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HEALTH AND SOCIO-CULTURAL PROBLEMS

OF

WOMEN IN RURAL BUTAJIRA

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Health and Socio-cultural problems of women in rural Butajira

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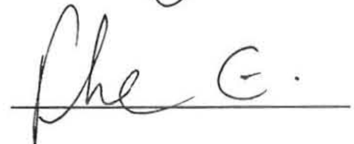

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DEDICATED TO:-

The *rural women in Ethiopia,* my dearest friend and a women advocate *Elsa Margaret Sand* and to my daughter *Kelemework Dabi*.

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I have so many people to thank, but I must first begin with my advisor Dr. Yemane Berhane for his unreserved guidance, worthy advices, tremendous encouragement, never unnerving manner and in general for teaching me to value research. This thesis other wise would have not been possible. I am grateful to the Department of Community Health for ensuring me every access to information and materials and to the Austrian Development Cooperation (ADC) for granting funds for the study. I sincerely thank my husband Gashaw Teferra, my son Roha and my daughter Kelemework for the atmost support and encouragement they provided me and for tolerating my full engagement in the research work. My thanks and appreciations also goes to Elsa Margaret Sand, Dr. Agonafer Tekalegn and Sister Margaret Gebre Mariam for their endurance support. My special appreciation and gratitude extended to Dr. Nigusse Taffa, for inspiring me in developing interest on the topic, Dr. Salma Eleerdy and Dr. Ahmed Ali for their useful critic and edition of the draft thesis. I am also indebted to thank Maria Emmelin, Umea University, Department of Epidemiology and Public Health, Umea, Sweden, for sharing her time and valuable thoughts in the preliminary pilot study and survey questionnaire preparation both in Butajira and Umea.

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LIST OF ABBREVIATIONS.

WHO	World Health Organization
MCH	Mother and Child Health
PHC	Primary Health Care
FGM	Female Genital Mutilation
STDs	Sexually Transmitted Disease
HIV	Human Immunodeficiency Virus
BRHP	Butajira Rural Health Project
PA	Peasant Association
UNICEF	United Nations Children's Fund
IEC	Information Education and Communication

ABSTRACT

Studies on the social and cultural problems affecting the health of women is rare in Ethiopia. This study illustrates the common socio-cultural problems influencing the health of women and the women's perception towards health and illness in rural Butajira. Qualitative and quantitative methods were employed to develop the data collection instrument and actual collection of data, respectively. A total of 675 randomly selected rural women participated in the study. Over 94 percent of women are illiterate and only 8.7 percent of girls are sent to school. The mean working hour for rural women in Butajira is 15 hours. Very high proportion (96.6%) women are victims of FGM. The decision making power of women at a house hold level is low. Women have almost no access to information, about 88 percent of them never listened to the radio for the last six months. About 97 percent of women reported that they are suffering from some kind of infectious, obstetrics or mental illness at the time of the survey. Punishment from God, lack of nutritious food, exposure to cold, evil eye and evil spirit possession were the major perceived causes of illness. The participants mostly use herbal medication during sickness or buy drugs with out consulting health workers in response to illnesses. They give high regard to traditional healers, witchcraft and religious leaders to solve health problems. The women by large have no idea on how to promote health except that they resume individual or group prayer. Therefore, it is concluded that women in rural Butajira are surrounded by traditional taboos and social problems affecting health.

In order to improve the situation of women the health service strategy needs to be devised after considering what women believe, what they actually do and need. Such strategies should be based on local problems and the involvement of locally accepted healers.

INTRODUCTION

According to historical documents, the concept of maternal health has been originated in the late 17th and early 18th centuries when depots were established in Europe and America to supply infants and children with milk and food items(1). The idea of MCH came to the developing world at the end of the World war II. Then it was primarily handled by charitable and voluntary organizations(1). Later, MCH has become one of the areas of WHO's interest and International Public Health. Its significance was restated at Alma Ata in 1978 when it was identified as one of the essential components of Primary Health Care(PHC). However, the progress made in the past twenty years has not been satisfactory, particularly in the poorest parts of the world (1).

Every year, millions of women suffer preventable illnesses and five hundred thousands die from pregnancy-related complications(2,3,19). Too many women suffer and die because they lack the information and resources to care for themselves.

In recent years, several global and national initiatives have begun to focus attention on the neglected area of women's health. "The Safe Motherhood" initiative started in 1987 in Nairobi, Kenya, is a good example to show a fairly great interest in addressing the issue of women's health from different perspectives: yet the root cause of the health problem of women occur at infancy

and childhood as a result of different harmful traditional practices and cultural taboos to which they are subjected (4,3).

This continues through out their lives, and they are continually affected by various social problems such as low socio-economic status, severe forms of poverty, low self esteem and lack of education(4,5). In addition, women have special health problems that men do not experience. They are also more vulnerable to certain disease conditions than are men(5).

Women's experience of health and illness involve their mind, body, sprit, social relationship as well as their working and living conditions. Unfortunately, the health service programmes designed for women and the general health programmes for the public do not consider all these issues(5). Women are hardly consulted for their views and interests regarding health; they are assumed to be reluctant and unable to analyze their problems and needs particularly concerning a sensitive subject such as reproductive health(6). In the September 1994 United Nations Conference on Population and Development held in Cairo, where women's health was a crucial issue, a major conceptual shift was suggested that it is necessary to hear what people, especially women have to say, rather than merely telling them what they should do(7).

The Situation Of Women In Ethiopia:

In Ethiopia female constitute about 50 percent of the total population, out of which the majority live in rural areas. Only five to seven percent of pregnant women have access to health or obstetric services by trained midwives. Between 19-60 percent of women are getting inadequate nutrition(8). The maternal mortality rate ranges between 560-880/100,000 births (9) and is one of the highest in the world. The national antenatal coverage is only 20.7 percent(9). The total fertility rate is 6.1 per woman and the national family planning coverage is 9.8 percent(9). The number of women is scanty in the higher educational levels. For instance, female student enrolment trends in institution of higher education level is 10.1 percent, 11.3 percent and 8.1 percent at a diploma level, undergraduate level and postgraduate level respectively(9). Women usually are responsible for house hold duties including farming and looking after cattle. Though figure vary from one culture to another as well as between different ethnic groups and religions, at least 50 percent of Ethiopians who are affected by harmful customs and practices are women (10).

This study held in the rural villages of Butajira attempts to explore the common socio-cultural and health problems that women are facing. There are little or no research available in this area in Ethiopia. National policy on Ethiopian women encourages such studies to be conducted especially in rural communities. The findings of this study are believed to be valuable for policy makers, development programme planners and health professionals working with and for women.

STUDY OBJECTIVE

General objective:-

To study health and socio-cultural conditions of women in rural communities.

Specific Objectives:-

1. To describe the common socio-cultural problems affecting the health of the women.

2. To identify the perceived health problems and causes of ill health among women.

3. To describe the coping strategies of women in promoting health and in combating illnesses.

1. Defining Women's Health.

Over the past few decades, our understanding of women's health has been driven by a focus on fertility regulation. This focus has left us with a narrow conceptualization of women's health bounded by the age 15-45 and by the reproductive system(2).

Though Women's Health is still known to be poorly defined ,a definition that goes beyond the reproductive functions is the following:

> "A women's health is the total well-being, not determined solely by biological factors and reproduction, but also by effects of work load, nutrition, stress and migration, among others"(2).
>
> (Van der Kwaak, 1991)

It is argued that women's health needs to be re conceptualized because we need to move away from a narrow disease-focused model of women's health. Therefore, we might start by rethinking where health is actually "located". Women's health is understood as embedded in communities, not just in woman's individual bodies. Although medical care contributes to women's health and well being, its importance should not be over-stated or accepted uncritically. Based on this, it is further advocated to envision different models of women's health from those that presently predominate.

One may categorize models as biomedical, feminist and social models of women's health. These models may be defined as follows:

Biomedical model:- The biomedical conceptualization of women's health has been used widely in government and medicine. The biomedical model focuses on disease conditions in women and it is reinforced in the media and in public policy. Women's health is devoted to the preservation of wellness and prevention of illness in women, and includes screening ,diagnosis and management of conditions which are unique to women, are more common in women , are more serious in women, and have manifestation ,risk factors or interventions which are different in women. But where health comes from ,or what is to be done if women do not have health; remains or denied(11).

Feminist model:- These models have similarities with social model. Feminist conceptualization of health emphasizes the ways in which working and living condition as well as personal health practices create health. Uniquely feminist model put women at the center of the analysis, not at the periphery. The models emphasize how gender as well as other social roles affect women's health(11).

Social models of women's health :- These models deal with the health problems that are rooted in social and cultural factors. A social model places women's core needs at the center of analysis and focuses attention on the diversity of women's health needs over the life cycle(12). A social model of health implies

that a different mix of health resources are needed to improve women's and well being. We must come to view resources allocated to economic development, education and housing as public health investment that along with primary care, are essential to the health and well being of women(12).

2.Reasons for Focusing on the health of women:

Focus on the health of women are due to three major reasons. Firstly, the women's reproductive role makes women's health different from that of men. Maternity is a unique privilege and a unique health challenge for women (3). Women are more vulnerable to STDs, HIV/AIDS, social burden of infertility, malignant neoplasms such as cancer of the cervix, Breast cancer, Gender violence, Osteoporosis due to decreased oestrogen production in old age, Harmful traditional practices etc than men are. The second reason is that the health of women is also influencing the health of their children. About 4.2 million children will die each year in the first month and 3 million will die in the first week. Of those who survive, about three quarters of a million will be mentally and physically handicapped. Twenty five million babies will be born with a birth weight below that required for optimal survival and healthy growth and development(3).

The third reason is that women's health is largely determined by societal and cultural factors. Women are subordinate to men. "The noble task of reproducing our species has not brought societal rewards to women". On the contrary it has

led to their domestication, subordination, and, worse to gender discrimination practices which among other consequences adversely impact on their health (3).

A majority of women and girls in the world live under conditions which limit educational attainment ,restrict economic participation and fail to guarantee them equal rights and freedom, as compared with men (3).

3.The social problems affecting the health of women:

The most frequently mentioned socio-cultural problems influencing the health of rural women in developing countries are harmful traditional practices such as FGM and early marriage, lack of education, multiple role of women and heavy workload, lack of control over resources and lack of decision making by women(2,5).

3.1 Lack of Education.

An educated women is more likely to use health services, take measures to prevent diseases and delay marriage and child bearing until she is prepared for it physically, emotionally and financially(5). Despite the clear benefit of education for women, today only 15 percent of all women in Africa are literate as opposed to 33 percent of all men (6). Primary school enrolment for girls is still lagging behind the rate for the boys in South Asia and Sub Saharan Africa (24). Girl students are the usual victims for school dropout. A survey in India has showed that while about 60% of rural boys and girls are enrolled in school,

after five years only 15% of girls remained as opposed to 55% of boys(6). The situation is worst in Africa. The number of girl student drop out from primary and secondary schools is mostly due to poverty (6).

