survey form: used structured standardized guide to explore in more depth issues about SRH services accessibility, and availability and to understand the current context.

Ministry of Health/Regional/Zonal - KII: used a structured guide to explore the gaps and challenges of health restoration, policies/strategies that are in place, coordination effort, and implementation of MISP.

3.9. DATA ANALYSIS METHODS

3.9.1. Description of variables

The outcome variable of this thesis is SRH service Utilization. The assumption between the independent variables and SRH service utilization was analyzed using a linear regression model. Bivariate analysis (simple linear regression) was run 25% level of significance to screen out potentially significant independent variables. A multiple linear regression model was run by including the significant independent variables from the simple linear regression model. To measure the presence and strength of association between the independent variables and SRH service utilization, regression coefficient (β), p-value, and 95%CI for β were used. From the final model, variables with p-value ≤ 0.05 were significantly associated with SRH service utilization.

Before leaping to the regression, different assumptions were tested. For linear, almost all models were practiced. Under the assumption of normality, in the output table, the P-value for both tests is < 0.05. the assumption of normality is satisfied. (Data is normally distributed). The assumption for the lack of fit test is > 0.05 (0.827) and failed to reject the null hypothesis. The assumption of linearity is not satisfied. The independence of the test was checked the using Dubin Watson test the value is 1.711 which is between 1.5 and 2.5 and the assumption of independence of error was satisfied.

The assumption of homoscedasticity outcome of level statistics is <0.05 (0.028) and the assumption is satisfied. There are no outliers above or below the plot bars, the assumption of no outliers is satisfied. The multiclonality assumption is satisfied by testing the independent

variable's VIF values below 10. In testing the model adequacy test the p-value for ANOVA is <0.05the linear regression model is adequate for the data.

3.9.2. ***Quantitative: -*** The study applied both descriptive and inferential statistics. These are derived from ODK/Kobo Toolbox – a mobile data collection tool and converted to Statistical Package for Social Scientists (SPSS) version 26. In this study, descriptive statistics (percentage) were used to describe the background characteristics of respondents and used simple linear regression to see the association between the predisposing factors and dependent variable and also to identify the major candidates for the next step. multiple linear regression was used to identify the significant factors associated with the dependent variable.

3.9.3. ***Qualitative: -*** Interview questions and responses will typically be tape-recorded. It was translated into English and transcribed verbatim into MS Word. Codes were developed, and a summary of the code was organized to the topic area of inquiry. Quotes were presented to show a range of perspectives.

3.10. VALIDITY AND RELIABILITY

Validity: The research instruments were validated during pilot testing. The researcher validated the subjectiveness, correctness, and relevance of the questionnaire. The researcher conducted a preliminary test of the data collection instrument before the actual data collection with a small group of respondents to eliminate, identify, adjust, and correct changes before collecting data from the study population. In the study, experts were consulted, and their opinions were sought in assessing or validating the contents of the research instruments (Mugenda and Mugenda, 1999).

Reliability: The reliability of the result was measured by the Test by using the Pearson correlation coefficient of the pre and post-test and found out score of 0.836 since the score is above 80% researcher concluded that the test has a good test-retest reliability.

3.11. LIMITATIONS OF THE STUDY

Despite producing important and useful findings, some factors influenced the process and the output of the study. Due to the ad hoc nature of the setting, people go back to their original place and the number of IDPs changes every time. There are newcomers to the sites when the conflict persists, and new IDPs with limited exposure to the service joining the camp may affect the findings of the study. The researcher and data collectors intentionally tried to include those who had stayed in the camp for a long.

The IDP sites are sensitive and highly secured places under government supervision and data collectors may face challenges or certain bureaucracy while collecting data. To curb this issue, the researcher got a support letter from the Ministry of Health and created a good relationship with the Amhara Food Security Coordination and Risk Management Bureau to ease the process at the entry-level.

In addition to that, as the camps or compounds in collective sites have limited spots to take the GBV victims and others in a confidential space and collect the data, this was assumed to affect the respondents to council some facts. In fact, during the actual data collection, the data collectors take respondents outside of the shelter and interview them in the compound in confidential spots.

As the region is in a conflict-war zone, the researcher refrains from collecting data from risky areas. Closely track the situation with the regional health bureaus however, the researcher intentionally avoids high-risk zones.

CHAPTER FOUR
RESULT

4.1. DEMOGRAPHIC CHARACTERISTICS

The study was conducted in three towns in the Amhara region: namely Gonder, Debre Birhan, and Woldiya. As shown in Table 1 below the sample was distributed among the three towns based in the Amhara region. Accordingly, the majority (80% of the respondents were from Debre Berhan town and the remaining 13% and 7 were from Gondar and Woldya towns, respectively. For 84% of the respondents, their place of origin is Oromia and 11% of the respondent's place of origin is Tigray. Because age between 15 – 19 were only 8 respondents and from 40-45 were 29, the researcher merges the age group into two categories 15-29 and 30-45 age groups. Accordingly, the majority (57%) of the respondents are in the first age category (15-29) and the remaining 42.9% are from age 30-45%. Similarly, data on the marital status of the respondents are categorized as "Married" and "All others" where 61% are found married and 37.3% are single, widowed, and whose husbands died due to the war. The majority (56%) of the respondents are Orthodox Christians and 43% are Muslims. Those respondents, whose husbands are assigned for military assignments are also considered married. and similarly, the majority (57%) of the households are headed by their husbands, and 38% of the women exercise headship in their household.

4.2. SOCIO-ECONOMIC CHARACTERISTICS

In Table 2 of the socio-economic characteristics of the respondents, 54% have no education and only 9% have secondary education. The remaining 37 % have some elementary-level or primary education. The majority (50%) of the households have a household size of 4-6. In terms of household income, for the majority (60%) of the respondents, there is no regular source of income for the household. The remaining 40% of the households mentioned some source of household income dependent on the aid provided by the government and donations.

4.3. AWARENESS ABOUT SRH SERVICE UTILIZATION

In Table 3, Awareness about SRH services at the facility respondents were asked about their SRH source of information. Accordingly, 49% of the respondents mentioned that their source of information is the health service providers mainly the Health Extension Workers and Service providers at the facility, and 35% mentioned other SRH sources of information that include radio, women's group discussion, in-laws, and at school. The remaining 16% mentioned they have no source of SRH information.

Table 1: Demographic characteristics of Respondents, Amhara region, (n=547)

Characteristics	n	%
Town		
Debre Berhan	439	80.3
Gondar	71	13.1
Woldiya	36	6.6
Place of Origin		
Oromia	459	83.9
Tigray	61	11.2
Others	27	4.9
Age		
15-29	278	57.1
30 -45	209	42.9
Marital status		
Married	297	61.0
Other	190	39.0
Religion		
Orthodox	273	56.1
Muslim	214	43.3
Others	3	0.6
Head of household		
Myself	208	38.1
My husband	311	56.9
Others	28	56.8

Table 2: Socio-economic characteristics of respondents (n=547)

Characteristics	no	%
Education		
Never attended	263	54.0
Primary	179	36.8
Secondary and above	45	9.2
No source	77	15.8
Household size		
0-3	149	30.6
4-6	241	49.5
> 6	97	19.9
Currently have income		
Yes	221	40.4
No	326	59.6

Table 3: Awareness of SRH Services at the facility

Characteristics	no	%
Distance		
< 1km	474	97.3
> 2km	13	2.7
Facility Availability		
Yes	487	89
others	60	10.9
Preference to go to the facility		
Yes	444	91.2
No	43	8.8
SRH source of Information		
Health Service Providers	238	48.9
Other Sources	172	35.3
No source	77	15.8

4.4. SRH SERVICE UTILIZATION

In terms of SRH service utilization in the region, the majority (82%) of the respondents reported that they visited the service provider at the facility for ANC service followed by DC (59%) where respondents deliver at the service facility, and 54% visited by the service provider or they went to the facility for PNC follow-ups. Similarly, 34% of the respondents reported that they use FP, and 34.4% got tested for HIV/AIDS in the past 12 months. GBV and abortion service utilization are the services least reported by the respondents 5.9% and 3% respectively.

The SRH service utilization among respondents was 53% (±23%).

Table 4: Percentage distribution of respondents by reported key SRH service utilization, Amhara region, 2022,

Characteristics	n (%)
Safe motherhood	
ANC	446 (81.7)
DC	315 (59.2)
PNC	293 (54.5)
Family Planning	183 (33.5)
HIV/AIDS	186 (34.4)
GBV	32 (5.9)
Abortion	15 (2.7)

4.5. MENTAL HEALTH-RELATED CHARACTERISTICS

Data on the mental health characteristics of the respondents was collected. Accordingly, more than 74% of the respondents mentioned they have experienced head, the second most common experience of respondents is feeling unhappy with their status almost 61% and crying more than usual 59 %, shaky hands (13%), and suicidal ideation (16%) are the least common experience among respondents.

Table 5: Frequency distribution of respondents by key mental health indicators and characteristics, Amhara region, 2022, n=547

Indicator	Number	Percentage
Headache	405	74.0
Poor Appetite	287	52.5
Sleep badly	277	50.6
Frightened	222	40.6
Shaky hand	76	13.9
Nervous, tensed, and worried	251	45.9
Poor digestion	272	49.7
Unhappy	331	60.5
Cry more than usual	320	58.5
Lost interest or hopeless	289	52.8
Suicide Ideation	86	15.7
Feel tired	274	50.1
Uncomfortable feelings	272	49.7

4.6. FACTORS ASSOCIATED WITH SRH SERVICE UTILIZATION

In terms of the association between SRH utilization and all other independent variables, the result showed that education (p-value -0.030), SRH source of information (p-value 0.000), HH size (p-value 0.003), and preference to go to the facility (p-value) 0.019) have a significant association with the SRH utilization.

After adjusting for other covariates, the average score of SRH service utilization among those with no education was 0.080 less than those with secondary or above education. Having no education as compared with secondary or above was associated with on average a 0.080 less SRH service utilization level. (coefficient = -0.080, 95% CI -0.153, -008, P-value 0.030).

After adjusting for other covariates, the average score of SRH service utilization among household size was 0.077 more than those with 6+ household size. (coefficient = 0.077, 95% CI 0.026, 0.128, P-value 0.003.

After adjusting for other covariates, the average score of SRH source of information among those who had been informed by service providers at the facility or through HEWs was 0.074 more than those with no source of SRH information. Or being informed about SRH information as compared with no source of information was associated with an average score of 0.074 more SRH service utilization (Coefficient = 0.074, 95%, CI = 0.019, 0.129, P-value 0.009).

Similarly, after adjusting for other factors, the average score of SRH Service Utilization among those who preferred to go to the facility in the camp was 0.079 and those with no preference to go to the facilities. Or having a preference to go the health facilities as compared with no preference to go to the health facility an average score of 0.019 more SRH utilization (Coefficient = 0.019, 95% CI = 0.013 – 0.146, p-value 0.019).

Table 7: Multiple linear regression between selected independent variables and SRH utilization, Amhara Region, 2022 (n=547)

Variables	Crude regression coefficient (β)	Adjusted regression coefficient (β) (95CI)	P-value
Age			
15 -29	0.052 (0.013, 0.090)	0.018(-0.027, 0.063)	.433
30 - 45	1	1	
Religion			
Orthodox	0.421 (0.094, 0.748)	0.018(-0.023, 0.059)	.382
Muslim		1	
Town			
Debre Berhan	-.180 (-.255, -.105)	-0.197(-0.616, 0.222)	0.356
Gondar	-0.080 (-.169, .009)	-0.173(-0.645, 0.298)	0.472
Woldiya		1	
Education			
No education	-1.201 (-.187, -0.054)	-0.080(-0.153, -008)	**0.030***
Primary	-0.049 (-.118, 0.020)	-0.027(-0.098,0.044)	0.458
Secondary and above	1	1	
Household size			
0-3	-1.201 (-.187, -0.054)	0.060(1.000, 0.121)	0.050
4-6	-0.049 (-.118, 0.020)	0.077(0.026, 0.128)	**0.003****
6 +	1	1	
SRH Source of Information			
Service provider	1.198 (.708, 1.687)	0.074(0.019, 0.129)	**0.009***
Other sources	1.665 (1.145, 2.186)	0.129(0.071 – 0.186)	**0.000***
No source of Information	1	1	
Place of origin			
Oromia	-.188 (-.275, -0.923)	-0.152(.-0.370 – 0.66)	.171
Tigray	-.115 (-1.716 – 0.067)	-0.121(.-0.249 – 0.006)	.062
Others	1		
Preference to go to health facility			
Yes	0.077 (0.007 – .147)	0.079 (0.013 – 0.146)	**0.019****
No	1	1	

The qualitative section of the study addresses the objectives related to major gaps and facilitators in terms of policy's resource allocations, coordination, and facility readiness. Which the researcher categorized as an enabler based on Anderson's model. The reinforcing or need factors of service availabilities are also included from service providers' and clients' perspectives.

ENABLING FACTOR

Effectiveness/functionality of policies at the regional level

The key informants from different offices and health offices claimed that a considerable amount of effort has been put into the improvisation of services in IDP camps. According to informants, different policies and emergency plans have been designed and implemented with a special focus on Sexual Reproductive Health (SRH).

To systematize and hasten the SRH services in IDP camps, several plans, guidelines, and policies are introduced. As aforementioned above, an emergency preparedness plan has been developed to accelerate the service delivery related to SRH. To further realize the implementation of the emergency plan, the incident management team has been established. Following the occurrence of internal displacement at Gedeo and Guji, much attention has been given to the internally displaced community. A separate team has been established by EPHI and is devoted to overseeing the IDP. In addition, the IDP emergency team has been established to strengthen the IDP camp medical service delivery including vaccines, preventable diseases, virus, and bacteria responses. With the initiation of EPHI, the focal person has been assigned to each region. MoH and EPHI launched SRH service in a humanitarian setting. For the facilitation of logistics, MoH has launched a separate directorate for logistics. The Directorate is responsible for the dissemination of logistics such as medical kits, drugs, and food.

The Health Sector Transformation Plan (HSTP) is an overarching transformative attempt made by MoH. It is composed of SRH as one of its pillars. Based on the HSTP, the Reproductive Health Strategy for five years (2020-2025) and the National Adolescent and Youth Health Strategy have been launched and included in the newly developed guideline. MoH is also working aggressively to ensure the requirement stipulated by the Global Inter-Agency Working Group (IAWG) which advocates for the incorporation of SRH in policies and guidelines.

Integration of MISP into the regional emergency plan was a landmark action taken by MoH. An incident management team comprised of seven components has been established to facilitate the training and dissemination of logistics in cooperation with EPHI and the Logistics Directorate. To include adolescents and youth in the IDP setting, the Ministry of Health has developed and
disseminated guidelines for adolescents and youth humanitarian action. The document is intended to guide service providers during service delivery for adolescents and youth.

Coordination with partners and funding

An emergency preparedness plan is launched at the regional level by the Amhara Regional Health Bureau. According to the informant, the emergency plan is revised every three months. The emergency plan is comprised of multiple technical working groups (TWGs) including TWG for SRH.

Apart from MoH and EPHI, various stakeholders are also partaking in resource mobilization, funding, and capacity building. Key informants indicated that there are many national and international organizations working with the Ethiopian government to address the needs of IDPs. In the Amhara region, United Nations Funds for Population (UNFPA), World Health Organization (WHO), United Nations Children's Fund (UNICEF), Marie Stops International (MSI), Jhpiego, Plan International, Engender Health, GOAL Ethiopia, WASH, Engender Health, Packard Foundation, International Organization for Migration (IOM), and Action Against Hunger.

According to key informants, the stakeholders partake in designing an emergency plan, capacity building, and provision of support including medical kits and funds. Task forces have been formed to respond to IDPs' needs. It was informed that UNICEF is closely working with IDP camps both in Debreberhan and Gondar. Furthermore, a technical working group comprised of UNFPA, Engender Health, WHO, USAID, and Packard Foundation has been also formed. Key informants reported that UNFPA is closely engaging with health bureaus and the Ministry. The UNFPA supports the IDP camps with reproductive health kits. The Plan International, GOAL Ethiopia, and WHO often deploy health teams to cover the human

resource gap within the context of IDP camps. Plan International also provides hygiene and sanitation equipment for IDP camps.

There are also local NGOs that are taking part in the mobilization of resources and funds for IDP camps in Debreberhan. Despite it being for a brief time, Emmanuel and Jerusalem,] local organizations and Kefita Project were providing support such as medical kits and clothing. However, there are no local NGOs reported for IDP camps in Gondar.

APHI is a mandated government body to mobilize public health emergency funding. Under this auspice, the emergency preparedness response plan proposes a budget including the contingency budget to the House of People's Representatives (HPR) for approval and disburses the budget upon approval.

Capacity Building:

To equip service providers with the required skills, training has been given for IDP camp service. The training mainly focuses on SRH and mental health treatment. Partner organizations have also placed mental health practitioners to strengthen service delivery capacity. EPHI is a responsible government body with the delivery of capacity building for service providers. UNICEF is the main partaker in capacity building among the stakeholders. But much more is still needed to work on capacity building for service providers in almost all IDP sites. Not all the service providers are trained specifically for the IDP community as their need is different.

Challenges Related to Resources

Despite major actions taken by government bodies and stakeholders, there are still gaps and challenges identified by key informants.

Service providers and IDP camp coordinators mentioned that there are discontinuities of support and funding. IDP coordinator explained:

> *The government had given much attention to IDP during the outbreak of war in north Ethiopia. Attention was given to them because no one wanted the pandemic to*

outbreak in the camp. But now, the commitment is not like what we used to have back in the past years. IDP Coordinator, Debreberhan.

Informants also mentioned that the dissemination of medical kits and mobilization of funds lacks flexibility. Adding to this, most of the medical kits are imported which takes a significant amount of time. Preparedness is reported as very minimal, though the number of IDPs is increasing and sudden by their nature. Related to capacity building, the informants mentioned that the training is given only once despite upgrading, and continuous updates are required.

Facility readiness

On the other hand, the Ethiopian Public Health Institute (EPHI) plays a key role in making sure MIPS is implemented in the IDP setting. To ensure the implementation of MIPS, the EPHI developed a guideline complemented by checklists that incorporate SRH. The key informants from EPHI recognized that the SRH had not gotten much attention. However, the Institute has been engaging with prior attention on SRH. The EPHI decimates resources and logistics through an incumbent government structure i.e., from regional throughout to Woreda health offices. The EPHI also caused the SRH specialists to be included in the emergency team within the context of IDP.

To further facilitate the dissemination of logistics and vital equipment, a logistics directorate has been established. To this effect, an attempt has been made to disseminate various reproductive health kits including sanitary pads throughout IDP camps including Debre Birhan and Gondar IDP camps.

NEED FACTOR

Service availability - Infrastructure.

Despite several actions that have been taken, there are still drawbacks reported by key informants and study participants. Informants and IDW indicated that the camp facilities do not have adequate water, and no electricity, and the road taken to the health center is inconvenient for transportation. Adding to this, with a sheer increase in the number of IDPs, the dissemination of equipment, distribution of food, and SRH service becomes taxing. IDP coordinator shared his concern saying:

We used to care for a certain number of the population but now a new number is added, which we have no plan to support. The issue is the number is increasing every day both at the community and camp. IDP Coordinator, Gondar.

Shortage of commodities

On top of that, elongated and bureaucratic procurement processes, and procedures for SRH commodities are also reported as the main constraints to accelerated response related to SRH demand. Moreover, discontinuity and irregularity of support and service provision were frequently mentioned by key informants and study participants as the gap within the context of IDP. According to informants, there are still gaps and challenges which have hindered proper implementation. It was reported that the SRH service was active and given high priority during the occurrence of displacement following the outbreak of war in north Ethiopia. However, it was informed that the SRH service has been dropping over time. Discontinuity of service, the inadequacy of medication, and skilled human resources are identified as the main constraining factors. IDP coordinator from Debreberhan camp explained:

A special focus has been given to SRH and we have been doing a remarkable job. We have established different committees – such as the hygiene committee, health team committee, and logistic committee – and we work closely and collaboratively for the better. The commitment is not like we used to have back in the past years. It's not been given attention from the regional or national level lately. The IDP camps often run out of stock. IDP Coordinator, Debreberhan.

Service providers from all camps felt that the camps were not offering adequate service. The service provider explained:

As I said earlier, laboratory kits like RDT kits, HCG kits, and HIV test kits are not available. We do not have family planning methods and medications, despite there is high demand. Service Provider, Debreberhan.

The IDP camp coordinator from Gondar also shared his concern saying:

We make sure the service that is given in the health center takes the IDPs into account. Our biggest challenge in this camp is we bring service providers from Azezo Health centers to the camp. We don't have health workers for the camp on a permanent base and it disrupts service. IDP Coordinator, Gondar.

Service provision for unmarried Youth

The study participants from IDP camps also confirm that several SRHs are being offered at the camp level and on a referral base. However, nearly all respondents from IDP camps in both target areas reported that service and medication are inadequate. The unmarried female explained:

I know for sure that they [the clinic at camp] do not have pills. Young people prefer to have pills or any other emergency tablets, but we could not find them here. They have no medication; they prescribe a similar drug for any type of case. Health workers are not always available. The health workers are changed frequently, and we must tell our case history for newly coming health workers now and then. FGD at Gondar, Unmarried Youth.

