

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

DEPARTMENT OF PEDIATRICS AND CHILD HEALTH NURSING AND MIDWIFERY

PRACTICE, PERCEPTION AND ASSOCIATED FACTORS OF TRADITIONAL UVULECTOMY AMONG CAREGIVERS OF CHILDREN UNDER FIVE YEARS OLD IN KEYIH TEKLI WEREDA, CENTRAL ZONE TIGRAY, ETHIOPIA 2025/2026. MIXED STUDY

BY:

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A THESIS SUBMMITED TO THE SCHOOL OF NURSING AND MIDWIFERY COLLEGE OF HEALTH SCIENCE GRADUATE STUDIES OF ADDIS ABABA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIRMENTS FOR THE DGREE OF MASTERS OF SCIENCE IN PEDIARICS AND CHILD HEALTH NURSING.

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This thesis by Berhe Tafere is accepted in its present form by the board of examiners as satisfying thesis requirement for the degree of masters in Pediatric and child health nursing.

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STATMENT OF DECLARATION

By my signature below, I honestly declared that this research thesis practice, perception and associated factors of traditional uvulectomy among caregivers of children under five years old; in Keyih Tekli Wereda, Central Zone, Tigray Ethiopia is my own work. I have followed all ethical principles of scholarship in the preparation, data collection, data analysis and completion of this thesis. All academic matter that is included in the thesis has been given acknowledgement through citation. I confirm that I have cited and referenced all sources used in this document. Every effort has been made to avoid plagiarism in the preparation of this thesis.

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LIST OF ACRONYMS AND ABBREVIATIONS

AAU	Addis Ababa University
AOR	Adjusted Odd Ratio
CI	Confidence Interval
COR	Crude Odd Ratio
DC	Data Collectors
DREC	Department Research Ethics Committee
MSC	Master of Science
PI	Principal Investigator
SD	Standard Deviations
SDGs	Sustainable Development Goal
SNNPR	South Nation Nationality People Region
SSH	Sub Saharan Africa
SPSS	Statistical Package for Social Science
TASH	Tikur Anbessa Specialized Hospital
TU	Traditional Uvulectomy
VIF	Variance Inflation Factors
WHO	World Health Organization

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ABSTRACT

Background: Traditional uvulectomy (TU) is a widely practiced traditional procedure in many African Country, particularly in sub-Saharan Africa including Ethiopia. Despite its cultural significance, the practice has been associated with adverse health consequences among children. Studies conducted in different parts of the world have reported varying levels of TU practice and identified diverse factors associated with its occurrence. Therefore, this study was aimed to assess the practice, perceptions and associated factors of TU among caregivers of children under five years in Keyih Tekli Wereda.

Methods: A community-based explanatory sequential mixed-methods study was conducted from December 2025 to May 30, 2026. First, a quantitative cross-sectional study was carried out among 632 caregivers of children were selected using a multistage sampling technique. Data were collected through face-to-face interviews using a structured questionnaire. In qualitative phase, seven participants were purposively selected and interviewed using an in-depth interview guide. Quantitative data were entered into EpiData and analyzed using SPSS software. Bivariable and multivariable logistic regression analyses were performed, and statistical significance was declared at $p < 0.05$ with a 95%CI. Qualitative data were analyzed using thematic analysis with the support of ATLAS.ti 9 software.

Result: The prevalence of TU in this study was 70.9% (95% CI: 67.4%-74.4%).Being rural resident (AOR:2.44;95% CI:1.34-4.44), occupational status (AOR:6.98; 95%CI:1.74-28.04), age of caregivers (AOR:0.64;95% CI:0.44-0.94), consider uvulectomy as culturally important (AOR:0.65; 95% CI:0.45-0.92), believed that the uvula causes recurrent illness (AOR:0.62; 95% CI:0.42-0.86) were significant factors. From the qualitative data, five themes were emerged: Strong cultural belief and acceptance of traditional uvulectomy, community and social influence on uvulectomy practice, community and family influence on decision-making of TU, perceived benefits and health risks of uvulectomy and traditional practices versus modern healthcare.

Conclusion and recommendation: TU was highly prevalent in the study area, with a prevalence of 70.9%. Residence, occupational status, cultural beliefs about uvulectomy, belief that the uvula causes recurrent illness, caregiver age were significantly associated with TU practice. Therefore, the findings suggest that TU remains a culturally embedded practice shaped by social, cultural and individual factors, underscoring the need for culturally sensitive interventions and community-based health education that address misconceptions to reduce its practice and promote safer child healthcare-seeking behaviors.

Keywords: Traditional uvulectomy, under five years, keyih tekli wereda

CHAPTER ONE

1. INTRODUCTION

1.1 Background

Traditional uvulectomy is a longstanding cultural practice that involves the partial or total removal of the uvula the small, fleshy projection hanging from the back of the soft palate usually by traditional healers using unsterilized instruments such as razor blades, knives and even threads(1).Although the uvula has important physiological roles in speech, swallowing and protection of the upper air way from aspiration, in many traditional society, it is observed as a source of throat related illness, recurrent cough and feeding difficulty(2). Globally, harmful traditional practices remain a significant public health concern particularly in low and middle income countries, where cultural norms, limited access to healthcare and misconceptions about disease causation strongly impact health-seeking behaviors (3).

While traditional medicine contributes to primary healthcare in many parts of the world, some practices like TU pose serious risks to child health due to their invasive and nonsterile nature (4). In sub Saharan Africa, TU is widely practiced in countries such as Sudan, Nigeria, Kenya, Tanzania and Uganda especially among rural populations(5, 6). Studies from these regions showed that TU is practiced for the aim of curing illnesses like sore throat, vomiting, swallowing difficulty, or just to prevent illness that could occur in the future among infants and young children (7). Meanwhile, studies indicated that it can result sever complications such as bleeding, infections, obstruction of air ways and even death (8).

The TU practice is majorly associated to cultural traditions, community pressures, low educational level, and inadequate community health education (9). Despite efforts to discourage this traditional practice TU remained common in Ethiopia, with a varied prevalence from 20% to 87% in among children less than five years old (10, 11). Many caregivers believed that an elongated uvula causes throat infections or feeding problems, prompting them to seek traditional healers rather than to modern healthcare services(12).These beliefs are often reinforced by family elders, neighbors and traditional healers who are trusted figures within the community.

Although the government has implemented the National Strategy and Action on Plan on Harmful Traditional Practices and integrated health education into community based health programs ,progress has been slow particularly in rural areas where health services are limited and traditional beliefs are deeply rooted (13). The Federal Ministry of Health recognizes traditional uvulectomy as a key contributor to preventable childhood morbidity and mortality(14).At the regional level in the Tigray region of northern Ethiopia traditional uvulectomy practices remain prevalent partly due to limited access to healthcare, cultural resistance to behavioral change and the aftermath of conflict that disrupted health infrastructure (15).

Reports from northern Ethiopia indicate that traditional uvulectomy continues to be performed on young children often resulting in complications such as bleeding, infection and malnutrition(16).

1.2 Statement of the Problem

Harmful traditional practices such as traditional uvulectomy continue to endanger the health and survival of children globally, particularly in low and middle-income countries where cultural norms strongly shape health seeking behavior. Despite expanding access to modern healthcare many communities especially in Africa, continue to rely on traditional healers for managing childhood illnesses.as a result thousands of children undergo TU every year often with life threatening complications (17,18,19). Although global data remain limited TU is reported in several African, middle Eastern and south Asian societies. In sub-Saharan Africa the practice is especially prevalent in countries including Nigeria, Sudan, Kenya, Tanzania, Uganda and Ethiopia (20).

A recent study from Sudan 2023 among 385 mothers of under five children found that 17.9% of children had undergone TU (21). In Ethiopia, the prevalence is substantially higher. A 2024 systematic review and meta-analysis involving nineteen studies and 23559 participants reported a pooled prevalence of 44% to 57% among children(22). Regional variations are significant northern Ethiopia reported a prevalence of up to 63%, while local studies range from 5% to 89% depending on community characteristics(23). A community survey in Central Ethiopia Lemo District in 2023 documented 61% prevalence among households with under five children(24).a recent institutional based study in northwest Ethiopia in 2023 found 46% prevalence among hospital visiting under five children with nearly all procedures on infants under six months (25).

The study in Godere district, Gambella region reported in 2022, 61.9% prevalence among children under two years (26). A study in the south Gonder zone Ethiopia reported a prevalence of 52.5% among caregivers of under five children. Despite these important findings there are gaps, many studies are localized and may not reflect the situation in rural, conflict affected, hard to reach areas; there is limited qualitative data on caregiver's perceptions, inspirations, decision making processes and few studies assess the broader social and economic impact of uvulectomy at community and health system level. Also with changing demographics, mobility, and health service disruptions for example due to conflict, earlier findings may no longer accurately depict current realities. TU poses significant medical risks primarily because it is performed under nonsterile conditions by traditional healers using razor blades, knives and threads. Complications

including hemorrhage, aspiration, airway obstruction, sepsis, tetanus, transmission of HIV and hepatitis (27). A meta-analysis conducted in Ethiopia reported a 29% pooled incidence of complications 95% CI: 14% to 44%(28).When complications occur caregivers face extended hospital stays, out of pocket medical expenses and emotional distress. When complications occur, caregivers face extended hospital stays, out-of-pocket medical expenses, lost workdays, and emotional distress. Health systems also incur preventable costs from emergency treatment and hospitalization of children who develop traditional uvulectomy related complications.

Although Ethiopia has national strategies promoting evidence-based child healthcare including the Health Extension Program and community education initiatives traditional uvulectomy persists in many areas. Preferably, childhood illnesses should be managed using modern diagnostic and treatment methods yet many households still depend on traditional healers. This gap exists due to cultural norms, limited health literacy, health system interruptions and inadequate access to healthcare facilities. Studies in Ethiopia and other African countries consistently shows that cultural beliefs, low parental education, misconceptions about the uvula and community pressure are major determinants of traditional uvulectomy(20, 23, 24). The research gap was that no previous study had assessed the practice, perceptions, and associated factors of TU in Keyih Tekli Wereda. In addition, most previous studies were conducted in other areas and before the recent conflict in Tigray. Therefore, there was a lack of updated, context-specific evidence from this rural post-conflict setting, particularly using a mixed-methods approach that could explore both the magnitude of the practice and the beliefs that sustain it.

Therefore, this study was designed to address these gaps by employing an explanatory sequential mixed-methods approach to assess the practice, perceptions and associated factors of traditional uvulectomy among caregivers of children under five years of age in Keyih Tekli Wereda. The findings will provide updated, context-specific evidence to inform policymakers, healthcare providers, and community stakeholders in developing targeted interventions to reduce this harmful traditional practice.

1.3. Significance of the Study

The findings of this study can provide implications for different bodies including health care service administrators, practitioners, policymakers and researches. Because the findings can be used by local and regional health offices to design culturally appropriate community programs that can raise awareness on the dangers of TU and promote safer child healthcare practices.

It provides an evidence base for policy makers to develop and strengthen health policies and strategies that aimed to reduce harmful traditional practice. It is also help guiding the integration of traditional belief systems into health promotion initiatives, improving the effectiveness of public health campaigns at the community level.

Health professionals such as nurses', health extension workers and public health experts can utilize the findings to improve health education and counseling approaches for caregivers. Understanding caregivers' cultural perceptions and practices will help them to communicate more effectively, encourage early healthcare seeking and discourage unsafe procedures.

The study also significantly contributes to academic researchers as it will generate updated context specific data on the TU practice in Ethiopia. It serves as a reference for future studies and comparative analysis across different regions. Ultimately, this study supports national and global health goals particularly sustainable development goal (SDG) 3, by reporting an evidence that can help reduce preventable diseases and deaths among children under five years of age.