3.2. Work Load.

Heavy work load, in combination with poor nutrition, is one of the main factors responsible for ill health of women. Routine duties such as water-fetching and cutting, collecting and carrying of fire-wood are demanding physical hard work (13). Rural women and girls in developing countries participate in agricultural work too. Studies indicated that the number of hours women are involved in work is greater than that of men in many countries of the world except in Australia, Canada and the United States (6). An average of 14-16 hours of work is not uncommon for women in developing countries (4). Over-work makes women more likely to get sick. Girls who begin to carry heavy loads of water at a young age are at risk for scoliosis(6). Too much work means also less time to attend school or health services.

3.3 Decision making and control over resources.

Women usually are not consulted when decisions are made about the family or the community. Men make the major decisions about where to live, what to buy, whether the children go to school, and whether money can be spent on things like health care. Often it is the man alone who decides whether or not family planning

should be used to space or limit the number of children. In many countries, a woman may not be able to get services of family planning or health care without permission from her husband(4). Women also have little access to other types of resources, such as training, credit programmes and machine or equipment that could make their tasks easier. General information which is also an important resource may not be available to them. This lack of access contributes to their poor health(4).

3.4 Harmful beliefs and practices.

FGM: In many areas of Africa including many parts of Ethiopia girls are subjected to FGM. Each year an estimated two million young girls in the world undergo FGM(14). FGM is an extremely dangerous and harmful practice which kills or injuries thousands of young girls and women. In a survey conducted in upper Egypt, over 62 percent of the girls and young women had undergone FGM (15). FGM has many complications. Immediate complications are Shock from fear, pain and haemorrhage and extensive laceration which involves vaginal, urethral opening and rectum. It affects the female child from an early age and remain with her through out her life. Tales of horror relating to the act is also another source of psychological trauma to a young girl(16). Mutilated women are reported to be at greater risk of haemorrhage in child birth because of obstructed labour and tearing of vaginal and perineal scar tissue (14).

Early marriage: Women in Africa often marry by age 16 and 17 and in some areas by 12 and 13 years(4). Growth is not complete until age 18 and the birth canal does not reach mature size until two to three years later(2). The practice is widespread in the third world countries with the highest incidence in Bangladesh; 72 percent marriage take place at the age of 15-19 years. In Africa 44 percents of marriages occur during 15-19 years where as in Latin America only 16 percent of marriages are reported to take place at that time(17). When teenage becomes a mother, she is not only at increased risk of complications related to the current pregnancy and childbirth, but she has to face long term consequences, physical, mental, and social, which impact on her health (3). Marriage by abduction or by force is common in some parts of Ethiopia. The worst type of marriage that is happening in Ethiopia is in Amhara region where marriage occurs even as early as 7 or 8 years but the girl stays in husbands families with out doing sex. The most serious effect of marriage is on pregnancy and delivery. Most of the cases in Addis Ababa Fistula Hospital are patients mainly affected during delivery due to early marriage (10).

4.Classification of Women's Health Problems:

The health problem of women's may be classified into two categories which are:

1. Maternal health problems which are directly related to child bearing and its complications such as infection, prolonged labour, retained placenta,, ruptured uterus, hypertensive disorder of pregnancy, maternal malnutrition etc.

2. The second category of women's health problems are those health problems related to the law socio-economic and cultural status of women such as sequelae of FGM, low birth weight babies, STDs/HIV/AIDS, cervical cancer and breast cancer of later years , gender violence, diseases aggravated by physical burden such as prolapsed uterus, damage to the spine and pelvis, osteoarthritis, health problems due to occupational and environmental health hazards. e.g. water-borne diseases; malaria, infections; and depression.

5. Women's perceptions towards their health:

Health service that originate from women's concerns are more likely to be sustainable and to truly improve the quality of their lives. women centered programmes are likely to be more effective because they address local needs and draw on local resources (6).

Listening and talking to women has more value and it has to be considered as an organizing principle in women's health. Communication and collaboration with local women is essential at the early stages of project design and through out the project implementation and evaluation. Talking to women increases women's awareness of their health needs. In Bolivia, the process of self-diagnosis of health needs made women more conscious of their health(6). Communication with women and learning about their perceptions about health is helpful to identify the priorities based on needs. Responses of women towards health programmes is

also a sign to the health policy makers as to whether the programmes are accepted by women or not. Women have their own perception of which health problems matter to them. These must be taken into consideration as women may prioritize their problems differently than medical staff(17).

Perceived causes of illness and the action taken as a remedy by the community and with in families may be different from what health care professionals may want to see since people may give a higher priority to their own cultural practices than to the offered health care services(17).

People often see most health problems arising from one's sin. Illness are believed to be caused by unnatural event. E.g. Complications in pregnancy are often assumed to be the results of women's sin. However, they believe that such sins can be committed both in thoughts and body(14). Excess heat, witch craft, weakness, child birth or consumption of processed foods were believed to be the causes for "white vaginal discharge".according to a study in India(7). The understanding of peoples beliefs and perception is enriching and may make the education of the health care provider more meaningful and complete(7).

1. Study Design:

The study utilized a cross-sectional epidemiological design supplemented by a qualitative technique to study women's health and socio-cultural problems.

2. Study Area:

The study was carried out in nine rural villages of Meskan and Mareko District. The nine PAs were selected out of eighty-two PAs in rural areas by a probability sampling method proportional to size and has been used as the study Base for the Butajira Rural Health Project (BRHP) since 1987. Butajira is situated in Meskan and Mareko District, Southern Nations, Nationalities and peoples Region. Geographically, the district is divided into lowland with tropical climate and highland with temperate climate. The total population of the district is about 227,135 (18). The district is the most densely populated area with 239 inhabitants/km^2(18). The male female ratio is almost equal. Eighty seven percent of the population reside in rural villages and depend upon cattle breading and subsistence farming. The district has one health centre, two health stations, four health posts and four rural drug vendors. A district hospital is under construction and is expected to be functional in the near future.

3. Study Population:

3.1 Source Population.

The source population for the study were women residents in rural villages of Meskan and Mareko district.

3.2 Study Subject.

The study subjects for the interviews were women residing in the nine PAs. Never married girls living with their parents were excluded and women 15 years and over, permanent resident, married or living alone in a separate household were included in the study.

4. Data collection:

In order to obtain an overall insight of the women's situation and to generate relevant information for developing a survey questionnaire a qualitative method was employed. In depth interviews and FGD were conducted with local women in the highland and lowland areas, and with women experts in the women's affairs bureau in the district. A structured survey questionnaire was prepared in English and then translated into Amharic. The quantitative data was collected by eight female high school graduate data collectors and their supervisor from July 29 to August 10, 1998.

The questionnaire was designed to collect information on women's socio-economic status, work pattern, reproductive health, common harmful traditional practices in the locality and decision making status of women in families. The questionnaire had been repeatedly and carefully revised before it was let for pre-test. In order to increase the reliability of the data, the data collectors and their supervisor were trained for one week. An intensive discussion had been held on the detail of the items and on how to use the instrument. Since the data quality is very dependent upon their skills, peer interviews among the interviewers were repeatedly practised. In addition, the data collectors were advised all the times to follow the instructions provided, to be polite, non judgemental, non leading and able to establish rapport with the study subjects. After the pretest outside the study area further modifications were made on the survey questionnaire. Difficult and unclear questions were simplified. A skipping pattern was adjusted accordingly. The questionnaire formats checked for their completeness and clarity. During the survey continuous feed back was exchanged between the data collectors and supervisors. The collected data have been inspected on daily basis for completeness by the principal investigator and a designated supervisor.

5. Sampling:

The women were selected in each PA using simple random sampling. The BRHP provide the sampling frame. The sample size was calculated using the formula for single proportion. The following were assumed for the calculation; a 50 %

prevalence of common socio-cultural problems with 95% certainty and expected difference of 4% between the sample and population.

The sample size calculation:

Given: $\text{Alpha}(\alpha) = 0.05$

$Z\alpha/_2$ for $(\alpha = 0.05) = 1.96$

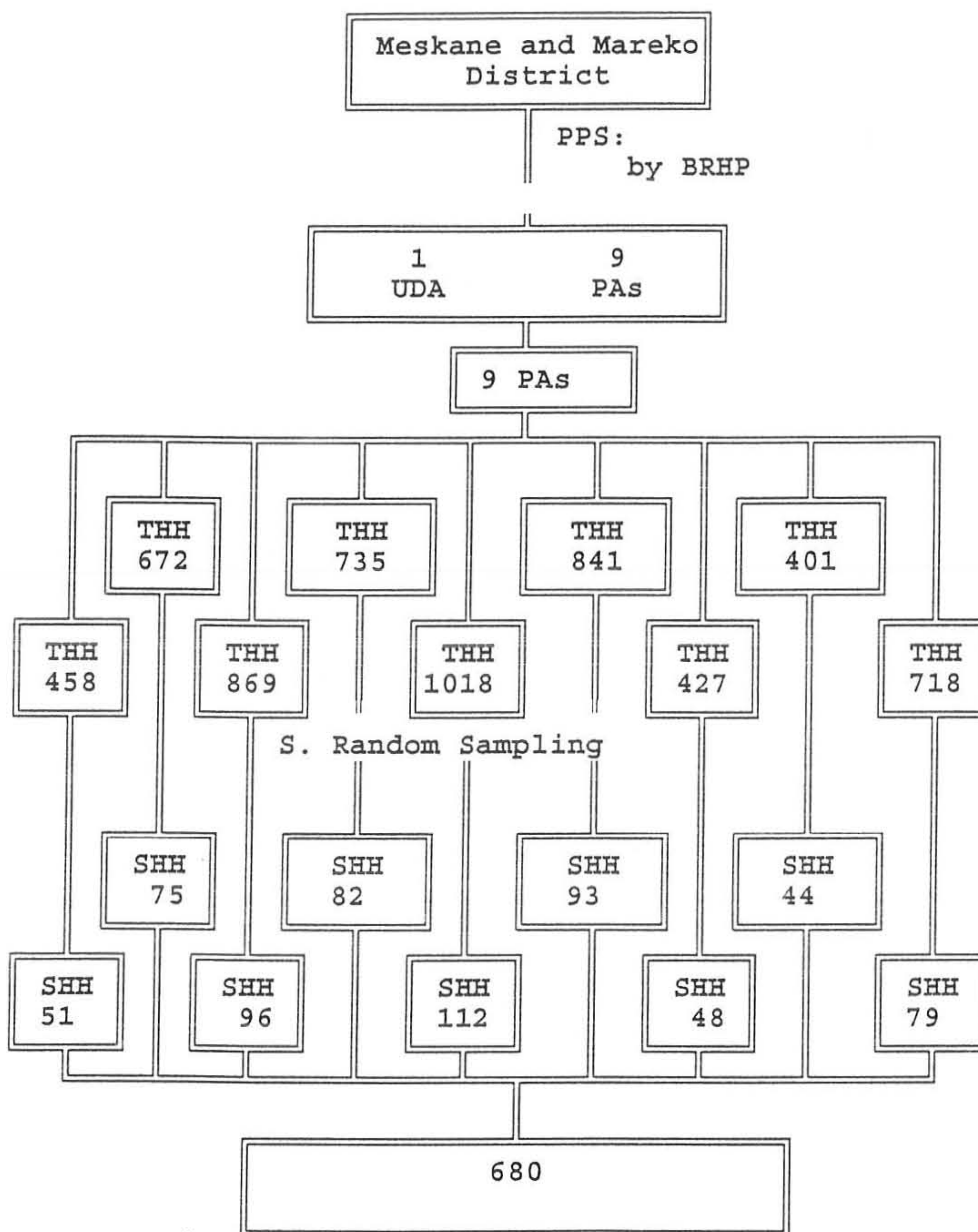
P(Proportion) = 0.5

d(margin of error) = 0.04

$$n = \frac{(1.96)^2 \times 0.5\ (1-0.5)}{(0.04)^2} = 600$$

600+15% contingence = 680

Figure 1. Schematic Diagram of Sampling Frame



Key Words:

PPS=Proportional to Population size
UDA=Urban Dwellers Association
PAs=Peasant Association
THH=Total Households
SHH=Sampled Households.