An unmarried female from the IDP camp at Debrebirhan also shared her resentment saying:

They do not understand my feelings, I sometimes prefer not to go there and rather follow some telegram pages that have information on young people. We do not have information on our sexual rights; if we do not know we lose confidence. When we lose confidence, we can't go and explain our situation to a service provider. This is the problem we are having. FGD at Debreberhan, Unmarried Youth.

Facility service - safe motherhood

Both in Debreberhan and Gondar IDP camps, service providers offer antenatal (ANC) and postnatal (PNC) care including pregnancy follow-up and vaccination for children, respectively. However, the attendants should go to another medical center out of the camp for delivery services owing to the scanty facility and skilled health workers. Unmarried youth mentioned:

There is no maternal delivery room and no places where pregnant women can wait until the ambulance arrives at this facility. The service providers came to the facility at 9 am and left the facility at 2 pm. We cannot get the service whenever we want to. FGD at Gondar, Unmarried Youth.

There is a major concern among the IDW regarding the inadequacy of ANC and PNC service at the clinic is very small. Both married and unmarried women at Debreberhan and Gondar camps informed that there is a noticeable inadequacy of medication. One of the discussants described:

Service providers are always available, but they are only two or three at a time and there is a queue; you may find a very long line of service-seeking IDPs sometimes. There is only one room for all kinds of services. FGD at Debreberhan, Married Women.

Most of the participants resented poor reception and alienation at the health center on account of being new to the area. Married women described:

Last week I went to the facility in the camp; I was sick, but I was informed that they do not have medication. They finally referred me to Azezo Health Center, but the service providers did not give us much attention when [I went] there... They explicitly told me that we were a burden to the Gondar town. I felt bad and cried that I was mistreated at the health facility. FGD at Gondar, Married Woman.

Service providers also shared their concern that the demand from IDPs and the service being offered is unmet. The service provider explained:

The health facility at camps is a 2 by 2 corrugated roof; we cannot stand the temperature in the afternoon –we store drugs in this same room, despite it being heat sensitive and unethical. We have 10 health professionals only; [but] we serve up to 150 clients per day. We refer the delivery cases to hospitals and health centers, but the road conditions are horrible, and difficult for pregnant women to go visit health centers. [On top of that,] we do not have available Ambulances for the IDP community. Service Provider, Debreberhan.

Moreover, the inadequacy of food was frequently raised as a precursor to poor ANC and PNC by participants from all camps. According to the participants, the IDP camp provides 15kg of flour at three or four-month intervals. A married woman reflected her indignation by saying:

> *Food provision is our main concern. We are given 15kg of flour for 4 months. This is all that we have been given; how am I expected to feed my children, myself, and my family for 4 months with 15kg of flour?* FGD at Gondar, Married Woman.

Family planning

The awareness among the IDW towards family planning seems improving. Most participants reflected that they should use contraception and other preventive mechanisms. The finding from the study reveals that the preference of unmarried youth is quite different from married women among options available for planning. According to key informants, unmarried youth usually prefer to take pills followed by *Implanon* while there is high demand for *Dippo Provera (injectable)* among married women. The current living context and high vulnerability to unplanned pregnancy influenced most IDWs to use preventive mechanisms. One of the married discussants shared her view on family planning saying:

> *…Of course, in our religion (Muslims), it is not allowed to use any contraceptive method. But we know what the consequence is here. In the situation, we are now it's difficult to have more babies. There must be an interval while giving birth. If one is after the other, we cannot afford to raise the children.* FGD at Debrebirhan, Married Woman.

In fewer cases, both married and unmarried women are still struggling with misconceptions about contraception. Married women reflected:

> *I know my neighbors are using the method [contraception]; but when they stopped using the method and wanted to get pregnant, they could not. We do not know the pros and cons of the methods and are afraid that we may not be able to give birth if we take the contraception. We do not want to have that kind of complication.* FGD at Debrebirhan, Married Woman.

Another married woman from Gondar also shared her opinion and described:

> *I am not taking any contraceptives. I do not think I will take any kind of contraceptives; they said women who take contraceptives end up in incision [C-section] during delivery.* FGD at Gondar, Married Woman.

Corollary to this, inadequacy and inaccessibility of contraceptives exacerbated the precariousness of service provision for family planning. The camps at Debreberhan do not have equipment and facilities for family planning services so the IDW should be referred to other health centers. Moreover, the IDW have limited options and are often forced to take the available ones or buy the contraceptives from their pocket. A married woman explained:

> *At the health facility, they have pills but most of the women here are looking for the 3-month method [Depo Provera injection]. That's what we used to get in Wollega and we want the same type of method here as well.* FGD at Debreberhan, a Married Woman.

Similarly, the finding from the study shows that the IDW at Gonder camp is often exposed to unwanted bureaucracy. Despite the service and medication for family planning are expected to be free, IDW usually buys contraceptives from private pharmacies. The discussants from IDW at Gondar camp reported:

> *Most of us are more comfortable with the 3-month contraceptive. We do not prefer the implant. However, we could not find Dippo. We could not get from the government Hospital at Azezo either. At last, I paid and got the dippo from a private health clinic. We must pay for the transport; we must pay for the service to get what we want.* FGD at Gonder, Married Woman.

Likewise, unmarried youths face difficulties in getting family planning treatment at the camp and outside of the camp. They are often mistreated by service providers or rejected at health centers. Unmarried women explained:

> *Since we live in huge compounds with everyone, we can't control the abuse; Girls engage in affairs willingly or unwillingly and get impregnated. However, the service providers at the camp are reluctant to give contraceptives to us. I once went to the*

clinic, and from the very start, they did not want even to talk to me. FGD at Debreberhan, Unmarried Youth.

Abortion

Abortion is a less frequent phenomenon among the IDP camps compared to other MISP components. Within the context of IDP camps, GBV during displacement or at the camp is a common precursor to abortion where females are impregnated unexpectedly or against their will. Next to GBV, family planning is also identified as the factor leading to abortion. Unmarried youth are reported to have considered abortion compared to married youth.

Like maternal delivery, abortion is referred to either adjacent health centers or hospitals in camps at Debreberhan and Gondar. According to the informants, abortion is only carried out for a pregnancy of less than one month. If the duration of pregnancy is found more than twelve up to fifteen weeks, the attendant would be referred to the hospital.

Gender-based violence

Even though many participants experienced gender-based violence (GBV) at their place of origin or during their journey to the camp, the effect of the violence inflicted on the IDW is still fresh and remains a triggering factor for most SRH services offered across all camps. Unmarried youth recalled her experience:

I am one of the victims. I used to live in Adinebrit [Tigray]. I was taken and raped by 3 Eritreans to save my family. The [health workers] gave me 3 tablets and after I finished, he gave me another round of tablets for one month and we came here. FGD at Gondar, Unmarried Youth.

Another unmarried female at Debreberhan camp also shared her experience in distress saying:

When we came to the camp for the first time, they made a quick pregnancy test for all of us, and seventeen female youths were found pregnant. This happened because, we came from a war zone, and we were at risk. We know so many young girls got raped at different places and it was happening here and there. My two friends are currently

pregnant, and they do not know who the real father of the baby is. After the incidents it is difficult to go to the service facility in Wollega, after we came here, we are looking for a place to stay and food to eat, rather than going to the facility to report or get tested. By the time they knew they were pregnant, it was too late to act.
FGD at Debreberhan, Unmarried Youth.

The participants from all camps were informed that they were still vulnerable to GBV at the camp. Unmarried youth experience GBV in the camp more frequently than married women. Unmarried youth mentioned that they are often forced to sleep with camp guards, coordinators, and ration distributors or otherwise deprived of the support and ration they would get. Unmarried youth described:

Whenever the aid organs came to the camp, they would hand over the items they brought to the camp coordinators, and the camp coordinators felt they had full autonomy over the items. They often inform women in the camp that they want to exchange what they have for sex…we do anything to get food to eat or clothes to wear. If I get hungry and they insist on having sex, I cannot think twice; because I need food to survive. I will do all I can to get myself and my family a portion of food to survive.
FGD at Debreberhan, Unmarried Youth.

Key informants from across camps also iterated that female youths are highly exposed to GBV. The finding also shows that less has been done to act and intervene to abate the GBV in the IDP camps. A service provider hopelessly explained:

… We have the information that the camp coordinators take advantage of their authority and abuse the young people to exchange sex for items in kind. If girls refuse, they will not have the support. We held meetings with the coordinators several times and informed them of the associated health risks. There is nothing else we could do other than give them advice. Service Provider, Debrebrehan.

Furthermore, the camp setting and the overflowing of camps with displaced people have exacerbated GBV in the IDP camps. Unmarried female described:

> *It's hard to control what happens to you in the camp. we are forced into so many abuses. We all live together in one compound, and we don't know each other.* FGD at Debreberhan, Unmarried Youth.

Key informants also recognize the camp condition as a precursor to GBV. IDP coordinator explained:

> *In our current context, we want to accommodate as many numbers as possible. In our region [Amhara], the total number of IDPs is 3 million. It is difficult to accommodate all these numbers as per the standard and appropriately fit. Since we cannot afford or do little in such aspects, all we can do is provide awareness to reduce the GBV risk.*
>
> IDP Coordinator, Amhara Regional Health Bureau.

The service delivery for GBV is available both in Debreberhan and Gondar IDP camps. Various stakeholders/NGOs also engage in service provision for GBV. The main services and treatments for GBV are creating space for victims to stay for a while, counseling services,

and other medical services including pregnancy prevention mechanisms. The finding from the study indicates that there is a difference between married and unmarried youth in terms of the degree of access in both camps. According to unmarried youth, more focus and priority are given to married women. It was iterated that the abuses experienced by unmarried youth are often disregarded by the service providers and camp system. Unmarried female described:

> *Our families, neighborhoods, and community do not consider that we also have issues that need us to go and see a health provider. They always consider the facility for mothers and children only. We have issues as well. We want someone at the facility to listen to our problems.* FGD at Debre Birhan, unmarried Youth.

This claim was also confirmed by key informants from the IDP camp at Gondar. The IDP Coordinator mentioned:

> *There is nothing that we did to entertain the needs of youth. There is no Youth friendly service at the camp. There is no comprehensive service. IDP Coordinator, Gondar.*

The expert from the Ministry of Health (MoH) also asserts that youth issues in the IDP context have been overlooked. The expert explained:

> *It is obvious that adolescents and youth are more exposed to the IDP settings, but they are neglected in terms of services. They are exposed to violence by humanitarian relief workers or security officers. They are [vulnerable]. The service providers are also not aware that the youth need the services.* IDP and Emergency Coordinator, Ministry of Health.

Several challenges contributed to the latent prevalence of GBV in the IDP camps which further inhibited service delivery. Most victims of GBV prefer to conceal the violence owing to a lack of awareness and their fear of being stigmatized by others. Moreover, the safety of the surrounding area is also the main challenge reported, particularly for unmarried youths. The latrine in the camp is far from a living place and girls are often raped in the toilet. Unmarried youth also mentioned that they are violated when they go out of the compound to buy goods or when they go to school. An unmarried female recounted:

> *whenever we go out to buy something outside of the compound, there is a gang of men group sitting outside and asking us to say Hi forcefully or to sit and talk to them against our will.* FGD at Debrebrehan, Unmarried Youths.

The victims are also forced to keep silent by their abuser. Heaps of these factors complemented by the inadequacy of service and facilities are the main gaps related to GBV.IDP Coordinator mentioned:

> *Several GBV victims come to the clinic, but they are reluctant to disclose it in front of other attendants. If we had a separate room, we could easily help them and treat them. Some midwives are trained in a specific field, but we don't have a separate table for the GBV-related services.*
>
> IDP Coordinator, Woreda Health Office, Debrehan

MENTAL HEALTH

In most cases, mental health is stemmed out of gender-based violence where victims are suffered from post-trauma of the violence and abuse, they experienced. Studded by the destruction and loss of their property, home, and aspiration, the GBV was identified as the main precursor to a mental problem most IDW are experiencing. A married woman recalled: *Armed rebels came and raped me for three. Now, I am mentally disturbed. I do not even trust my husband. I suffered a lot; how could one do this to a 9-month pregnant woman?* FGD at Gondar, Married Woman.

The loss of their family and property has also exposed several IDWs to mental health problems. A married woman described:

> *One of my sisters is not normal. She lived and worked for 6 years in Saud Arabia. She came and built a house with the money she accumulated, unfortunately, she lost her house; they burnt the house and took everything she had. She was distressed. She is a mother to a 7-month-old baby. We reached here at the camp, and we were informed my father was killed when he was about to escape and that worsened her situation. We took her to holy water, and she is now getting better. She was treated at the camp facility, and they gave her medication.*

The intensity of mental health problems was reported high for adults compared to youths. The most common mental health problems are Post Traumatic Stress Disorder (PTSD) and depression. Service provider informed:

> *The mental disorder and anxiety are noticed mainly among the adult age group, as they leave their asset and all they have in their place of origin. When they lose control over their lives, they become hopeless and get stressed.* Service Provider, Debreberhan.

The treatment for mental health is carried out at the camp, adjacent health centers, and hospitals for both camps. In the case of IDP camps at Debre Berhan, university lecturers from Debrebirhan University intervened in mental health cases, especially during the first round of IDP. Likewise, the IDP at Gondar would get mental health treatment at the campsite in

cooperation with Gonder University. The International Organization for Migration also engages mothers in different crafting activities to stabilize their mental state.

The finding from the study shows that there are two main types of mental health services being delivered in both camps: psychosocial support and psychotherapy. The clinic at the camp would identify the mental health patients and give psychosocial treatment which is believed minor and treatable at the camp level. If the case involves psychotherapy or serious mental illness, the patient would be referred to the hospital.

The finding shows that mental health problem is the most common ailment among IDPs but invisible and unnoticeable for nearly all IDPs. Endless stress, hopelessness, and alienation from the community were iterated by study participants. However, unawareness of the IDPs about the mental health problem, or overlooking the stress or depression unless it becomes notorious insanity has limited the number of mental health service seekers. On top of that, discontinuity of the service has left the mental health issue unattended.

HIV/STI

Key informants reported that STIs/HIV are spreading in the IDP camps alarmingly. The spread of STIs/HIV showed a sheer increase over the period. The informants attributed the outbreak of war to an underlying issue of STI/HIV spread since most IDW was the victim of GBV. IDP coordinator described:

> *During the [outbreak of] northern conflict, the number of HIV carrier IDP was more than we expected*. IDP Coordinator, Debreberhan.

The majority of respondents, both married and unmarried women have little or no awareness of STIs and prevention mechanisms. In fewer cases, respondents recalled the awareness they had about STIs at their place of origin. Respondents blamed the camp administration for there being a minimum attempt made to aware the camp dwellers aware of STI/HIV. Married women explained:

...here we live together with people we do not know; I wish they give us information about STI/HIV. I often see information posted here and there, but most of the dwellers cannot read and write. FGD at Debreberhan, Married Woman.

Unmarried females also iterated that their awareness of STIs is minimal. The unmarried discussant responded:

I don't know what STI is but I heard about it, I don't know what causes STI and what the consequences are. FGD at Gondar, Unmarried Youth.

The low awareness about STIs, the service utilization among the IDW is reported minimal. Inadequate service provision, scanty equipment, and logistics have also aggravated the service gap for STIs/HIV. According to key informants, the service delivery for STIs is currently at its nadir and has prematurely decreased over time owing to meager and discontinuous medical provision. Key informants informed:

Laboratory kits such as rapid diagnostic test (*RDT) kits, and HIV test kits are not available.* Service Provider, Debreberhan.

4.7. DISCUSSION

PREDISPOSING FACTOR

The current study aimed to assess sexual and reproductive health service utilization and its associated factors among internally displaced women in three towns of the Amhara region. In this study, it was revealed that the overall sexual and reproductive health service utilization (SRH) among internally displaced mothers was an average score of 53% (±23%).

Women's education was identified as a significant factor in the utilization of sexual and reproductive health services. It was indicated that the utilization of sexual and reproductive health services was less likely among the internally displaced women who did not attend their education compared with those who attended their secondary and above education. (Beegle, Frankenberg & Thomas, 2001) supported this finding that the women's formal education level plays a more important role in utilizing SRH service. This might be explained by the fact that no question educated women can have better information about the available sexual and reproductive health services. Education provides better health knowledge, improves the effectiveness of health behavior, and enables clients /mothers to utilize the SRH service.

The household family size was also found as a determinant of sexual and reproductive health service utilization among internally displaced women. The study found that displaced women with a household family size of 4-6 were more likely to utilize sexual and reproductive health services compared with those with a family size of more than six. This is probably because mothers with fewer family sizes would better know the benefit of the service as they can limit or space the number of family sizes and have a healthy family that will enable them to have better education, nutrition, and psychological support likened to those increased family sizes.

On the other hand, it was pointed out that the utilization of sexual and reproductive health services was more likely to increase among internally displaced mothers who got information from SRH service providers compared to those mothers without any SRH information.

This might be because SRH service providers provide comprehensive information about the available SRH services and the benefits of utilizing the service, so the mothers decided to utilize the intended service based on the information provided. As revealed in this study, almost 49 % of the respondents reported service providers, health extension workers, or any other service providers. This means that strengthening SRH information for the IDP community and awareness-creating activities can scale up the uptake of SRH service utilization. As per the UNFPA (2010) report, more educated women are more likely to know available SRH services and develop more confidence to use and seek them. For example, in Thailand, the literacy rate for women is 96% a massive fertility decline was recorded, and the population growth was 1.4% per annum.

A significant association was observed concerning preferring health facilities for SRH service. It was figured out that utilization of sexual and reproductive health services by internally displaced women was more likely to increase among those who preferred health facilities to obtain the SRH service. It might be explained when women prefer the health facility to obtain the service, they could get better information about the service from the providers so that they would develop a positive attitude towards the service and be motivated to access the SRH service.

ENABLING FACTOR:

To systematize and hasten the SRH services in IDP camps, several plans, guidelines, and policies are introduced. The Health Sector Transformation Plan (HSTP) is an overarching transformative attempt made by MoH. It is composed of SRH as one of its pillars. Based on the HSTP, the Reproductive Health Strategy for five years (2020-2025) and the National Adolescent and Youth Health Strategy have been launched and included in the newly developed guideline. MoH is also working aggressively to ensure the requirements stipulated by the Global

Inter-Agency Working Group (IAWG) which advocates for the incorporation of SRH in policies and guidelines. In terms of coordination and collaboration, task forces have been formed to respond to IDPs' needs. There is a great collaboration among different actors. UN agencies,

NGOs, and GOs are supporting the needs of the region. regarding SRH utilization, other organizations are also supporting but UNFPA is providing the RH kit for the IDP health facilities and adjust health centers.

There is the discontinuation of support and funding. Service providers and IDP camp coordinators mentioned that there are discontinuities of support and funding. Apart from MoH and EPHI, various stakeholders are also partaking in resource mobilization, funding, and capacity building. Key informants indicated that there are some national and international organizations working with the Ethiopian government to address the needs of IDPs. However, the funding is discontinued due to budget cuts.

PREDISPOSING FACTORS

The camp facilities do not have adequate water, and no electricity, and the road taken to the health center is inconvenient for transportation, especially for pregnant women and those who have follow-ups. There is a major concern among the IDW regarding the inadequacy of ANC and PNC services at the clinic. Both married and unmarried women at Debreberhan and Gondar camps have complaints that there is a noticeable inadequacy of medication.

Surprisingly, the FP need among IDPs is very high but there is a high disparity between the need and its availability. The demand and supply are incomparable. Inadequacy and inaccessibility of contraceptives exacerbated the precariousness of service provision for family planning.

There are no services available for GBV and Abortion at the facility in the camp, but they referred the clients with such issues to the adjustment health center and hospital. There are complaints from the IDPs side that they are not well treated at the hospitals and sometimes they are asked to pay for the services even if they provide the referral support letter in Gondar.

It's surprising, to understand that the humanitarian relief workers are sometimes the perpetrators of the GBV. The discussion with married and unmarried youth helps the researcher understand there is a service need for the difference between the two age groups. The discussion with service

providers and married and unmarried youth informed that mental health problem is the most common ailment among IDPs but invisible and unnoticeable for nearly all IDPs.

Limitation

While interpreting the findings of this study, readers/researchers/scholars need to consider the following limitations. Due to the sensitive nature of the information, the accuracy of the information might be missed. The researcher and data collector tried to mitigate the bias by interviewing the respondents outside of the shelter, where their families and friends were not around with all the difficulties.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. CONCLUSION

The research aimed to assess the SRH Utilization among Internally displaced women in the Amhara region. The following conclusions were drawn: In the current study, the utilization of sexual and reproductive health services among internally displaced women was an average score of 53% (±23%).

PREDISPOSNG FACTOR: Women's educational status, household family size, source of information about the SRH service, and prefer the health facility to access the SRH service were identified as the significant factors for the utilization of SRH among the internally displaced women in the three towns of the Amhara region.

ENABLING FACTOR: several plans, guidelines, and policies are introduced regarding IDP in Ethiopia such as the RH strategy, 5 years HSTP plan, and AYH strategies of the Ministry of Health and regular preparedness, response, and restoration plan by the Ethiopian Public Health Institutes. There seems to be a coordination among different actors in the region but now there is a discontinuity with regards to funding and support.

NEED FACTOR: Regarding service availability the camp has no water, or electricity and the facilities at the camp are not designed for health facility purposes. The needs of married women and unmarried youth are different. The service providers did not consider the youth to have SRH needs. Unavailability of commodities, supplies, and equipment at the facility both at the camp and at the adjacent health facilities.

This study also identifies that mental health is a prominent health concern among Internally displaced women in the Amhara region, and little attention has been given.