1.4. Justification of the Study

Despite improvements in healthcare accessibilities TU remains a widespread practice in many parts of Ethiopia, including Keyih Tekli Wereda. Its continued existence suggests that cultural norms, limited awareness and misconceptions about childhood illness strongly influence caregivers' health decisions. However, there is a lack of comprehensive and updated data on the extent perceptions and contributing factors of this practice in the study area. This study is justified because it aims to explore the current situation, caregivers' beliefs and associated factors related to traditional uvulectomy among children under five years. Generating such localized evidence is essential to design effective culturally appropriate interventions that address the underlying causes of the practice.

The research findings will provide evidence-based input for regional and national health office, non-governmental organizations and policymakers to develop strategies that discourage harmful traditional procedures while respecting community values. Furthermore, it will create a foundation for further research and help integrate traditional belief systems into health education programs in a way that encourages safe practices. By addressing this knowledge gap, the study contributes to efforts aimed at improving child health, reducing preventable morbidity and enhancing community awareness across the Tigray region and beyond.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. Introduction

This chapter presents a summarized review of existing literature on the practice, perception and association factors of TU among caregivers of children under five years of age. TU defined as the removal of the uvula by traditional practitioners remains a culturally rooted practice in numerous regions particularly across sub-Saharan Africa, including Ethiopia. It is typically carried out on infants and young children motivated by beliefs that it prevents throat related illness. The continuation of this practice is shaped by multiple factors, including sociodemographic characteristics, caregivers of knowledge levels, attitudes and underlying cultural or spiritual beliefs. This review produces studies published mainly since 2019, drawing on worldwide, regional and Ethiopian evidence to describe prevalence trends and contributing factors (29, 30, 31).

2.2. Practice of Traditional Uvulectomy

Globally, the practice of TU varies considerably. A 2021 in Saudi Arabian study sample size not reported estimated that 10 to 15% of nomadic communities perform the procedure to avoid respiratory illness with prevalence reaching 20% among rural children under five years. A key weakness of this study is the absence of sample size an sampling details which limits the reliability of the estimates(32). Correspondingly, a 2022 multinational survey across fifteen countries no country specific or sample data reported showed that only 5% of diaspora populations practiced uvulectomy, attributing its reduction to modernization and improved health service access. Though, the lack of detailed methodological information weakens circumstantial interpretation (33).Similar studies were reported in Nigeria were conducted 86.1%and 90% misconceptions about uvula related disease were identified as major reasons for performing the procedure(59, 60).

In sub-Saharan Africa the practice remains more common. A 2020 multi-country examination in Nigeria, Sudan and Chad estimated a prevalence of 30 to 50% among children less five years and recognized complication rates up to 25%, although methodological specifics were not provided (34). A 2025 African systematic review reported a shared prevalence of approximately 41% (95% CI:25%-56.9%) among children under fifteen years old(35). In Nigeria a 2023 community survey informed a 45% prevalence in Hausa communities driven by strong cultural traditions, though the limited methodological account remains a problematic (35).

The study in Sudan, a 2025 community-based study from 1135 mothers reported 15% prevalence highest among infants 16% and adolescents 17%. Maternal belief was strongly associated with younger child age; however, reliance on convenience sampling limits(35). In Ethiopia, considerable regional variations persist. A 2021 cross-sectional study in the Amhara region reported 42% prevalence(29). A 2023 community based study in Lemo District Hadya zone from 842 households documented a prevalence of 61%, with primary reasons including lack of knowledge about modern healthcare 40.8% and cultural norms 33.4%(36). A 2022 study in Godere district majang zone, from the sample size 664 mothers also found a high prevalence of 61.9%(30).

In Oromia, a 2022 study reported a lower prevalence of 28% mainly linked to beliefs about preventing throat swelling(37,38). A 2020 survey in the Southern Nation, Nationalities and Peoples Region (SNNPR), sample size not specified showed 35% prevalence. While a 1019 in Addis Ababa study showed the lowest levels at 10 to 15% (38, 39). a 2025 hospital based study at Tibebe Ghion Specialized Hospital from a total sample size 402 caregivers reported a 46% prevalence, with 97.3% of procedures done on infants younger than six months, However, being a single center study limits external validity(31). A 2020 triangulated cross-sectional study in the South Gondar Zone from 634 sample size revealed a 52.5% prevalence, which was associated with lack of information and perceived uvula related illness (29, 39).

A 2024 national systematic review nineteen studies, a total sample size 23559 estimated Ethiopia's pooled prevalence at 44% (95% CI:31-57%), with individual estimates ranging from 5% to 89% across regions(40).Variation in definitions, age groups and study stings limits comparability.

2.3. Factors Associated with Traditional Uvulectomy

2.3.1. Socio-Demographic Characteristics

Socio demographic determinants strongly shape caregivers' decisions to engage in TU. A 2022 global scopes systematic review synthesizing eight observational studies from Ethiopia, Nigeria Sudan, Niger and Uganda found that caregivers with only primary education were significantly more likely to practice uvulectomy and rural families accounted for around 70% of all reported cases(41). A 2021 UK study reported continuation of the practice among 15% of African descent households particularly those earning under £20,000 annually(42).evidence from Sub-Saharan Africa consistently links the practice with poverty and low educational fulfilment.

In Nigeria 2020, 55% of cases occurred in households earning less than 100 USD monthly and 65% involved mothers with no formal education. A 2023 Kenyan study showed that 40% of caregivers practicing uvulectomy were from large families greater than five children and single mothers were nearly twice as likely to select for the procedure(43). In Sudan 2019, half of the cases occurred in low-literacy, female headed households(37). In Ethiopia, studies reflect similar socioeconomic gradients. A 2021 Amhara study found that 48% of procedures occurred in rural households without formal education and 60% among families earning less than 500 ETB monthly. A 2022 study in Jimma Oromia showed 35% prevalence among orthodox Christians and higher rates 45% among households with more than four children (38).

Research in Arba Minch town in 2023, from 402 sample size identified rural residence and negative attitudes as key predictors. In SNNPR about 40% of cases were linked to low-income agricultural households in 2020. Post war assessment in Tigray by 2023 indicated 25% prevalence among displaced families with disrupted educational access(44). Addis Ababa maintained the lowest prevalence 12% in 2019, primarily among recent rural migrants (39, 45). Most studies are cross- sectional and categorize rural versus urban broadly lacking better socio-economic classification or causal implication.

2.3.2. Knowledge of Caregivers toward Risks and Consequences of TU

Caregivers' knowledge plays a central role in sustaining or discouraging TU. Globally , studies reveal widespread knowledge gaps; a 2021 international review found that only 25% of caregivers recognized infection as a potential complication, while 60% prioritized cultural explanations(5, 32). A 2022 Yemen study reported that 40% of mothers believed uvulectomy prevented illness, although only 30% acknowledged the risk of bleeding. Across sub-Saharan Africa inadequate awareness continues to impact attitudes. In Chad 2020, about 35% understood sepsis risks yet half held positive attitudes due to perceived treatment profits. In Nigeria 2023, about 45% of mothers were uninformed of long term speech problems, while 55% believed the procedure served as a natural cure(46).

Kenyan survey in 2023 indicated that while 28% of mothers documented aspiration risks about 40% in rural areas still supported the practices(47).In Ethiopian studies highlight prominent regional variances. In Amhara 2021 a total of 38% were aware of infection risks yet 52% still supported the practice. In Lemo district in 2023, lack of knowledge was a main reason for uvulectomy 40.8%(36). In Oromia 2022, only 30% understood bleeding risks with 45% maintaining positive attitudes (38).SNNPR studies in 2020 described 25% awareness of sepsis but 50% support for the practice(30). Post conflict in Tigray region 2023 presented 40% revised knowledge and 20% declining positive attitude(44). The study in Addis Ababa in 2019 urban studies noted 55% knowledge of risks with only 15% positive attitudes among educated mothers(39).

Limitations include knowledge valuations are mainly based on simple questionnaire items without confirmed scales and qualitative depth is often deficient. Information on the sources and quality of knowledge such as community education health workers is occasionally recognized.

2.3.3. Attitudes of Caregivers toward Traditional Uvulectomy

Caregiver attitudes are often culturally strengthened even when risks are familiar. A 2022 Asia Africa survey found that 35% of caregivers viewed uvulectomy positively while 20% opposed it due to growing modernization. A 2021 Saudi arabinan study found 25% neutral and 40% supportive attitudes in conventional communities(40). Across sub-Saharan Africa, positive

attitudes remain more common especially in rural areas. In Sudan 2019 about 605 of caregivers associated uvulectomy with child safety. In Nigeria 2023, 505 of grandparent's key decision makers held satisfactory views. Kenyan studies 2023 documented 45% supportive attitudes related to common norms.

Ethiopian findings reflect similarly deep-rooted beliefs. In2021 study in Amhara, 55% expressed positive attitudes, believing it essential for throat health. Oromia 2022 recorded 40% supportive and 305 opposing views, especially in semi-urban areas. In south Gondar 2022, from the sample size 634 about 64.7% believed that the uvula causes illness. 57.6 did not consider uvulectomy is harmful, and 59.1% opposed discontinuation of the practice(29). SNNPR studies showed 48% supported in 2020. In Tigray 2023, however, only 25% expressed positive attitudes reflecting the impact of health education. Addis Ababa studies reported only18% supported and over 705 opposition(32). Most attitude assessments trust on structured questionnaires limiting deeper cultural interpretation.

2.3.4. Reasons and Beliefs for Traditional Uvulectomy

Cultural beliefs and locally accepted explanations for illness strongly influence decisions around TU. Globally, a 2021 review reported that 15% of middle eastern communities believed uvulectomy cured recurrent infections and 10% practiced it for spiritual protection(32). In 2022 study in Yemen indicated that 35% believed it prevented throat blockage(5). In sub-Saharan Africa, similar beliefs persist a Nigerian study in 2020 reported 50% citing prevention of swallowing difficulties and 30% raising protection from evil spirits. Sudanese evidence 2019 indicated beliefs in purification 45% and perceived medical benefits 25%. Kenyan research in 2023 reported that 40% associated the practice with relief of tonsillitis.

In Ethiopia, motivations vary widely. Many caregivers believe the uvula itself causes illness as reported in the south Gondar 2022 and Lemo District 2023 studies(29, 36). Additional reasons include lack of trust in modern healthcare, limited access to services and reliance on traditional healers as documented in Godere 2022 and Lemo 2023. Cultural continuity and intergenerational transmission also reinforce the practice. The Amhara region in 2021 reported 48% mentioning prevention of uvula elongation and 20% invoking spiritual beliefs (48).Oromia data in 2022

noted 35% practicing uvulectomy for persistent cough. In SNNPR findings 2020 indicated 42% practicing to prevent infections.

In Tigray 2023 documented 30% still adhering to beliefs centered on child protection, although declining with education(44). Addis Ababa in 2019 showed the lowest prevalence of cultural justifications at 12% with most participants attributing the practice to tradition rather than medical evidence (39).

2.4. Conceptual Framework

This conceptual framework was developed by reviewing different literature and relevant behavioral theories that explain the persistence of traditional health practices (29,30, 35,36,38, 39). It illustrates how various socio-demographic, reasons & belief, knowledge, attitude related factors interact to shape caregivers' perceptions and practices toward traditional uvulectomy among children under five years of age.