ETHICAL CONSIDERATION

Ethical clearance is obtained from the Faculty of Medicine, Addis Ababa University. An informed consent was obtained from each interviewee prior to the session. The indepth interviews and FGD were conducted by the principal investigator and a trained note taker in a complete privacy. The information collected and the issues raised in the discussion were all kept confidentially. The Collected data have been placed only in the reach of those people involved in the study.

DATA ANALYSIS

The data was entered and processed using Epi Info Version 6 statistical package. The data cleaning completed. Frequencies and percentages were calculated on all variables that are related to the objectives of the study.

RESULT

1. Demographic characteristics of the women:

A total of 675 women participated in the study. Of them 529(78.4%) live in a male headed household. Over 70% of the respondents were women in their reproductive age. The major ethnic groups were Meskan(46.4%) and Siliti(23.4%). Five hundred twenty(77.0%) of the women were Moslems and the rest 155(23.0%) were Christians. The majority(94.5%) of the women were illiterate. About 86% of the women are in marital union, 57.9% in monogamous and 28.0% in polygamous marriage. Mean($\pm$SD) age at first marriage was 16($\pm$2) years. About 80% of the women were housewives. The rest 20% are engaged in some kind of activity outside the house like farming and trading (Table 1).

Table 1.Demographic characterisitics of the women. Butajira. 1998.

Characteristics	Number	Percent
Household head		
Female	146	21.6
Male	529	78.4
Age group (in years)		
15-19	7	1.0
20-29	167	24.7
30-39	203	30.1
40-49	105	15.6
50+	153	22.7
Not stated	40	5.9
Ethnicity		
Meskan	313	46.4
Silti	158	23.4
Sodo	74	11.0
Mareko	67	9.9
Dobi	16	2.4
Wolenae	10	1.5
Others	37	5.4
Religion		
Moslem	520	77.0
Christian	155	23.0
Education		
Illiterate	638	94.5
Read and write	12	1.8
Attended school	25	3.7
Marital Status		
Married, monogamous	391	58.0
Married, polygamous	189	28.0
Widow	70	10.3
Separated	21	3.1
Divorce	4	0.6
Occupation		
House wife	541	80.1
Trader	93	13.8
Farmer	34	5.0
Other	7	1.0

2.Marital Information and Husband education situation of women in rural Butajira.

For 619(91.7%) of the women, decision on whom to marry and when to marry was made by the parents, usually the father. Considerable proportion of women(7.4%) were kidnapped and forced into marriage without their interest/will. Majority, 523 (77.5%), of the women are living with their first husband. Many of the women are married with illiterate (70%) and with farmer(91.7%) men.

Table 2. Marital Information and Husband education situation of women in rural Butajira. 1998.

Condition of First marriage	Number	Percent
- Parental decision	619	91.7
- Abducted/kidnap	50	7.4
- Own decision	6	0.9
Living with the husband		
- Yes	523	77.5
- No	152	22.5
Husband education		
- Illiterate	408	70.3
- Read and write	84	14.5
- Attended school	188	15.2
Husband occupation		
- Farmer	532	91.7
- Farmer and trader	32	5.2
- Trader	9	1.6
- Other	7	1.2

*Total do not add up to 675 because of none response.

**Age at first marriage(years)mean $\pm$ S.D = 15.97 $\pm$ 1.98

3.Child Education:

Out of the 463 women with children above five years of age at home, 64 of did not have daughters. Of the remaining 339 women (80.7%) did not send their girls to school. The main reason was that girls usually assist at home. Other reasons included were schools are far away and priority is given to marriage. Only 10.5 of the women reported that they send all girls to school. Out of the 479 women women who had above five years old boys 41.8 percent reported that they did not send the boys to school. Among the reasons for not sending the boys to school assisting in the farm was prominent. About 39% of the women said that they let boys to go to school.

Table 3. Child Education Situation in Butajira, 1998.
*Analysis include women with at least one child above 5 years age.

n=463 **Send daughters to school:****	Number	Percent
- Do not send	322	80.7
- Send all	42	10.5
- Send some	35	8.8
Total	**399**	
Reasons for not sending girls to school:		
- They assist at home	103	32
- Schools are too far	55	17.1
- Priority is to marriage	52	16.1
- Don't see the use	50	15.5
- Expensive sch. fee	46	14.3
- Fathers'opposition	7	2.2
- Schools spoil girls	6	1.9
- Girls assist in farm	3	0.9
Total	**322**	
n=479 **Send Boys to school:*****		
- Do not send:	200	41.8
- Send all	188	39.2
- Send some	91	19.0
Total	**479**	
Reasons for not sending boys to school:		
- They assist in the farm	47	23.5
- Expensive sch.fee	24	12.0
- Do not see the use of schooling	47	23.5
- School is far away	38	19.0
- Boys assist at home	37	18.5
- Priority is to marriage	4	2.0
- Fathers oppose	3	1.5
Total	**200**	

**The 64 respondents said that they have no daughters.

***The 52 respondents said that they have no sons

4.Women's Work Situation In Rural Butajira:

The mean working is 15 hours with in 24 hours for women in the study. Sixty eight percent of the respondents replied that they felt like their health is not affected by the work load. In the contrary, 14.8% of them remarked that their health is affected and 10.1 of them said their health is seriously affected by the amount of work they are doing. Those who felt (n=216) that their health condition is affected by heavy work were further interrogated to mention the type of health problem they are encountered with. Abdominal pain including prolapse of uterus was mentioned as a priority problem by 85.5 percent of the women. About 55 percent of the mothers said that the routine work was reduced in their last pregnancy. About 87% reported being relieved from their routine work after delivery.

Table 4. A Table showing the Work Situation of Women in Butajira, 1998.

Perceived effect of work load on health n=675	Number	Percent
-Has no effect on health	459	68.0
-Has effect on health	100	14.8
-Has serious effect	68	10.1
-Affects to some extent	48	7.1
Perceived illnesses indicated due to work load:-n=216		
-Abdominal pain & uterus prolapse	185	85.5
-eye Disease	21	9.8
-Joint pain and leg swelling	10	4.7
Work load during pregnancy and after delivery.(n=657)		
work load reduced during pregnancy.		
- Yes	364	55.4
- No	293	44.6
work load reduced after delivery		
- Yes	569	86.6
- No	88	13.4

5.Health Care Utilization:

Among the women who replied that they have been visiting a near by health unit (576), about 58.5 % of them said that they went for child illness, the 18.9 % for their own treatment and the 13.4% visited for their husband's illness. It was only 7.1 percent of them who went for delivery. Only 2.1 % of women in the study said that they went for child vaccination.

Table 5. Reasons for visiting Health Institutions by women in Butajira, 1998.

n=576

Reasons for the last visit at a health unit	**Number**	**percent**
-Child illness	337	58.5
-Own treatment	109	18.9
-Husband's illness	77	13.4
-For delivery	41	7.1
-Child vaccination	12	2.1
Total	**576**	100

6.Perceived Causes of illnesses by women in Butajira:

Basing the list of commonly available illnesses indicated by the key informants through the pilot preliminary qualitative study, a question was forwarded asking about perceived causes of illnesses by the respondents. For infectious diseases such as Malaria, Pulmonary Tuberculosis(Samba),Scabies and Diarrhoea perceived causes include, insects or flies bites, exposure to cold (Berde),less resistance due to lack of nutritious food (Gudat),God's punishment, consuming unpleasant food or drink and evil eye were mentioned as major causes. For illnesses related to pregnancy perceived causes include like accidental fall, less resistance due to lack of food (Gudat),heavy work load and physical problem like narrow pelvis were indicated. In the case of mental illnesses excess worry was believed to be the cause by 56.2 % of the women. Poverty(" Dehenet") was also considered as responsible to cause mental illness.

Table 6. Perceived Causes of Illnesses By Study Participants in rural Butajira, 1998. (n=675)

Illness	cause	number	percent
1.Infectious			
Malaria	Insects/flies	319	47.2
	exposure to cold	209	31.0
	less resistance/ Lack of food/Gudat	147	21.8
Samba (Pulmonary TBc)	lack of nutrition	294	43.6
	Exposure to cold	150	22.2
	Evil spirit/ evil eye	134	19.9
	Insects/flies	97	14.3
Scabies	God's punishment	299	44.3
	lack of cleanliness	276	40.9
	Unknown to us	100	14.8
Diarrhoea	Eating unpleasant food	456	67.6
	Unknown to us	158	23.4
	Evil eye	61	9.0
2.Obstetric			
Bleeding in pregnancy			
	Unknown	228	33.8
	Accident/falling	188	27.9
	Lack of food/less resistance/Gudat	163	24.1
	-Mitche	96	14.2
Retained Placenta			
	God's punishment	276	40.9
	lack of food/less resistance (Gudat)	241	35.7
	heavy work load	138	20.4
	Evil spirit/evil eye evil tounge	20	3.0
Prolonged labour	Lack of nutrition	313	46.4
	unknown to us	189	28.0
	God's punishment	110	16.3
	Evil spirit/ evil eye	14	2.1
	inadequate Pelvis	49	7.2
3.Mental illness.			
	Excess worry	380	56.3
	poverty(dehent)	167	24.7
	Unknown to us	73	10.8
	Evil spirit/ evil eye	55	8.1

7. Women's Coping Strategy:

Besides the perceived causes of illness the women were asked to explain the first measures to be taken in case they themselves or others are sick due to the listed illnesses. Consumption and application of herbal medications, doing Tellel, slaughtering animals as Chida were the prime action taken according to the study participants. However, considerable proportion of women go to the near by health institutions and drug shops(Table 7).

Table 7. First Measures Taken to cure Common Illnesses by Women in Butajira, 1998. (n=675)

Infectious Illnesses	**number**	**percent**
Malaria		
consuming herbal med.	453	67.1
Visit a health center	117	17.3
Resume prayer(Dua)	105	15.6
Vaginal Discharge		
Tellel or chida	168	24.9
visit health center	135	20.0
Use herbal medication	354	52.4
unknown	18	2.7
scabies		
Apply herbal med	337	49.9
Visit health institutes	120	17.8
Keep personal hygiene	102	15.1
Telle or chida	62	9.2
Do nothing	54	8.0
Diarrhoea		
Buy tabs	276	40.9
consuming herbal med	246	36.4
visit health unit	153	22.7
Pulmonary Tb. (Samba)		
visit health unit	325	48.1
Go to witch craft	159	23.6
Take nutritious food	191	28.3

Continued...