5.2. RECOMMENDATIONS

This study proposes several recommendations for different actors to improve service utilization in IDP camps:

IMPLICATION FOR PREDISPOSING FACTORS

- Multi-sectoral collaboration is most needed between the education and health sectors, as keeping girls in school has a huge impact on utilizing SRH services. One of the major reasons for dropout among adolescents and youth is associated with menses and availing of sanitary pads for girls is vital.

- A tailored SRH information is critical for the IDP community, as an SRH source of information found to be important to utilize the services, it's important to know the modality to disseminate information about SRH. Intervention programs can be designed to increase the source of channels to reach out to the IDP communities. Health providers need to be enriched with communication skills and refresh themselves with updated SRH information.
- As the majority of the IDPs prefer to go to the facility and as one of the significant factors to SRH service utilization, supplies and commodities availability is critical to meet the client's need. In addition to that, youth-friendly services for unmarried youth are important to attract the youth to utilize the services.

IMPLICATIONS FOR ENABLING FACTORS

- Enough policies, guidelines, and preparedness plans are available at the Ministry of Health, Ethiopian Public Health Institutes, and Amhara Regional Health Bureau. Implementation of what's in the policy and guideline is the next important step to follow and ensure what's in the policy is executed.

- The Ministry of Health needs to make sure that facilities at the camp fulfill the standards and ensure the readiness of the facility in terms of supplies, equipment, and commodities.

- The government needs to come up with an advocacy plan to increase the availability of funding to reproductive health commodity security and closely work with different stakeholders.
- Organize a consensus-building meeting with pertinent CSOs to understand their role in holding the government accountable for financing FP commodities and monitor progress.

IMPLICATION FOR REINFORCING FACTOR

- The Ministry of Health and Amhara Regional Health Bureau strongly work to fill the gaps in terms of Family planning commodities and other supplies with EPSA on how to minimize the bureaucracy in the logistics and customs to get the commodity promptly.

- Intensive capacity-building training for service providers on SRH services managing the IDP community and engaging the adjacent Universities to manage and follow up with mental health patients.

IMPLICATION FOR FUTURE STUDIES

- Some factors significantly influence SRH utilization among IDPs. Thus, this is suggested that further studies focus more on these factors for each minimum initial service. To meet these purposes, further studies can investigate specific determinants from each factor to develop a more comprehensive understanding of each service associated and influencing factors.

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ANNEXES

ጤና ሚኒስቴር - ኢትዮጵያ
የዜጎች ጤና ለሀገር ብልፅግና !

Ministry of Health - Ethiopia
Healthier Citizens for Prosperous Nation !

ቀን Date 26 APR 2022

ቁጥር Ref.No. ኅመ32/49/190

Amhara Public Health Institute
➔ Health Research and Technology Transfer Directorate

As we all know, In the Amhara region, the Tigray invading force displaces hundreds of thousands of people from their homes every week. During the war in the past 1 year, more than 40 hospitals, 453 health centers, 1850 health posts, 4 blood banks, 2 Health science colleges, 465 private health facilities are destroyed, and more than 1,119,810 IDPs are living in the Amhara region, of whom 35,505 (3.2%) are living in 22 collective sites. An additional 8,209,317 people need essential health services in war-affected areas. The regular data from the region shows the health facilities are mainly affected and Funding is a critical gap for early recovery and response. There is a shortage of drugs, medical supplies, and equipment, and essential health service restoration is a huge challenge in the region.

Only a few partners are involved in the humanitarian response, to persuade partners, it's necessary to generate evidence-based data from individuals and institutional levels. As per the request from the individual researcher from Addis Ababa University – Center for Population and Reproductive Health Studies planning to work on her master's thesis on:

PREDICTORS OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES UTILIZATION AMONG INTERNALLY DISPLACED PEOPLE: EVIDENCE FROM AMHARA REGIONS

This researcher, Bethelhem Fekade will be working on her academic research in close collaboration with the Ministry of health – MNCH Directorate and St. Paul Institute for Reproductive Health and Rights (SPIRHR).

Taking the importance of the research into account for future implementation, this is to kindly request, Amhara Public Health Institute: Health Research and Technology Transfer Directorate to write a support letter

1. Gondar City – Kebero Meda IDP camp
2. North Wollo – Woldiya Town IDP camp
3. North Showa – Debre Birhan Town IDP camp

Thank you very much for your continued collaboration. Please let us know if you have any questions.

Regards

Meseret Zelalem Tadesse (Dr.)
Director, Maternal & Child Health Directorate

ETHIOPIA * MINISTRY OF HEALTH *

Cc/

- Maternal and Child Health Directorate
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በአማራ ብሔራዊ ክልላዊ መንግስት
Amhara National Regional State
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Amhara Public Health Institute

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ጉዳዩ፡- ትብብር እንዲደረግላቸዉ ስለመጠየቅ

በፊድራል ጤና ሚንስቴርና (MNCH Directorte) ና በትዱስ ፓዉሎስ (Reproductive health and rights (SPIRHR) ጋር በመተባበር በ ቤተልሄም ፈቃዱ አጥንነት አማካኝነት (Predictors of sexual and Reproductive health services utilization Among internally Displaced prople Evidence from Amahara Region) በሚል ርዕስ ጥናት ለማከናወን የጥናቱ ንድፈ ሀሳብ የአዲስ አበባ ዩንቨርስቲ ስነ-ምግባር ገምጋሚ ኮሚቴ ታይቶ የፀደቀ ስለሆነ አጥኝዎቹ ወደ ተቋማችሁ ሲመጡ አስፈላጊዉ ትብብር እና ድጋፍ እንዲደረግላቸዉ ስንጠይቅ ምስጋናችንን በማስቀደም ነዉ። በመጨረሻም ጥናቱ ሲጠናቀቅ ውጤቱ ለጤና ተቋማት ጥቅም ላይ ለማዋልና ለመከታተል እንችል ዘንድ ቅጅ ለጤና ምርምርና ቴክሸግር ዳይሬክቶሬት እንዲቀርብ ጥናቱን ለሚያከናውነው ቡድን በግልባጭ እናሳውቃለን።

"ለሕብረተሰብ ጤና ልማት እንተጋ"

ዶ/ር ግዛቸዉ ይስማው ውቤ
Dr.Gizachew Yismaw Wubetu
የጤና ምርምር ልማት
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ግልባጭ//
- ለቤተልሄም ፈቃዱ

Tana Sub-City, Kebele 13, Bahir Dar | Ethiopia P.O. Box: 477 ☎ 0582221493 ✉ admin@aphi.gov.et Website: www.aphi.gov.et

አማራ ብሔራዊ ክልላዊ መንግስት የጤና ቢሮ

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Amhara National Regional State Health Buearu

North shoa health Department

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ቁጥር ሰሸጤመ41/1752/2014

ቀን 25/8/14

ለደ/ብርሀን IDP

__ደ/ብርሀን__

ጉዳዩ፤-__ትብብር እንድደረግላቸዉ ስለመጠየቅ__

የአማራ ክልል ህብረተሰብ ጤና ኢንስቲትዩት በቁጥር አብክመ ኢየጤ/ምርቴ/ስሽ/03/1330 በቀን20/08/2014ዓ.ም በተፃፈ ደብዳቤ (predictors of sexual and reproductive health services utilization among IDP from amhara region በሚል ርእስ ጥናት ለማከናወን የጥናቱ ንድፍ ሀሳብ የአድስ በባ ዩኒቨርሲቲ ስነምግባር ገምጋሚ ኮሚቴ ታይቶ የፀደቀ ስለሆነ አጥኝዎቹ ወደተቋሙ ሲመጡ አስፈላጊዉን ትብብር እና ድጋፍ እንዲደረግላቸዉ ጠይቆናል በዚህም መሰረት ለጥናቱ የሚመጡ ባለሙያወች ወደ እናንተ ተቋም ሲመጡ የተለመደዉን ትብብራችሁን እንዲታደርጉላቸዉ እየጠየቅን በመጨረሻም ጥናቱ ሲጠናቀቅ ዉጤቱ ለጤና ተቋማት ጥቅም ላይ ለማዋልና ለመከታተል እንችል ዘንድ ለዞን ጤና መምሪያዉ ግልባጭ እናሳዉቃለን፡፡

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FAX 0581122239

ቁጥርጎከጤ/ 2748/ስ04
ቀን 4/9/2014

ለቀበሮ ሜዳIDP CAMP

ጎንደር

ጉዳዩ ፣ ትብብር እንዲደረግላቸው ስለመጠየቅ

የአዲስ አበባ ዩኒቨርስቲ ጤና ሳይንንስ ክልጅ እና የጤና ሚ/ር በጋራ ለሚሰሩት ጥናታዊ ጽሁፍ መረጃ እንዲሰበሰቡ የተላኩ ባመ.ያዎች 1ኛ ቤቱልሄም ፈ.ቃዴ 2ኛ መ.ሉቀን አራጋው 3ኛ አለማዝ ቸኮለ በተሚችሁ የምርምር ጥናት ለመስራት ስለሚንቀሳቀሱ አሰፈ.ላጊው ትብብር እንዲደረግላ እንጠይቃለን።

ክብሩ ጋር

Belete Fente Tebat

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QUALITATIVE STUDY INTERVIEW GUIDE

SERVICE PROVIDER KII INTERVIEW GUIDE

- Tell me about your time at the facility. How long have you been a service provider? How long have you worked here?
- During this time at the facility, what has supported you? What other support would you like? (Probe – access to new training, professional development, Material support)
- Did you get support from woreda, NGO, or any other governmental institute to excel in your work and lead others? What did you appreciate most about the support? Describe in what way the community in the camp encourages you and stay in it at these difficult times. What sort of support would help IDPs in this facility help more?
- What are the prominent health issues among women in the IDPs?
- What are the age-specific needs of IDPs of different age groups?
    - Safe motherhood – ANC/DC/PNC
    - Family Planning
    - GBV
    - Abortion
    - Mental health
- Who is not coming to the facility, but you wish would? What needs to be changed so that they can deliver the care and can come and visit on a regular base?
- How do you define the quality of care? What enables you to provide quality care? What more support do you need to be able to deliver the care and service that your clients seek?

AVAILABILITY AND ACCESSIBILITY

    - ANC
    - Labor and Delivery Care
    - Safe Abortion/ Post Abortion
    - Immediate post-partum
    - Family planning
    - Blood transfusion
    - Postnatal care
    - Laboratory testing
- Psychosocial care, counseling, and support service
    - Physical intimate partner violence
    - Sexual intimate partner

- Non-partner sexual assault
- Physical and sexual assault

- Does a psychosocial care package include?
    - Medical care for sexual and physical assault
    - Referral linkage
- How many health service providers work in this health facility?

INFRASTRUCTURE

- Is electricity available? Generator? Solar system/power?
- Does the facility refer?
    - Pregnant women, Laboring women, postpartum women, newborns, women seeking safe abortion care.
- Does this facility have access to the ambulance? For emergency transport of the patient to/from this facility? Other means? How much time on average to transport emergency patients?
- Is the service provided free of charge?
- What are the routine activities to complete ANC (probe: weighting pregnant woman, blood pressure, urine test, blood test for anemia, blood group, RH factor, counseling, breastfeeding, HIV counseling, testing for HIV, blood glucose testing, counseling on post-partum FP)?
- How many maternal waiting rooms are available – (Probe – delivery room, is a heat source in the delivery room, labor delivery bed, Newborn corner)
- Are skilled birth attendants available at the facility or on-call 24 hours a day? Skilled providers, who can perform C-sections at health facilities?

FAMILY PLANNING

- What does the family planning service for adolescents and Youth (unmarried) aged 10 – 19 or 20 – 29 look like?
- What kinds of methods are available for clients? What are the most used?
- Do clients need to pay to obtain the method?
  Probe – FP stockouts – if any, have the methods been out of stock at any time in the past three months? Does the facility have trained personnel available to remove implants (removal/Insertion) – IUD – removal or insertion?

GBV and Mental Health

- What are the services available for GBV victims and/or survivors? What is the referral system? Rape victims and treatment?
- How are mental health issues handled in the facility?
- How far is the facility from the camp? How far is the camp from the referral health center?

What are your three wishes to enable you and your facility to reach more # of people in the IDP setting who need your service, what would your three wishes be?

INTERVIEW GUIDE -

POLICY, COORDINATION, RESOURCE ALLOCATION, AND FACILITY READINESS

1. Does the country have a national emergency preparedness plan or does the response policy exist? If exists are these plans rolled out at the regional level?
2. Is SRH or MISP integrated into the National/ regional emergency plan?
3. Is there a coordination mechanism (SRH working group) at the national level/ regional level? Are there civil society organizations? The UN agencies? INGO? Or are community-based organizations represented?
4. Are there mechanisms for rapid mobilization of the fund? What other mechanisms do we have in place if donors are out of the picture? Are there any initiatives by the government to fill the gap?
5. Are all the SRH commodities needed for MISP implementation part of the National essential medicines? How do you see the shortage of commodities? What are the plans to cover the gap?
6. Is there a system in place, to deliver services, equipment, medicines, and commodities?
7. Do the health care training curriculum or other relevant training for health service providers/staff?
8. Are mechanisms in place for health staff to be moved or take on new roles in the emergency setting?
9. Does the health response team contain specialists in SRH service providers?
10. Are there barriers or challenges you think are for conflict areas to assess SRH services?

FGD MARRIED WOMEN QUESTIONNAIRE GUIDE

1. Now I would like to begin with a few questions. what sort of things do you and people like you, who are married in the IDP setting take of your health and avoid getting sick?
2. Is there a health facility at the camp? What kind of services do you seek from the health facility? Do you like the service at the facility? What is the kind of service you are seeking but couldn't find?
3. Are service providers available? Why do married women like you go to the health facility outside of the camp? How friendly and welcoming are the health care services provided towards married women like you?
4. Who do you prefer to go with to the health facility? What does good health care look like for women in the IDP setting?
5. What kind of services are available for pregnant women at the health facility in the camp and adjacent health centers? Have you or your friends or family delivered at the health facility after coming to the camp? what services are available? Are you or your friend satisfied with the services available? What more needs to be done? Do mothers who have given birth go to the facility after giving birth or will the service providers come to visit?
6. Are FP services available at the facility? What is the type of service available at the facility in the camp? what are the methods available at the health center? What is the kind of FP methods you can't find at the facility but wish to find?
7. What are the challenges at the health facility to provide the method? Are there FP services available whenever a married woman asks? What are the challenges?
8. Is there HIV/ AIDS testing at the Facility? Are there HIV treatment services at the facility? Do HIV-positive IDPs get the services?
9. Are married women in IDP abused, raped, physically hurt, or detained during the conflict? Do you know anyone at the shelter with a similar case? What are the services like for people in such kinds of situations? Are there any GBV cases at the camp?

Consent Form for Survey

(Flesch-Kincaid Readability Grade 6)

Hello, my name is **Bethelhem Fekade** and I am currently a student at Addis Ababa University, College of Developmental Studies – Center for Population Studies. We are gathering information on SRH service access and utilization. We are here only to ask questions. We are conducting this survey among women between 10 and 49 years ofage. We want to use what we learn to plan health services in your area.

Purpose of the Survey

The researcher is doing this survey to find ways to improve access to and utilization of SRH services among IDPs in the Amhara region. The findings from this survey may help us find ways to decrease SRH-related issues.

Your house has been chosen from the list of houses in this area. You were chosen from this list because you are between the ages of 10 -and 45. You were randomly selected using numbers on a chart. This number is not linked to you for any other reason except that it helped us choose women from the list. More than 600 IDPs from this region will be asked to participate in this survey.

You are free to join the survey or not. If you do not join, you will not lose any health care services that you normally get. We will ask you some questions about your service-seeking behavior, your health, and your experiences with violence. We will also ask about the conflict in your home country if this applies to you.
Other questions are about AIDS and sexual behavior. It will take about 45 minutes to answer all of the questions.

Risks and Benefits

There is no risk to your health from being in this survey. Some of the questions in the survey ask about your health and your family. We will also ask you questions about your experiences with violence.
Answering questions like this can be difficult. If the questions are upsetting or difficult for you to answer, we can stop the interview at any time or we can skip those questions. You may not want to answer someof them. If you do not want to answer a question, we will just skip it and go to the next question.

We hope to learn how health care and community programs in this community can serve women and their families better. We will give you names of people you can go to if you have any questions or concerns about what we discuss. If someone enters the room while we are talking about something private,we will change the topic.

Questions or Concerns

There are people you can contact if you have any questions or concerns. If you have questions about thesurvey, you can contact **Bethlehem Fekade**. You can reach her by calling her **[+251 938943451]**

Confidentiality and consent for interview

You will be asked some very personal questions that some people find difficult to answer. Your answers will be kept private and secret. No one will know that the answers came from you. Also, no one else in the camp or household will know what you tell us. We will never use your name with anything you tell us.

You do not have to answer a question if you do not want to. You may stop answering questions at any time. We would be very grateful for your help. The questions will take about 45 minutes. Do you agreeto participate?

Participant: I agree to answer the questions.

(Signature of the interviewer to whom oral consent was given by the participant) or if they can read and write they may sign on the consent form.

If Respondent Refuses, Read the Following and Then Complete the Visit Record

I'm sorry you will not be able to participate in this survey. May I ask you why you do not want to participate in the survey?

1. No time/busy
2. Not interested
3. Information too sensitive
4. Other (specify)
5. No reason given/don't know

Thank you very much for your time. ---------- END—COMPLETE THE VISIT RECORD

CDC REPRODUCTIVE HEALTH ASSESSMENT QUESTIONNAIRE FOR CONFLICT-AFFECTED WOMEN 2011

01 QUESTIONNAIREIDENTIFICATIONNUMBER|_____|_____|_____| **STARTTIME:___**

02 COUNTRY |___|___|___|(providetelephonecountrycode)

003 REGION |____|____| (provide locally appropriate categories)

004 SITE |____|____| (provide locally appropriate categories)

05 TYPE OF SITE _____
Resultcodes:1–Refugee;2–IDPCamp;3–Returnee;4–Hostcommunity;[5–Other]_____

06 INTERVIEWER:Code[_____|____]Name_____

07 DATE OF INTERVIEW: _____/ _____/_____
Day Month Year

08 CHECKEDBYSUPERVISOR:Code[_____|____]Name_____

09 DATAENTEREDBY:Code[_____|____] Name_____

Section1:Backgroundcharacteristics

We are doing a women's health survey with, _____and appreciate your taking the time to help us complete thefollowingquestions.Yourresponsesarevoluntaryandwillbeconfidential,whichmeansthatwewillspeak in private and that I will not write your name on the questionnaire.Therefore whatever information you share with me todaywillnothaveyournameonit,andyoucanchoose to notrespondtocertainquestionsordiscontinueparticipation at any time; I'd like to start by asking you some general questions about your daily life here in your household. By household,Imean(providelocaldefinitionofhousehold)_____.Areyoureadytobegin?

No.	Questionsandfilters	Codingcategories	Skipto
Q101	Howmanypeoplecurrentlyliveinyour household? ***EXCLUDE VISITORS AND DON'T FORGET TO INCLUDE CHILDREN AND ELDERS.***	Males[||] Females[||] Totalnumberofpeople[||] NoResponse99	
Q102	Whoiscurrentlytheheadofyourhousehold?	Myself1 Husband/partner2 Father3 Mother4 Otherrelative5 Other(specify)_____6 NoResponse9	
Q103	Are you currently married or living together with a man as if married?	Yes, currently married ..... 1 Yes, living with a man ..... 2 Divorced/separated..... 3 Not currently in union: Widow ..... 4 No, never in union ..... 5 No response ..... -99	
Q104	Howoldareyounow? ***(COMPAREANDCORRECTQ104IFNEEDED)***	Ageincompletedyears[||] Don'tKnow88 NoResponse99 ***ESTIMATEBESTANSWER***	
Q105	Whatreligiondoyoupractice?	Orthodox1 Catholic2 Protestant3 Muslim4 Jehovah'sWitness5 Traditional6 Wakefetah7 Non-believer8 Other 98 NoResponse99	
Q106	WhatisthehighestlevelofschoolYOUattended?	Neverattended ..... 0 Primary..... 1 Secondary ..... 2 Technical&vocational..... 3 Higher... ..... 4 Noresponse.....-99	

Q107	Wheredidyoulivebeforeyouweredisplacedfor the first time? ***CIRCLE ONE***	1. WolkayitTsegede 2. North Shoa 3. South Gondar 4. Gojjam 5. Wollo 6. Gondar 7. Wag Himra 8. Awi 9. South Welio 10. Bahir Dar 11. Oromia Zone 12. Central Gondar 13. Gondar City 14. West Gondar Other(specify)_____20 NoResponse99	
Q108	How long have you lived here in _____ (prov	Numberofyears[|_] iflessthan1year00 Don'tKnow88 NoResponse99	
Q109	what is your monthly income	---------- birr in month I don't know exactly.....1 Unwilling to respond.....2	
Q110	Do you read a newspaper or magazine? If so how often?	Almost every day.....1 At least once a week..... 2 Less than once a week .....3 Not at all.....4	
Q111	Do you watch television?	Almost Every day.....1 At least once a week..... 2 Less than once a week .....3 Not at all.....4	
Q112	Do you listen to the radio? If so, how often?	Almost Every day.....1 At least once a week..... 2 Less than once a week .....3 Not at all.....4	
Q113	Is there a health facility at the camp	Yes1 No2 Don'tKnow8 NoResponse9	
Q114	How is the health facility from where you live	1 and less than 1km----1 Less than 2km -----2 Less than 5km ------3 I don't know ------8	
Q115	Do you prefer to go to the health facility at the camp	Yes1 No2 NoResponse9	Q. 116
Q.116	What is your reason for not choosing the facility at the camp		

Section2:REPRODUCTION AND FERTILITY PREFERENCES

Nowlamgoingtoaskyouquestionsaboutyourcurrentandpreviouspregnancies,if applicable.