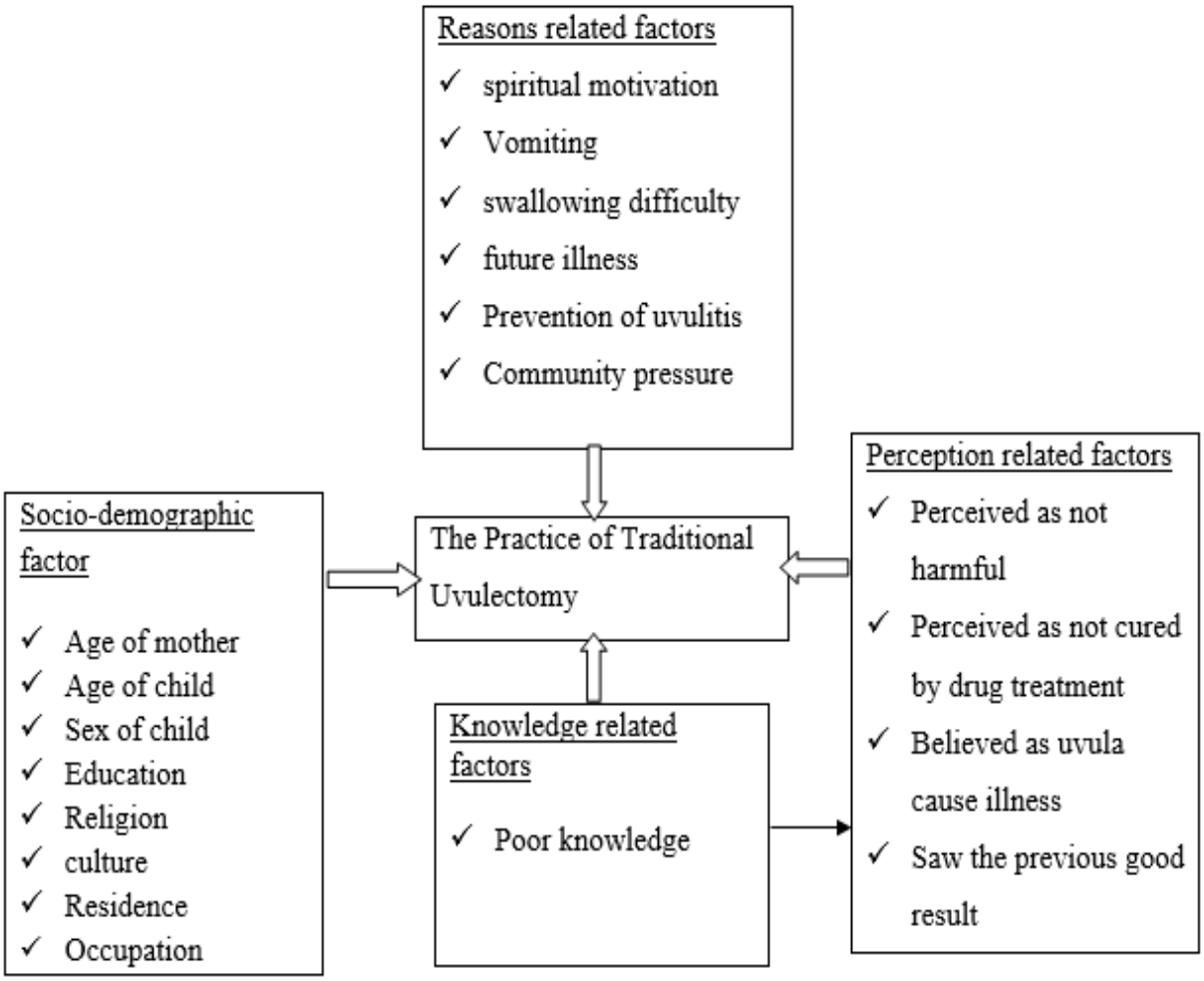


Figure 1: Conceptual framework adapted from previous literature on factors that affect traditional uvulectomy among caregivers of children under five years.

CHAPTER THREE

3. OBJECTIVE

3.1. General Objective

To assess the practice, perception, and associated factors of traditional uvulectomy among caregivers of children under five years in Keyih Tekli Wereda, Central Zone, Tigray, Ethiopia, 2025/2026 G.C.

3.2. Specific Objectives

1. To determine the prevalence of traditional uvulectomy among children under five years in Keyih Tekli Wereda.
2. To identify factors associated with traditional uvulectomy among caregivers of children under five years old in keyih tekli wereda.
3. To explore perceptions of caregivers of children under five years regarding traditional uvulectomy in keyih tekli wereda.

CHAPTER FOUR

4. METHOD

4.1. Study Area and Period

This study was carried out in selected kebeles of the Keyih Tekli Wereda, located in the Central Zone of the Tigray Region, Ethiopia, from December 15 to May 30, 2026. Keyih Tekli is located 895 km from the capital city of Addis Ababa and situated approximately 105km northwest of Mekelle, the regional capital city of Tigray. The wereda covers a total area of about 4,253.48 square kilometers. According to the 2024 Keyih Tekli Wereda Administrative Office, the total population is estimated at 83,160, comprising 41,746 females and 41,414 males. Among the total population, 12,133 are children under the age of five years. In terms of health infrastructure, the wereda is served by 4 government health centers, 14 health posts, and 13 kebeles. Educational institutions include 4 high schools and 33 primary schools(16).

4.2. Study Design

A community-based explanatory sequential mixed-methods study approach was employed. This mixed method design permits for quantitative data collection to determine the prevalence and associated factors followed by qualitative investigation to gain a deeper understanding of caregivers' perceptions and cultural beliefs regarding TU.

4.3. Population

4.3.1. Source Population

The source population for this study were all caregivers who had children under five years of age residing in Keyih Tekli Wereda.

4.3.2. Study Population

The study population were caregivers of under-five children who live in the selected kebeles of Keyih Tekli Wereda.

4.4. Inclusion and Exclusion Criteria

4.4.1. Inclusion Criteria

- Caregivers who had children under five years of age who lived in the study area for at least six months prior to data collection.

4.4.2. Exclusion Criteria

- Caregivers who were unable to communicate effectively during the data collection period due to illness or other reasons.

4.5. Sample Size Determination, Sampling Technique and Procedures

4.5.1. Sample Size Determination

The sample size for this study was calculated using the single population proportion formula for objective one with the assumptions of 95% confidence level, 5% margin of error (d = 0.05) derived from a previous study conducted in South Gondar, which reported that 52.5% of caregivers practiced traditional uvulectomy among children under five years of age(29). For the second objective, (associative factors), EPI-infoV.7.1 was used to estimate sample size by taking factors from previous study.

I. For single population proportion the following parameters were considered.

Where:

n = required sample size

Zα/2 = critical value of the standard normal distribution at 95% confidence level (1.96)

p = estimated proportion of caregivers practicing traditional uvulectomy (0.525)

d = margin of error (0.05)

$$n = \frac{(Z\ a/2)^2\ p\ (1-p)}{d^2} \qquad n = \frac{(1.96)^2\ (0.525)\ (1-0.525)}{(0.05)^2} = 383$$

To account for the design effect due to the multistage sampling procedure, a factor of 1.5 was applied 383 x 1.5 =574.7 and considering a 10% non-response rate, the final sample size was adjusted as 574.7 +(0.10 x574.7) = 632 caregivers

II**.** The sample size was calculated by using EPI-infoV.7.1 by taking factors from previous study for objective two with the assumptions

P1 = % of outcome among the exposed group P2= % of outcome among the unexposed group

Confidence interval = 95% and power = 80%

Table 1: list of exposure variables used to calculate sample size for the second objectives.

Exposure variables	% of outcome among unexposed	% of outcome among exposed	Odd ratio	Sample* DE +10% NR	Reference
Knowledge about TU	31.3	47.7	2.009	484	(36)
Attitude about TU	46.96	15.7	0.210	132	
Cultural belief preventing the modern health	13.92	53.99	7.256	86	
Information about TU	33.99	53.8	2.261	357	(29)

∗-indicates times, DE-design effect and NR- nonresponse rate.

The sample size calculation of the first objective was greater than the sample size calculations of the second objective was 632. Therefore, this was the final sample size for the study in Keyih Tekli Wereda, Central Zone Tigray, Ethiopia 2025/2026**.**

Qualitative Sample Determination

For the qualitative component of the study, a purposive sampling approach was employed to select participants. A total of 7 caregivers and health extension worker were included, excluding those who participate in the quantitative section. The selection was carried out with the support of health extension workers, caregivers, elders and key informants with substantial knowledge or experience concerning TU practices among children. Caregivers with extensive child care experience and a deep understanding of cultural beliefs or personal participation in traditional uvulectomy was prioritized. Participants were continued to be engaged until data saturation were achieved, when additional interviews no longer yield new information or insights.

4.5.2. Sampling Technique and Procedure

A multistage sampling technique was used to select study participants for the quantitative component. Initially, five kebeles Dr. Ataklti, Limat, G/werqiamba, K/werqiamba, and Getski-Milesley were selected from the total thirteen kebeles in Keyih Tekli Wereda using a simple random sampling method. This approach was proposed to ensure that the sample adequately represents the entire district. A comprehensive list of households of caregivers with children under five years of age were obtained from the health posts within each selected kebeles. This list was served as the sampling frame for the study. The total sample size of 632 caregivers was assigned proportionally amongst the five selected kebeles based on the number of less than five children exist in each kebeles by using the formula: ($ni = n*Ni/N$)

Where n denotes the total sample size, *Ni* was the number of less five children in each kebeles, and N was the total number of less five children in all selected kebeles. Next, systematic random sampling was applied to select participants from the household list. The sampling interval (k) was determined by dividing the total number of eligible households (N= 4,287) the required sample size (n= 632), yielding an approximate interval of k = 7. The first household was chosen randomly, and then every 7th household was included until the desired number of participants was obtained. If a household contains more than one eligible caregiver, one was randomly chosen using the lottery method. In cases where a selected caregiver was absent during the initial

visit, one follow-up visit was made. If the caregiver remains unavailable, the next household in sequence was move toward as a replacement. (See figure 2).

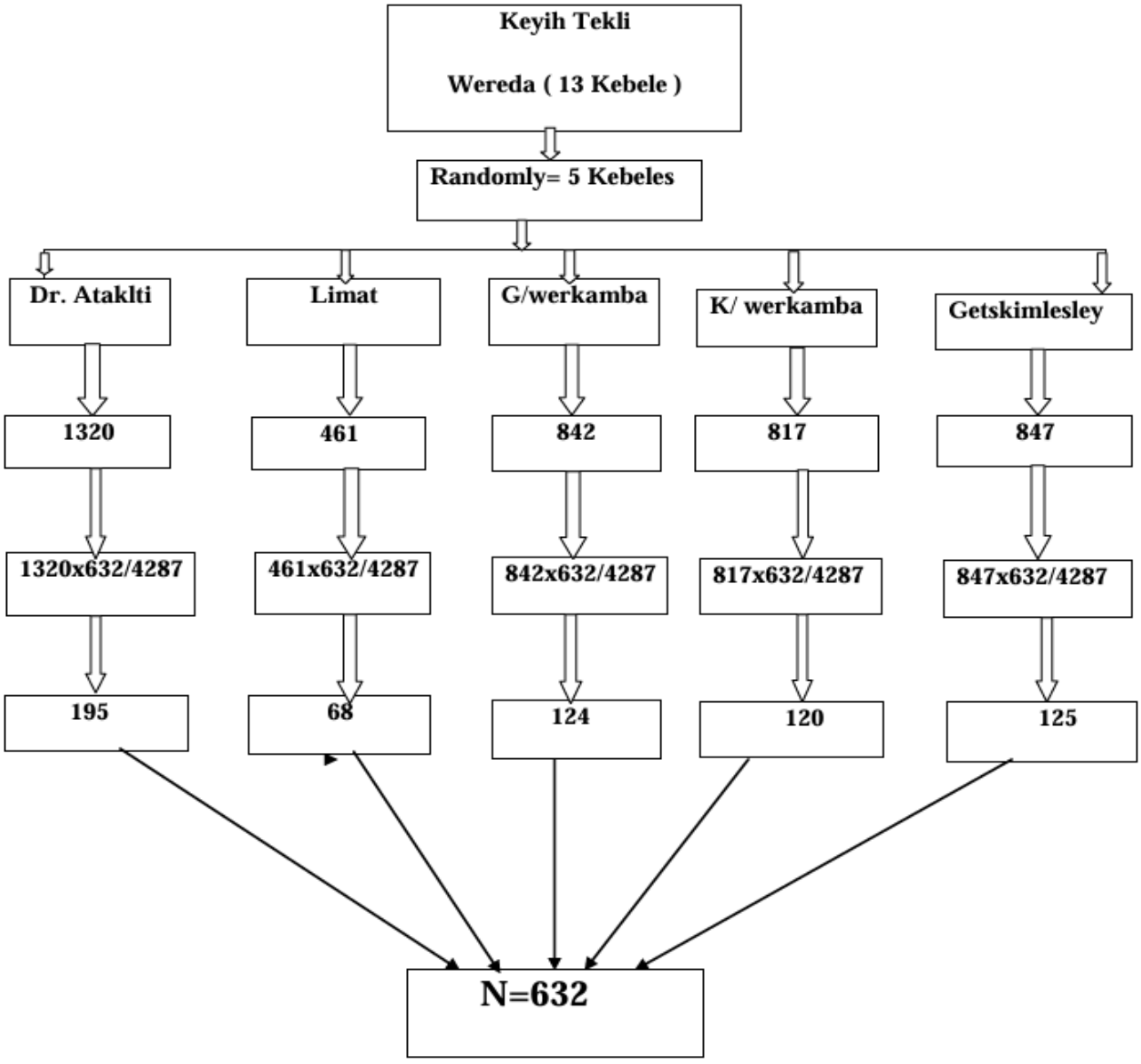


Figure 2*:* Schematic presentation of sampling technique on practice perception and associated factors among care givers of children under five years in keyih tekli wereda, central zone Tigray 2025/2026.