Obstetric Illness		
Bleeding in pregnancy		
Telle or chida	378	56.0
Consuming herbs	167	24.7
Visit health unit	130	19.3
Prolonged labour		
Go to traditional healer	281	41.6
Visit health center	172	25.5
Resume prayer	222	32.9
Mental illness		
Telle, chida or holy water (Tebel)	279	41.3
Go to witch craft	396	58.7

Continued...

Obstetric Illness		
Bleeding in pregnancy		
Telle or chida	378	56.0
Consuming herbs	167	24.7
Visit health unit	130	19.3
Prolonged labour		
Go to traditional healer	281	41.6
Visit health center	172	25.5
Resume prayer	222	32.9
Mental illness		
Telle, chida or holy water (Tebel)	279	41.3
Go to witch craft	396	58.7

8.Harmful Traditional Practices:

The common harmful traditional practices according to the information obtained from the key informants were FGM and the nail extraction. Women in the village (91.5%) experienced FGM on themselves, on their daughters and on other women of the community. Almost all respondents (96.6%) said female circumcision is good. The main reason according to the women (51.5%) was because it is a culture to remain untouched. There were women who supported (22.1%) FGM for females because girls will get good food inorder that the wound is rapidly cured and that indirectly helps the children to grow better. Others (11.3%) said that it is a sign of honour to the family and to a sign of purity to the girls otherwise girls are insulted (15.0%) if not circumcised. The second practice is the nail extraction of young girls few months before marriage. Women were asked about their opinion to continue or not to continue the procedure on the young girls. Sixty eight percent of the women said that it should not. The main reason given for its discontinuation was that it causes severe pain, bleeding ,infection and deformity. Those who liked the practice (31.0%)to continues stated that girls are more beautiful after the procedure. The remaining respondents said that it is already an out dated practice(Table 8).

Table 8. Experience of women on Harmful Traditional Practices. Butajira, 1998.(n=675)

Traditional Practices	number	percent.
Experience on FGM. n = 675		
- On my self, on girls and other women	618	91.5
I have no experience	57	8.5
Acceptance of FGM n=675		
- I accept	652	96.6
- I do not accept	22	3.3
- I do not know	1	0.1
Reasons for accepting n=652		
- It is our culture	336	51.5
- Girls get good food	144	22.1
- It is a sign of honour and purity	74	11.3
- Girls will be insulted	98	15.0
Experience on Nail Extraction.		
- On my self,on girls & other women	608	90.1
- I have no experience	9	1.3
- It is outdated	58	8.6
Acceptance of Nail extraction		
- I accept	209	31.0
- I do not accept	460	68.1
- I do not know	6	0.9
Reasons for accepting n=209		
- Girls are more beautiful	169	80.9
- It is our culture	40	19.1
Reasons for not accepting. n=460		
- It is painful,causes bleeding,deformity or infection	348	75.7
- It is out dated	112	24.3

9.House hold Decision Making ability of Women in rural Butajira:

With regard to the decision making of married women at a house hold level, 87.4% of the respondents said that the suggestions of their husbands is more valuable by the family members than the suggestion of wives. Both husband and wife decide on visiting friends, taking children to a health unit, on marriage of youngsters, child education, and child discipline. However, about 88 % of the respondents said that they seek permission from their husbands to visit a health unit. Purchase of house hold commodities mostly done by women.

10.Access to Public Information:

The majority women (88.3%) have never listened to the radio. Women also were asked about participation in women's association. About 39 % said that they had never been participating and almost 37% reported they had sometimes.

Table 10. Access to Public Information and additional finding of interest for women in Butajira, 1998. n = 675

	Number	Percent
Listening to the radio for the last six months.		
- Yes always	35	5.2
- Yes some times	44	6.5
- Never listen	596	88.3
Participation in women's association for the last six months.		
- Yes always	165	24.4
- Yes some times	249	36.9
- Never participate	261	38.7
What will happen to childless women in your community?		
- Nothing happens	113	16.7
- Husbands bring another wife	321	47.6
- women have subjected to divorce	56	8.3
- No one takes care of them	185	27.4

DISCUSSION

In general, the results obtained from this study are consistent with similar studies done in other part of the world on the same problem. Though the result of the study may not be considered representative for the rural women in Ethiopia, it has shown the overall picture of the health and socio-cultural problems of women in Meskan and Mareko district. It is also reflecting the health and the socio-cultural problem of women in the country. More over, such a study could create curiosity in the minds of health professionals, health policy makers, women's organizations and development planners and community organizations to see to the women's health at a broader perspective. The majority study subjects were married monogamous yet polygamy is a common practice in both Muslim and Christian families. The practice of polygamy is always a threat from the women's point of view and may result in jealously, insecurity, and instability(16). The coming of a new wife is always harassing and upsetting to the previous women.

The women hardly decide on their own marriage. Some women are still abducted. Girls marry at a young age. These factors are the reflection of low status of women in the society and a crucial factor in the increased risk of mortality due to pregnancy related conditions. A similar observation was made in a study conducted in Somalia (16).

The study has shown that boys have better chance for education. That may be the reason why literacy among men usually rose faster than that among women. Women in almost every country are less educated than men (2). The women's educational status might have influenced the measures they are taking in dealing with health issues. " Education is perhaps the strongest variable that affects the status of women. It is a key requirement for ensuring their empowerment and enhancing their ability to make decisions on their own lives. Therefore, girls education needs a special emphasis. Priorities should include efforts to expand girls' enrolment in schools and adopt measures to allow girls remain in schools and prevent dropout(3). The perception of women about health and illness could also be affected due to the level of awareness which could be determined by the level of education. Though different reasons such as expensive school fee and far distance of schools in the area were given as additional ground, the main reason told by the women in the study for not sending girls to school was their engagement with house work. Laborious activities such as "Kocho"processing from false banana plant and pepper plantation are usually performed by women besides the other farm activities. According to the finding from this study almost two third of the women's time in 24 hours is allocated for work. The life time and lengthy working hours and the routine duties that demand a great deal of physical work might affect the health of women(4). Too much work can strain a women's body and might make her too weak to withstand the physical demands of pregnancy and child birth(4). Many women in the study reported that work

is not reduced because of pregnancy. Women should be taught to avoid heavy physical work during pregnancy. Other family members should also be encouraged to assist women with work. But most women in this study could not imagine that the work they are doing is affecting their health in any way. Those women who noted the consequences of excess work mentioned health problems that are more or less similar with the illnesses reported else where(4). Physically demanding work during pregnancy can cause miscarriage, premature labour or under weight infants especially if a women is not eating enough(4).

Women in rural Butajira do not decide on important issue concerning their lives or their health. Suggestions and voices of husbands in every circumstances are more valuable and acceptable in families. The study showed that most women ask for permission even to visit a health institution during sickness. In case the husbands are not interested the wishes and interest of wives may not be fulfilled. Therefore women advocates at a local level should work with the community, rural women and governmental and non-governmental organizations so as to increase awareness on the issue in the community.

FGM is a common harmful traditional practice performed on young girls. The result has shown that almost all women have experienced FGM on themselves and witnessed it happening on others. The women still wanted it to happen since it is their tradition which should neither be violated nor changed. The most

prevalent reason for the continuation of the practice is the same as the reasons given in other studies (14). A group of women in this study also stated that girls could get good food when they are circumcised thus it has an advantage. The health hazard of FGM is well evidenced. Yet it is still strongly accepted and seems untouchable in rural Butajira. Finger nail or toe nail extraction of girls some months before marriage has been a controversial issue. As that of FGM, most of the women have experienced it on themselves and had seen it happening on others but they said that it is rarely practised at present. Since it is believed to cause unnecessary bleeding, infection and deformity it is already replaced by nail polish. This shows that the society has gradually understood the health consequences of such a harmful tradition. The reason for nail extraction as per the key informants is that engaged girls will be more beautiful and more attractive when they are exempted from work and well fed for the wound to heal before marriage. Though women have a lot of health problems, there are women who never visited a health center at all. Women usually visit a health center when their children are sick. This should be used as an opportunity to talk to women, to teach them or to treat them. Rural women may not have time or interest to deliberately visit a health unit. The health professional must contact women whenever it is convenient for the women to come to the health institutes. It is estimated that 70- 90% health care takes place with in the popular sector of health care in which the main arena of health care is family and women are the main actors (24).

Women's perception may reflect their experiences, beliefs and general understanding of a situation. In families, women, usually mothers, tend to diagnose common illnesses and treat them with the materials at hand. Women in rural Butajira have a lot of things to do. They go to the witch craft. They resume prayer with or with out consulting religious leaders. Women do "Tellel". Tellel as described by the key informants is a procedure done by the women alone inorder to please the unnatural power; when they feel that their own spirit, the spirit of their parents or ancestors is angry with them and makes them sick or infertile. Tablets and capsules are misused. For infectious diseases like Diarrhoea, the respondents said that Tetracyclines capsules are simply bought from shops with out consulting a health worker. The same thing is true for Malaria. White tablets are bought from ordinary shops. This could not be helpful or it could even be hazardous to health. Going to a health unit is usually a last measure taken to solve a health problem by most women in the study. Some of the action taken by the women are typically dangerous to health and lives. For instance, women resume prayer or prefer to go to a traditional healer when a woman is bleeding in pregnancy or suffering from prolonged labour. This is indicating that the traditional healers, the witch craft or the religious leaders are more accepted and are consulted first and their involvement in the health matter has to be considered by the health professionals. Husbands have more tendency to bring another wife whenever their spouses fail to have children. Some women are also subjected to divorce if they can't give birth. Child less

woman in general have no guarantee in life. According to the key informants the rural women in Butajira have a great desire to have many children. They strongly believe that a women is entirely meant to rear and bear children. Such an attitude might have contributed to the demand of having many children and to increase fertility. Rural women in Butajira have less access to information. More than 88 percent of the women in the study reported that they have never been listening to the radio for the last six months. Surprisingly enough, some women have never listened to the radio. Most women were not participating in associations. This needs a due consideration by the local women advocates and women's associations to let the rural women get organize themselves.

Limitations of the study:

1. Due to the detailed and complex nature of the problem, it is unlikely that the social problems affecting the health of women in rural Butajira are exhaustively investigated.

2. Though a careful attempt has been made to effectively use both the open ended and closed ended questions, the open ended questions were difficult to be fully understood by every respondent as well they may not be administered in the same way by every interviewer.

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3. Since the study was attempting to see the over all situation of women including their decision making ability especially at a house hold level, unmarried, younger women who are free from family responsibility, women who were dependent on their families or relatives including older women in families were excluded from the study. Therefore the responses of all variety women could not be obtained.

CONCLUSION

This study has demonstrated that women in rural Butajira are exposed to the social problems affecting health such as high level of illiteracy, exposure to harmful traditional practices, exposure to long hour of work and limited decision making ability. Further more, the women's perception towards health and illness as well as their general health seeking behaviour are too traditional. The women give the at most priority to their cultural practices inorder to solve health and reproductive related problems. Eventhough there are few actions and beliefs which could be encouraged like replacing nail extraction by the nail polish , in most instances the understanding of the local women towards health, illness, causes of illness and towards measures taken during illnesses are far away from the modern concept of health. The tradition in rural Butajira still give a high value to fertility. Many of the women are still intimidated by polygamy. They have a very limited access to information. Therefore taking into account what women believe about health and what they say about their health problems and needs, how they would like to solve their problems in the health services has an enormous importance to serve as a foundation and in improving their health.