No.	Questionsandfilters	Codingcategories	Skipto
Q201	Haveyoueverbeenpregnant?	Yes1 No2 NoResponse9	 →Q300 →Q300
Q. 202	Haveyouever been deliveredtoahealthfacility before?	Yes..... 1 No..... 0 NoResponse.....9	
Q203	Areyoucurrentlypregnant?	Yes1 No2 Don'tKnow8 NoResponse9	 →Q210 →Q210 →Q210
Q204	How many months pregnant are you?	Months[ ] Don'tKnow88 NoResponse9	
Q205	Where would you like to deliver your baby?	Camp 1 home/place of origin 2 Government hospital11 Government health center12 Government health post 13 Other public sector 14 Private hospital/clinic 21 Oher private medical sector 22 NGO/Faith-based health facility 31 Other_____ 96 Have not decided yet ..... -88 No response 9	
Q206	Whowouldyouliketodeliveryourbaby to?	Doctor 1 Health officer 2 Nurse/Midwife 3 Any professional healthcare provider (can't distinguish) 4 HEW 5 Traditional birth attendant 6 Family member 7 No one 0 Have not decided yet ..... -88 No response 9	**Circle responses and go to** →Q209
Q207	Isthisyourfirstpregnancy?	Yes1 No2 NoResponse9	→Q300 →Q300
Q208	Nowspeakingaboutyourchildrenwhoare alive. Howmanysonsandhowmanydaughtersdo you have? They can be living with you or elsewhere.	Sonswhoarealive[ ] Daughterswhoarealive[ ] Total children alive [ ] NoResponse99 ***IFTHEREARENONEWRITE00***	
Q209	Didyouhaveanysonsordaughterswhowere born alive and died, though they lived a short time?	Yes1 No2 NoResponse9	 →Q213 →Q213

Q210	Howmanyofthesesonsanddaughterswere born alive and have died?	Sonswhodied[ ] Daughterswhodied[ ] Totalchildrenwhohavedied[ ] NoResponse99	
Q211	Have you had any sons or daughters who wereborndead**AFTER**completingsixmonths of pregnancy (stillborn)?	Yes1 No2 NoResponse9	→**Q216** →**Q216**
Q212	How many losses (spontaneous or induced abortions)haveyouhad,beforecompleting the sixth month of pregnancy?	Numberofabortions[ ] NoResponse99	

Nowlwouldliketoaskyouaboutthemost recentpregnancyyouhadthatendedinalive birthorastillbirth.			
Q219	Didyouseeanyoneforantenatalcareforthis pregnancy?	Yes1 No2 NoResponse9	→**Q223** →**Q223**
Q220	Whodidyouseeforantenatalcare? Anyone else?	Doctor12 Nurse/midwife12 Traditionalbirthattendant/healthworker12 Other (specify) _____ 12 NoResponse12	
Q221	Howmanytimesdidyouseesomeonefor antenatal care?	Onetime1 Twotimes2 Fourtime s3 Morethan fourtimes4 NoResponse9	
Q222	Duringyourantenatalcarevisit(s),didsomeone: ***READALL*** ***1=MENTIONED2=NOTMENTIONED***	Checkyourbloodpressure12 Performanabdominalexamination12 Listen to the baby's heartbeat12 Askaboutyourmedicalhistory12 Takeaurinesample12 Giveyouadviceonwhattodoifyouhaveaproblem12 Give you an injection(s) for tetanus toxoid12 Giveyoumalariamedicine/conductamalariatest12 Askyouto take/conductasyphilistest12 Ask you to take/conduct an HIV test12 Discusswaystogettoa healthcenterinanemergency12	**Circle responses and go to →Q224**

3	Whatarethereasonsthatyoudidnotsee someone? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	***LACKOF ACCESS*** Nohealthcareprovideravailable12 Couldnot afford12 Distancetoofar12 Lackoftransportation12 Poorroadconditions12 ***OPPOSITIONTOCARE*** Husband/partnerwouldnotpermit12 ***PERCEPTIONSOFCARE*** Afraidofdoctor,nurse,orotherprovider12 Haveneveruseddoctor,nursebefore12 Not treated well previously12 Embarrassedorashamed12 ***TIME*** Tooearlyinpregnancy12 Notenoughtime12 Other (specify)_____12 NoResponse12	

PRENATAL CARE - This questions are to understand the prenatal situation of the pregnant woman

Q224	Thinkingbackaboutthatpregnancy,**before**you started or went into labor, did you have a problem or complication during pregnancy	Yes1 No2 NoResponse9	 **→Q228** **→Q228**
Q225	Whatproblem(s)orcomplication(s)didyou have? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Severefatigue12 Severeabdominalpain(paininthebelly)12 Bleedingfromthevagina12 Fever12 Unusualswellingofface,fingers,orlegs12 Severe and continued headache12 Rapidbreathingordifficultbreathing12 Foulsmellingvaginaldischarge12 Convulsionsorfits12 Lossofconsciousness12 Blurredvision12 Other (specify) _____12 Don'tKnow12 NoResponse12	
Q226	Didyouseekhelpforthep r o b l e m (s) o r complication(s)?	Yes1 No2 NoResponse9	 **→Q228** **→Q228**
Q227	Wheredidyouseek help?	Hadhelpathome1 Healthcenter2 Hospital3 Other(specify)_____4 NoResponse9	
	DURING DELIVERY:This questions are designed to understand the situations during delivery of the woman		

Q228	Wheredidyoudeliveryourmostrecent pregnancy?	Athome1 Healthclinic/hospital2 Onthewaytothehospital/clinic3 Other(specify)_____4 NoResponse9	
Q229	Didsomeonehelpyouwiththedelivery?	Yes1 No2 Don'tKnow/NoResponse9	→Q231 →Q231
Q230	Whohelpedwiththedelivery?	Relative/friend1 Traditionalbirthattendant2 Midwife, nurse, or doctor3 Other(specify)_____4 NoResponse9	
Q231	Werethereanycomplicationsduringlaborand delivery?	Yes1 No2 NoResponse9	→Q233 →Q233
	The question below questions are designed to understand postnatal situation of the woman		
Q232	Whatcomplicationsdidyouhave? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Heavybleeding12 Laborpainslastinglongerthan12hours12 Vaginaltearing12 Convulsions12 Fever12 Green or brown water coming from the vagina12 Waterbreaksandlaborisnotinducedwithin6hours12 Placenta not expelled within 1 hour of the birth12 Other (specify)_____12 NoResponse12	
Q233	During the 6 weeks after birth, did a health workercometoyourhometocheckonyouor did you go to the health center to check your health?	Yes,healthworkervisited1 Yes,wenttohealthcenter2 Yes,the healthworkervisitedandwenttohealthcenter3 No4 NoResponse9	→Q235 →Q235
Q234	Duringthisvisit,didyoureceiveinformationor counseling about family planning?	Yes1 No2 NoResponse9	
Q235	Duringthe6weeksafterbirth,didyouhaveany problems or complications?	Yes1 No2 NoResponse9	→Q300 →Q300
Q236	Whatproblem(s)orcomplication(s)didyou have? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Heavybleeding12 Badsmellingvaginaldischarge12 Highfever12 Painfulurination12 Hot,swollenpainfulbreasts12 Other(specify)_____12 NoResponse12	
Q237	Wheredidyouseekhelpfortheseproblem(s)or complications (s)?	Hadhelpathome1 Healthcenter2 Hospital3 Other(specify)_____4 NoResponse9	

Q238	**Areyouplanningtobreastfeed?**	Yes 1 No 0 Not sure yet.....-88 No response.....-9	
Q239	**Are you planning to use breastfeeding to delay or avoid getting pregnant?**	Yes .....1 No .....0 Notsureyet.....-88 Noresponse.....- 9	

Section3:FamilyPlanning

Nowlamgoingtoaskyouquestionsaboutwaystopreventpregnancy.Thefirstsetofquestionsisaboutyourknowledge of family planning methods. These are not questions about your current use of family planning methods.

CODESFORQ303(DONOTREAD OUT LOUD)

1. Healthcenterin camp/community
2. Privatehealthclinic
3. Supermarket/market
4. Friends/ relatives
5. Pharmacy
6. Other (specify) _____
8. Don'tKnow
9. Noresponse

CODESFORQ304(DONOTREAD OUT LOUD)

1. Cannotobtainmethod
2. Husband/partnerwill notpermit
3. Religiousreasons
4. Stopsmyperiod
5. Increases/irregularperiods
6. Cannot afford
7. Doesnotwork
8. Other(specify)_____
11. No problems
88. Don'tKnow
99. Noresponse

METHOD	Q300 Haveyoueverheard of it? NR=NoResponse	Q301 Have you ever been taughtorinstructedon how it works? NR=NoResponse	Q302 Haveyoueverused it? NR=NoResponse	Q303 Where would yougotogetit? **(SEE CODES ABOVE)**	Q304 In your opinion, what is themainproblem,ifany, with using (method)? **(SEE CODES ABOVE)**
A.The Pill (OralContraceptives)	Yes1→**Q301A** No2→**B** NR9→**B**	Yes1→**Q302A** No2→**Q302** NR9→**Q302**	Yes1→**Q303A** No2→**Q303** NR9→**Q303**	→Q304	→B
B.IUD (*Loop*)	Yes1→**Q301B** No2→**C** NR9→**C**	Yes1→**Q302B** No2→**Q302** NR9→**Q302**	Yes1→**Q303B** No2→**Q303** NR9→**Q303**	→Q304	→C
C.Condoms(male) (*Localname)*	Yes1→**Q301C** No2→**D** NR9→**D**	Yes1→**Q302C** No2→**Q302** NR9→**Q302**	Yes1→**Q303C** No2→**Q303** NR9→**Q303**	→Q304	→D
D.FemaleCondoms	Yes1→**Q301D** No2→**E** NR9→**E**	Yes1→**Q302D** No2→**Q302** NR9→**Q302**	Yes1→**Q303D** No2→**Q303** NR9→**Q303**	→Q304	→E
E.Implants	Yes1→**Q301D** No2→**E** NR9→**E**	Yes1→**Q302D** No2→**Q302** NR9→**Q302**	Yes1→**Q303D** No2→**Q303** NR9→**Q303**	→Q304	→F
F.Injectables (e.g.Depo-Provera)	Yes1→**Q301E** No2→**F** NR9→**F**	Yes1→**Q302E** No2→**Q302** NR9→**Q302**	Yes1→**Q303E** No2→**Q303** NR9→**Q303**	→Q304	→G
G. Emergency Hormonal Contraception(' Morning !fterPill")	Yes1→**Q301F** No2→**G** NR9→**G**	Yes1→**Q302F** No2→**Q302** NR9→**Q302**	Yes1→**Q303F** No2→**Q303** NR9→**Q303**	→Q304	→H
H.TubalLigation	Yes1→**Q301G** No2→**H** NR9→**H**	Yes1→**Q302G** No2→**Q302** NR9→**Q302**	Yes1→**Q303G** No2→**Q303** NR9→**Q303**	→Q304	→I
I.Rhythm/calendar/ countingdays	Yes1→**Q301I** No2→**J** NR9→**J**	Yes1→**Q302I** No2→**Q302** NR9→**Q302**	Yes1→**Q303I** No2→**Q303** NR9→**Q303**	**→Q304**	→J
J.Withdrawal (CoitusInterruptus)	Yes1→**Q301J** No2→**K** NR9→**K**	Yes1→**Q302J** No2→**Q302** NR9→**Q302**	Yes1→**Q303J** No2→**Q303** NR9→**Q303**	**→Q304**	→K
K.Othercontraceptive methods(SPECIFY):	Yes1→**Q301K** No2→**Q305** NR9→**Q305**	Yes1→**Q302K** No2→**Q302** NR9→**Q302**	Yes1→**Q303K** No2→**Q303** NR9→**Q303**	→Q304	→Q305

Thesenextquestionsareaboutyourcurrentuseoffamilyplanningmethods.

No.	Questionsandfilters	Codingcategories	Skipto
Q305	Doyouwanttohaveababyinthefuture?	Yes1 No2 Noresponse9	 →Q307 →Q307
Q306	Whendoyouwanttohaveyournext baby?	Withinthenext12months1 Within1-2years2 After2years3 After I marry4 WhenGodwants5 Other(specify)_____6 NoResponse9	
Q307	Areyoucurrentlyusinganymethodtodelayor avoid pregnancy?	Yes1 No2 NoResponse9	→Q309 →Q312
Q308	Whatarethereasonsyouarenotusingamethod todelayoravoidgetting pregnant? ***CIRCLEALLMENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	***FERTILITY-RELATEDREASONS*** Hysterectomy12 Currentlypregnant12 Wantsmorechildrennow12 Nothavingsex/infrequentsex12 Unable/difficultygettingpregnant12 Postpartum(6weeksafterbirth)12 Breastfeeding12 ***OPPOSITIONTOUSE*** Respondentopposed12 Husbandopposed12 Othersopposed12 Religiousprohibition12 ***LACKOF KNOWLEDGE*** Knowsnomethod12 Knowsnosource12 ***METHOD-RELATEDREASONS*** Fearssideeffects12 Inconvenienttouse12 ***LACKOF ACCESS*** Toofar/methodnotavailable12 Expensive12 Other (specify) _____12 NoResponse12	 →Q401 **Circle responses andgoto →Q312**
Q309	Are you using the method because you want to haveanotherchildlaterorbecauseyouwantno more children at all?	Wantsanotherchildlater1 Wantsnomorechildren2 NoResponse9	

Q310	Whichmethodhaveyoubeenusing? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Pill12 IUD12 Malecondom12 Femalecondom12 Implants12 Injectables12 Emergencyhormonalcontraception12 Femalesterilization/tuballigation12 Male sterilization /vasectomy12 Lactationalamenorrhea12 Rhythm/calendar/countingdays12 Withdrawal12 Periodicabstinence12 Other(specify)BC_WHAT_____12 NoResponse12	
Q311	Wheredidyoulastobtainyourmethod?	Healthcenterinthecamp/community1 Hospital2 Supermarket/market3 Pharmacy4 Other(specify)_____5 Notapplicable6 NoResponse9	**Circle response andgoto →Q401**
Q312	Doyouthinkyouwilluseamethodtodelayor avoid pregnancy in the next 12 months?	Yes1 No2 Don'tKnow8 NoResponse9	**→Q314** **→Q315** **→Q315**
Q313	Whatarethereasonsthatyouthinkyouwillnot use a method? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	***FERTILITY-RELATEDREASONS*** Wantsmorechildrennow12 Not having sex / infrequent sex12 Unable/difficultygettingpregnant12 Postpartum (6 weeks after birth)12 Breastfeeding12 ***OPPOSITIONTOUSE*** Respondentopposed12 Husbandopposed12 Othersopposed12 Religiousprohibition12 ***LACKOF KNOWLEDGE*** Knowsnomethod12 Knowsnosource12 ***METHOD-RELATEDREASONS*** Fearssideeffects12 Inconvenienttouse12 ***LACKOF ACCESS*** Toofar/methodnotavailable12 Expensive12 Other (specify)_____12 NoResponse12	**Circle responses and go to →Q315**

Q314	Whichmethodwouldyoupreferto use? ***CIRCLEALLMENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Pill1 2 IUD1 2 Malecondom1 2 Implants1 2 Injectables1 2 Femalecondom1 2 Emergencyhormonalcontraception1 2 Femalesterilization/tuballigation1 2 Malesterilization/vasectomy1 2 Lactationalamenorrhea1 2 Rhythm/calendar/countingdays1 2 Withdrawal 1 2 Periodicabstinence1 2 Other (specify) _____ 1 2 NoResponse1 2	
Q315	Doyouthinkyoucanphysicallygetpregnant now ifyouwanttoorareyoucurrentlypregnant?	Yes 1 No 2 Currentlypregnant 3 NoResponse 9	→**Q401** →**Q401** →**Q401**
Q316	Whatisthe**mainreason**whyyouthinkyou cannot physically get pregnant? ***CIRCLE ONE***	Menopause1 Respondentorpartnerhadanoperationwhichmakes pregnancyimpossible2 Respondenthastriedtogetpregnantforatleast2years withoutsuccess3 Respondentisnotsexuallyactive4 Postpartum(6weeksafterbirth)5 Breastfeeding6 Other(specify) _____7 NoResponse9	

Section4: SexuallyTransmittedInfections(STIs)

Thesenextquestionsareaboutsexuallytransmittedinfections.Weunderstandthatthesequestionsarepersonalandwant to assure you again that your answers will be kept confidential.

No.	Questionsandfilters	Codingcategories	Skipto
Q401	Have you ever heard of diseases that can be transmittedthroughsexualintercourse,other than HIV/AIDS?	Yes1 No2 NoResponse9	 →Q403 →Q403
Q403	Haveyouhadanyunusualgenitaldischargeinthe past 12 months, such as foul smelling or green/curd like discharge?	Yes1 No2 NoResponse9	 **Ifnotogo to** **→Q501**
Q404	Haveyouhadanygenitalulcersorsoresinthe past 12 months?	Yes1 No2 NoResponse9	**Ifno** **go to** **→Q501**
Q405	The last time you had any unusual genital discharge,genitalulcers,orsores,didyouseek treatment?	Yes1 No2 NoResponse9	 **→Q407** **→Q501**
Q406	Wheredidyougoorwhomdidyousee?	Healthcenterincamp/community1 Healthcenteroutsideofcamp/community2 Hospital3 Localhealer4 Pharmacist5 Supermarket/market6 Other(specify)_____7 NoResponse9	 **Circle** **response** **andgoto** **→Q501**
Q407	Whydidn'tyouseeanyoneforthesesymptoms? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	***LACKOF ACCESS*** Nohealthcareprovideravailable12 Couldnotafford12 Distancetoofar12 Lackoftransportation12 Poorroadconditions12 ***OPPOSITIONTOCARE*** Husband/partnerwouldnotpermit12 ***PERCEPTIONSOFCARE*** Afraidofdoctor,nurse,orotherprovider.12 Haveneveruseddoctor,nursebefore12 Not treated well previously12 Embarrassedorashamed12 Other (specify) _____12 NoResponse12	

ection5:Knowledge,Opinions,andAttitudesaboutHIV/AIDS

Thenextsetofquestionsisaboutyourknowledge,opinion,andattitudesaboutHIV/AIDS.Itisimportanttonote thatsome of the questions that will be read reflect statements that are true and other questions reflect statements that are false.