Sampling Technique for the Qualitative Part

For the qualitative component of the study, a purposive sampling technique was employed to select participants who can provide rich and relevant information regarding the practice and perceptions of TU. Participants were drawn from caregivers who are not included in the quantitative study. The selection was supported by health extension workers who are familiar with the community and can help identify appropriate participants. The focus was on caregivers, elders and key informants who have extensive knowledge or experience related to TU, a total 7 participants including four health extension workers were engaged with the final number determined by data saturation the point at which no new information emerges from subsequent interviews. This approach ensures the collection of comprehensive and meaningful qualitative data to complement the quantitative findings.

4.6. Study variable

4.6.1. Dependent Variable

Practice of traditional uvulectomy among caregivers of children under five years.

4.6.2. Independent Variables

1. Socio demographic variables: Age of caregiver, sex of caregiver, marital status, educational status, occupation, religion and residence

2. Child characters: Age of the child, Sex of the child, Number of children in the household, previous experience of illness in the child

3. Knowledge: Awareness about the health risks and complications of TU, Perceived benefits or beliefs about uvulectomy, removing the uvula can cause sever bleeding, modern healthcare treat throat infections without remove the uvula.

4. Perception Questions: uvula causes disease, perceived as not harmful, encouragement of the practice to others, believes uvulectomy should continue in the community and perceived as not cured by drug treatment.

5. Reason for TU: spiritual motivation, Influence of elders or traditional healers, Cultural beliefs and norms regarding child illness, Community pressure, belief the previous good result**,** vomiting and difficulty of swallowing.

4.7 Operational Definitions

Caregivers: Refers to an individual such as a parents, or relatives who were primarily responsible for providing daily care and making health-related decisions for a child under five years of age residing in the study area(49).

G*uardians*: Refers to any adult individual who had legally or socially responsible for the care and well-being of an under-five child in the absence of the biological mother or father. This includes relatives such as grandparents, aunts, uncles, older siblings aged ≥18 years(50).

Traditional uvulectomy: Describes the partial or complete removal of the uvula by traditional healers using unsterilized instruments, typically conducted outside the formal healthcare system(51).

Perception of TU: Refers to the caregivers' beliefs, attitudes, and opinions regarding the benefits, risks, effectiveness, and acceptability of TU for children under five years of age(51).

Belief of TU: Caregivers' acceptance of traditional uvulectomy as a beneficial, effective and culturally appropriate practice for managing childhood illnesses, measured using belief-related items and categorized based on the overall belief score(51).

Practice of traditional uvulectomy: Indicates whether a caregiver's child had undergone traditional uvulectomy as reported by the caregiver during the interview (Yes/No)(29).

Good Caregivers' Practice: defined as caregivers who scored five or more out of nine items on the traditional uvulectomy practice assessment questions. caregivers who had not practiced traditional uvulectomy, seek care from formal health facilities for throat-related illnesses, avoid traditional procedures for their under-five (52).

Poor Caregivers' Practice: refers to caregivers who scored below five out of nine items on the traditional uvulectomy practice assessment questions. caregivers who had practiced or support

TU, rely on traditional healers, permit the use of unsterilized instruments, delay seeking modern medical care, or repeat the practice following perceived recurrence of illness (52).

Knowledge of caregivers: Denotes the level of understanding caregivers had about the function of the uvula, the complications of uvulectomy, and the availability of modern healthcare alternatives, as assessed through structured questions (52).

Adequate knowledge: Caregivers who had scored greater than or equal to the mean knowledge score from the nine knowledge assessment questions were categorized as having adequate knowledge (52).

Inadequate knowledge: Caregivers who had scored below the mean knowledge score from the nine knowledge assessment questions and its complications were categorized as having inadequate knowledge (52).

Attitudes: Refers to caregivers' overall viewpoint either favorable or unfavorable toward traditional uvulectomy was assessed using ten attitude related statements measured with a Likert scale statement. For each item responses reflecting support for TU were scored as 1,while responses reflecting opposition to TU were scored as 0.The total attitude score was obtained by summing the score of all attitude items (52).

Positive attitude: Caregiver who had scored below the mean attitude score were categorized as having a positive attitude. Positive attitude indicates opposition to TU and preference for modern healthcare (52).

Negative attitude: caregivers who had scored greater than or equal to the mean attitude score were categorized as having a negative attitude. Negative attitude indicates support or acceptance of traditional uvulectomy (52).

4.8. Data Collection Methods and Tools

4.8.1. Data Collection Tools

For the quantitative component, data was collected using a pretested designed questionnaire. The questionnaire was first ready in English and translated into Tigrigna local language to confirm clarity and easy understanding for participants. To maintain language correctness the Tigrigna version was subsequently back-translated into English by self-determining language proficient to prove consistency and conceptual correspondence between both versions. The designed questionnaire was adapted and modified by the principal investigator after a detailed assessment of existing literature and previously validated instruments related to TU and harmful traditional practices (29, 36, 53, 54). To confirm content validity, cultural relevance and clarity was reviewed and revised by a panel of three professionals with relevant experience. The reliability of the questionnaire was evaluated using Cronbach's alpha coefficient for multi-item scales measuring knowledge, perception and practice-related constructs, which was value of 0.70.

It was organized into four major sections: Section I**:** Items addressing socio-demographic characteristics of the caregivers and their under-five children. Section II**:** Questions assessing caregivers' practice of traditional uvulectomy among children under five years of age. Section III**:** Questions evaluating caregivers' knowledge about the procedure, its perceived benefits and possible health risks or complications. Section IV**:** Items exploring attitudes, reasons and beliefs toward TU and its continued use within the community.

Before data collection, the questionnaire was pretested on 5% of the total sample size among caregivers residing in non-selected kebeles Gelebeda and Selam within Keyih Tekli Wereda. The pretest was assessed clarity, cultural appropriateness and internal consistency of the questions. Revisions were made based on the feedback obtained to improve reliability and validity(36, 54).

Qualitative Part: an in-depth interview guide was used to collect detailed information on caregivers' perceptions, cultural beliefs, attitudes and experiences related to TU. The interview guide was adapted by the principal investigator after a wide review of relevant literature and similar qualitative studies conducted on harmful traditional practices. To ensure content validity, cultural relevance and clarity the initially developed interview guide was reviewed and revised by a panel of three experts with relevant experience. The experts were included: one public

health expert with experience in qualitative research and community-based studies, one child health or nursing professional with expertise in maternal and child health and one social and behavioral science expert with experience in cultural practices and health seeking behavior.

The experts assessed the interview guide for relevance, wording, cultural correctness, completeness and logical flow of questions. The interview questions were organized in English, translated into Tigrigna and back-translated into English by a self-determining language proficient to maintain language and theoretical consistency. The interview guide contains of open-ended questions with probing prompts considered to explore caregivers' perceptions of TU, basic cultural beliefs, perceived benefits and risks, social influences and attitudes toward modern healthcare changes.

4.8.2. Data Collection Methods

Data was collected through house to house in the kebeles by interviewing the respondent using a structured interview administered questionnaire. Data collection was conducted by 5 health extension workers from the non-selected kebeles and supervised by 1 BSC nurses. Before data collection all data collectors and supervisors were received two days of intensive training on the objectives of the study, contents of the questionnaire, ethical considerations and techniques of effective interviewing to ensure uniform understanding and minimize interviewer bias.

The data collection process was taken place through face-to-face interviews with the selected caregivers of under five children at their homes. Supervisors were managed the entire process daily review completed questionnaires for completeness, consistency and provide feedback and support to the data collectors. Any missing or inconsistent information was corrected on time through revisits when necessary. Data quality was maintained through continuous supervision and cross-checking of data by supervisors and daily meetings to determine challenges encountered during data collection. The principal investigator was also conduct random spot checks and confirmation of collected data to ensure accuracy and completeness(55).

Qualitative part: in-depth interviews were conducted by the trained data collector one Master of Science (MSC) with experience in qualitative research. Data collectors received a day of training covering the study purpose, ethical considerations and effective facilitation of in-depth interview. The interviews took place in a quiet and private setting face-to-face in each of a

selected kebeles either in the caregiver's home or another convenient location to promote open discussion. Before each interview, participants were informed about study objectives and a consent form. Each interview was audio recorded with participants' consent and supplemented by field notes to capture nonverbal cues and contextual information. Interviews were continued until data saturation was reached when no new themes or insights emerge. The data was later be transcribed verbatim in Tigrigna and translated into English for analysis.

4.9. Data Quality Assurance

To maintain high data quality standards, data collectors and supervisors received two days of intensive training by the principal investigator. The training covered data collection methods, gaining informed consent, ethical considerations, participant appointment techniques, and overall information about caregivers' practices related to TU. The questionnaire was first been developed in English then translated into Tigrigna and back-translated into English by self-determining translator to ensure language consistency and theoretical accuracy. A pretest was conducted on 5% of the total sample size in two non-selected kebeles Gelebeda and Selam to assess the clarity, consistency and correctness of the questions.

The feedback gained from the pretest were showed necessary reviews to wording, structure and order of items. Throughout the data collection process, daily supervision and review of completed questionnaires were accepted by supervisors and the principal investigator to verify completeness and internal consistency. Data was cross-checked daily for accuracy, comprehensiveness and any contradictions or missed information was on time corrected. For data entry EpiData version 4.2 was used to reduce entry errors and improve accuracy, confirming that the collected data were both reliable and valid for subsequently analysis.

For the qualitative component of the study, data quality assurance was completed through audio recordings, detailed note taking and immediate transcription of each interview. The transcribed data was double-checked with the equivalent audio files to confirm accuracy and completeness. Translation of transcripts from Tigrigna to English were conducted by fluent language experts followed by back translation to verify consistency in meaning and context. The interviews were facilitated by one experienced MSc-level nurses conducted totally in Tigrigna to ensure participants' comfort and full expression. Throughout the sessions, both audio recording and note

taking was used to capture all appropriate details. A question-and-answer format was showed the discussions, permitting participants to express their perceptions freely and without disruption. To improve the credibility and trustworthiness of the qualitative findings, methods such as triangulation, member checking and peer-debriefing with fellow researchers were employed. These strategies were help confirm the accuracy of interpretations and strengthen the validity of emerging themes and understandings derived from the data (56, 57, 58).Additionally the following data quality measures were taken to improve the quality of the data**.**

4.9. Trustworthiness:

Four techniques were considered to assure trustworthiness of finding. These were included; credibility, transferability, dependability and confirmability of the study

4.9.1. Credibility (Truth Value)

Type notes were taken throughout the interview for the purpose of cross validation with the audio recordings. Additionally, peer debriefing was used, colleagues and advisors were reviewed the transcribed document and extracted concepts. Finally, the interview was supported by probing.