RECOMMENDATION

1. A multitude of traditions and social factors surrounded the health of women in rural Butajira. Information is yet scares on the social and cultural problems influencing the health. Therefore the local health bureau and the health professionals needs to be aware of the broader perspective of women's health beyond MCH services. Further studies should continue to solicit sufficient information on the perception and coping strategies of the women.

2. The over all health IEC strategy needs to include aiming at the women to change their perceptions, belief and action towards health and causes of illness and the social problems affecting health. Such strategies should be based on local problems and encourage the involvement of locally accepted leaders.

3. The process of emancipation towards empowering women especially in rural areas should be a priority and intensive work by all concerned governmental and non governmental organizations, political bureaux, development planners, community organizations, health policy makers and women's associations both at the national, regional and local levels. For the long term improvement of women's health a special emphasis should be given to girls education through devising a special strategy. Efforts must be consolidated to encourage income generating scheme is enabling women be economically independent.

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Annex 1.

LIST OF DEFINITIONS.

1.**Berde**= The French concept of "courant d'air"(current of air, draught) as a possible cause of illnesses shared by most Ethiopian. Eg.Pneumonia (23).

2.**Chida**= An animal (sheep, goat, hen, etc.)ready to be slaughtered usually by the order of a witch craft when a person is sick.

3. **Dehenet**= A local term used to describe poverty.

4. **Dua**= is a prayer usually done in a group by religious people and locally accepted older men and women. Dua mostly is accompanied by Kchat chewing to focus in prayer or to stabilize emotion.

5.**Gudat**= A saying to describe less resistance especially due to lack of nutrition, illness or heavy work load.

6.**Mitche**= An illness caused due to sudden exposure to sun light after eating spicy food or drink like coffee and with out proper washing of hands and mouth.

7. **Samba**= A local term to describe Pulmonary Tuberculosis.

8.**Tebel**= A term used to describe holy water.

9.**Tellel**= is a procedure done by the women alone when they feel that their own spirit or the spirit of their parents is angry with them and makes them sick or infertile. Some amount of local cheese is prepared and sufficient amount of spicy and melted butter is poured on it. The butter is used as a mirror to show the sick women's face through. The women belief that when they look at their own faces through the butter as a mirror the bad spirit will go out of their body. The butter and cheese after the procedure is eaten by the sick women. In case it is excess she is assisted by small children under five.

Annex 2

AN INDIVIDUAL IN-DEPTH INTERVIEW QUESTIONNAIRE FORMAT. TO STUDY HEALTH AND SOCIO-CULTURAL PROBLEMS OF WOMEN IN BUTAJIRA.

This questionnaire format is to be used by an expert interview who wishes to get a required in depth information on issues of interest by interviewing an individual believed to be a resource person.

INTRODUCTION:

Introduction of self and purpose of the interview.

Ask for permission to tape or record the interview in any form including the reason for doing so.

Be sure whether the permission is obtained or not.

GENERAL SITUATION:

1. According to your view, what are the common problems that women face in this community these days? (Probe for different kinds of problems, ask for examples, probe for reasons or causes). * Accompanied by a free listing format.

2. What do you see or think as the women's most important needs? * Accompanied by a free listing format.

HEALTH SITUATION

3. In your opinion what does health mean?

4. When do you say that a woman is healthy? Give a story of a woman whom you may think is healthy.

5. How do you know that a woman is not doing well? Give an example.

6. What are the different kinds of health problems that a woman in this community face at this time? Please try to mention all what you know or have met yourself in your practice. Give examples. * Accompanied by a free listing format.

7. What are the complaints that a woman would make for the health problems that you have mentioned? (Specify for each problem.)

8. In your opinion, what are health problems or illnesses that you have mentioned? (Specify for each problem).

9. What are the health problems or illness which you think are considered difficult or shameful for a woman to talk about openly in your community? (Probe for Metaphors used).

10. What will happen to women if it is revealed that she has this kind of health problem? (Probe for example and ask a story).

11. Could you describe any health hazard related to domestic violence affecting the health of women? What is regarded as a violence in your community?

12. What do you like to say about a type a treatment you are getting and about the attitude of health workers in health institutions in a community? (Probe for reasons they are pleased about and for reasons they are unhappy).

COPING STRATEGIES:

13. What do women do when they are ill? (Probe for different type health care seeking behaviour, self treatment, traditional healer or medical care).

14. What are the reasons for choosing the different options? (Interms of problem type, cost, distance, taboos, stigmatization, belief).

15. How does the family cover expenses for the care needed to solve health problems? (Probe for differences b/n family members age and gender give examples and probe for reasons).

16. What do women do to keep their health and prevent diseases in your community?

DECISION MAKING:

17. When a person in a family is seriously ill, who makes the decision to take him or her to the health center? (Probe on difference by illnesses and gender. Probe for reasons, request for a specific story).

18. How are decision made for serious health problems during child birth? (Probe on timing, cost, center of decision. Probe for reasons request of a story.)

19. If a women is sick who will decide for the cost of treatment?

20. Who is the most important person in the household? Why?

21. Who is making important decisions like marriage of youngsters in the family?

22. How is the pattern of labour division in the families of this community. (Probe for household chores, for farming).

NUTRITIONAL TABOOS:

23. How is the feeding pattern of families in the community?

24. Do women and men eat together? What about children? Do you serve the same food for every family member? If you serve different foods how is that? Who is served the best food?

14. What are the reasons for choosing the different options? (Interms of problem type, cost, distance, taboos, stigmatization, belief).

15. How does the family cover expenses for the care needed to solve health problems? (Probe for differences b/n family members age and gender give examples and probe for reasons).

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23. How is the feeding pattern of families in the community?

24. Do women and men eat together? What about children? Do you serve the same food for every family member? If you serve different foods how is that? Who is served the best food?

SUGGESTION FOR CHANGE:

25. What suggestion you like to make to improve the health of women in the community?

26. Is there any thing that you would like to add upon the issues we have been discussing so far.

Annex 3

A FOCUS GROUP DISCUSSION GUIDE TO STUDY THE HEALTH AND SOCIO-CULTURAL PROBLEMS OF WOMEN IN BUTAJIRA. 1998.

Theme I. **warm up Questions:**

1. According to your view what are the common health problems encountered by the community you are living in?
2. What is your opinion about the differences between the health of women and the health of other people in a community and in a family?(Accompanied by free listing form.)

Theme 2. **Health problems:**

3. What are the different kinds of health problems that women in your community face this days?(Please try to mention all what you know or have met your self in your experience?)

Give example:

3 a. When do you say a women is healthy?

3 b. How do you know that a women is not doing well? 3 c. What are the complaints women made?

3 d. What are the diseases considered shameful to women to discuss them freely? (Probe for metaphors).

(Probe for what will happen in case a woman is having that disease and when people came to know she is possessed).

4. In your opinion, what are the causes of ill health in your community?

Theme 3. **Coping Strategies:**

5. What do women do when they are sick? Do they go for a medical care or to traditional Healers? What about other places? What are the **reasons** for choosing the options?

    *Probe for social reasons.

    *Probe for economical reasons.

    *Probe for Geographical reasons.

    *Probe for health providers attitude and discipline.

    *Probe for service availability and quality.

    What is the cost variation?

6. What do women do to keep up their health?

    (Probe for specific activities and for the reasons doing each action).

Theme 4. **General situation in the household:**

7. In the family, who is responsible for permitting the use of money in case a family member is sick?

8. Who is the most important person in a family in making very important decisions like marriage and resource utilization?

Theme 5.**Suggestion:**

9. What suggestion do you like to make inorder to improve the health of women in your community?

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A Survey Questionnaire to study the Health and Socio Cultural Problems of women in Butajira, July, 1998.

Annex 4.

No	Question	Response category	Code
I.	**IDENTIFICATION DATA**		
101	Name of PA		
102	Household number		
103	Name of household head		
104	Household sex	1=Male headed 2=Female headed	
105	What is your name?(interviewee)		
106	What is you age?(in completed years)		
107	What is your ethnicity ?	0. Welwne 1. Sodo 2. Dobi 3.Meskan 4. Mareko 5. Silti 6. others	
108	What is your religion?	1. Orthodox 2. Muslim 3. Catholic 4. Protestant 5. No religion 6. Others	
109	What is your educational status?	1 00=Illeterate 2 66=Read and write 3 □ □ = grade completed	
110	What is your marital status?	1□ Married monogamous 2□ Married two wives 3 □ Married thrid wives 4 □ Married fourth wife 5□ Divorced 6. Separated 7. Others	
111	What was your age at first marriage?	----- Years	
112	How did your first marriage arranged?	□1. Self □2. Abducted □ 3.Arranged by Father □ 4. Arranged by Mother □ 5. Aranged by both Father & mother □6 other(Specify)	
113	Are you in your first marriage? If the answer is "Yes" skip to ques.115	□1. yes 2 No.	
114	If you are not in your first marriage, how many marriages did you committee?		
115	What is your occupation (more than one response is possible)	1. House wife 2. Family dependent 3. Farmer 4. Petit trade 5. Others	

	Information about husband (Ask to those currently in marriage.)		
116	What is the educational status of your husband?	1 00=Illeterate 2 66=Read and write 3 □□ = grade completed	
117	What is the occupation of your husband?	1.□ Farmer 2.□ Trading □3. Both farmer & trader □ 4. Other(Specify)	
118	What is the age of your husband?		
119	Does your husband have currently another wife?If the answer is No skip to ques.122	1. Yes 2. No	
120	How many wives does your husband have?		
	Information about children		
121	How many children do you have, currently living with you?	1. Males 2. Females 3.total 4. I have no children.	
122	How many people currently live in your household ?	1. Males 2.Females 3.Total	
II	**INFORMATION ABOUT CHILDREN EDUCATION. ASK THE WOMEN WITH CHILDREN ABOVE 5 YEARS..**		
123.	Do you send girl children to school? (If the answer is I Have no girl children skip to ques.128)	1. yes all 2.yes some 3.No 4 I have no girl children.	
124	If the answer is NO what is the reason?	1. There is no near by school 2.Do not afford school fee. 3.Priority is for marriage 4. Going to school is not safe. 5.Girls asssist at home 6.Husbands object the idea. 7. Girls assist in the farm. 8.Education is not needed. 9. Other specify,	
125	If you are sending some ,what is the reason?	1. There is no near by school 2.Do not afford school fee. 3.Priority is for marriage 4.Going to school is not safe. 5.Girls assist at home. 6 Husbands object the idea. 7.Girls assist in the farm. 8.Education is not needed. 9. Other specify.	
126	Do you send boys to school? (If the answer is I have no boys , skip to ques.131)	1.Yes all 2.Yes some 3.No 4.Have no boys.	
127	If you are not sending all of them , what is the reason?	1. There is no near by school 2.Do not afford school fee. 3.Priority is for marriage 4.Going to school is not safe. 5.Boys assist at home. 6 Husbands object the idea. 7.Boys assist in the farm. 8.Education is not needed. 9. Other specify.	