No.	Questionsandfilters	Codingcategories	Skipto
Q501	HaveyoueverheardofHIV,oradiseasecalled AIDS?	Yes1 No2 NoResponse9	→Q601 →Q601
Q502	CanpeopleprotectthemselvesfromHIV/AIDS infectionbyhavingoneuninfectedfaithfulsex partner?	Yes1 No2 Don'tKnow8 NoResponse9	
Q503	Can people protect themselves from HIV/AIDS infectionbyusingacondomcorrectlyeverytime they have sex?	Yes1 No2 Don'tKnow8 NoResponse9	
Q504	CanpeopleprotectthemselvesfromHIV/AIDSby abstaining from sexual intercourse?	Yes1 No2 Don'tKnow8 NoResponse9	
Q505	CanapersongetHIV/AIDSfromamosquitobite?	Yes1 No2 Don'tKnow8 NoResponse9	
Q506	CanpeoplegetinfectedwithHIV/AIDSbysharinga toothbrush with someone who is infected?	Yes1 No2 Don'tKnow8 NoResponse9	
Q507	CanpeoplegetinfectedwithHIV/AIDSbyhaving anal sex with a male partner and not using a condom?	Yes1 No2 Don'tKnow8 NoResponse9	
Q508	CanapersongetHIV/AIDSbygettinginjectedwith a needle that was already used by someone else?	Yes1 No2 Don'tKnow8 NoResponse9	
Q509	CanapersongetHIV/AIDSbysharingfoodwith someone who is infected?	Yes1 No2 Don'tKnow8 NoResponse9	
Q510	Isitpossibleforahealthy-lookingpersontohave HIV/AIDS?	Yes1 No2 Don'tKnow8 NoResponse9	
Q511	CanapregnantwomaninfectedwithHIV/AIDSgive the virus to her unborn child during pregnancy or delivery?	Yes1 No2 Don'tKnow8 NoResponse9	

Q512	CanawomaninfectedwithHIV/AIDSgivethevirus to her baby during breastfeeding?	Yes1 No2 Don'tKnow8 NoResponse9	
Q513	If a member of your family got infected with HIV/AIDS,wouldyouwantittoremainasecret?	Yes1 No2 Don'tKnow8 NoResponse9	
Q514	Ifa relativeofyoursbecame sickwithHIV/AIDS, wouldyoubewillingtocareforhim/herinyour own household?	Yes1 No2 Don'tKnow8 NoResponse9	
Q515	IfateacherwasinfectedwithHIV/AIDS,should he/she be allowed to continue teaching?	Yes1 No2 Don'tKnow8 NoResponse9	
Q516	Wouldyoubuyfreshvegetablesfromashopkeeper who was infected HIV/AIDS?	Yes1 No2 Don'tKnow8 NoResponse9	
Q517	Shouldyoungadolescentsbetaughtonhowtouse condoms?	Yes1 No2 Don'tKnow8 NoResponse9	
Q518	HaveyoureceivedinformationaboutHIV/AIDSin the past 12 months?	Yes1 No2 Don'tKnow8 NoResponse9	 →Q520 →Q520 →Q520
Q519	Fromwhatscurceshaveyoureceivedinformation about HIV/AIDS in the past 12 months? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED*** ***VCT=VOLUNTARYCOUNSELINGANDTESTING ANC = ANTENATAL CARE*** ***MTCT=MOTHERTC CHILDTRANSMISSION***	***MASSMEDIA*** Radio12 TV/video12 Newspaper12 Poster/pamphlet12 ***HEALTHSERVICES*** Government/publichealthfacility12 Privatehealthfacility12 VCTcenter12 ANC/MTCTcenter12 ***PEOPLE*** Communityhealthworker12 Friend12 Familymember12 PersonlivingwithHIV/AIDS12 Peeroutreachworker12 ***OTHERPLACES*** School12 Placeofworship12 Publicmeeting12 Others(specify)_____12 NoResponse12	

Q520	Fromwhatsourceswouldyou*prefer*toreceive information on HIV/AIDS? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED*** ***VCT=VOLUNTARYCOUNSELINGANDTESTING ANC = ANTENATAL CARE*** ***MTCT=MOTHERTOCHILDTRANSMISSION***	***MASSMEDIA*** Radio12 TV/video12 Newspaper12 Poster/pamphlet12 ***HEALTHSERVICES*** Government/Publichealthfacility12 Privatehealthfacility12 VCTcenter12 ANC/MTCTcenter12 ***PEOPLE*** Communityhealthworker12 Friend12 Familymember12 PersonlivingwithHIV/AIDS12 Peeroutreachworker12 ***OTHERPLACES*** School12 Placeofworship12 Publicmeeting12 Others(specify) _____12 NoResponse12	
Q521	Doyouknowaplacewhereapersoncanbetested for HIV/AIDS?	Yes1 No2 Don'tKnow8 NoResponse9	→**Q523** →**Q523** →**Q523**
Q522	WherecanapersonbetestedforHIV/AIDS?	Inrefugeecamp1 Inlocalcommunity2 Inbothrefugeecampandlocalcommunity3 Other(specify)_____4 Don'tKnow8 NoResponse9	
Q523	Idon'twanttoknowtheresult,buthave *you*ever had an HIV/AIDS test?	Yes1 No2 NoResponse9	→**Q529** →**Q529**
Q524	Whenwasthelasttimeyouweretestedfor HIV/AIDS?	Lessthan1yearago1 1-2yearsago2 3ormoreyearsago3 NoResponse9	
Q525	ThelasttimeyouweretestedforHIV/AIDSwasit voluntary or mandatory?	Voluntary1 Mandatory2 NoResponse9	
Q526	ThelasttimeyouweretestedforHIV/AIDSdidyou receive counseling?	Yes1 No2 NoResponse9	

Q527	ThelasttimeyouweretestedforHIV/AIDS,where did you go to get tested?	***PUBLICSECTOR*** Hospital1 Governmenthealthfacility2 Clinic / family planning3 Mobileclinic(government,public)4 ***PRIVATESECTOR*** Privatehospital/clinic5 Pharmacy6 Privatemedicaldoctor7 Mobile clinic (private)8 Traditional healer9 Other(specify)_____ 10 NoResponse99	
Q528	Didyoufindouttheresultofyourtest?Pleasedo not tell me the result.	Yes1 No2 NoResponse9	
Q529	WouldyougoforaHIV/AIDStestinthefuture?	Yes1 No2 Don'tknow/notsure8 NoResponse9	→Q601 →Q601
Q530	Whatistheprimaryreasonyoudonotwanttogo for a test?	Sureofbeinginfected1 Afraidoftheresult2 Afraidofthebloodtaking3 Afraidofcatchinganinfection4 Fear of stigmatization5 Tooexpensive6 Other(specify)_____7 NoResponse9	

Section6:Gender-BasedViolence

Now I would like to focus on difficulties that may have happened to you **during the conflict**. I am asking about things that may have been done to you by persons outside your family such as soldiers, militiary, police officers, and guards. These acts could have happened in places such as on the road, in a refugee or internally displaced person (IDP) camp, or in another village. Please remember that if you need to, we can stop and take a break at any time. Andalsopleaserememberthat!willcontinuetomakesureyouranswersareabsolutelyconfidential.Wealsowantyouto know that we can refer you to someone who can help.

Q601.Duringtheconflict,were you subjected to any of these forms of violence by people outside of your family? These acts could have been done by anyone who is not a family member. Were you: (READ A-I) **NR=NoResponse**	Q602.Howoften did (A-I) happen to you? Would you say once or twice, several times, or many times? **NR=NoResponse**	Q603.Whodidthisto you? **Circleallmentioned** 1=mentioned2=notmentioned	Q604.Wheredidthistake place? **Circleallmentioned** 1=mentioned 2=notmentioned
A.Physicallyhurt,suchas slapped,hit,choked,beaten or kicked? ***YES1*** ***NO2→B*** ***NR9→B***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ___12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/ boat 1 2 Other(specify) _____ 1 2 NoResponse1 2
B. Threatenedwithaweaponof any kind ***YES1*** ***NO2→C*** ***NR9→C***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor,'communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/ boat 1 2 Other(specify) _____1 2 NoResponse 1 2
C. Shotatorstabbed ***YES1*** ***NO2→D*** ***NR9→D***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse 1 2

D.Detainedagainstyourwill ***YES1*** ***NO 2→E*** **NR 9→E**	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse 1 2
E. Subjectedtoimpropersexual comments ***YES1*** ***NO 2→F*** ***NR 9→F***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/ boat 1 2 Other(specify) _____1 2 NoResponse1 2
F. Forcedtoremoveorstripped ofyour clothing ***YES1*** ***NO 2→G*** ***NR 9→G***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2
G.Subjectedtounwantedkissing ortouchingonsexualpartsof your body ***YES1*** ***NO 2→H*** ***NR 9→H***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/ boat 1 2 Other(specify) _____1 2 NoResponse1 2

H. Forcedorthreatened with harmtomakeyougiveor receiveoralsexorhave vaginaloranalsex ***YES1*** ***NO 2→I*** ***NR 9→I***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ____12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/ boat 1 2 Other(specify) _____ 1 2 NoResponse 1 2
I. Anythingelse(specify)? _____ ***YES1*** ***NO 2→Q805*** ***NR 9→Q805***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) ___12 NoResponse12	Currentlocation 1 2 Anypreviouscamp 1 2 Homevillage/ town 1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2

Now I would like to focus on difficulties that may have happened to you **after the conflict** [*specify dates* _____].Like before, I am asking about things that may have beendone to you by persons **outsideyour family** such as soldiers, militia, policeofficers,andguards.Theseactscouldhave happenedinplacessuchasontheroad,inarefugeecamporinanother village. These are the samequestionsI justaskedyou,but now Iwouldliketo know if anyofthemweredone to youafter the conflict by persons **outside of your** family. Please remember that if you need to, we can stop and take a break at any time. And also please remember that I will continue to make sure your answers are absolutely confidential. We also want youtoknowthatwecanreferyoutosomeonewhocan help.

Q605. After the conflict, were you subjected to any of these forms of violence by people outside of your family?Theseactscouldhavebeen donebyanyonewhoarenotfamily members. Were you (READ A-i) **NR=NoResponse**	**Q606**.Howoften did (A-I) happen to you? Would you say once or twice, several times, or many times? **NR=NoResponse**	**Q607**.Whodidthistoyou? **Circleallmentioned** 1=mentioned2=notmentioned	**Q608**.Wheredidthistakeplace? **Circleallmentioned** 1=mentioned 2=notmentioned
A.Physicallyhurt,suchas slapped,hit,choked,beaten, or kicked? ***YES1*** ***NO2→B*** ***NR9→B***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) _____12 NoResponse12	Currentlocation1 2 Anypreviouscamp1 2 Homevillage/town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2

B. Threatenedwithaweaponof any kind ***YES1*** ***NO2 →C*** ***NR9 →C***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify)_____12 NoResponse12	Currentlocation1 2 Any previous camp1 Home 2 village / town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2
C. Shotatorstabbed ***YES1*** ***NO2 →D*** ***NR9 →D***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) _____12 NoResponse12	Currentlocation1 2 Any previous camp1 Home 2 village / town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2
D.Detainedagainstyourwill ***YES1*** ***NO2 →E*** ***NR9 →E***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) _____12 NoResponse12	Currentlocation1 2 Any previous camp1 Home 2 village / town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2
E. Subjectedtoimpropersexual comments ***YES1*** ***NO2 →F*** ***NR9 →F***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) _____12 NoResponse12	Currentlocation1 2 Any previous camp1 Home 2 village / town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2
F. Forcedtoremoveorstripped of your clothing ***YES1*** ***NO2 →G*** ***NR9 →G***	Onceortwice1 Severaltimes2 Manytimes3 NR99	Military12 Paramilitary12 Police12 Jailorprisonguard12 Doctor/medicalperson12 Religiousworker12 Humanitarianreliefworker12 Neighbor/communitymember12 Fellowrefugee/IDP12 Other(specify) _____12 NoResponse12	Currentlocation1 2 Any previous camp1 Home 2 village / town1 2 Travelingbyroad/boat1 2 Other(specify) _____1 2 NoResponse1 2

G. Subjected to unwanted kissing or touching on sexual parts of your body ***YES1*** ***NO2 → H*** ***NR9 → H***	Once or twice 1 Several times 2 Many times 3 NR99	Military 12 Paramilitary 12 Police 12 Jailor prison guard 12 Doctor/medical person 12 Religious worker 12 Humanitarian relief worker 12 Neighbor/community member 12 Fellow refugee/IDP 12 Other(specify) _____ 12 No Response 12	Current location 1 2 Any previous camp 1 2 Home village/town 1 2 Traveling by road/boat 1 2 Other(specify) _____ 1 2 No Response 1 2
H. Forced or threatened with harm to make you give or receive oral sex or have vaginal or anal sex ***YES1*** ***NO2 → I*** ***NR9 → I***	Once or twice 1 Several times 2 Many times 3 NR99	Military 12 Paramilitary 12 Police 12 Jailor prison guard 12 Doctor/medical person 12 Religious worker 12 Humanitarian relief worker 12 Neighbor/community member 12 Fellow refugee/IDP 12 Other(specify) _____ 12 No Response 12	Current location 1 2 Any previous camp 1 2 Home village/town 1 2 Traveling by road/boat 1 2 Other(specify) _____ 1 2 No Response 1 2
I. Anything else (specify)? _____ ***YES1*** ***NO2 → INSTRUCTION BOX 8.1*** ***NR9 → INSTRUCTION BOX 8.1***	Once or twice 1 Several times 2 Many times 3 NR99	Military 12 Paramilitary 12 Police 12 Jailor prison guard 12 Doctor/medical person 12 Religious worker 12 Humanitarian relief worker 12 Neighbor/community member 12 Fellow refugee/IDP 12 Other(specify) _____ 12 No Response 12	Current location 1 2 Any previous camp 1 2 Home village/town 1 2 Traveling by road/boat 1 2 Other(specify) _____ 1 2 No Response 1 2

INSTRUCTIONS TO INTERVIEWER 8.1

IF ANY VIOLENCE REPORTED, DURING (Q801) OR AFTER (Q805) THE CONFLICT, CONTINUE TO → Q809 IF NO VIOLENCE REPORTED, GO TO → Q815

Q609	Did you ever have any injuries from any of these incidents?	Yes 1 No 2 No Response 9	 **→ Q812** **→ Q812**
Q610	What type of injury did you have? ***READALL*** ***YES=1*** ***NO=2*** ***NORESPONSE=9***	Cuts, punctures, bites, 129 Scratches, abrasions, bruises 129 Sprains, dislocations 129 Burns 129 Penetrating injury, deep cuts, gashes 129 Broken eardrum, eye injuries 129 Fractures, broken bones 129 Broken teeth 129 Other(specify)_____ 129	

Q611	Did you see a doctor or any other medical care providerformedicaitreatmentoftheseinjuries?	Yes1 No2 NoResponse9	
Q612	Didyoutalkaboutthis/theseincidentsofvioience with ***READA-F*** ***YES = 1*** ***NO=2*** ***NORESPONSE=9***	Afamilymember 129 Afriend 129 Adoctor/otherprovider 129 Police/military 129 NGOWorker 129 Other(specify)_____ 129	
INSTRUCTIONSTOINTERVIEWER8.2 ***IFRESPONDENTTALKEDTOANYONEABOUTTHEVIOLENCEINQ812,GOTO →Q814*** ***IFRESPONDENTDIDNOTTALKTOANYONEABOUTTHEVIOLENCEINQ812,CONTINUETO →Q813***			
Q613	Whatwerethemainreasonsyouwerenotableto talk to anyone about the violence? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Didnotknowwheretogo12 Nouse/wouldnotdoanygood12 Embarrassed12 Afraidofmoreviolence12 Afraidofcausingproblemsinrelationship12 Would not be believed / taken seriously12 Violence normal / no need to complain12 Thought she would be blamed12 Bringbadnametofamily12 Other (specify) ____12 NoResponse12	
Q614	Aretherethingsthatyouthinkmightbehelpfulto you in coping with your experiences of violence? ***CIRCLE ALL MENTIONED*** ***1=MENTIONED2=NOTMENTIONED***	Supportgroupforwomen12 Talking it over with friends12 Talking it over with family12 Assistance from NGO workers12 Legaladvice/traditionaljustice12 Religiouscounseling12 Mentalhealthcounseling12 Medicalassistance12 Tryingtoforgetaboutit12 Other (specify) _12 NoResponse12	

Section7:EmotionalHealth

Thefollowingquestionsareonemotionaldistressandthemostimportanthealth problemsthatfacewomeninyourcommunity.

No.	Questionsandfilters	Codingcategories	Skipto
Q701	The next questions are related to common problems that may have bothered you in the past 4 weeks. If you had the problem in the past 4 weeks, answer yes. If you haven't had the problem in the past 4 weeks, answer no. ***READ A-T*** A. Do you have headaches? B. Is your appetite poor? C. Do you sleep badly? D. Are you easily frightened? E. Do your hands shake? F. Do you feel nervous, tense, or worried? G. Is your digestion poor? H. Do you have trouble thinking clearly? I. Do you feel unhappy? J. Do you cry more than usual? K. Do you find it difficult to enjoy your daily activities? L. Do you find it difficult to make decisions? M. Is your daily work suffering? N. Are you unable to play a useful part in life? O. Have you lost interest in things? P. Do you feel that you are a worthless person? Q. Has the thought of ending your life been on your mind? R. Do you feel tired all the time? S. Do you have uncomfortable feelings in your stomach? T. Do you easily become tired?	***YES=1*** ***NO=2*** ***NORESPONSE=9*** A) headaches 1 29 B) appetitepoor 1 29 C) sleepbadly 1 29 D) frightened 1 29 E) handsshake 1 29 F) nervous 1 29 G) digestionpoor 1 29 H) thinking 1 29 I) unhappy 1 29 J) crymore 1 29 K) notenjoy 1 29 L) decisions 1 29 M) worksuffers 1 29 N) usefulpart 1 29 O) lostinterest 1 29 P) worthless 1 29 Q) endinglife 1 29 R) feeltired 1 29 S) stomach 1 29 T) easilytired 1 29	
Q702	In your opinion, what is the most important health problem for women in your community? ***READ LIST*** (If a woman mentions more than one, probe as follows to narrow it down to a single problem: "if you had to choose one as the most important, which one would that be?")	Pregnancy-relatedproblems1 Vaginalinfections2 Respiratoryinfections3 Diarrhea4 Malaria5 Violencewithinthefamily6 Feelingsofsadnessorhopelessness7 Headaches/backaches/muscleaches 8 Other (specify)_____20 NoResponse99	

TIME_END

END TIME:_____That istheendofourquestionnaire.Thankyouverymuchfortakingtimetoanswerthesequestions.We appreciate your help.Please wait here while my supervisor reviews the questionnaire completely.He/she will not be looking specifically at your responses, but only to make sure that all the necessary questions were asked.

ከግጭት ጋር በተያያዘ ተጽእኖ የደረሰባቸውን ሴቶች በተመለከተ በCDC አማካኝነት
የተዘጋጀ የስነተዋልዶ ጤና ግምገማ መጠይቅ
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01 የመጠይቅ መለያ ቁጥር|_____|___|___|___| የመጀመሪያ ሰዓት:___

02 ሀገር |_____|_____||(የሀገሪቷን የስልክ ኮድ ያስገቡ)
03 ክልል |_____|_____| (በአካባቢው ውስጥ አግባብነት ያላቸውን መደቦች ያስገቡ)
05 መስክ |_____|_____| (በአካባቢው ውስጥ አግባብነት ያላቸውን መደቦች ያስገቡ)
06 የመስኩ አይነት
*የውጤት ኮዶች:*1—ስደተኛ;2—IDP ካምፕ;3—ተመላሽ;4—ተቀባይ ማህበረሰብ;[5—ሌላ]_____

07 ቃለመጠይቅ አቅራቢ:ኮድ [_____|_____]ስም_

08 የቃለመጠይቅ ቀን: _____/ _____/_____
ቀን ወር ዓመት

09 የተፈተሸው በ፡ የተቆጣጣሪ ኮድ [_____|_____]ስም_____

10 መረጃውን ያስገባው፡ ኮድ [_____|_____]ስም_____

ክፍል : የቅድመታሪክ ባህሪያት

ይህንን የሴቶች ጤና ዳሰሳ ከ፣ _____ጋር እያከናወንን ሲሆን፣ የሚከተሉት ጥያቄዎች ለመመለስ እኛን ለማገዝ ጊዜዎን በመሰዋትዎት ምስጋናችንን ለመቸር እንወዳለን። .የእርስዎ ምላሽ በፍቃደኝነት ላይ የተመረኮዘ ሲሆን በፍጽም ሚስጥራዊነትም የሚያገ ይሆናል። ይህም ማለት በግል ንግግር የምናደርግ ሲሆን የእርስዎንም ስም አልጽፈውም። ስለዚህም፣ በዛሬው ቀን የሚያጋሩኝ ማንኛውም አይነት መረጃ የእርስዎ ስም አይጻፍበትም፤ የተወሰኑ ጥያቄዎች ላይ መልስ አለመስጠትን መምረጥ ይችላሉ፤ እንዲሁም በማንኛውም ጊዜም ተሳትፎዎን ማቋረጥ ይችላሉ። በመጀመሪያ በቤትዎ ውስጥ ያለውን የእለት ተዕለት ህይወትዎን በተመለከተ የተወሰኑ አጠቃላይ ጥያቄዎችን በመጠየቅ መጀመር እፈልጋለሁ።

በቤትዎ ውስጥ ስል(በአካባቢው ቤትን በተመለከተ አግባብነት ያለውን ትርጓሜ ይስጡ)። ለመጀመር ዝግጁ ነዎት?