4.9.2. Transferability (Applicability)

The data collection and analysis plan were described step by step. Based on the original transcript, the extracted concept or codes were described in detail manner. All field notes, recorded interviews, and transcripts were checked on each day for errors and correction was given.

4.9.3. Dependability (Consistency)

Inquiry audit was used; colleagues and advisors were reviewed the interview guide and the entire plan. Related literatures and the actual transcript were supported the result.

4.9.4. Confirmability (Neutrality)

The audio record and typed notes were transcribed verbatim and translated carefully

4.10. Data Processing and Analysis

After completion of data collection, each questionnaire was checked manually for accuracy, consistency and completeness before data entry. The data was entered into EpiData version 4.2 to minimize entry errors and ensure data quality after which it was exported to SPSS version 26 for statistical analysis. Descriptive statistical analysis including frequencies, percentages, means and standard deviations was used to summarize caregivers' socio-demographic characteristics, levels of knowledge, attitudes and practices related to TU. Before interpreting the results of the multivariable logistic regression, the fitness and appropriateness of the model were assessed.

The Hosmer Lem show goodness of fit test (P= 0.424) was checked to evaluate how well the model fits the observed data, with a non-significant p-value indicating adequate model fit. Additionally, multicollinearity among independent variables was examined using the Variance Inflation Factor. The maximum VIF was 1.67 and there was no multicollinearity. To identify factors associated with caregivers' practices of TU, a bivariate logistic regression analysis was performed first.

Independent variables with a p-value less than 0.25 in the bivariate analysis was entered into a multivariable logistic regression model to adjust for potential confounding variables. The strength of associations between independent and dependent variables were expressed using Adjusted Odds Ratios (AORs) with 95% Confidence Intervals (CI). Statistical significance was set at $p < 0.05$. The final results were presented in the form of tables, figures and narrative descriptions.

Qualitative Data Analysis

For the qualitative component all interviews were audio recorded, transcribed verbatim in Tigrigna and then translated into English. Transcripts were carefully reviewed against audio files to ensure completeness and accuracy. The data was analyzed using thematic analysis following six key steps: familiarization with data, generating codes, identifying themes, reviewing and filtering themes, defining and naming themes, and compiling the final report(58). Coding and theme development were conducted with the aid of ATLAS. ti 9 software. Thematic patterns and relationships were explored to gain understandings into caregivers' beliefs, perceptions and cultural practices regarding TU.

Finally, qualitative result was triangulated with the quantitative result.

4.11. Ethical Consideration

Ethical approval and official permission were secured from the Department Research Ethics Committee (DREC) of Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery Department of Pediatrics, Child Health and Midwifery prior to data collection. Authorization letters were also obtained from the Tigray Regional Health Bureau and the Keyih Tekli Wereda Health Office to conduct the study. Before the beginning of data collection, the purpose, objectives and procedures of the study were clearly explained to all participants. Written informed consent was obtained immediately before data collection. Participants were encouraged to listen the consent information and was reminded that their participation were voluntary.

They were also be informed that they had the right to refuse to answer any specific question or to withdraw from the interview at any time without facing any negative consequences. Confidentiality and anonymity were maintained throughout the study by avoiding the use of personal identifiers and securely storing all collected data.

4.12. Dissemination of the Results

The findings of this study will be submitted to the Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery as part of the fulfillment of academic requirements. Copies of the final report will be shared with relevant stakeholders including the Keyih Tekli Wereda Health Office and the Tigray Regional Health Bureau. Results will be offered in seminars, workshop and conferences including local health authorities, community representatives, and researchers. Both hard and electronic copies of the report will be completed available in the university library for future guidance by students and researchers.

Moreover, efforts will be made to publish the study findings in honest scientific journals and distribute them through professional networks and academic platforms to promote wider utilization of the results.

CHAPTER FIVE

5. RESULT

5.1. Quantitative Result

5.1.1. Socio-demographic characteristics of the study participant

A total of 632 caregivers of children under five years of age participated in the study, which makes the response rate of 100%. The age of caregivers ranged from 18 to 46 with a mean ±SD of 29.4± 6.8 years and the age of children in month ranged from 1-59 with a mean ±SD of 19.8±12.01 months. Most care givers were young adults, with more than half 336 (53.2%) aged 21–30 years. Almost all care givers were married 622 (98.4%) and 10 (1.6%) were divorced. Regarding educational status, about 276 (43.7%) participants were unable to read and write, and the majority of respondents 577 (91.3%) were housewives (Table 2).

Table 2: Socio-demographic characteristics of caregivers having children under five years old in KeyihTekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632)

Variables	Category	Frequency (n)	Percentage (%)
Age of caregivers	18-20years	68	10.8
	21-30years	336	53.2
	31-40years	193	30.5
	41-49years	35	5.5
Residence	Urban	120	19.0
	Rural	512	81.0
Marital status	Married	622	98.4
	Divorced	10	1.6
Educational level	No formal education	276	43.7
	Primary education	195	30.9
	Secondary education	122	19.3
	College and above	39	6.2
Occupation status	Housewife	577	91.3
	Governmental	55	8.7
Child age in month	<12month	213	33.7
	13-24 month	247	39.1
	25-36 month	108	17.1
	37-48 moth	35	5.5
	49-59 month	29	4.6
Number of children<5 in the household	1	286	45.3
	2	261	41.3

	3	46	7.3
	>-4	39	6.2
The last child delivered at	Health facility	598	94.6
	Home	34	5.4
Birth order of the child	First	286	45.3
	Second	262	41.5
	Third	45	7.1
	Fourth	39	6.2
Sex of the child	Male	339	53.6
	Female	293	46.4

5.1.2. Knowledge of caregivers about traditional uvulectomy

Out of the 632 respondents, 458 (72.5%) had good knowledge about removing uvula can cause bleeding and 363 (57.4%) did know about traditional uvulectomy can lead to infection. Regarding modern healthcare, 511 (80.9%) of participants had good awareness that throat infections can be treated without removing the uvula, (Table 3).

Table 3:Knowledge of caregivers about traditional uvulectomy among children under five years old in KeyihTekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632)

Variables	Category	Frequency (n)	Percentage (%)
Uvula has important function in swallowing	Yes	295	46.7
	No	337	53.3
Removing uvula can cause bleeding	Yes	458	72.5
	No	174	27.5
Traditional uvulectomy can lead to infection	Yes	363	57.4
	No	269	42.6
Traditional uvulectomy has no proven medical benefit	Yes	450	71.2
	No	182	28.8
Uvulectomy can cause breathing problem	Yes	261	41.3
	No	371	58.7
Persistent cough is not cause by uvula	Yes	609	96.4
	No	23	3.6
The function of uvula	Yes	157	24.8
	No	475	75.2
Modern health care treats throat infection without removing the uvula	Yes	511	80.9
	No	121	19.1
Uvula helps protect the body from infection	Yes	137	21.4
	No	497	78.6

5.1.3. Practice of Traditional uvulectomy among caregivers of children under five years old

The result of this study showed that about 448(70.9%) caregivers had practiced traditional uvulectomy their under-five child and 184 (29.1%) of the respondents had not practiced traditional uvulectomy. Regarding the timing of the procedure, about 234 (37.0%) uvulectomies were performed before one month of age. Among children who had undergone traditional uvulectomy 130 (20.6%) experienced post procedural complications. The major complications reported by caregivers included bleeding, poor feeding and hospital admission. (Table 4).

Table 4: Practice of Traditional uvulectomy among caregivers of children under five years old in KeyihTekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632).

Variables	Category	Frequency (n)	Percentage (%)
Child had undergone Traditional uvulectomy	Yes	448	70.9
	No	184	29.1
Age the procedure was done	<1month	234	37.0
	1-5month	134	21.2
	6-11month	64	10.1
	>11month	16	2.5
	No uvulectomy done	184	29.1
How many of your children have under gone traditional uvulectomy(n=448)	1	251	39.7
	2	148	23.4
	3	32	5.1
	4	17	2.7
who decided to practice TU	Mother only	177	28.0

	Both parents	271	42.9
who performed the procedure	Traditional healer	448	70.9
what tools were used	Razor blade	448	70.9
was the tool sterilized	Yes	448	70.9
child have complication following uvulectomy	Yes	130	20.6
which of the following occurred	Bleeding	57	9.0
	Poor feeding	68	10.8
	Hospital admission	3	0.5
	Infection	2	0.3

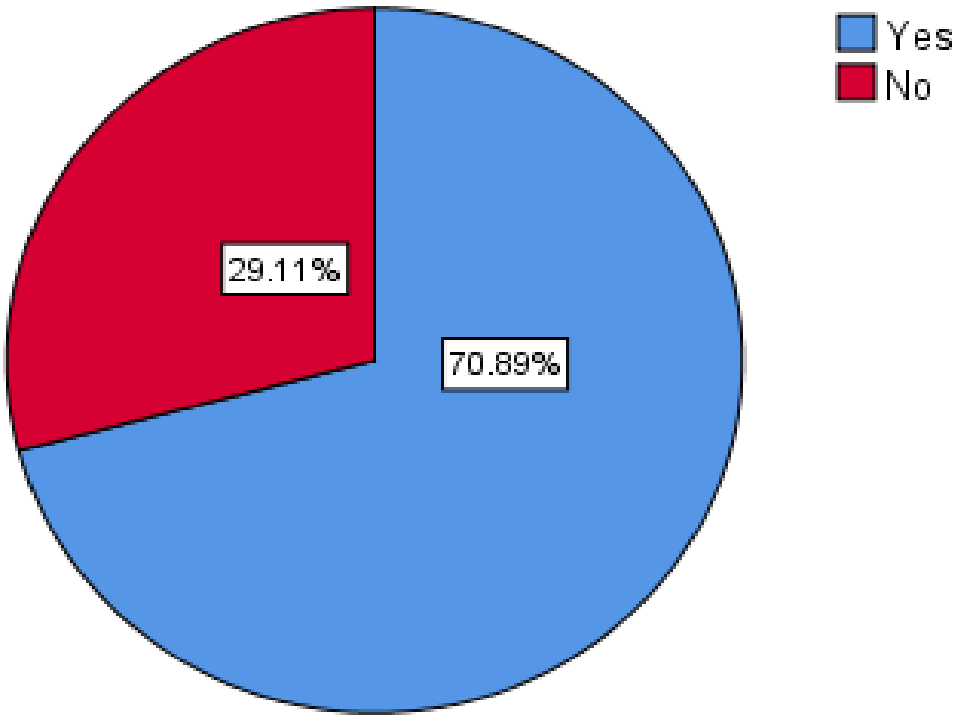


Figure 3: Practice of Traditional uvulectomy among caregivers of children under five years old in KeyihTekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632).