128	If you are sending some of them , what is the reason?	1. There is no near by school 2.Do not afford school fee. 3.Priority is for marriage 4.Going to school is not safe. 5.Boys assist at home. 6 Husbands object the idea. 7.Boys assist in the farm. 8.Education is not needed. 9. Other specify.	
III	**INFORMATION ON WORK SITUATION.**		
129	What time do you normally start work in the morning ?	_________ hours	
130	What time do you normally finish work in the evening?	_________ hours	
131	Do you think that your work has affected your health?	1 Yes, very much 2, Yes, much 3 Yes, to some extent. 4. No, it does not.	
132	If the answer is Yes , what is the health problem?		
133	how do you cope with heavy work load at home like preparation of I Enset?	1. Hire assistance 2.Work with other group of women. 3. Men assist us. 4.Other (specify.)	
IV	**QUESTIONS FOR WOMEN WHO HAVE BEEN PREGNANT AND GIVE BIRTH. 139-145.**		
134	Have you been free from work during your current pregnancy?	1. yes 2. No	
135	If the answer is yes for how many days?	_________ days	
136	Have you been free from work during your current perperium?	1. yes 2.No	
137	If the work load was unusual what was the reason?		
138	For how many days were you specially treated during your first perperium?	_____________ days	
V	**ABOUT FERTILITY AND CHILD CARE.**		
139	Who is at first called to attend delivery in your community?	1.TTBA 2. women from neighborhood 3 relatives 4 TBA 5.other specify.	
140	Have you been delivering at the health center? (If the answer is no skip to question 150)	1. yes 2.No	
141	If the answer is "Yes" , how did you travel to the health center?	1. On foot 2. Carried by people 3. By car 4. by animal cart. 5.Other specify	
142	After how many days of labor were you taken to the health center?	1. One day (12 hours) 2.One day and one night 3.Two days (48 hours) 4. three days and more.	
143	Who is assisting you in taking care of your children?	1.Girls 2.Boys 3.Husband 4.Relatives 5. Neighbor women 6. Other specify	
144	Who is assisting you in taking care of children when you are delivering ,sick or away from home?	1.Girls 2.Boys 3.Husband 4.Relatives 5. Neighbor women 6. Other specify	

145	What type of problem do infertile women encounter in the community	1. They encounter no problem 2. Husbands marry other wife. 3. They are subjected to divorced 4. Others (specify)		
VI	**HEALTH RELATED ISSUES**			
146	What are the major problems encountered by women in this community?			
147	What are the major health problems affecting women in this community?			
148	What is the health problem you have been currently facing			
149	When did you last face the health problem?	1. One month ago 2.Two months ago 3. Three months ago 4. with in 4-6 months. 5. with in 7-12 months 6. One year ago.		
150	What did you do to solve your health problem?	1. Self treatment 2. Tellel 3. Consult witch craft 4. consult health center 5. consult private clinic 6. consult drug shop 7. consult religious leaders 8. consult magicians 9. consult community health agent 10. other specify		
151	Where did you get the solution for the current health problem you faced?	1. Self treatment 2. Tellel 3. Consult witch craft 4. consult health center 5. consult private clinic 6. consult drug shop 7. consult religious leaders 8. consult magicians 9. consult community health agent 10. other specify		
152	What do you think about the cause of the health problem you currently face?			
153	How do you perceive your health?	1. very good 2. good 3. not good or bad 4. bad 5. very bad		
	For the following list of diseases please mention their cousts and what you are going to do and if you get sick			
	List of diseases	Cause	First measure	Second measure
154	Malaria			
155	Bleeding during pregnancy			
156	Vaginal discharge			
157	Scabies			
158	Bleeding due to retained placenta.			
159	pulmonary Tuberculosis.			
160	Glandular Tuberculosis			
161	Depression			
162	Prolonged Labor			
163	Abdominal pain			
164	Diarrhea			

165	What do you do to promote health and prevent illnesses?	1.Dua 2. Consult health worker 3.clean environment 4 . eat nutritious food 5.chida 6.Consult witchcraft 7.wear helmites 8. Tellel 9. others (specify)	
166	Have you ever been visiting the near by health care unit?	1. yes, many times 2.Yes, some times 3.Yes, one time 4 I have never visited.	
167	Have you ever been failed to visit a health care unit during your sickness?	1. Yes, many times 2. Yes some times 3. Yes, one time. 4. I have never been failed.	
168	If the answer is "yes" (1,2,3) what was the reason?	1.financial problem 2.Distance 3. Less quality of the service 4. Cultural problem 5.Lack of transport facility 6.Husbands object 7.There are no people to take care of the house. 8. Other (specify)	
VII	**HEALTH CARE UTILIZATION**		
	Reasons for visit	Perception of the care	Reasons for dissatisfaction
169	Vaccination 1.Yes 2.No (If the answer is No skip to ques, 179)	1. Very good 2. good 3. not good or bad. 4 . Bad 5. Very bad.	
170	For my sickness. 1.Yes 2.No (If the answer is No skip to ques, 180)	1. Very good 2. good 3. not good or bad. 4 . Bad 5. Very bad.	
171	For a sick child 1.Yes 2.No (If the answer is No skip to ques, 181)	1. Very good 2. good 3. not good or bad. 4 . Bad 5. Very bad	
172	For delivery. 1.Yes 2.No (If the answer is No skip to ques, 182)	1. Very good 2. good 3. not good or bad. 4 . Bad 5. Very bad	
173	For sick husband. 1.Yes 2.No	1. Very good 2. good 3. not good or bad. 4 . Bad 5. Very bad	
	Information on harmful traditional practices.		
174	Have you been experiencing FGM?	1. On my self. 2.On my girl children 3.On other relatives 4. I he never seen it. 5. It is banned.	
175	Do you think that FGM is good for girls?	1. Yes 2.No 3.I do not know.	
176	If the answer is Yes , why?		
177	If the answer is No , what is the reason?		
178	Have you been experiencing Nail extraction done on girls before marriage? (Please mention on whom.)	1. On my self 2.On my daughters 3.On other relatives 4.I have never seen 5. It is banned.	
179	Do you think that Nail extraction should continue as a tradition.	1. Yes 2.No. 3. I do not know.	
180	If the answer is Yes , why?		
181	If the answer is No, what is the reason?		
VIII	**INFORMATION ON DECISION MAKING ROLE.**		
	For the following list of activities mention the individual who is deciding and whose voice is most important in the family.		
	List of Activities	Decision Maker.	
182	To visit relatives and friends.	1. My self 2.My husband 3.My self and my husband 4.Other	

183	To buy household items.	1. My self 2.My husband 3.My self and my husband 4.Other	
184	To take sick children to the health center.	1. My self 2.My husband 3.My self and my husband 4.Other	
185	To arrange marriage of youngsters.	1. My self 2.My husband 3.My self and my husband 4.Other	
186	To use birth control methods.	1. My self 2.My husband 3.My self and my husband 4.Other	
187	To send children to school.	1. My self 2.My husband 3.My self and my husband 4.Other	
188	To discipline children.	1. My self 2.My husband 3.My self and my husband 4.Other	
189	When you and your husband make suggestions on important issues at home ,whose idea is more valuable and accepted in the family?	1. Both have more value and accepted. 2. Mine has more value and acceptance. 3. My husbands idea is more valuable and accepted. 4,My idea is never considered useful.	
190	Do you ask for permission to visit a health unit when you are sick?	1. Yes 2. No 3. Other.	
191	If the answer is Yes ,whom do you ask for permission?	1. My husband 2.My in-laws. 3. Other male family members. 4. Other female family members.	
192	1. Eggs and butter.	1. I ask permission to seal or exchange. 2. I do not ask permission to seal or exchange. 3. I can not seal or exchange	
193	2. Who in the family decides on money expenditure to purchase household items.	1. My husband 2. My self 3. Both of us. 4. Others	
194	Are you a member of an association in your area?	1.Yes 2.No	
195	If the answer is Yes , of what type of association?	1. Religious association 2. Woman's organization' 3. Farmers association 4.Edir 5.Political association 6.Others.	
196	Where is your money resource to buy household items?	1My husband 2.Petit trade 3. Crops 4. I have no resource 5. Other.	
197	Have you been listening to the radio since the last six months?	1. Yes, many times. 2.Yes, some times 3. Never.	
198	Have you been participating in women's meetings?	1. Yes, many times. 2.Yes, some times 3. Never	

183	To buy household items.	1. My self 2.My husband 3.My self and my husband 4.Other	
184	To take sick children to the health center.	1. My self 2.My husband 3.My self and my husband 4.Other	
185	To arrange marriage of youngsters.	1. My self 2.My husband 3.My self and my husband 4.Other	
186	To use birth control methods.	1. My self 2.My husband 3.My self and my husband 4.Other	
187	To send children to school.	1. My self 2.My husband 3.My self and my husband 4.Other	
188	To discipline children.	1. My self 2.My husband 3.My self and my husband 4.Other	
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197	Have you been listening to the radio since the last six months?	1. Yes, many times. 2.Yes, some times 3. Never.	
198	Have you been participating in women's meetings?	1. Yes, many times. 2.Yes, some times 3. Never	