ቁ.	ጥያቄዎች እና ማጥሪያዎች	የኮድ መደቦች	ወደዚህ ይለፉ
ጥ101	በአሁኑ ጊዜ በቤትዎ ውስጥ ምን ያህል ግለሰቦች ይኖራሉ? *ጎብኚዎችን አያካትቱ፤ እንዲሁም ልጆችን እና አዛውንቶችን መቁጠር አይዘንጉ*	ወንዶች[l] ሴቶች[l] አጠቃላይ የሰዎች ብዛት [l] ምላሽ የለም 99	
ጥ102	በአሁኑ ጊዜ በቤትዎ ውስጥ አባወራ/እማወራ ማን ነው?	እኔ 1 ባል/አጋር 2 አባት 3 እናት 4 ሌላ ዘመድ 5 ሌላ (ይግለጹ)_6 ምላሽ የለም 9	
ጥ103	በአሁኑ ጊዜ እንደባለትዳር ከወንድ ጋር እየኖሩ ይገኛሉ?	አዎ፣ በአሁኑ ጊዜ ባለትዳር ነኝ..... 1 አዎ፣ ከወንድ ጋር እየኖርኩ ነው።..... 2 ተፋትቻለሁ/ተለያይቻለሁ.....3 በአሁኑ ጊዜ በጥምረት ውስጥ አይደለሁም፤ ባል የሞተባት ..... 4 አይ፣ ተጣምሬ አላውቅም..... 5 ምላሽ የለም ..... -99	
ጥ104	በአሁኑ ጊዜ ስንት አመትዎ ነው? *(አስፈላጊ ከሆነ በማነጻጸር ጥ104 ላይ ማስተካከያ ያድረጉ)*	እድሜ፤ በተጠናቀቁ አመታት [l] አላውቅም 88 መልስ የለም 99 *የተገመተ የተሻለ ምላሽ*	

ጥ105	የየትኛው ሀይማኖት ተከታይ ነዎት?	ኦርቶዶክስ 1 ካቶሊክ 2 ፕሮቴስታንት 3 መስሊም 4 የይሆዋ ምስክር 5 የባህል አምልኮ 6 ዋቄፌታ 7 አማኝ አይደለሁም 8 ሌላ.....98 ምላሽ የለም99	
ጥ106	የተማሩበት ከፍተኛው የትምህርት ደረጃ ምንድን ነው?	ተሳትፌ አላውቅም..... 0 አንደኛ ደረጃ ..... 1 ሁለተኛ ደረጃ..... 2 ቴክኒክ እና ሙያ..... 3 ከፍተኛ ደረጃ ትምህርት..... 4 ምላሽ የለም.....-99	
ጥ107	በመጀመሪያ ጊዜ ከመፈናቀልዎ በፊት ይኖሩ የነበረበት ስፍ የት ነበር? *አንደኛው ላይ ያክብቡ*	1. ወልቃይት ጸገዴ 2. ሰሜን ሸዋ 3. ደቡብ ጎንደር 4. ጎጃም 5. ወሎ 6. ጎንደር 7. ዋግ ህምራ 8. አዊ 9. ደቡብ ወሎ 10.ባህር ዳር 11.ኦሮሚያ ዞን 12.ማዕከላዊ ጎንደር 13.ጎንደር ከተማ 14.ምዕራብ ጎንደር ሌላ (ይግለጹ)_____20 መልስ የለም 99	
ጥ108	በዚህ _____ ስምን ያህል ጊዜ ኖረዋል(ስሁን የሚገኙበትን ማህበረሰብ ስም ያስገቡ)	የአመታት ብዛት [l_] ከ1 ዓመት ያነሰ 00 አላውቀም 88 መልስ የለም 99	
ጥ109	ወርሃዊ ገቢዎ ምን ያህል ነው?	---------- ብር በወር በትክክል አላውቅም.....1 ምላሽ ለመስጠት ፍቃደኛ አይደለሁም.....2	
ጥ110	ጋዜጣ ወይም መጽዜት ያነባሉ? የሚያነቡ ከሆነ በየስንት ጊዜው ያነባሉ	ከሞላ ጎደል በየቀኑ.....1 ቢያንስ በሳምንት አንድ ጊዜ ..... 2 ከሳምንት አንድ ጊዜ ያነሰ .....3 ጭራሽ አላነብም.....4	

ጥ111	ቴሌቪዥን ይመለከታሉ	ከሞላ ጎደል በየቀኑ.....1 በ.ያንስ በሳምንት አንድ ጊዜ ..... 2 ከሳምንት አንድ ጊዜ ያነሰ .....3 ጭራሽ አልመለከትም.....4	
ጥ112	ራዲዮ ያዳምጣሉ? የሚያዳምጡ ከሆነ፣ በየስንት ጊዜ ያዳምጣሉ?	ከሞላ ጎደል በየቀኑ.....1 በ.ያንስ በሳምንት አንድ ጊዜ ..... 2 ከሳምንት አንድ ጊዜ ያነሰ .....3 ጭራሽ አላዳምጥም.....4	
ጥ113	በካምፑ ውስጥ የጤና ተቋም አለ?	አዎ 1 አይ 2 አላውቅም 8 ምላሽ የለም 9	
ጥ114	የጤና ተቋሙ እርስዎ ከሚኖሩበት ስፍራ በምን ያህል ይርቃል?	1 እና ከ1ኪ..ሜ ያነሰ----1 ከ2ኪ..ሜ ያነሰ -----2 ከ5ኪ..ሜ ያነሰ ------3 አላውቅም ------8	
ጥ115	በካምፑ ውስጥ ወደሚገኘው የጤና ተቋም መሄድን ይመርጣሉ?	አዎ1 አይ2	ጥ. 116
		ምላሽ የለም 9	
ጥ.116	በካምፑ ውስጥ የሚገኘውን ተቋም የማይመርጡበት ምክንያት ምንድን ነው?		

ፍል 2 :ዘርን የመተካት እንዲሁም የወላድነት ምርጫዎች

አሁን ደግሞ የቀድሞ እና ነባራዊ እርግዝናዎን(ተግባራዊ ከሆነ) በተመለከተ ጥያቄዎችን የምጠይቅዎት ይሆናል::

ቁ.,	ጥያቄዎች እና ማጥሪያዎች	የኮድ መደቦች	ወደዚህ ይለፉ
ጥ201	አርግዘው ያውቃሉ?	አዎ 1 አይ 2 ምላሽ የለም 9	ጥ300 ጥ300
ጥ. 202	ከዚህ በፊት በጤና ተቋም ውስጥ ወልደው ያውቃሉ?	አዎ .....1 አይ..... 0 ምላሽ የለም.....9	
ጥ203	በአሁኑ ጊዜ ነፍሰጡር ነዎት?	አዎ 1 አይ 2 አላውቅም 8 ምላሽ የለም 9	ጥ210 ጥ210 ጥ210
ጥ204	የስንት ወር ነፍሰጡር ነዎት?	ወራት!] አላውቅም88 ምላሽ የለም9	

ጥ205	ልጅዎን የት መገላገል ይፈልጋሉ?	ካምፕ 1 ቤቱ/የተወለድኩበት ስፍራ 2 የመንግስት ሆስፒታል 11 የመንግስት የጤና ማዕከል 12 የመንግስት ጤና ጣቢያ13 ሌላ 14 የግል ሆስፒታል/ክሊኒክ 21 ሌላ የግል የህክምና ዘርፍ 22 NGO/ ሀይማኖታዊ የጤና ተቋም 31 ሌላ_____ 96 እስካሁን አልወሰንኩም..... -88 ምላሽ የለም..... 9	
	ልጅዎን ማን እንዲያዋልድዎት ይፈልጋሉ?	ዶክተር 1 የጤና መኮንን 2 ነርስ/አዋላጅ 3 ማንኛውም ባለሙያ የጤና ጥበቃ አትራቢ (መለየት አልቻልኩም) 4 HEW5 የባህል አዋላጅ 6 የቤተሰብ አባል 7 ማንም 0 እስካሁን አልወሰንኩም ..... -88 መልስ የለም..... 9	ምላሾች ላይ በማክበብ ወደ ጥ209 ይሂዱ
ጥ207	ይህ የመጀመሪያ እርግዝናዎ ነው?	አዎ1 አይ2 መልስ የለም9	ጥ300 ጥ300
ጥ208	አሁን ደግሞ በህይወት የሚገኙ ልጆችዎን በተመለከተ እንነጋገር ስንት ወንድ እና ሴት ልጆች አሉዎት? ከእርስዎ ጋር የሚኖሩ ወይም በሌላ ስፍራ የሚኖሩ ሊሆኑ ይችላሉ፡፡	በህይወት የሚገኙ ወንድ ልጆች [I] በህይወት የሚገኙ ሴት ልጆች[I] በህይወት የሚገኙ አጠቃላይ ልጆች [I] መልስ የለም 99 *ማንም ከሌለ 00 ብለው ይጻፉ*	
ጥ209	በህይወት ተገላግለዋቸው ለአጭር ጊዜ ኖረው ህይወታቸው ያለፈ ወንድ ወይ ሴት ልጆች ነበሩዎት?	አዎ 1 አይ 2 መልስ የለም 9	ጥ213 ጥ213
ጥ210	ስንት ወንድ እና ሴት ልጆችዎ በህይወት ተወልደው ከዚያ አርፈውቦታል?	ህይወታቸው ያለፈ ወንድ ልጆች [I] ህይወታቸው ያለፈ ሴት ልጆች [I] ህይወታቸው ያለፈ ልጆች ብዛት ድምር [I] መልስ የለም 99	
ጥ211	የ6 ወር እግዝና ላይ ከደደረሱ በኋላ ህይወታቸው አልፎ የተወለዱ ልጆች ነበሩዎት?(ሾተላይ)?	አዎ 1 አይ 2 መልስ የለም 9	ጥ216 ጥ216
ጥ212	የ6 ወር እርግዝናውን ከማጠናቀቅዎ በፊት ምን ያህል ድንገኛ ወይም በፍላጎት የተከናወነ ውርጃ አከናውነዋል?	የውርጃዎች ብዛት [I] መልስ የለም 99	

አሁን ደግሞ በቅርብ ጊዜ በሰላም የተገላገሉትን ጤናማ ልጅ ወይም ያጋጠመዎትን ሾተላይ በተመለከተ ልጠይቅዎት እወዳለሁ።			
ጥ219	በዚህ እርግዝና ላይ ክትትል አድርገው ነበር?	አዎ 1 አይ 2 መልስ የለም 9	ጥ223 ጥ223
ጥ220	የእርግዝና ክትትል ያደረጉት ከማን ዘንድ ነበር? ሌላስ ሰው ነበር?	ዶክተር 12 ነርስ/አዋላጅ12 ባህላዊ አዋላጅ/ የጤና ሰራተኛ12 ሌላ (ይግለጹ) _____ 12 መልስ የለም 12	
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ጥ222	በእርግዝና ክትትል ጉብኝት ጊዜዎ ላይ የሚከተሉትን ያከናወነ ሰው ነበር? *ሁሉንም ያንብቡ* *1=የተጠቀሰ = ያልተጠቀሰ*	የእርስዎን የደም ግፊት መለካት 12 የሆድ ምርመራ ማከናወን 12 የህጻኑን የልብ ምት ማዳመጥ 12 የእርስዎን የህክምና ታሪክ በተመለከተ መጠየቅ 12 የሽንት ናሙናዎችን መውሰድ 12 ችግር ካጋጠመዎት ምን ማድረግ እንዳለብዎት የሚገልጽ ምክር መለገስ 12 ለመንጋጋ ቆልፍ የሚሆን ጸረ ጎጂ ተህዋሲያን መድሃኒት መርፌ መስጠት12 የወባ መድሃኒት መስጠት/ የወባ ምርመራ ማከናወን12 የቂጥኝ ምርመራ እንዲወስዱ እርስዎን መጠየቅ12 የHIV ምርመራ እንዲያከናውኑ እርስዎን መጠየቅ12 በአደጋ ጊዜ እንዴት ወደ ጤና ማዕከል መሄድ እንደሚችሉ ከእርስዎ ጋር መወያየት12	**ምላሾች ላይ በማክበብ ወደ ጥ224 ይሂዱ**
3	ከሰው ጋር ግንኙነት ያለደረጉባቸው ምክንያቶች ምንድን ነበሩ? *የተጠቀሱትን በሙሉ ያክብቡ* *1= የተጠቀሰ 2=ያልተጠቀሰ*	*ተደራሽነት ማጣት* ምንም አይነት የጤና ጥበቃ አትራቢ የለም 12 በቂ ገንዘብ አልነበረኝም 12 ርቀቱ ከፍተኛ ነበር 12 የትራንስፖርት እጦት ነበር12 ደካማ የመንገድ ሁኔታዎች ነበሩ 12 *እንክብካቤውን በተመለከተ የነበረ ተቃውሞ* ባል/አጋር አልፈቀደም ነበር12 *ከእንክብካቤው ረገድ የነበሩ የተዛቡ እይታዎች* ዶክተር፣ ነርስ ወይም ሌላ የጤና ጥበቃ አቅራቢን መፍራት 12 ከዚህ በፊት ዶክተር ወይም ነርስ ተጠቅሞ አለማወቅ 12 ከዚህ በፊት በአግባቡ	

		አለመታከም12 የሀፍረት ስሜት መሰማት12 ጊዜ እርግዝናው አለመግፋቱ 12 በቂ ጊዜ አለመኖሩ12 ሌላ (ይግለጹ)_____12 ምላሽ የለም 12	
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ጥ227	እርዳታውን ከየት አፈላልገው ነበር?	በቤት ውስጥ እርዳታ አግኝቻለሁ 1 በጤና ማዕከል ውስጥ 2 በሆስፒታል 3 ሌላ (ይግለጹ)_____4 መልስ የለም 9	

ጥ228	በቅርብ ጊዜ በነበረው እርግዝናዎ ላይ የተገላገሉት የት ነበር?	በቤት ውስጥ 1 በጤና ክሊኒክ/ሆስፒታል 2 ወደሆስፒታል /ክሊኒክ በመሄድ ላይ 3 ሌላ(ይግለጹ)----------4 መልስ የለም 9	
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ጥ230	በወሊዱ ላይ ማን ረዳዎት?	ዘመድ/ጎደኛ 1 ባህላዊ አዋላጅ 2 አዋላጅ፣ ነርስ ወይም ዶክተር 3 ሌላ(ይግለጹ)_____4 መልስ የለም 9	
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ጥ232	ምን አይነት ውስብስብ ሁኔታዎች አጋጥመዎታል? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1=የተጠቀሰ=ያልተጠቀሰ*	ከፍተኛ መድማት 12 ከ12 ሰዓታት በላይ የቆየ የምጥ ህመም12 የብልት መሰንጠቅ 12 መንተጥተጥ/መንዘፍዘፍ 12 ትኩሳት 12 ከብልት ውስጥ የሚወጣ አረንጓዴ ወይም ቡኒ ፈሳሽ 12 የሽርት ውሃ ፈሶ ምጥ በ6 ሰዓታት ውስጥ አለመጀመር12 ከወሊድ በኋላ በ1 ሰዓት ጊዜ ውስጥ የእንግዴ ልጅ አለመወገድ12 ሌላ(ይግለጹ)_____12 መልስ የለም 12	
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ጥ235	ከወሊድ በኋላ በነበሩት 6 ሳምንታት ላይ ማንኛውም አይነት ችግር ወይም ውስብስብ ሁኔታ ገጥሞዎታል?	አዎ 1 አይ 2 መልስ የለም 9	ጥ300 ጥ300

ጥ236	ምን ችግር (ምች) ወይም ውስብስብ ሁኔታ(ምች) ገጥመዎታል? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1=የተጠቀሰ=ያልተጠቀሰ*	ከፍተኛ መድማት 12 መጥፎ ጠረን ያለው የብልት ፈሳሽ 12 ከፍተኛ ትኩሳት 12 ሽንት በሚሸናበት ጊዜ የነበረ ህመም 12 የሚያቃጥሉ፣ ያበጡ እንዲሁም የህምም ስሜት የነበራቸው ጡቶች12 ሌላ (ይግለጹ)_____12 መልስ የለም 12	
ጥ237	ለእነዚህ ችግር(ምች) ወይም ውስብስብ ሁኔታ(ምች) እርዳታ በየት አፈላልገዋል?	በቤት ውስጥ እርዳታ አግኝቻለሁ 1 የጤና ማዕከል 2 ሆስፒታል 3 ሌላ (ይግለጹ)_____4 መልስ የለም 9	
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ጥ239	እርግዝናን ለማስወገድ ወይም ለማዘግየት ጡት ማጥባትን ለመጠቀም አቅደዋል?	አዎ 1 አይ 0 እስካሁን እርግጠኛ አይደለሁም.....-88 መልስ የለም.....- 9	

ክፍል 3:የቤተሰብ እቅድ

አሁን ደግሞ የእርግዝና መከላከያ ዘዴዎችን በተመለከተ ጥያቄዎችን አጠይቅዎታለሁ። የመጀመሪያዎቹ ጥያቄዎች እርስዎ በቤተሰብ እቅድ ዘዴዎች ላላ ያለዎትን እውቀት ለመፈተሽ የተዘጋጁ ናቸው። እነዚህ ጥያቄዎች እርስዎ በአሁኑ ጊዜ እየተጠቀሙ የሚገኙትን የቤተሰብ እቅድ በተመለከተ የተዘጋጁ አይደሉም።

የጥ303 ኮዶች (ፍክ ብለው አያንብቡ)

1. በካምፕ/ማህበረሰብ ውስጥ የሚገኝ የጤና ማዕከል
2. የግል የጤና ክሊኒክ
3. ሱፐርማርኬት/ገበያ
4. ጓደኞች/ዘመዶች
5. ፋርማሲ
6. ሌላ (ይግለጹ) _____
8. አላውቅም
9. ምላሽ የለም

የ304 ኮዶች(ፍክ ብለው አያንብቡ)

1. ዘዴውን ማግኘት አልቻልኩም
2. ባል/አጋር አልፈቀደም
3. ህይማኖታዊ ምክንያት
4. የወር አበባዬን ያቆማል
5. የወር አበባዬን ይጨምራል/አ-መደበኛ ያደርጋል
6. የገንዘብ አቅሜ አይፈቅድም
7. አይሰራልኝም
8. ሌላ (ይግለጹ)_____
11. ምንም አይነት ችግር የለም
88. አላውቅም
99 ምላሽ የለም

ዘዴ	ጥ300 ስለዚህ ዘዴ ሰምተዋል? NR=መልስ የለም	ጥ301 እንዴት እንደሚሰራ በቴመለከተ ትምህርት ወይም መመሪያ ተሰጥቶዎታል? NR= መልስ የለም	ጥ302 ተጠቅመውት ያውቃሉ? NR= መልስ የለም	ጥ303 ለማግኘት ወዴት ይሄዳሉ? (ከላይ ያሉትን ኮዶች ይመልከቱ)	ጥ304 በእርስዎ እይታ፣ ዘዴውን ከመጠቀም ረገድ ዋንኛው ችግር ምንድን ነው?(ካለ) (ከላይ የሚገኙትን ኮዶች ይመልከቱ)
ሀ. ኪኒን (የሚዋጥ የወሊድ መከላከያ)	አዎ1→ጥ301 A አይ2→B NR9→B	አዎ1→ጥ302A አይ2→ጥ302 NR9→ጥ302	አዎ1→ጥ303A አይ2→ጥ303 NR9→ጥ303	→ጥ304	→B
B.IUD (*Loop*)	አዎ1→ጥ301B አይ2→C NR9→C	አዎ1→ጥ302B አይ2→ጥ302 NR9→ጥ302	አዎ1→ጥ303B አይ2→ጥ303 NR9→ጥ303	→ጥ304	→C
C.ኮንዶሞች (የወንድ) (የአካባቢው ስያሜ)	አዎ1→ጥ301C አይ2→D NR9→D	አዎ1→ጥ302C አይ2→ጥ302 NR9→ጥ302	አዎ1→ጥ303C አይ2→ጥ303 NR9→ጥ303	→ጥ304	→D
D.FemaleCondoms	አዎ1→ጥ301D አይ2→E NR9→E	አዎ1→ጥ302D አይ2→ጥ302 NR9→ጥ302	አዎ1→ጥ303D አይ2→ጥ303 NR9→ጥ303	→ጥ304	→E

E.Implants	አዎ1→ጥ301 D አይ2→E NR9→E	አዎ1→ጥ30 2D አይ2→ጥ30 2 NR9→ጥ302	አዎ1→ጥ30 3D አይ2→ጥ30 3 NR9→ጥ303	→ጥ304	→F
F.መርፌዎች (e.g.Depo-Provera)	አዎ1→ጥ301 E አይ2→F NR9→F	አዎ1→ጥ30 2E አይ2→ጥ30 2 NR9→ጥ302	አዎ1→ጥ30 3E አይ2→ጥ30 3 NR9→ጥ303	→ጥ304	→G
G. የድንገተኛ ጊዜ የሆርሞን የወሊድ መከላከያዎች("በጠዋት የሚወሰዱ ደህረ-እንክብሎች")	አዎ1→ጥ301 F አይ2→G NR9→G	አዎ1→ጥ30 2F አይ2→ጥ30 2 NR9→ጥ302	አዎ1→ጥ30 3F አይ2→ጥ30 3 NR9→ጥ303	→ጥ304	→H
H.የዘር ቱቦዎችን መቋጠር	አዎ1→ጥ301 G አይ2→H NR9→H	አዎ1→ጥ302G አይ2→ጥ30 2 NR9→ጥ30 2	አዎ1→ጥ303G አይ2→ጥ30 3 NR9→ጥ30 3	→ጥ304	→I
I.ሪትም /ካላንደር/ቀናችን መቁጠር	አዎ1→ጥ301I አይ2→J NR9→J	አዎ1→ጥ302I አይ2→ጥ30 2 NR9→ጥ30 2	አዎ1→ጥ303I አይ2→ጥ30 3 NR9→ጥ30 3	→ጥ304	→J
J.ግብረስጋ ማቋረጥ(ዘር ሳይረጭ ማቋረጥ)	አዎ1→ጥ301J አይ2→K NR9→K	አዎ1→ጥ302J አይ2→ጥ30 2 NR9→ጥ30 2	አዎ1→ጥ303J አይ2→ጥ30 3 NR9→ጥ30 3	→ጥ304	→K
K.ሌሎች የወሊድ መከላከያ ዘዴዎች (ይግለጹ):	አዎ1→ጥ301K አይ2→ጥ305 NR9→ጥ305	አዎ1→ጥ302K አይ2→ጥ30 2 NR9→ጥ30 2	አዎ1→ጥ303K አይ2→ጥ30 3 NR9→ጥ30 3	→ጥ304	→ጥ30 5

ከዚህ በታች የሚገኙት ጥያቄዎች እርስዎ በአሁኑ ጊዜ የሚጠቀሙትን የቤተሰብ እቅድ ዘዴ በተመለከተ የተዘጋጁ ናቸው።

ቁ.	ጥያቄዎች እና ማጥሪያዎች	የኮድ መደቦች	ወደዚህ ይለፉ
ጥ305	ወደፊት ልጅ መውለድ ይፈልጋሉ?	አዎ1 አይ2 መልስ የለም 9	→ጥ307 →ጥ307