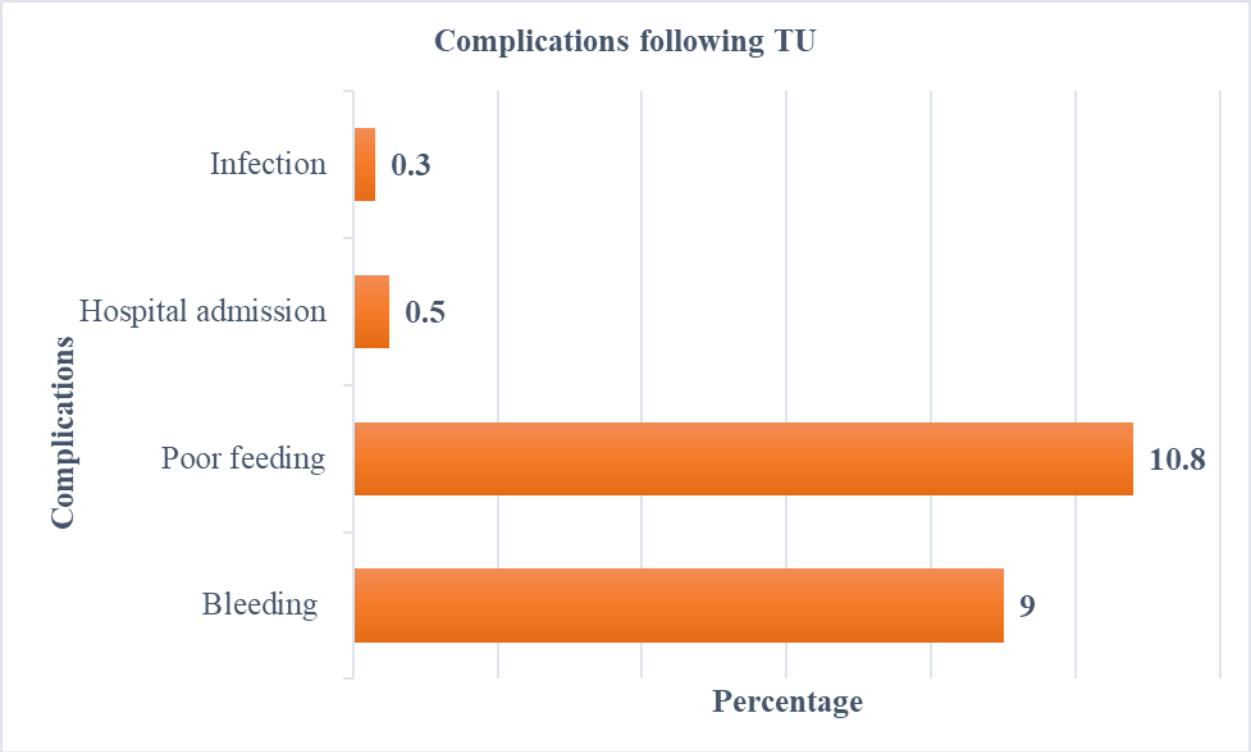


Figure 4: Complications following traditional uvulectomy among caregivers of children under five years old in Keyih Tekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632).

5.1.4 Attitude toward traditional uvulectomy among caregivers of children under five years

The majority, 616 (97.5%) of the respondents had believed as uvula cause illness when it becomes swollen and about 471 (74.5%) of the study participants agreed that removing the uvula prevents future health problems. Regarding modern healthcare, most caregivers, 433 (68.5%) do not agree on “modern medicine is not effective for treatment uvula related problems.” implying that they trusted modern medical treatment and about 385 (60.9%) participants believed that uvulectomy should continue in this community (Table 5).

Table 5: Attitude toward traditional uvulectomy among caregivers of children under five years old in KeyihTekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632)

Variables	Category	Frequency (n)	Percentage (%)
Traditional uvulectomy is an effective treatment for childhood throat illness	Agree	292	46.2
	Disagree	340	53.8
Removing the Uvula prevents future health problems	Agree	471	74.5
	Disagree	161	25.5
Modern medicine is not effective for Rx uvula related problems	Agree	199	31.5
	Disagree	433	68.5
Uvulectomy is culturally important practice in our community	Agree	392	62.0
	Disagree	240	38.0
Encourage others to perform TU	Agree	374	59.2
	Disagree	258	40.8
Removing uvula is safe when done by experienced traditional healers	Agree	393	62.2
	Disagree	239	37.8
Uvulectomy should continue in this community	Agree	385	60.9
	Disagree	247	39.1
Uvula cause illness when it becomes swollen	Agree	616	97.5
	Disagree	16	2.5
Community elders encourage TU b/c it is proven to work	Agree	236	37.3
	Disagree	396	62.7
TU is harmless when performed by experienced healers	Agree	376	59.5
	Disagree	256	40.5

5.1.5 Reasons for traditional uvulectomy among caregivers of children under five years old

In this study, 445 (70.4%) respondents practiced traditional uvulectomy for their child for prevention of future throat swelling or blockage and 431 (68.2%) of the study participants had allowed uvulectomy on their child due to feeding difficulty or vomiting. Additionally, previous positive experience with uvulectomy, belief that the uvula causes recurrent illness and advice from elders, grandparents or relatives as described by 361 (57.1%),374 (59.2%) and 340 (53.8%) of the study caregivers of children were performed uvulectomy for their children, respectively (figure 5).

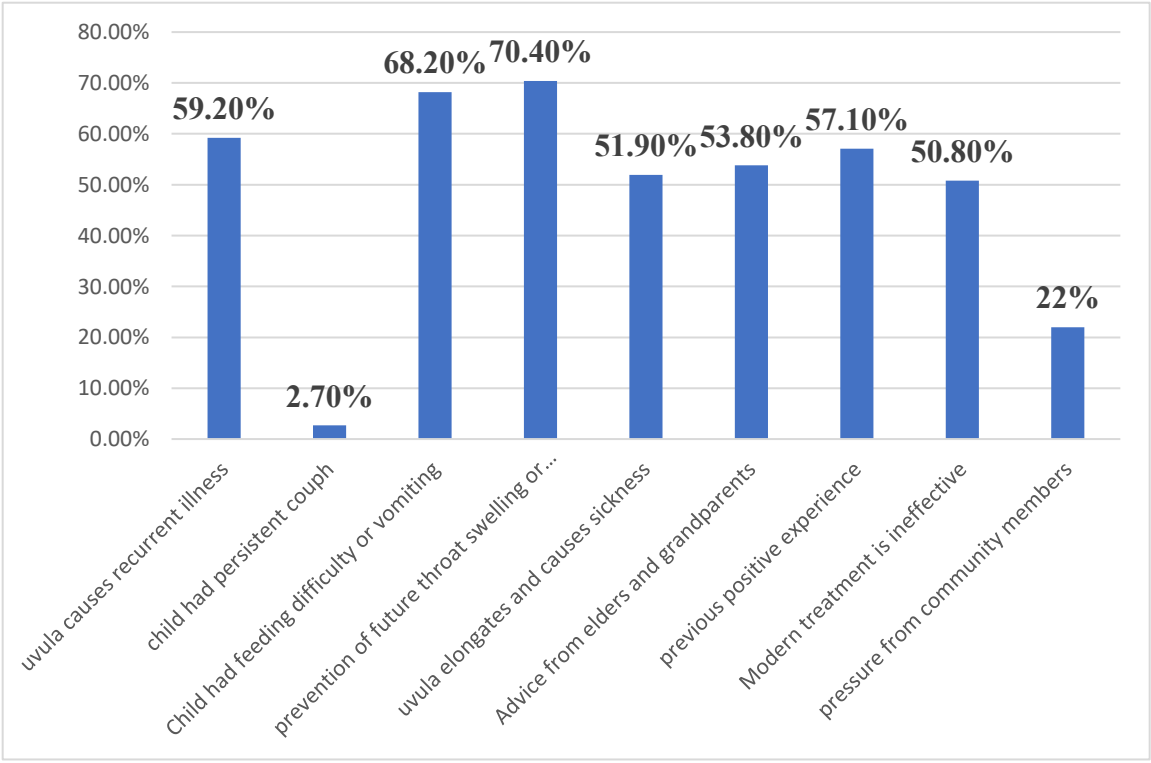


Figure 5: Reasons to choice traditional uvulectomy in Keyih Tekli Wereda, 2026 (n=632)

5.1.6. Factors associated with Traditional Uvulectomy

In this study about 50 independent variables were assessed if an association is present with practice of TU. Both bivariate and multivariate logistic regression analysis were conducted to identify factors associated with the practice traditional uvulectomy. About 17 variables with a p-value less than 0.25 in the bivariate analysis were included in the multivariable logistic regression model. After controlling for potential confounding factors, only five variable including caregiver age, residence, occupational status, the perception that uvulectomy was a culturally important practice in the community and the belief that the uvula causes recurrent illness were found to be significantly associated with traditional uvulectomy at p-value less than 0.05 and 95% confidence interval.

Age of caregivers was significantly associated with traditional uvulectomy practice. Caregivers aged below 20 years were 35.8% less likely to practice traditional uvulectomy compared with those caregivers aged 41-49 years [AOR=0.64(p=0.02,0.44-0.94)].

Residence was also a significantly associated with the practice. caregivers residing in rural areas were 2.44 times more likely to practice traditional uvulectomy than those living in urban areas [AOR = 2.44(p=0.003,1.34-4.44)].

Regarding occupational status, housewives were 6.98 times more likely to practice traditional uvulectomy compared with government employees [AOR = 6.98(p=0.006, 1.74-28.04)].

Caregivers who believed that the uvula causes recurrent illness were significantly associated with the practice traditional uvulectomy [AOR=0.60 (p=0.005,0.42-0.86)]. This indicates that caregivers with such beliefs had about 40% lower odds of practicing TU compared with those who did not hold this belief.

Similarly, caregivers who considered uvulectomy as a culturally important practice in their community were significantly associated with the practice of traditional uvulectomy [AOR=0.65(p=0.02,0.45-0.92)]. Caregivers who perceived the procedure as culturally important had 35% lower odds of practicing traditional uvulectomy compared with those who did not believe uvulectomy as a culturally important practice.

Table 6: bivariate and multivariate logistic regression analysis of factors associated with traditional uvulectomy among caregivers of children under five years old in Keyih Tekli Wereda, Central zone Tigray, Ethiopia, 2026 (n=632).

Variables	Category	Yes	No	COR (95%CI)	AOR (95%CI)	p-value
Age of caregiver in year	<20	49	19	0.76 (0.29-1.98)	0.64 (0.44-0.94)	0.022*
	21-30	248	88	0.84 (0.37-1.91)	1.09 (0.37-3.32)	0.876
	31-40	124	69	0.53 (0.23-1.24)	1.036 (0.39-2.69)	0.942
	41-49	27	8	1	1	
Child age in month	<12	152	61	1	1	
	13-24	184	63	1.17 (0.78-1.77)	1.16 (0.77-1.76)	0.480
	25-36	74	34	0.87 (0.53-1.45)	0.87 (0.53-1.44)	0.589
	37-48	20	15	0.54 (0.26-1.11)	0.52 (0.25-1.09)	0.084
	49-59	18	11	0.66 (0.29-1.47)	0.67 (0.30-1.50)	0.327
Number of under five children	1	193	93	1	1	
	2	195	66	1.42 (0.98-2.07)	1.73 (1.15-2.60)	0.093
	3	33	13	1.22 (0.62-2.43)	1.58 (0.74-3.35)	0.236
	>-4	27	12	1.08 (0.53-2.24)	1.44 (0.61-3.36)	0.405
Residence	Urban	83	37	1	1	
	Rural	365	147	1.11 (0.72-1.71)	2.44 (1.34-4.44)	0.003*
Marital status	Married	439	183	0.27 (0.03-2.12)	0.08 (0.002-2.45)	0.146
	Divorced	9	1	1	1	
Place of delivery	Health facility	421	177	1	1	

	Home	27	7	1.62 (0.69-3.79)	0.40 (0.12-1.35)	0.141
Occupational status	Housewife	444	133	42.56 (15.11-119.9)	6.98 (1.74-28.04)	0.006*
	Governmental	4	51	1	1	
Sex of the child	Male	231	108	1	1	
	Female	217	76	1.34 (0.94-1.89)	0.91(0.59-1.41)	0.675
Uvula has important function in swallowing	Yes	250	87	1.41(0.99 -1.99)	1.28 (0.86-1.89)	0.223
	No	198	97	1	1	
Uvulectomy is effective for childhood throat illnes	Agree	249	91	1.28 (0.91 - 1.80)	1.05 (0.71-1.55)	0.814
	Disagree	199	93	1	1	
Uvula helps protect the body from infection	Yes	359	138	1	1	
	No	89	46	1.35 (0.89-2.02)	1.03 (0.65-1.65)	0.895
Uvulectomy is culturally important	Agree	158	82	0.68 (0.48-0.96)	0.65 (0.45-0.92)	0.016*
	Disagree	290	102	1	1	
Removing uvula is safe	Agree	163	76	0.81 (0.57- 1.15)	0.95 (0.65-1.38)	0.788
	Disagree	285	108	1	1	
Belief that the uvula causes recurrent illness	Yes	168	90	0.63 (0.44-0.89)	0.60 (0.42-0.86)	0.005*
	No	280	94	1	1	
Child had feeding difficulty or vomiting	Yes	133	68	0.72 (0.50-1.03)	0.86 (0.59-1.26)	0.440
	No	315	116	1	1	
Belief that the uvula elongates &cause sickness	Yes	205	99	0.72 (0.51- 1.02)	0.84 (0.58-1.23)	0.373
	No	243	85	1	1	
Advice from elders, Grandparents or relatives	Yes	197	95	0.74 (0.52-1.04)	0.77 (0.54-1.11)	0.166
	No	251	89	1	1	

NB: significant at p-value <0.05 in multivariable analysis, 1=considered as reference category.