Annex 5

የሴቶችን የጤና ሁኔታ ለማጥናት የተዘጋጀ መጠይቅ ቡታጅራ፥

የጠያቂ ስም ______________________ ቀን __________

የጥያቄ ወረቀት ቁጥር ______________

ተ.ቁ	1. የተጠያቂዋ ሁኔታ	መልስ	ኮድ
101	የቀበሌዉ ስም		
102	የቤት ቁጥር		
103	የቤቱ ባለቤት ስም		
104	የቤቱ ባለቤት ፆታ	1. ሴት 2. ወንድ	
105	የተጠያቂዋ ስም		
106	የተጠያቂዋ ዕድሜ		
107	የተጠያቂዋ ብሄረሰብ	0.ወለኔ 4. ማረቆ 1. ሶዶ 5. ስልጢ 2. ዶቢ 6. ሌላ ይገለፅ 3. መስቃን	
108	የተጠያቂዋ ሀይማኖት	1. ኦርቶዶክስ 4. ፕሮቴስታንት 2. እስላም 5. ሀይማኖት የሌለው 3. ካቶሊክ 6. ሌላ ይገለፅ	
109	የተጠያቂዋ የትምህርት ደረጃ	00 - ያልተማሩ 66 - ማንበብና መፃፍ ___ - የክፍል ደረጃ	
110	የተጠያቂዋ የጋብቻ ሁኔታ	1. ያገባ አንድ ባለቤት 5. ፈት 2. ሁለት ሚስት 6. የተለያዩ 3. ሶስት ሚስት 7. ሌላ ይገለፅ 4. አራት ሚስት	
111	በመጀመሪያ ሲያገቡ ዕድሜዎ ስንት ነበር?	_____	
112	ከመጀመሪያ ባለቤትዎ ጋር ጋብቻዎ በምን ሁኔታ ተፈፀመ?	1. በራሴ 4. በእናቴ ፈቃድ 2. በጥልፊያ 5. በአባቴ እና እናቴ ፈቃድ 3. በአባቴ ፈቃድ 6. በሌላ መንገድ	
113	በአሁኑ ጊዜ ከመጀመሪያ ባለቤትዎጋር ነዎት? (መልሱ "አዎ" ከሆነ ወደ ጥያቄ 115 ይለፉ)	1. አዎ 2. አይደለም	
114	ከመጀመሪያ ባለቤትዎ ጋር ካልሆኑ በአጠቃላይ ስንት ጋብቻ ፈፅመዋል?	_________	
115	ስራዎ ምንድነው? (ከአንድ በላይ መልስ ይቻላል)	1.የቤት እመቤት 4.ነጋዴ 2.የቤተሰብ ጥገኛ 5.ሌላ 3.ገበሬ	
	የባል ሁኔታ፥ አሁን በጋብቻ ላይ ላሉ ብቻ የሚጠየቅ		
	የባለቤትዎ የትምህርት ደረጃ ምንድነው?	00 - ያልተማሩ 66 - ማንበብና መፃፍ - የክፍል ደረጃ	
117	የባለቤትዎ ስራ ምንድነው?	1. ገበሬ 3. ገበሬና ነጋዴ 2. ነጋዴ 4. ሌላ ይገለፅ	
118	የባለቤትዎ ዕድሜ ስንት ነው?	___	
119	ባለቤትዎ በአሁኑ ጊዜ ሌላ ሚስት አላቸዉ? (መልሱ "አይደለም" ከሆነ ወደ ጥያቄ 122 ይለፉ)	1.አዎ 2.አይደለም	
120	ባለቤትዎ ከእርስዎ ጋር ስንት ሚስቶች አላቸው?	_______	
	ስለ ልጆች ሁኔታ፥		
121	በአሁኑ ጊዜ ከእርስዎ ጋር የሚኖሩና የወለዷቸው ስንት ልጆች አለዎት?	1. ወንዶች ____ 2. ሴቶች ____ 3. ጠቅላላ ድምር ____ 4. ልጅ የለኝም	

122	በአሁኑ ጊዜ በቤትዎ ውስጥ ስንት ሰው ይኖራል?		
	ስለ ትምህርት ሁኔታ፦ (ከአምስት አመት ዕድሜ በላይ ልጆች ያላቸውን ቤቶች ብቻ ይጠይቁ)		
123	ሴቶች ልጆችዎን ወደ ትምህርት ቤት ይሰዳሉ?	1. አዎ ሁሉንም 3. አልክም 2. አዎ በከፊል 4. ሴት ልጅ የለኝም	
124	ሁሉንም የማያስተምሩ ከሆነ ምክንያቶቹን ቢገልፁልን?	1. በአቅራቢያ ት/ቤት ባለመኖሩ 2. ለትምህርት የሚከፈለውን ባለመቻል 3. ለጋብቻ ቅድሚያ በመስጠት 4. ት/ቤት መላኩ አደጋ ስላለው 5. ሴት ልጆች በቤት ውስጥ ስራ ስለሚያግዙ 6. አባቶች ስለሚቃወሙ 7. ሴት ልጆች በእርሻ ስለሚያግዙ 8.ትምህርት አስፈላጊ ስላልሆነ 9.ሌላ	
125	በከፊል የሚያስተምሩ ከሆነ ምክንያቶችዎን ቢገልፁልን?	1. በአቅራቢያ ት/ቤት ባለመኖሩ 2. ለትምህርት የሚከፈለውን ባለመቻል 3. ለጋብቻ ቅድሚያ በመስጠት 4. ት/ቤት መላኩ አደጋ ስላለው 5. ሴት ልጆች በቤት ውስጥ ስራ ስለሚያግዙ 6. አባቶች ስለሚቃወሙ 7. ሴት ልጆች በእርሻ ስለሚያግዙ 8.ትምህርት አስፈላጊ ስላልሆነ 9.ሌላ	
126	ወንዶች ልጆችዎን ትምህርት ቤት ይሰዳሉ? (መልሱ ወንድ ልጅ የለኝም ከሆነ ወደ ጥያቄ 131 ይለፉ)	1. አዎ ሁሉንም 2. አዎ በከፊል 3. ሁሉንም አልክም 4. ወንድ ልጅ የለኝም	
127	ሁሉንም የማያስተምሩ ከሆነ ምክንያቶቹን ቢገልፁልን?	1. በአቅራቢያ ት/ቤት ባለመኖሩ 2. ለትምህርት የሚከፈለውን ባለመቻል 3. ለጋብቻ ቅድሚያ በመስጠት 4. ት/ቤት መላኩ አደጋ ስላለው 5. ወንድ ልጆች በቤት ውስጥ ስራ ስለሚያግዙ 6. አባቶች ስለሚቃወሙ 7. ወንድ ልጆች በእርሻ ስለሚያግዙ 8.ትምህርት አስፈላጊ ስላልሆነ 9.ሌላ	
128	በከፊል የሚያስተምሩ ከሆነ ምክንያቶችዎን ቢገልፁልን? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. በአቅራቢያ ት/ቤት ባለመኖሩ 2. ለትምህርት የሚከፈለውን ባለመቻል 3. ለጋብቻ ቅድሚያ በመስጠት 4. ት/ቤት መላኩ አደጋ ስላለው 5. ወንድ ልጆች በቤት ውስጥ ስራ ስለሚያግዙ 6. አባቶች ስለሚቃወሙ 7. ወንድ ልጆች በእርሻ ስለሚያግዙ 8.ትምህርት አስፈላጊ ስላልሆነ 9.ሌላ	
III	ስለ ስራ ሁኔታ፦		
129	እርስዎ ጠዋት በስንት ስዓት ስራ ይጀምራሉ?	_____ ሰዓት	
130	እርስዎ ማታ ስራዎን በስንት ሰዓት ያጠናቅቃሉ?	_____ ሰዓት	
131	ያለብዎት የስራ ጫና በጤናዎ ላይ ተፅዕኖ ያደረገ ይመስልዎታል?	1. አዎ እጅግ በጣም 2. አዎ በጣም 3. አዎ በመጠኑ 4. ተፅዕኖ አላደረገብኝም	
132	መልሱ "አዎ" ከሆነ ያስከተለውን የጤና ችግር ቢገልፁልን?		

IV	ለወለዱ ሴቶች ብቻ የሚቀርቡ ጥያቄዎች፥ (ከጥያቄ 139 እስከ 145)		
133	በመጨረሻው የእርግዝና ጊዜዎ የስራ ጫና ተቀንሶሎት ነበር?	1. አዎ 2. አይደለም	
135	መልሱ "አዎ" ከሆን ለምን ያህል ቀን ብዙ ስራ እንዳይሰሩ ተደረገ?	______ ቀናት	
136	በመጨረሻው የአራስነት ጊዜዎ የስራ ጫና ተቀንሶሎት ነበር?	1. አዎ 2. አይደለም	
137	የስራ ጫናዎ ካልቀነሰ በምን ምክንያት እንደሆን ቢገልፁልን?		
138	በመጀመሪያ አራስነትዎ ጊዜ ለስንት ቀናት የተለየ እንክብካቤ ተደረገለዎት?	______ቀናት	
V	ስለ ልጅ መውለድና ማሳደግ		
139	ምጥ የያዛቸውን ሴቶች ለማዋለድ በመጀመሪያ የሚጠራው ማን ነው?	1. የልምድ አዋላጅ 2. የጎረቤት ሴቶች 3. ዘመድ 4. አሮጊቶች 5. ሌላ ካለ ይግለጹ	
140	በጤና ጣቢያ ውስጥ ተገላግለው ያውቃሉ? መልሱ "አይደለም" ከሆን ወደ ጥያቄ 150 ይለፉ)	1. አዎ 2. አይደለም	
141	መልሱ "አዎ" ከሆን ወደ ጤና ጣቢያ እንዴት ተወሰዱ?	1. በእግሬ 2. በሸክም 3. በመኪና 4. በጋሪ 5. በሌላ ይገለፅ	
142	ከስንት ጊዜ ምጥ በኋላ ወደ ሃኪም ቤት እንዲሄዱ ተወሰነ?	1. በአንድ ቀን (12 ሰዓት) 2. ከአንድ ቀንና ሌሊት (በ24 ሰዓት) 3. በሁለት ቀናት (48 ሰዓት) 4. ከሶስት ቀናትና ከዚያ በላይ	
143	ልጆች በመንከባከብ የሚያግዞት ማን ነው?	1. ሴቶች ልጆች 2. ወንዶች ልጆች 3. ባል 4. ዘመድ 5. የጎረቤት ሴቶች 6. ሌላ ይገለፅ	
144	እርስዎ በታመሙ፥ በወለዱ ወይም ርቀው ከቤት በሄዱ ጊዜ ልጆችዎን ማን ይንከባከብሎታል?	1. ሴቶች ልጆች 2. ወንዶች ልጆች 3. ባል 4. ዘመድ 5. የጎረቤት ሴቶች 6. ሌላ ይገለፅ	
145	ልጅ ያለወለዱ ሴቶች ምን አይነት ችግር ሊደርስባቸው ይችላል?	1. ምንም አይነት ችግር አይደርስባቸውም በትዳራቸው በሰላም ይኖራሉ 2. ባሎች ሌላ ሚስቶች ያገባሉ 3. ባሎቻቸው ይፋቷቸዋል 4. ሌላ ይገለፅ	

VI	ጤና ነክ ጥያቄዎች፥		
146	በዚህ አከባቢ ሴቶችን የሚያጋጥማቸው ዋነኛ ችግሮች ምንድናቸው?		
147	በዚህ አካባቢ በአሁኑ ወቅት ሴቶቹን የሚያጠቁ በሽታዎች ምን ምን ናቸው? ይዘርዝሩ፥		
148	እርስዎ በመጨረሻ ጊዜ የገጠመዎት የጤና ችግር ምንድነው?		
149	በመጨረሻ የጤና ችግር የደረሰቦት መቼ ነበር?	1. የዛሬ ወር 2. የዛሬ ሁለት ወር 3. የዛሬ ሶስት ወር 4. ከ4-6 ወራት ውስጥ 5. ከ7-12 ወራት ውስጥ 6. የዛሬ አመት	
150	የገጠምዎትን የጤና ችግር ለማቃለል ምን አደረጉ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. የራሴን ዕርምጃ ወሰድኩ 2. ጠሊል አደረኩ 3. ወደ ጠንቋይ ሄድኩ 4. ወደ ጤና ጣቢያ ሄድኩ 5. ወደ ግል ክሊኒክ ሄድኩ 6. ወደ መድሀኒት ቤት ሄድኩ 7. ወደ ሀይማኖት መሪ ሄድኩ 8. ወደ መፅሀፍ ገላጭ ሄድኩ 9. ወደ ቀበሌ ጤና ተጠሪ ሄድኩ 10. ሌላ	
151	ለመጨረሻ ግዜ ለደረሰቦት የጤና ችግር መፍትሄ ያገኙት የት ነው?	1. በራሴ ዕርምጃ 2. በጠሊል 3. በጠንቋይ ቤት 4. ጤና ጣቢያ 5. በግል ክሊኒክ 6. በመድሀኒት ቤት 7. በሀይማኖት መሪ 8. በመፅሀፍ ገላጭ 9. በቀበሌ ጤና ተጠሪ 10. ሌላ	
152	በመጨረሻ ጊዜ ለገጠመዎት የጤና ችግር መንስኤው ምክንያቱ ምን ነበር ብለው ያስባሉ?		
153	በአሁኑ ጊዜ ጤንነትዎ እንዴት ነው?	1. በጣም ጥሩ 2. ጥሩ 3. ጥሩም መጥፎም ያልሆነ 4. መጥፎ 5. በጣም መጥፎ	