ጥ306	ቀጣይ ልጅዎን መቼ መውለድ ይፈልጋሉ?	በቀጣይ 12 ወራት ውስጥ 1 በ1-2 ዓመት ውስጥ 2 ከ2 ዓመት በኋላ 3 ትዳር ከመሰረትኩ በኋላ 4 እግዜር በፈቀደ ጊዜ 5 ሌላ (ይግለጹ)_____6 መልስ የለም 9	
ጥ307	እርግዝናን ለማዘግየት ወይም ለማስቀረት በአሁኑ ጊዜ ማንኛውንም አይነት ዘዴ እይተጠቀሙ ይገኛሉ?	አዎ1 አይ2 መልስ የለም 9	ጥ309 ጥ312
ጥ308	እርግዝናን ለማዘግየት ወይም ለማስቀረት የሚያስችሉ ዘዴዎችን አሁን እየተጠቀሙ ያልሆኑት በምን ምክንያት ነው? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1= የተጠቀሰ 2= ያልተጠቀሰ*	*ከውህድነት ጋር የተያያዙ ምክንያቶች* የማህጸን በቀዶ ህክምና መወገድ12 በአሁኑ ጊዜ ነፍሰጡር ነኝ 12 አሁን ተጨማሪ ልጆችን እፈልጋለሁ 12 ወሲብ አለመፈጸም/በየጊዜው ወሲብ አለመፈጸም 12 ለማርገዝ አለመቻል/መቸገር 12 በቅርቡ ተገላግያለሁ(ከወለድ በኋላ የሚገኙ ስድስት ሳምንታት ጊዜ ውስጥ ነኝ) 12 ጡት ማጥባት 12 *መጠቀምን በተመለከተ ያጋጠመ ተቃውሞ* መልስ ሰጪ ተቃውሞ ነበረው 12 ባል ተቃውሞ ነበረው 12 ሌሎች ተቃውሞ ነበራቸው12 ሀይማኖታዊ ክልከላ 12 *የእውቀት ማጠር* ምንም አይነት ዘዴዎችን አለማወቅ 12 ምንም አይነት ምንጮችን አለማወቅ 12 *ስዘዴ ጋር የተያያዙ ምክንያቶች* የጎንዮሽ ውጤቶችን መፍራት12 ለአጠቃቀም አመቺ አለመሆን 12 *ተደራሽ አለመሆን* ከፍተኛ ረቀት/ዘዴው ተደራሽ አይደለም 12 ውድ 12 ሌላ (ይግለጹ) _____12 ምላሽ የለም 12	<u>ጥ401</u> በመልሶች ላይ በማክበብ ወደ ጥ312 ይሂዱ
ጥ309	ይህንን ዘዴ እይተጠቀሙ ያሉት ሌላ ልጅ በሌላ ጊዜ መውለድ ስለሚፈልጉ ነው ወይስ ምንም አይነት ተጨማሪ ልጅ ስለማይፈልጉ ነው?	በሌላ ጊዜ ሌላ ልጅ እፈልጋለሁ 1 ተጨማሪ ልጅ አልፈልግም 2 መልስ የለም 9	

ጥ310	የትኛውን ዘዴ ሲጠቀሙ ቆይተዋል? *ከተጠቀሱት ውስጥ በአንደኛው ላይ ያክብቡ 1=ተጠቅሷል 2=አልተጠቀሰም*	አንክብል12 IUD12 የወንድ ኮንዶም 12 የሴት ኮንዶም 12 በማህጸን ውስጥ የሚተበር ኢመፕላንት 12 መርፈዎች 12 ለድንገተኛ ጊዜ የሚውል የሆርሞን የወሊድ መከላከያ 12 የሴት ስቴሪላይዜሽን/ የማህጸን ቱቦ መቋጠር12 የወንድ ስቴሪላይዜሽን /የዘር ቱቦ መቋጠር12 ጡት ማጥባት12 ሪትም/ካላንደር/ቀናት መቁጠር12 ዘር ከመፍሰሱ በፊት ግብረስጋ ግንኙነት ማቋረጥ12 ልጅ ሊወለድ በሚችልባቸው ጊዜያት ላይ ከግብረስጋ መቆጠብ 12 ሌላ (ይግለጹ)BC_WHAT___12 መልስ የለም12	
ጥ311	ዘዴውን ለመጨረሻ ጊዜ ያገኙት መቼ ነበር?	ባለሙያ/በማህበረሰቡ ውስጥ የሚገኝ የጤና ማዕከል 1 ሆስፒታል 2 ሱፐር ማርኬት / ገበያ 3 መድሃኒት ቤት 4 ሌላ (ይግለፁ)_____5 ተግባራዊ አይሆንም 6 መልስ የለም 9	**በመልሶች ላይ በማክበብ ወደ ጥ401 ይሂዱ**
ጥ312	ይህንን ዘዴ በቀጣይ 12 ወራት ውስጥ እርግዝናን ለማዘግየት ወይም ለማስቀረት እጠቀማለሁ ብለው ያስባሉ?	አዎ 1 አይ 2 አላውቅም 8 መልስ የለም 9	ጥ314 ጥ315 ጥ315
ጥ313	ይህንን ዘዴ አልጠቀምም ብለው የሚያስቡባቸው ምክንያቶች ምንድን ናቸው? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1፡ የተጠቀሰ* *2፡ ያልተጠቀሰ*	*ከወሳድነት ጋር የተያያዙ ምክንያቶች* አሁን ተጨማሪ ልጆች መውለድ እፈልጋለሁ 12 ወሲብ አለመፈጸም/በየጊዜው ወሲብ አለመፈጸም 12 ለማርገዝ አለመቻል/መቸገር 12 በቅርቡ ተገላግያለሁ(ከወሊድ በኋላ የሚገኙ ስድስት ሳምንታት ጊዜ ውስጥ ነኝ) 12 ጡት ማጥባት 12 **መጠቀምን በተመለከተ ያጋጠመ ተቃውሞ** መልስ ሰጪ ተቃውሞ ነበረው 12 ባል ተቃውሞ ነበረው 12 ሌሎች ተቃውሞ ነበራቸው12 ሀይማኖታዊ ክልከላ 12 **የእውቀት ማጠር** ምንም አይነት ዘዴዎችን አለማወቅ 12 ምንም አይነት ምንጮችን አለማወቅ 12 **ከዘዴ ጋር የተያያዙ ምክንያቶች** የጎንዮሽ ውጤቶችን መፍራት12 ለአጠቃቀም አመቺ አለመሆን 12	**ምላሾች ላይ በማክበብ ወደ ጥ315 ይሂዱ**

		ተደራሽ አለመሆን ከፍተኛ ረቃት/ዘደመው ተደራሽ አይደለም 12 ውድ 12 ሌላ (ይግለጹ) 12 ምላሽ የለም 12	

314	የትኛውን ዘዴ መጠቀም ይመርጣሉ? *የተጠናቀቁት ላይ በሙሉ ያክብቡ* *1፡ የተጠቀሰ* *2፡ ያልተጠቀሰ*	እንክብል12 IUD12 የወንድ ኮንዶም 12 የሴት ኮንዶም 12 ቦግሀጸን ውስጥ የሚተበር ኢመፕላንት 12 መርፈሞች 12 ለድንተኛ ጊዜ የሚውል የሆርሞን የወሊድ መከላከያ 12 የሴት ስቴራላይዜሽን/ የሚሃን ቱቦ መቋጠር12 የወንድ ስቴራላይዜሽን /ያሀር ቱቦ መቋጠር12 ጡት ማጥባት12 ሪትም/ካላንደር/ተናት መቁጠር12 ዘር ከመፍሰሱ በፊት ግብረስጋ ግንኙነት ማቋረጥ12 ልዎ ለወላድ በማችለባቸው ጊዜያት ላይ ከግብረስጋ መቆጠብ 12 ሌላ (ይግለጹ)BC_WHAT___12 መልስ የለም12	
ጥ315	አሁን ከፈለጉ ማርገዝ የሚችሉ ይመስለዎታል፣ ወይም በአሁኑ ጊዜ ነፍሰጡር ነሞት?	አም አይ በአሁኑ ጊዜ ነፍሰጡር ነኝ መልስ የለም	ጥ401 ጥ401 ጥ401
ጥ316	ማርገዝ አልችልም ብለው የሚያስቡበት ዋነኛ ምክንያት ምንድን ነው? *አንደኛው ላይ ያክብቡ*	ማረጥ 1 መልሶ ሰጪ ወይም አጋር ማርገዝ አንዳይቻል የሚያደርግ ቀዶ ጥገና አከናውነዋል 2 መልስ ሰጪ ቢያንስ ለ2 ዓመታት ያህል ለማርገዝ ጥረት ቢያደርጉም ስኬታማ አልነበሩም። 3 መልስ ሰጪ ወሲዊ ንቃት(ዝግጁነት) የላቸውም 4 ከወሊድ ቡኋላ ከወለዱ 6 ሳምንታት ቡኋላ ጊዜ ውስጥ መሆን) 5 ጡት ማጥባት 6 ሌላ (ይግለጹ) 7	

		መልስ የለም 9	

ክፍል 4: የአባላዘር በሽታዎች(STIs)

ከዚህ በታች የሚገኙት ጥያቄዎች የአባላዘር በሽታዎችን በተመለከተ የቀረቡ ናቸው። እነዚህ ጥያቄዎች የግል ህይወትን የሚዳስሱ እንደሆኑ እንረዳለን። የእርስዎም ምላሾች በሚስጥራዊነት እንደሚያዙ ልናረጋግጥልዎት እንወዳለን።.			
አይ.	**ጥያቄዎች እና ማጣሪያዎች**	**የመልስ መደቦች**	**ወደዚህ ይለፉ**
ጥ401	ከHIV/AIDS ባሻገር በግብረስጋ ግንኙነት ስለሚተላለፉ በሽታዎች ሰምተዋል?	አዎ1 አይ2 መልስ የለም 9	 □ጥ403 □ጥ403
ጥ403	ባለፉት 12 ወራት ውስጥ ያልተለመደ ፈሳሽ ከብልትዎ ውስጥ ወጥቶ ያውቃል? መጥፎ ሽታ ወይም አረንጓዴ/እርጎ የሚመስል ፍሳሽ ነበረዎት?	አዎ1 አይ2 መልስ የለም 9	Ifአይtogo to □ጥ501
ጥ404	ባለፉት 12 ወራት ውስጥ ማንኛውም አይነት የመራቢያ አካል ላይ የደረሰ ቁስል ወይም ሲነካ የሚያምም አባጭ ነበረዎት?	አዎ1 አይ2 መልስ የለም 9	Ifአይ go to □ጥ501
ጥ405	ማንኛውም አይነት ያልተለመደ የመራቢያ አካል ፍሳሽ፣ የማራቢያ አካል ቁስለት ወይም ህመም ያለው እብጠት በነበረዎት ጊዜ ህክምና አፈላልገዋል?	አዎ1 አይ2 መልስ የለም 9	 □ጥ407 □ጥ501
ጥ406	በየት ሄዱ? ወይም ከማን ጋር ግንኙነት አደረጉ?	በካምፕ/ማህበረሰቡ ውስጥ የሚገኝ የጤና ማዕከል 1 ከካምፕ/ማህበረሰቡ ውጪ የሚገኝ የጤና ማዕከል 2 ሆስፒታል 3 የባህል ሀኪም 4 መድሃኒት ቤት 5 ሱፐር ማርኬት/ ገበያ 6 ሌላ (ይግለጹ)________7 መልስ የለም 9	በመልሶች ላይ በማክበብ ወደ □ጥ501 ይሂዱ
ጥ407	እነዚህን ምልክቶች ተከትሎ ከማንም ጋር ግንኙነት ያላደረጉት ለምን ነበር? *የተጠቀሱት ላይ በሙሉ ያክብቡ።* *1=የተጠቀሰ* *2=ያልተጠቀሰ*	*የተደራሽነት እጦት* ምንም አይነት የጤና ጥበቃ አቅራቢ የለም 12 በቂ ገንዘብ አልነበረኝም 12 ርቀቱ ከፍተኛ ነበር 12 የትራንስፖርት እጦት ነበር12 ደካማ የመንገድ ሁኔታዎች ነበሩ 12 *እንክብካቤውን በተመለከተ የነበረ ተቃውሞ* ባል/አጋር አልፈቀደም ነበር12 *ስለእንክብካቤው ረገድ የነበሩ የተዛቡ እይታዎች* ዶክተር፣ ነርስ ወይም ሌላ የጤና ጥበቃ አቅራቢን መፍራት 12 ከዚህ በፊት ዶክተር ወይም ነርስ ተጠቅሞ አለማወቅ 12 ከዚህ በፊት በአግባቡ አለመታከም12 የሀፍረት ስሜት መሰማት12 ሌላ (ይግለጹ) ___12	

		መልስ የለም 12	

ክፍል 5: HIV/AIDSን በተመለከተ የሚገኝ እውቀት፣ እይታ እና ግንዛቤን ለመፈተሽ የቀረቡ ጥያቄዎች

ከዚህ በታች የቀረቡት ጥያቄዎች እርስዎ ስለ HIV/AIDS ያለዎትን እውቀት፣ እይታ እና ግንዛቤ ለመፈተሽ የቀረቡ ናቸው። ከሚነበቡት ጥያቄዎች ውስጥ የተወሰኑት ትክክለኛ የሆኑ መግለጫዎችን እንደሚያንጸባርቁ እና የተወሰኑት ጥያቄዎች ደግሞ ሀሰተኛ መግለጫዎችን እንደሚያሳዩ ማስተዋል ያስፈልጋል።

አይ.	Questionsandfilters	Codingcategories	Skipto
ጥ501	ስለ HIV ወይም AIDS በመባል ስለሚጠቀሰው በሽታ ሰምተዋል?	አዎ1 አይ2 መልስ የለም 9	▯ጥ601 ▯ጥ601
ጥ502	አንድ ታማኝ እና የበሽታው ታማሚ ያልሆነ አጋር በመያዝ ሰዎች ራሳቸውን ከHIV/AIDS መጠበቅ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ503	ሰዎች የግብረስጋ ግንኙነት በሚጽሙበት ጊዜ በሙሉ ኮንዶም በመጠቀም እራሳቸውን ከHIV/AIDS ሊጠብቁ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ504	ሰዎች ከግብረስጋ ግንኙነት በመታቀብ ራሳቸውን ከHIV/AIDS ሊጠብቁ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ505	ሰዎች በወባ ትንኝ ተነክሰው HIV/AIDS ሊያዙ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	

ጥ506	ሰዎች የHIV/AIDS ታማሚ ከሆነ ግለሰብ ጋር የጥርስ ቡሩሽ በመጋራት በበሽታዊ ሊጠቁ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ507	ሰዎች ከወንድ አጋራቸው ጋር በፊንጢጣ ወሲብ በመፈጸም እና ኮንዶም ባለመጠቀም HIV/AIDS ሊያዙ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ508	በሴላ ሰው ጥቅም ላይ በዋለ መርፌ በመወጋት ሰዎች HIV/AIDS ሊያዙ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ509	ሰዎች ከታማሚ ሰው ጋር ምግብ አብረው በመብላት HIV/AIDS ሊያዙ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ510	ጤናማ የሚመስል ግለሰብ HIV/AIDS ሊኖርበት ይችላል?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ511	የHIV/AIDS ታማሚ የሆነች ሴት ግለሰብ በእርግዝና ወይም በወሊድ ጊዜ ቫይረሱን ላልተወለደው ልጇ ልታስተላልፍ ትችላለች?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ512	ሴቶች ጡት በማያጠቡበት ጊዜ ልጃቸውን HIV/AIDS ሊያስይዙ ይችላሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ513	የእርስዎ የቤተሰብ አባል HIV/AIDS ከተያዘ፣ ሁኔታው ሚስጥር ሆኖ እንዲቆይ ይፈልጋሉ?	አዎ1 አይ 2 አላውቅም 8 መልስ የለም 9	
ጥ514	የእርስዎ ዘመድ በHIV/AIDS ከታመመ፣ በቤትዎ ውስጥ እርሱን/ሷን ለመንከባከብ ፍቃደኛ ይሆናሉ?	አዎ 1 አይ 2 አላውቅም 8 መልስ የለም 9	
ጥ515	አስተማሪ በHIV/AIDS ከታመመ ማስተማሩን እንዲቀጥል ሊፈቀድለት ይገባል?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ516	የ HIV/AIDS ታማሚ ከሆነ ባለሱቅ በጥሬው የሚበሉ አትክልቶችን ለመግዛት ፍቃደኛ ይሆናሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	

ጥ517	ታዳጊ ወጣቶች ኮንዶም እንዴት መጠቀም እንዳለባቸው የሚያሳይ ትምህርት ሊሰጣቸው ይገባል?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	
ጥ518	ባለፉት 12 ወራት ውስጥ HIV/AIDSን በተመለከተ መረጃ ደርሶዎታል?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	☐ጥ520 ☐ጥ520 ☐ጥ520
ጥ519	ባለፉት 12 ወራት ውስጥ HIV/AIDSን በተመለከተ መረጃ ያገኙባቸው ምንጮች ምንድን ነበሩ? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1=የተጠቀሰ* *2=ያልተጠቀሰ* *VCT=በፍቃደኝነት ላይ የተመሰረተ ማማከር እና ምርመራ ANC = የእርግዝና ክትትል* *MTCT=ከእናት ወደ ልጅ መተላለፍ*	*የመገናኛ ብዙኃን* ራዲዮ12 ቲቪ/ ቪዲዮ12 ጋዜጣ 12 ፖስተር / ፓምፕሌት12 ***የጤና አገልግሎት*** የመንግስት/የህዝብ የጤና ተቋም12 የግል የጤና ተቋም 12 VCT ማዕከል12 ANC/MTCT ማዕከል 12 *ሰዎች* የማሕበረሰብ ጤና ሰራተኞች 12 ጓደኛ 12 የቤተሰብ አባል12 ከHIV/AIDS ጋር የሚኖሩ ግለሰቦች 12 የአቻ ለአቻ ተደራሽነት ሰራተኛ 12 *ሌሎች ስፍራዎች* ትምህርት ቤት 12 የአምልኮ ስፍራ12 የህዝብ ስብሰባ 12 ሌላ (ይግለጹ)_____12 መልስ የለም 12	
ጥ520	ስለ HIV/AIDS መረጃ ማግኘት የሚመርጡት ከየትኛው ምንጮች ነው? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1=የተጠቀሰ* *2=ያልተጠቀሰ* *VCT=በፍቃደኝነት ላይ የተመሰረተ ማማከር እና ምርመራ ANC = የእርግዝና ክትትል* *MTCT=ከእናት ወደ ልጅ መተላለፍ*	*የመገናኛ ብዙኃን* ራዲዮ12 ቲቪ/ ቪዲዮ12 ጋዜጣ 12 ፖስተር / ፓምፕሌት12 ***የጤና አገልግሎት*** የመንግስት/የህዝብ የጤና ተቋም12 የግል የጤና ተቋም 12 VCT ማዕከል12 ANC/MTCT ማዕከል 12 *ሰዎች* የማሕበረሰብ ጤና ሰራተኞች 12 ጓደኛ 12 የቤተሰብ አባል12 ከHIV/AIDS ጋር የሚኖሩ ግለሰቦች 12 የአቻ ለአቻ ተደራሽነት ሰራተኛ12 *ሌሎች ስፍራዎች*	

		ትምህርት ቤት 12 የአምልኮ ስፍራ12 የህዝብ ስብሰባ 12 ሌላ (ይግለጹ)_____12 መልስ የለም 12	
ጥ521	ሰዎች ስHIV/AIDS ምርመራ ሊያደርጉ የሚችሉበትን ስፍራ ያውቃሉ?	አዎ1 አይ2 አላውቅም8 መልስ የለም 9	☐ጥ523 ☐ጥ523 ☐ጥ523
ጥ522	ሰዎች ስHIV/AIDS በየት ሄደው ምርመራ ሊያደርጉ ይችላሉ ?	በስደተኞች ጣቢያ 1 በአካባቢ ማህበረሰብ 2 በስደተኞች ጣቢያ እና በአካባቢው ማህበሰረብ ውስጥ 3 ሌላ(ይግለጹ)_____4 አላውቅም 8 መልስ የለም 9	
ጥ523	እኔ ውጤቱን ለማወቅ አልጠይቅም፤ነገር ግን የ HIV/AIDS ምርመራ አድርገው ያውቃሉ?	አዎ1 አይ2 መልስ የለም 9	☐ጥ529 ☐ጥ529
ጥ524	ስHIV/AIDS በመጨረሻ ምርመራ ያደረጉት መቼ ነበር?	ከአንድ ዓመት ያነሰ ጊዜ በፊት 1 ከ1-2 ዓመት በፊት 2 ከ3 ዓመት በፊት እና ከዛ በላይ 3 መልስ የለም 9	
ጥ525	በመጨረሻ የHIV/AIDS ምርመራ ያደረጋችት በፍቃደኝነት ላይ በተመረኮዘ መልኩ ነበር ወይስ በግዴታ?	በጎ ፈቃደኛ 1 አስገዳጅ 2 መልስ የለም 9	
ጥ526	ለመጨረሻ ጊዜ የHIV/AIDS ምርመራ ሲያደርጉ የማማከር አገልግሎት ቀርቦልዎታል?	አዎ1 አይ2 መልስ የለም 9	
ጥ527	ለመጨረሻ ጊዜ የHIV/AIDS ምርመራ ሲያደርጉ በየት ሄደው ተመረመሩ?	*የመንግስት ዘርፍ* ሆስፒታል 1 የመንግስት የጤና ተቋም 2 ክሊኒክ / የቤተሰብ እቅድ 3 ተንቀሳቃሽ ክሊኒክ (የመንግስት፣ የህዝብ)4 *የግል ዘርፍ* የግል ሆስፒታል / ክሊኒክ 5 መድሃኒት ቤት 6 የግል የህክምና ዶክተር 7 ተንቀሳቃሽ ክሊኒክ (የግል)8 ባህላዊ ሐኪም 9 ሌላ (ይገለጽ)_____ 10 መልስ የለም 9	
ጥ528	የምርመራ ውጤትዎን አወቁ? እባክዎትን ውጤቱን አይንገሩኝ	አዎ1 አይ2	