5.2. Qualitative Result

5.2.1 Socio-Demographic Characteristics of participants

A total of seven (7) women participants were interviewed for the qualitative study on TU conducted in two kebeles of woreda Keyih Tekli. Participants were selected purposively based on their experience and knowledge related to traditional uvulectomy practices in the community. Data collection continued until data saturation was achieved where no new idea, themes or information emerged from the interviews.

Table 7: Socio-demographic characteristics of the study (Qualitative)

Socio-Demographic Characteristics of participants	Category	Number
Age of caregivers (Year)	20-30	3
	31-45	4
Who decided to practice TU	Mother	3
	Both parents	1
Marital status	Married	7
	Divorced	0
Education level	No education	2
	Primary education	2
	Diploma and above	3
Occupational status	Housewife	4
	Government	3

5.2.2. Emerged Themes

The qualitative data obtained from the in-depth interview were analyzed using thematic analysis. During the analysis process interview transcripts were coded line by line and similar codes were grouped into categories based on their meaning and relationship. Through repeated reading, comparison and interpretation of the data five major themes and thirteen subthemes emerged.

The identified themes provided rich and detailed descriptions of participants perceptions, beliefs, experiences and practices regarding TU among caregivers of under five children in selected kebeles of Keyih Tekli Wereda central zone of Tigray, Ethiopia. The analysis also explored how cultural beliefs, community influence, perceived benefits and experiences with health services shaped the practice of traditional uvulectomy.

To ensure trust worthiness of the findings, the researcher carefully reviewed and compared the responses of participants to identify repeated ideas, similarities and variations across interviews. The themes and sub themes were developed from participants direct narratives and supported by representative quotations.

The five themes and their corresponding thirteen sub-themes are summarized in the following tables (Table 8).

Table 8: Themes, subthemes and codes about traditional uvulectomy

Themes	Sub-themes	Codes
Strong Cultural Belief and Acceptance of Traditional Uvulectomy	➢ Cultural beliefs and perceived benefits ➢ Misconceptions about uvula related illness ➢ Differences in awareness and education	• Uvulectomy is useful • Uvulectomy is harmful • Prevents vomiting and feeding problems • No medical cure for uvula disease
Community and social influence on uvulectomy practice	➢ Family and community influence ➢ Social norms and cultural expectations ➢ Fear of child illness	• Respect for culture • Fear of disease • Children without uvulectomy get sick • Social pressure to perform uvulectomy
Community and Family Influence on Decision-Making	➢ Timing and performers of the practices ➢ Household decision-making and past experiences	• Performed before 2months • Done by traditional healers • family mother or father decision • based on previous experience
Perceived Benefits and Health Risks of uvulectomy	➢ Perceived effectiveness of the practice ➢ Complications following the procedure	• Bleeding after procedure • feeding difficulty/chocking • Perceived improvement after cutting • No complication perceived
Traditional Practices versus Modern Healthcare	➢ Preference for traditional care ➢ Trust and perception toward health facilities ➢ Influence of health education	• Preference for traditional care • Health facilities not trusted • Health workers discourage practice • Education influences decision

Theme 1: Strong cultural belief and acceptance of TU

This theme describes the strong cultural acceptance of TU with in the community. Most participants believed that uvulectomy is beneficial and protects children from illnesses such as vomiting, feeding difficulty, sore throat and choking. The finding also showed differences in awareness between educated and non-educated participants. Participants with limited education commonly viewed the practice as useful and culturally accepted. Whereas health professionals and educated participants described it as harmful and unsupported medically.

For example, in my experience of health working, I have been observed many of children immediately after undergoing traditional uvulectomy they coming to health institutions with complicated such as infection, anemia and difficulty feeding and inability to swallow. Therefore, instead of traditional uvula cutting caregivers of children should be trust medical care to help prevent from these complications

Sub-themes 1: cultural beliefs and perceived benefits

Participants described TU as a culturally accepted practice believed to protect children from illness and improved child health. Many caregivers said that the practice had been transferred from generation to generation and is widely accepted in the community as important for children's wellbeing. One participant stated that, *"I understand it is useful". (Interview 1, 42 years old). Another participant explained, "they believed that children who have had their uvula cutting grow well." (interview 1, 42 years old). Similarly, another mother said that, "they survived because we cut them off." (Interview 4,30 years old).*

Sub-theme 2: Misconceptions about uvula related illness

Participants commonly believed that the uvula causes recurrent illness such as vomiting, chocking and feeding difficulty. Many caregivers perceived that removing the uvula prevents these health problems and protect children from disease. one caregiver explained, *"vomiting and feeding problems" (interview 1, 42years old). Another participant, by 35 years old added that, "they think that when it is cut, the disease will go away."*

Sub-theme 3: Differences in awareness and education

Educated participants and health professionals observed TU as harmful and medically unsupported. In comparison, participants with limited education frequently considered the practice useful and culturally acceptable. A health professional participant explained that*, "No, it does not prevent any disease, it is just a bad culture that had been passed down from generation to generation." (interview 2,35 years old).* Similarly, another *health extension worker by a 35years old added* that, *"traditional uvulectomy is harmful because it exposes children to infectious disease such as HIV and hepatitis."*

Theme 2: Community and social influence on Uvulectomy practice

This theme explains how community expectations, social norms, fear of illness and cultural pressure influences caregivers' decisions to perform traditional uvulectomy. Participants described that families fear children will become sick if the uvula is not removed. Community members commonly believed that children who do not undergo uvulectomy are more likely to experience recurrent illness, feeding difficulty and choking.

Sub-theme 1: Family and community influence

Participants described that family members and the wider community strongly influenced caregiver decisions to perform TU. Community beliefs and cultural expectations encouraged to continue of the TU practice. One participant described the community perception as,

..."respect for culture, fear of disease". Those who do not cut the uvula are believed to be sick and have eating disorders" (Interview 1,42years old), similarly Another participant, by a 30years old added that, "They say children are getting sick because they are not cutting."

Sub-theme 2: Social norms and cultural expectations

Caregivers reported that children who undergo uvulectomy were perceived as healthier and stronger within the community. The practice was socially accepted and considered part of cultural expectations. *participant, by 35 years old added that, "they think that when it is cut, the disease will go away." and also added that, "They believe they will not get sick and will grow well." (Interview 6,35 years old).*

Sub-theme 3: Fear of illness

Fear that children may develop recurrent illness, feed problems and chocking if the uvula is not removed motivated caregivers to continue the practice. One participant Explained that,

… *"They say children are getting sick because they are not cutting." (Interview 4,30 years old). Another participant added that, "those who did not cut their uvula were believed to be sick and have eating dis order." (Interview 1, 42 years old).*

Theme 3: Community and family influence on Decision-making process of TU

This theme describes when, how and by whom traditional uvulectomy is practiced in the community. Most participants reported that uvulectomy is commonly performed before two months of age, often by traditional healers or elderly women known in the community for performing the procedure.

Sub-theme 1: Timing and performers of the practice

Caregivers described that traditional uvulectomy was commonly done before two months of age. The procedure was mainly carried out by traditional healers or elderly women recognized within the community for performing the traditional practices. Participants reported that,

…"they believe in an age of below two months." "She also said that, there were traditional cutters in our neighborhood." (Interview 1,42 years old). Another participant, by a 30years old added that, I cut them in 12days." Other participants also described that, "There is an old woman of traditional uvula cutting in our area." (Interview 4, 30 years old).

Sub-theme 2: household decision making and past experiences

Participants explained that both parents especially mothers were involved in decision making regarding traditional uvulectomy. Previous experiences with older children also influenced caregiver's decisions to perform the practice.one participant stated that,

… "both of us, father and mother decided." Similarly, added that, "The child's symptoms were similar with our children previous experiences, so we took experience from them." (Interview 1, 42 years old).

Theme 4: Perceived Benefits and Health Risks of Uvulectomy

This theme highlights the coexistence of perceived benefits and actual health complications related to traditional uvulectomy. Many caregivers believed that children improved after the procedure and were protected from illness. participants commonly reported improvement in vomiting and feeding problems after uvulectomy.

Sub-theme 1: Perceived effectiveness of the practice

Many caregivers believed that children improved after undergoing traditional uvulectomy. Participants commonly perceived that the practice relieved vomiting, feeding difficulty and other childhood illness. One participant by a 30years old described that,

… *"He was cured of the disease and cured of the vomiting and feeding difficulties."*

Sub-theme 2: Complications following the procedure

Participants also reported several complications after the procedure including bleeding, feeding difficulty, chocking and fever. Health professionals particularly emphasized the harmful effects and risks associated with traditional uvulectomy. One participant, *by a 20years old said that, "There was a bleeding, difficulty of feeding and choking." Another participant explained that, "Nothing happened, there was bleeding but it stopped." (interview 1,42years old).* One health extension worker explained that, *"Traditional uvulectomy should be discouraged to prevent children from suffering complications such as bleeding." (interview 2, 35years old).*

Theme 5: Traditional Practices versus Modern Healthcare

This theme describes the conflict between traditional beliefs and modern healthcare practices. Many participants preferred TU because they believed health facilities could not treat uvula related illnesses. Traditional practices were often viewed as more effective and culturally acceptable than medical treatment.

Sub-theme 1: Preference for traditional care

Participants preferred traditional uvulectomy because they believed health facility could not effectively manage uvula related illness. Traditional care was perceived as more effective and culturally acceptable than modern healthcare services. One participant explained that,

…*"there is no cure for uvula disease in medical or health facility in our area, so we turn to the traditional" (Interview 1, 42years old).* Similarly, one participant added that*, "I prefer traditional uvula cutting rather than care by health professionals" (Interview 3,20 years old).*

Sub-theme 2: Trust and perception toward health facilities

Health professionals discouraged the practice and explained that symptoms attributed to the uvula were caused by infections rather than the uvula itself. This formed differences in perception between caregivers and healthcare providers. A participant stated that, *"They tell us that the uvula should not cut" (interview 1,42years old). Another health professional added that, by a 35years old, "health professional teaches the society that this not a sign of uvula disease but infection"*

Sub-theme 3: influence of health education

Educated caregivers and health workers believed that increasing community awareness and health education could reduce the practice of traditional uvulectomy. *One health extension worker explained that, "it should be stopped by several teachings to the society" (interview 5, 35years old).*

5.2.3. Complementing quantitative findings with qualitative results

The quantitative findings indicated that caregivers living in rural areas were more likely to practice TU than living in urban areas. This result was reliable with the qualitative findings, which established that TU remains extremely rooted in the community culture and is broadly accepted as a normal child healthcare practice. Participants defined the procedure as a tradition passed down over generations and strengthened by community expectations. The presence of traditional practitioners in the community further facilitates the persistence of the practice.

Caregivers less than 20 years were less likely to practice TU than those aged 41 to 49 years. The qualitative findings deliver a possible clarification for this association. Educated participants and health professionals generally observed TU as harmful and deficient medical justification, whereas older caregivers often stated stronger adherence to cultural traditions and long-lasting community beliefs. This suggests that younger caregivers might be more interested to modern health information and health education communications, thereby reducing their likelihood of practicing TU.