	ከዚህ በታች ለተዘረዘሩት የበሽታ አይነቶች መንስኤው ምን እንደሆን እና እርስዎ በበሽታው ቢያዙ ምን እንደሚያደርጉ ይግለፁ፥			
	የበሽታው አይነት	መንስኤ	የመጀመሪያ ድርጊት	ካልተሻለዎት የሚያደርጉት
154	ወባ			
155	በዕርግዝና ጊዜ የደም መፍሰስ			
156	የማህፀን ፈሳሽ (ሽፍጥ)			
157	እከክ			
158	የዕንግዴ ልጅ ሲቀርና የደም መፍሰስ			
159	የሳንባ ነቀርሳ			
160	የአንገት ነቀርሳ			
161	የአእምሮ ጭንቀትና መረበሽ			
162	የምጥ መዘግየት			
163	የሆድ ህመም			
164	ተቅማጥ			
165	ጤንነትዎን ለመጠበቅና በሽታን ለመከላከል ምን ያደርጋሉ? (ከአንድ በላይ መልስ ይቻላል)	1. ዱአ 6. ጠንቋይ መጠየቅ 2. ሀኪም ማማከር 7. ፅፈት ማሰር 3. አከባቢን ማፅዳት 8. ጠሊል ማድረግ 4. ጥሩ ምግብ መብላት 9. ሌላ 5. ጭዳ ማረድ		
166	አቅራቢያዎ ወደሚገኝ የጤና ድርጅት ሄደው ያውቃሉ?	1. አዎ፡ ብዙ ጊዜ 2. አዎ፡ ጥቂት ጊዜ 3. አዎ፡ አንድ ጊዜ 4. በፍፁም ሄጄ አላውቅም		
167	በጤና ችግር ምክንያት ወደ ጤና ጣቢያ ለመሄድ ፈልገው ነገር ግን ሳይሆንልዎት ቀርቶ ያውቃል?	1. አዎ፡ ብዙ ጊዜ 2. አዎ፡ ጥቂት ጊዜ 3. አዎ፡ አንድ ጊዜ 4. በፍፁም ሳይሆንልኝ ቀርቶ አያውቅም		
168	መልሱ "አዎ" (1,2,3) ከሆነ ምክንያቱ ምን ነበር?	1. የገንዘብ እጦት 5. የመጓጓዣ እጥረት 2. እርቀት 6. ባለቤቴ ባለመስማማቱ 3. ህክምናው ጥሩ ባለመሆኑ 7. ልጆች የሚጠብቅልኝ በማጣት 4. ባህላችን ስለማይፈቅድ 8. ሌላ		

VII	የጤና አገልግሎት አጠቃቀም፥ ወደ ጤና አገልግሎት ሄደው ለማያውቁ ብቻ		
	ወደ ጤና አገልግሎት የሄዱበት ምክንያት	በዚያን ግዜ የተሰጥዎት አገልግሎት እንዴት ነበር?	በአገልግሎቱ ካልተደሰቱ ምክንያትዎ ምን ነበር?
169	ክትባት 1. አዎ 2. አይደለም (መልሱ "አይደለም" ከሆነ ወደ ጥያቄ 179 ይለፉ)	1. በጣም ጥሩ 2. ጥሩ 3. ጥሩም መጥፎም ያለሆነ 4. መጥፎ 5. በጣም መጥፎ	
170	ታምሜ 1. አዎ 2. አይደለም (መልሱ "አይደለም" ከሆነ ወደ ጥያቄ 180 ይለፉ)	1. በጣም ጥሩ 2. ጥሩ 3. ጥሩም መጥፎም ያለሆነ 4. መጥፎ 5. በጣም መጥፎ	
171	ልጅ ታሞብኝ 1. አዎ 2. አይደለም (መልሱ "አይደለም" ከሆነ ወደ ጥያቄ 181 ይለፉ)	1. በጣም ጥሩ 2. ጥሩ 3. ጥሩም መጥፎም ያለሆነ 4. መጥፎ 5. በጣም መጥፎ	
172	ለመውለድ 1. አዎ 2. አይደለም (መልሱ "አይደለም" ከሆነ ወደ ጥያቄ 182 ይለፉ	1. በጣም ጥሩ 2. ጥሩ 3. ጥሩም መጥፎም ያለሆነ 4. መጥፎ 5. በጣም መጥፎ	
173	ባለቤቴን ለማሳከም 1.አዎ 2. አይደለም	1. በጣም ጥሩ 2. ጥሩ 3. ጥሩም መጥፎም ያለሆነ 4. መጥፎ 5. በጣም መጥፎ	

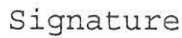
	ጎጂ ባህሎችን በተመለከተ		
174	የሴቶች ግርዛት ሲፈጸም አጋጥምዎት ያውቃል? በማን ላይ ሲፈፀም እንዳዩ ቢገልፁልን? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. በራሴ ላይ 2. በሴት ልጄ ላይ 3. በሌሎች (ዘመድ ጎረቤት) 4. አይቼ አላውቅም ግን እንደሚደረግ እሰማለሁ 5. በማንም ላይ ሲፈፀም አላየሁም 6. መፈጸሙ ቀርቷል	
175	በሴቶች ልጆች ላይ የሚፈጸመው ግርዛት ለሴቶች ጥሩ ነው ብለው ያስባሉ?	1. አዎ 2. አይደለም 3. አላውቅም	
176	መልሱ "አዎ" ከሆነ ምክንያቱን ቢገልፁ?		
177	መልሱ "አይደለም" ከሆነ ምክንያቱን ቢገልፁ?		
178	በጋብቻ ወቅት የጥፍር መንቀል ሲፈጸም አጋጥሞዎት ያውቃል? በማን ላይ ሲፈፀም እንዳዩ ቢገልፁ? (ከአንድ በላይ መልስ መመለስ ይቻላል)	1. በራሴ ላይ 2. በሴት ልጄ ላይ 3. ሌሎች (ዘመድ እና ጎረቤት) 4. አይቼ አላውቅም ግን እንደሚደረግ እሰማለሁ 5. በማንም ላይ ሲፈፀም አላየሁም 6. መፈፀሙ ቀርቷል	
179	ይህን የጥፍር መንቀል ባህል ሴቶች አሁንም ሊፈጽሙት ይገባል ብለው ያስባሉ?	1. አዎ 2. አይደለም 3. አላውቅም	
180	መልሱ "አዎ" ከሆነ ለምን?		
181	መልሱ "አይደለም" ከሆነ ለምን?		
VIII	የቤተሰብ ውሳኔ አሰጣጥ፥ በቤተሰባችሁ ውስጥ የሚከተሉትን ድርጊቶች ለመፈፀም መወሰን የሚችለው እና ቃሉ የሚከበረው የማነው?		
	ድርጊቶች	ውሳኔ ሰጪ	
182	ቤተሰብንና ጓደኛን መጠየቅ	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
183	ለቤት አገልግሎት የሚውል ሸቀጥ ለመግዛት	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
184	ህፃናትን ለማሳከም	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
185	በወጣቶች ጋብቻ ላይ ለመወሰን	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
186	የወሊድ መቆጣጠሪያ ለማድረግ	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
187	ልጆችን ት/ቤት ለመላክ	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
188	ልጆችን ለመገሰጽና ለመቅጣት	1. እኔ ራሴ 3. እኔና ባለቤቴ 2. ባለቤቴ 4. ሌላ	
189	በቤት ውስጥ የምትሰጡትንና የምትሰነዘሩትን የባለቤትዎ እና የርሶን ሀሳብ በተመለከተ የማንኛችሁ አስተያየት ክብደትና ተቀባይነት አለው ብለው ያስባሉ?	1. ሁለቱም ተመሳሳይ ክብደትና ተቀባይነት አለው 2. የኔ የበለጠ ክብደትና ተቀባይነት አለው 3. የባለቤቴ የበለጠ ክብደትና ተቀባይነት አለው 4. የኔ ሀሳብ ከቁጥር አይገባም	

190	በታመሙ ጊዜ ወደ ሀኪም ቤት ለመሄድ ፈቃድ መጠየቅ አለቦዎት ወይ?	1. አዎ 3. ሌላ ይገለፅ 2. አይደለም	
191	መልሱ "አዎ" ከሆነ ማንን ፈቃድ ይጠይቃሉ?	1. ባለቤቴን 2. አማቴን 3. ሌላ የቤተሰብ አባል ወንድ 4. ሌላ የቤተሰብ አባል ሴት	
IX	በቤተሰብ ውስጥ በንብረት ይዞታ እና በገንዘብ ወጪ ላይ የእርስዎ መብት እና አጠቃቀም እንዴት ነው?		
192	ለቤት ውስጥ አገልግሎት አስፈላጊ የሆነውን ለመግዛት በገንዘብ እና ሌላ ገቢ ላይ የሚወስነው ማነው?	1. ባለቤቴ 2. ራሴ 3. ሁለታችንም 4. ሌላ	
193	በአከባቢዎ የማህበር ወይም የድርጅት አባል ነዎት?	1. አዎ 2. አይደለሁም	
194	መልሱ "አዎ" ከሆነ የምን አይነት ማህበር? (ከአንድ በላይ መልስ መመለስ ይቻላል) አንድ በአንድ ጠይቅ	1. የሀይማኖት ማህበር 2. የሴቶች ማህበር 3. የገበሬ ማህበር 4. የእድር ማህበር 5. የፖለቲካ 6. ሌላ	
195	ለቤት የሚያስፈልጎትን ነገሮች ለመግዛት ገንዘብ ከየት ያገኛሉ?	1. ከባለቤቴ 2. ከንግድ 3. ከእህል ሽያጭ 4. ገንዘብ አግኝቼ አላውቅም 5. ሌላ	
196	ባለፉት 6 ወራት ውስጥ ሬድዮ አዳምጠው ያውቃሉ?	1. አዎ ብዙ ጊዜ 2. አዎ አንዳንድ ጊዜ 3. በፍፁም አዳምጬ አላውቅም	
197	ባለፈው አንድ አመት ውስጥ የሴቶች ስብሰባ ተካፍለው ያውቃሉ?	1. አዎ ብዙ ጊዜ 2. አዎ አንዳንድ ጊዜ 3. በፍፁም አዳምጬ አላውቅም	

DECLARATION

I, the undersigned, declare that this thesis is my work and that all sources of material used for this thesis have been duly acknowledged.

Name Yegoma work Gossaye

Signature 

Place Addis Ababa

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This thesis has been submitted for examination with my approval as University advisor.

Dr. Yemane Berhane