		መልስ የለም 9	

ጥ529	ለወደፊቱ የHIV/AIDS ምርመራ ለማድረግ ይፈልጋሉ?	አዎ 1 አይ 2 አላውቅም/ እርግጠኛ አይደለሁም 8 መልስ የለም 9	ጥ601 ጥ601
ጥ530	ለምርመራው መሄድ የማይፈልጉበት ዋንኛ ምክንያት ምንድን ነው?	ታማሚ መሆኔን እርግጠኛ ነኝ 1 ውጤቱን አፈራለሁ 2 ደም ሥሰጥ ያስፈራኛል 3 ቦሰሽተው መያዝ ያስፈራኛል 4 መገለልን አፈራለሁ 5 በጣም ውድ ነው 6 ሌላ (ይገለጽ)_____7 መልስ የለም 9	

ክፍል 6: በስርዓተጾታ ላይ የተመረኮዘ ጥቃት

አሁን ደግሞ በግጭቱ ጊዜ በእርስዎ ላይ ያጋጠነሙ ችግሮች ላይ ለማተኮር እወዳለሁ ። የምጠይቅዎት ጥያቄ ለለቤተሰብዎ ውጪ፣ በሆኑ እንደ ወታደሮች፣ የጦር ሰራዊት አባላት፣ የፖሊስ መኮንኖች እና የጥበቃ ሰራተኞች አማካኝነት እርስዎ ላይ ተፈጽመው ሊሆኑ ስለሚችሉ ድርጊቶች ነው። እነዚህ ድርጊቶች በመንገድ ላይ፣ የስደተኞች ወይም በሀገር ውስጥ የተፈናቀሉ ግለሰቦች (IDP) የሚኖሩባቸው ካምፖች ውስጥ ወይም ቦሌላ መንደር ውስጥተፈጽመው ሊሆን ይችላል። አስፈላጊ ከሆነ በማንኛውም ጊዜ አቁመን እረፍት መውሰድ እንደምንችል እባክዎትን ያስታውሱ።
በተጨማሪም የእርስዎ ምላሾች በጥብም ማስጥራዊነት የሚያዙ መሆናቸውን ማረጋገጫን እንደምቀጥል እባክዎትን ያስታውሱ። በተጨማሪም እርዳታ ሊቸርሙት ወደሚችል ግለሰብ ለንመራምት እንደምንችል እንድታውቁ እንፈልጋለን።

ጥ601. በግጭቱ ጊዜ፣ ከቤተሰብዎ ውጪ በሆኑ ግለሰቦች አማካኝነት ከዚህ በታች የተጠቀሱት ማናቸውም የጥቃት አይነቶች ደርሰውብዎት ነበር? እነዚህ ድርጊቶች የእርስዎ የቤተሰብ አባል ባልሆነ ማንኛውም ግለሰብ አማካኝነት ተፈጽመው ሊሆን ይችላል። እንደዚህ ሆነው ነበር፡ (A-ን ያንብቡ) NR= ምላሽ የለም	ጥ602. (A-I) በየስንት ጊዜው በእርስዎ ላይ ይፈጠር ነበር? አንድ ጊዜ፣ ሁለት ጊዜ፣ የተለያዩ ጊዜያት ወይስ በርካታ ጊዜያት? NR=ምላሽ የለም	ጥ603.ይህንን በእርስዎ ላይ ያደረገው ማን ነበር? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1=የተጠቀሰ* *2=ያልተጠቀሰ*	ጥ604. ይህ የተፈጠረው በየት ነበር? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1=የተጠቀሰ* *2=ያልተጠቀሰ*
A.አካላዊ ጉዳት መድረስ፣ ለምሳሌ በጥፊ መመታት፣ መታነቅ ፣ መረገጥ ወይም መደብደብ *አዎ1* *አይ2 B*	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 1 2 ማንኛውም የቀድሞ ካምፕ 1 2 የትውልድ መንደር/ከተማ 1 2 በመንገድ/በጀልባ ስንዝ 1 2 ሌላ (ይገለጽ) _____ 1 2 መልስ የለም 1 2

NR9☐B		የሰብዓዊ እርዳታ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	
B በማንኛውም አይነት የጦር መሳሪያ አማካኝነት ማስፈራራያ መድረስ አዎ1 አይ2☐C NR9☐C	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 ቦርካታ ጊዜያት 3 NR99	ዩኒፎር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
C. መተኮስ ወይም በጨበጣ መወጋት አዎ1 አይ2☐D NR9☐D	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	ባአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
D.ያለፍቃድ በቁጥጥር ስር መዋል አዎ1 አይ2☐D NR9☐D	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
E. ተገቢ ያልሆኑ ወሲባዊ አስተያየቶች መሰንዘር አዎ1 አይ 2☐F	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 ፖሊስ 12 የእስር ቤት	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንዝ 12

NR 9☐F	ወይም የማረሚያ ቤት ጠባቂ 12	የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	ሌላ (ይገለጽ) 12 መልስ የለም 12
F. ልብስ ለማውለቅ መገደድ አዎ1 አይ 2☐G NR 9☐G	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	ቦአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
G.በፍላጎት ላይ ባልተመሰረተ መልኩ መሳም ወይም ወሲባዊ የሰውነት ክፍሎች ላይ መነካት አዎ1 አይ 2☐H NR 9☐H		የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12

H.በአፍ፣ በብልት ወይም በፊንጢጣ ወሲብ ለማከናወን የጉዳት ማስፈራሪያ ወይም የማስገደድ ክንውን መፈጸም አዎ1 አይ 2 NR 9		የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስጓዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
I. ሌላስ(ይግለጹ)? አዎ1 አይ 2 ፐ805 NR9 ፐ805		የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስጓዝ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12

አሁን ከግጭቱ[ቀኑን ይግለጹ-----------]. በኋላ እርስዎ ኦጋጥሞዎት ሊሆን የሚችል ችግር ላይ ለማተኮር እወዳለሁ። እንደቀድሞው ሁሉ ከቤተሰብዎ ውጪ በሆኑ እንደ ወታደሮች፣ ሚሊሻ፣ ፖሊስ መኮንኖች እና የጥበቃ ሰራተኞች አማካኝነት በእርስዎ ላይ ተከናውነው ሊሆኑ የሚችሉ ድርጊቶችን በተመለከተ ጥያቄዎችን እጠይቅዎታለሁ። እነዚህ ድርጊቶች በመንገድ ላይ፣ የስደተኞች ወይም በሀገር ውስጥ የተፈናቀሉ ግለሰቦች (IDP) የሚኖሩባቸው ካምፖች ውስጥ ወይም በሌላ መንደር ውስጥተፈጽመው ሊሆን ይችላል። አስፈላጊ ከሆነ በማንኛውም ጊዜ እቀመን እረፍት መውሰድ እንደምንችል እባክዎትን ያስታውሱ።
በተጨማሪም የእርስዎ ምላሾች በፍጹም ሚስጥራዊነት የሚያዙ መሆናቸውን ማረጋገጤን እንደምቀጥል እባክዎትን ያስታውሱ። በተጨማሪም እርዳታ ሊቸርዎት ወደሚችል ግለሰብ ለንመራዎት እንደምንችል እንድታውቁ እንፈልጋለን።

ፐ601. በግጭቱ ጊዜ፣ ከቤተሰብዎ ውጪ በሆኑ ግለሰቦች አማካኝነት ከዚህ በታች የተጠቀሱት ማናቸውም የጥቃት አይነቶች ደርሰውብዎት ነበር? እነዚህ ድርጊቶች የእርስዎ የቤተሰብ አባል ባልሆነ ማንኛውም ግለሰብ አማካኝነት ተፈጽመው ሊሆን ይችላል። እንደዚህ ሆነው ነበር፡	ፐ602. (A-I) በየስንት ጊዜው በእርስዎ ላይ ይፈጠር ነበር? አንድ ጊዜ፣ ሁለት ጊዜ፣ የተለያዩ ጊዜያት ወይስ በርካታ ጊዜያት?	ፐ607.ይኼንን በእርስዎ ላይ ያደረገው ማን ነበር? የተጠቀሱት ላይ በሙሉ ያክብቡ 1=የተጠቀሰ 2=ያልተጠቀሰ	ፐ608.Wheredidthistakeplace? የተጠቀሱት ላይ በሙሉ ያክብቡ 1=የተጠቀሰ 2=ያልተጠቀሰ

(A-ነን ያንብቡ) NR= ምላሽ የለም	NR=ምላሽ የለም		
A.አካላዊ ጉዳት መድረስ፤ ለምሳሌ በጥፊ መመታት፣ መታነቅ ፣ መረገጥ ወይም መደብደብ አዎ1 አይ2→B NR9→B	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማገኛውም የቀድሞ ካምፕ 12 ያትውልድ መንደር/ ክተማ 12 በሙንገድ/በጀልባ ስንገ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
B, በማንኛውም አይነት የጦር መሳሪያ አማካኝነት ማስፈራሪያ መድረስ አዎ1 አይ2→C NR9→C	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማገኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ክተማ 12 በመንገድ/በጀልባ ስንገ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
C. መተኮስ ወይም በጨበጣ መወጋት አዎ1 አይ2→D NR9→D	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማገኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ክተማ 12 በመንገድ/በጀልባ ስንገ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12

		ማልስ የለም 12	
D.ያለፍቃድ በቱጥጥር ስር መዋል *ኣም1* *ኣይ2D* *NR9D*	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንጠ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
E. ተገቢ ያልሆኑ ወሲባዊ አስተያየቶች መሰንዘር *ኣም1* *ኣይ 2F* *NR9F*	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንጠ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
F. ልብስ ለማውለቅ መገደድ *ኣም1* *ኣይ 2F* *NR9F*	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንጠ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
G.በፍላጎት ላይ ባልተመረኮዘ	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12

መልኩ መሳም ወይም ወሲባዊ የሰውነት ክፍሎች ላይ መነካት *አዎ1* *አይ2 H* *NR9 H*	በርካታ ጊዜያት 3 NR99	ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንገ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
H.በአፍ፣ በብልት ወይም በፊንጢጣ ወሲብ ለማከናወን የጉዳት ማስፈራሪያ ወይም የማስገደድ ክንውን መፈጸም *አዎ1* *አይ 2* *NR 9*	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ሠይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንገ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12
I. ሌላስ(ይግለጽ)? *አዎ1* *አይ 2* *መመሪያ ሳጥን 8.1 NR9* *መመሪያ ሳጥን ይ.1*	አንድ ጊዜ ወይም ሁለቱ 1 በተለያዩ ጊዜያት 2 በርካታ ጊዜያት 3 NR99	የጦር ሰራዊት 12 ታጣቂ ሰራዊት 12 ፖሊስ 12 የእስር ቤት ወይም የማረሚያ ቤት ጠባቂ 12 ሐኪም /የሕክምና ባለሙያ12 የሐይማኖታዊ ተልዕኮ ሰራተኛ 12 የሰብዓዊ ድጋፍ ሰራተኛ 12 ጎረቤት / የማህበረሰብ አባል 12 ሌላ ስደተኛ/IDP12 ሌላ (ይገለጽ)__12 መልስ የለም 12	በአሁኑ ጊዜ የምገኝበት ስፍራ 12 ማንኛውም የቀድሞ ካምፕ 12 የትውልድ መንደር/ ከተማ 12 በመንገድ/በጀልባ ስንገ 12 ሌላ (ይገለጽ) 12 መልስ የለም 12

ለቃለመጠይቅ አቅራቢ የተቀመጡ መመሪያዎች 8.1
ከግጭቱ በኋላ ማንኛውም አይነት ሪፖርት ከቀረበ፣ በ(ጥ801) ወይም ከ(ጥ805) በኋላ፣ ወደ ጥ809 ይሂዱ፣ ምንም አይነት ሪፖርት ካልቀረበ ግን ወደ ጥ815 ገጽ ይሂዱ::

ጥ609	በእነዚህ ክስተቶች ምክንት ማንኛውም አይነት ጉዳት ደርሶብዎታል?	አዎ1 አይ2 መልስ የለም 9	 ጥ812 ጥ812

ጥ610	ምን አይነት ጉዳት ደርሶብዎታል? *ሁሉንም ያንብቡ* *አዎ=1* *አይ=2* *መልስ የለም =9*	መቆረጥ፣ መወጋት፣ መነከስ,129 መሰበር፣ መጋጋጥ፣ መበለዝ 129 ወለምታ፣ ውልቃት 129 ቃጠሎ 129 የመወጋት ጉዳት፣ ጥልቅ መቆረጥ፣ መቀርድ129 የጆሮ ታቡር መበጠስ፣ የአይን ጉዳት 129 የአጥንት ስብራት እና መሰንጠቅ 129 የጥርስ መሰበር 129 ሌላ (ይግለጹ)________ 129	
ጥ611	እነዚህን ጉዳቶች ተከትሎ ህክምና ለማግኘት ዶክተር ወይም ሌላ የጤና ጥበቃ አቅራቢ ጋር ግንኙነት አድርገዋል?	አዎ1 አይ2 መልስ የለም 9	
ጥ612	እነዚህን የጥቃት ክስተቶች ከሚከተሉት ጋር ተወያይተዋል? *የሚከተሉትን ያንብቡ* *A-F* *አዎ = 1* *አይ=2* *መልስ የለም =9*	የቤተሰብ አባል 129 ጓደኛ 129 ዶክተር/ሌላ የህክምና አቅራቢ 129 ፖሊስ /የጦር ሰራዊት 129 የNGO ሰራተኛ 129 ሌላ(ይግለጹ)________ 129	

ለቃለመጠይቅ አቅራቢዎች የተሰጡ ለመመሪያዎች 8.2
መልስ ሰጪዎቹ ጥቃቱን በተመለከተ ከማንኛውም አካል ጋር ውይይት አድርገው ከነበረ፣ ከጥ812 ወደ ጥ814 ይሂዱ

መልስ ሰጪዎቹ ከማንም ጋር ስለጥቃቱ በጥ814 መሰረት ካልተወያዩ ወደ 813 ይቀጥሉ

ጥ613	ጥቃቱን በተመለከተ ከሰዎች ጋር ለመነጋገር ያልቻሉባቸው ዋና ዋና ምክንያቶች ምንድን ናቸው? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1፡ የተጠቀሰ* *2፡ ያልተጠቀሰ*	የት መሄድ እንዳለብኝ አላውቅም ነበር 12 ጥቅም የለውም/ምንም አላገኝበትም 12 ሀፍረት ተሰማኝ 12 ተጨማሪ ጥቃትን ፈራሁ 12 በግንኙነት ላይ ተጨማሪ ችግር መፍጠር አልፈለኩም 12 ሰዎች አያምኑኝም/በቀምነገር አይመለከቱኝም 12 ጥቃቱ የከፋ ስላልሆነ ቅሬታ ማቅረብ አላስፈለገኝም 12 እሷ የምትወቀስ መስሎኝ ነበር 12 ለቤተሰቡ መጥፎ ስም መስጠት 12 ሌላ (ይግለጹ) ____________12 መልስ የለም 12	
ጥ614	እርስዎ ከጥቃት ጋር በተያያዘ ያጋጠመዎትን ተሞክሮ ተከትሎ የሚያግዙ ነገሮች አሉ ብለው ያስባሉ? *የተጠቀሱት ላይ በሙሉ ያክብቡ* *1፡ የተጠቀሰ* *2፡ ያልተጠቀሰ*	የሴቶች የድጋፍ ቡድን 12 ከጓደኞች ጋር መወያየት 12 ከቤተሰብ ጋር መወያየት12 ከNGO ሰራተኞች የተገኘ ድጋፍ 12 የህግ/የተለምዶ የፍትህ አማራጮች12 ሀይማኖታዊ ማማከር 12 የአእምሮ ጤና ማማከር 12 የህክምና እርዳታ ለመርሳት መሞከር 12	

		ሌላ (ይግለጹ) _12 መልስ የለም 12	

ክፍል 7 :ስሜታዊ ጤና

የሚከተሉት ጥያቄዎች የስሜት መረበሽን እንዲሁም በእርስዎ ማህበረሰብ ውስጥ የሚገኙ ሴቶችን የሚያጋጥሙ የጤና ችግሮችን ይመለከታሉ።			
ቁ.	ጥያቄዎች እና ማጥሪያዎች	የኮድ መደቦች	ወደዚህ ይለፉ
ጥ701	ቀጣዮቹ ጥያቄዎች እርስዎን ባለፉት 4 ሳምንታት ውስጥ አስቸግረው ሊሆኑ የሚችሉ የተለመዱ ችግሮችን ይመለከታሉ። ችግሩ ባለፉት 4 ሳምንታት ውስጥ አጋጥሞዎት ከነበረ አዎ በማለት ምላሽ ይስጡ። ባለፉት 4 ሳምንታት ውስጥ ችግሩ ካላጋጠመዎት አይ በማለት መልስ ይስጡ። *ለሁሉም ያንብቡ* A. ራስ ምታት አለዎት? B. የምግብ ፍላጎትዎት ደነስቷል? C. በአግባቡ እንቅልፍ አይተኙም? D. በቀላሉ ፍራቻ ያድርብዎታል? E. እጆችዎት ይንቀጠቀጣሉ? F. መረበሽ፣ መረበሽ እና መጨነቅ ይሰማዎታል? G. የምግብ አፈጓጨትም ደካማ ነው? H. በትክክል ለማሰብ ይቸገራሉ? I. ደስተኛነትን ማጣት ይሰማዎታል? J. ከመደበኛ መጠን በላይ ይተኛሉ? K. የእለት ተእለት እንቅስቃሴም ላይ ደስታን ለማግኘት ይቸገራሉ? L. ውሳኔ ለመወሰን ይቸገራሉ? M. የእለት ተእለት ስራዎ እየተበደለ ነው? N. በህይወት ውስጥ ጠቃሚ ሚናን ለመጫወት ተስኖዎታል? O. በነገሮች ላይ ያለዎትን ፍላጎት አጥተዋል? P. እርባናቢስ ሰው እንደሆኑ ይሰማዎታል? Q. ህይወትዎን የማጥፋት ሀሳብ መጥቶብዎታል? R. ሁሌም ድካም ይሰማዎታል? S. በሆድዎ ውስጥ ምቾት የሚነሱ ስሜቶች አሉዎት? T. በቀላሉ ድካም ይሰማዎታል?	*አዎ=1* *አይ=2* *መልስ የለም =9* A) ራስምታት 1 29 B) አነስተኛ የምግብ ፍላጎት 1 29 C) በደንብ አለመተኛት 1 29 D) መፍራት 1 29 E) የእጅ መንቀጥቀጥ 1 29 F) መርበትበት 1 29 G) የምግብ በሰማዙ ኢሰመጓጨት 1 29 H) ማሰብ 1 29 I) ደስታ ማጣት 1 29 J) ይቦልጥ ሃንሶስ 1 29 K) ደስታ ኦሰማግኘት 1 29 L) ውሳኔሥት 1 29 M) የስራ መበደል 1 29 N) ጠቃሚ ሚና 1 29 O) ፍላጎት ማጣት 1 29 P) ዋጋ ማጣት 1 29 Q) ህይወትን ማጥፋት 1 29 R) የድካም ሶማት 1 29 S) ሆድ 1 29 T) በቀላሉ መድከም 1 29	
ጥ702	በእርስዎ አይታ፣ አጅግ አትኩሮት ሊሰጠው የሚገባው እና በእርስዎ ማህበረሰብ ውስጥ በሚገኙ ሴቶች ላይ የተጋረጠው የጤና እክል ምንድን ነው? *ዝርዝሩን ያንብቡ* (አንድ ሴት ከአንድ በላይ ችግር ከጠቀሰች በሚከተለው መልኩ ጥያቄ በማንሳት ጠበብ ለማድረግ ይሞክሩ፡ "ከእነዚህ ውስጥ አንደኛውን እጅግ ወሳኝ ብለው መምረጥ	ከእርግዝና ጋር የተገናኙ ችግሮች1 የብልት ኢንፌክሽን 2 የመተንፈሻ አካል ኢንፌክሽ 3 ተቅማጥ 4 በቤት ውስጥ የነበረ ጥቃት 6 የሀዘን እና የተስፋ መቁረጥ ስሜት 7 ራስ ምታት፣ የቸርባ እና የጡንቻ ህመም8	

	ቢናገርበምትሥ የትኛውን ይመርጣለት?")	ሌላ (ይገለጽ)____20 መልስ የለም 99	

የሰዓት _ማብቂያ

ማብቂያ ሰዓት_____ ይህ የመጠይቁ ማብቂያ ነው። እነዚህን ጥያቄዎች ለመመለስ ጊዜዎን ስለመደቡ የላቀ ምስጋናችንን ለናቀርብ እንወዳለን። አርዳታችሁን እናበረታታለን። የእ ተቆጣጠሪ መጠይቁን ሙሉ በሙሉ እስከሚመረምር ድረስ እባክዎትን ዘዚህ ይጠብቁ። እሱ/ሷ የአርስዎን ጥያቄ በተለየ መልክ አይመለከትም። ነገር ግን ሁሉም አስፈላጊ ጥያቄዎች መጠየቃቸውን ያረጋግጣል።