Housewives were significantly more likely to practice TU compared with government employees. The qualitative findings support this association by viewing that caregivers' decisions were strongly formed by family members, neighbors and leading community beliefs. Participants reported that mothers were frequently stimulated by relatives and community members to perform uvulectomy to avoid childhood illnesses. Accordingly, housewives might be greater exposure to these cultural impacts and traditional beliefs than government employees who often had better access to health information and formal education.

Caregivers who perceived TU as culturally important were more likely to practice TU. This finding was strengthened by the qualitative data, particularly under the theme of strong cultural belief and acceptance of TU. Participants frequently defined the practice as a valued cultural tradition that encourages child welfare and protects against illness. Many caregivers highlighted that the practice had been maintained across generations and remainders an important component of community life.

The quantitative discovered that caregivers who believed the uvula causes recurrent illness were more likely to perform TU. This finding was supported by the qualitative results where participants commonly associated the uvula with situations such as vomiting, chocking, feeding problems and repeated sickness. Many participants believed that eliminating the uvula could prevent these health complications. In addition, fear of illness emerged as a main factor influencing the decision to accept the procedure.

The qualitative findings complimented the quantitative results by providing profounder insight into the factors that tolerate TU in the community. Cultural beliefs, regarding the role of the uvula in childhood illness, social and family pressure, fear of disease and favorite for traditional treatment emerged as important influences on caregivers' choices. Conversely, increased awareness of the health risks associated with the procedure and better trust in modern healthcare services were more usually stated by educated participant and health professionals. Organized, these findings show that TU was maintained not only by cultural traditions and also by strongly held beliefs regarding child health and illness. This highlights the importance of culturally sensitive health education involvements aimed at correcting misunderstandings and encouraging evidence-based healthcare practices.

CHAPTER SIX

6. DISCUSSION

The current study was aimed to assess the practice of traditional uvulectomy and its associated factors among caregivers of children under five years old in keyih tekli wereda, central zone Tigray region, Ethiopia. The result showed that age of caregiver, occupation, residence, Uvulectomy is culturally important practice in our community and Belief that the uvula causes recurrent illness were the factors significantly associated with TU. The prevalence traditional uvulectomy in this study was lower than in the study conducted in plateau state and jigwa state Nigeria which was practiced by 86.1% and 90% of the respondents respectively (59,60). The difference may be cultural disparities between the studies in Nigeria uvulectomy which was considered as religious dictate and making ritual as well as naming ceremony.

In addition, the prevalence uvulectomy in this study was higher than in a several studies conducted across Ethiopia. In Lemo District, southern Ethiopia, central Ethiopia and south Gonder zone Amhara region which was practiced by 47.4%, 52.5% and 48.8% respectively (24), (29, 36). This difference might be socio-cultural beliefs; variations access to health care services and differences of effectiveness of health education programs across regions. Similarly, studies from Gonder city (38.2%) and Tibebe Ghion specialized hospital (44.6%) also reported lower prevalence compared to the current study (48, 31). However, it was lower than the prevalence reported from Godere district, southwest Ethiopia 82.6% (30). These differences might be related to the variation of the study settings, cultural beliefs, healthcare accessibility, educational status and community awareness across the study locations. In communities where traditional beliefs were strongly accepted and access to healthcare was limited, caregivers may continue relying on traditional practices for managing childhood illness.

Regarding factors associated with traditional uvulectomy, the study showed that caregivers of age was significantly associated with TU practice. Caregivers aged below 20 years were 35.8% less likely to practice traditional uvulectomy compared with caregivers aged 41 to 49 years. This may be because younger caregivers were more exposed to formal education, modern healthcare information and health promotion activities than older caregivers. Older individuals might be

stronger attachment to cultural traditions and previous experiences related to traditional child healthcare practices. Similar findings were reported in studies conducted in Ethiopia and other African countries (9),(35). where older caregivers were more likely to continue harmful traditional practices because of long standing cultural beliefs.

Studies conducted in South Gondar Zone, Ethiopia reported a prevalence of 65.7% (29). The qualitative findings further supported this explanation, as educated participants and health professionals described TU as harmful and medically unsupported. One health professional stated that, *"No, it does not prevent any disease, it is just a bad culture that had been passed down from generation to generation." (interview 2,35 years old).*

Residence was also significantly associated with TU practice. Caregivers residing in rural areas were 2.44 times more likely to practice TU compared to urban residents. This could be due to lower access to healthcare services, limited exposure to health education and stronger cultural influence in rural communities. Rural caregivers may also depend more on traditional healers because healthcare facilities were less accessible. This finding was consistent with studies conducted across Ethiopia, where rural prevalence ranges between 60%and 80%, compared to 30% to 50% in urban areas (23),(29),(38). The qualitative findings also highlighted the influence of community expectations and fear of illness.

Participants explained that families believed children may become sick if the uvula is not removed. One participant stated that, *"Those who do not cut the uvula are believed to be sick and have eating disorder." (Interview 1,42years old).* This indicates that social pressure and cultural norms strongly influence the continuation of the practice.

Occupational status was also a significant associated with traditional uvulectomy practice. Housewives were 6.98 times more likely to practice TU compared to government employee. This might be because government employees were more likely to access health information, formal education, and healthcare services through work place exposure and social interaction. Housewives, on the other hand might be spent more time within community environments where traditional beliefs were commonly shared and practiced. This finding was comparable with studies conducted at Tibebe Ghion specialized hospital in northwest Ethiopia, which reported a

prevalence of 61.2% (31), and in Lemo District central Ethiopia where the prevalence was 58.2%(36).

The qualitative findings further supported this result. Participants described that TU was strongly influenced by community beliefs, cultural expectations, and previous family experiences. Caregivers described the practice as culturally accepted and beneficial for protecting children from illness. One participant stated that, *"they believed that children who have had their uvula cutting grow well." (interview 1, 42 years old).*

Belief that the uvula causes recurrent illness was significantly associated with TU practice. Caregivers who believed that the uvula causes recurrent illness were 40% lower odds of practice TU compared with caregivers who did not have such beliefs. This might be because caregivers associate the uvula with symptoms such as vomiting, choking, feeding difficulty and recurrent illness, leading them to seek traditional treatment to protect their children. This finding is consistent with studies conducted in Ethiopia, where more than 60% to 75% of caregivers reported cultural beliefs as a major reason for practicing uvulectomy (10, 29). Similar studies were reported in Nigeria were conducted 86.1% and 90% misconceptions about uvula related illness were identified as major reasons for performing the procedure (59, 60). The qualitative finding strongly supported this association. Participants frequently defined that children become sick if the uvula is not removed. One participant *by a 30years old explained that, "they say children are getting sick because they are not cutting."* These misconceptions appear to encourage continued practice of TU within the community.

Similarly, caregivers who considered TU culturally important were 35% lower odds of practice the procedure compared with those who did not consider it culturally important. This might be because cultural beliefs and social expectations strongly shape health related behaviors within the community. Practices passed down from generation to generation were often viewed as normal, acceptable and beneficial for children's wellbeing. Studies in Ethiopia reported prevalence ranging from 52.5% to 82.6% in Gondar city and in Godere District (48, 30). respectively. which identified cultural beliefs and community norms as major contributors to harmful traditional practices. The qualitative findings also confirmed that TU was culturally respected and socially accepted. One participant Described that, *"They say children are getting*

sick because they are not cutting." and also defined that, "respect for culture, fear of disease." (Interview 4,30 years old). This recommends that fear of illness and pressure to follow to community traditions contribute to sustaining the practice.

The finding of this study had significant public health implications. This high prevalence of TU and associated complications showed a need for targeted interferences to decrease harmful practices. Health education programs should attention on correcting misunderstandings about the uvula and encouraging safe healthcare practices. These interventions should be culturally sensitive and include community leaders, elders and traditional healers to confirm receiving and effectiveness. In addition, improving access to healthcare services in rural areas and strengthen maternal and child health programs help to decrease confidence on traditional practices. Health education programs should attention on correcting misunderstandings about the uvula and encouraging safe healthcare practices.

6.1. Strength and Limitation of the study

Some of the strengths of this study are:

- ♣ The use of mixed methods approach allowed for a more comprehensive understanding of the issue by combining quantitative data with qualitative insights.
- ♣ It is the first study carried out in the study area especially in Keyih Tekli Wereda Ethiopia.
- ♣ The relatively large sample size also enhances the reliability of the study.

However, the study also has limitations:

- ♣ As a cross-sectional study, it cannot establish causal relationships.
- ♣ There may also be recall bias, as caregivers were required to report past practices.
- ♣ Additionally, social desirability bias may have influenced responses particularly in reporting culturally sensitive practices.

7. Conclusion and Recommendation

7.1. Conclusion

This mixed-methods study revealed a high prevalence of traditional uvulectomy (70.9%) among caregivers of children under five years of age in the study area, indicating that the practice remains deeply rooted in the community despite the availability of modern healthcare services. Both quantitative and qualitative findings demonstrated that cultural beliefs and perceptions play a central role in sustaining the practice. Significant factors associated with traditional uvulectomy included caregivers' residence, age of caregivers, occupation, belief that the uvula causes recurrent illness and perceptions regarding the cultural importance of uvulectomy.

The qualitative findings further explained the persistence of the practice by highlighting strong cultural acceptance of traditional uvulectomy, the influence of family members and community norms on decision-making, perceived benefits of the procedure, concerns regarding modern healthcare accessibility and effectiveness and the continued reliance on traditional healing practices. Therefore, the findings suggest that TU remains a culturally embedded practice shaped by social, cultural and individual factors, underscoring the need for culturally sensitive interventions and community-based health education that address misconceptions to reduce its practice and promote safer child healthcare-seeking behaviors.

7.2. Recommendation

To Central Zone Health Department and Keyih Tekili Wereda Health Office

- ♣ Strengthen community-based health education programs focusing on the harmful effects and complications of TU, particularly targeting rural communities and caregivers with low educational status.

- ♣ Develop culturally sensitive awareness campaigns to correct misconceptions related to the uvula and childhood illness through mass media, community meetings and religious leaders.

To Health Institution

- ♣ Strengthen health education and counseling services for caregivers during child health visits, emphasizing the risks and complications of traditional uvulectomy.

- ♣ Conduct consistent outreach plans in the rural societies to raise awareness about safe child health practices and early treatment seeking behaviors.

- ♣ Work carefully with health extension worker (HEW) to detect high risk communities and afford targeted interventions.

- ♣ Improve the accessibility and quality of maternal and child healthcare services to increase community trust in modern healthcare systems.

To Researchers

- ♣ Conduct longitudinal designs to improved understanding the long-standing health consequences of TU and assess the efficiency of intervention strategies among children less five years old.

8. Reference

1. Abebe AM, Kassaw MW. Traditional uvulectomy and its complications among children in developing countries. Pan Afr Med J. 2020;37(245):1–6.
2. Lartey M, Dako-Gyeke P. Cultural perceptions and health beliefs related to traditional uvulectomy in sub-Saharan Africa. Afr Health Sci. 2019;19(3):2629–2636.
3. World Health Organization (WHO). Traditional Medicine Strategy 2014–2023. Geneva: WHO; 2014.
4. Abdalla M, Osman M. Health risks associated with traditional surgical practices in Africa. East Afr Med J. 2018;95(2):84–90.
5. Ndu IK, Asinobi IN, Ekwochi U, Osuorah CD. Harmful traditional practices affecting child health in Africa. J Trop Pediatr. 2021;67(2):114–121.
6. Onyango D, Ogonda L. Persistence of traditional uvulectomy among rural communities in East Africa. Health Soc Care Community. 2020;28(5):1825–1833.
7. Ezeonu CT, Ezeonu PO. Cultural determinants of harmful traditional health practices in sub-Saharan Africa. Afr J Reprod Health. 2019;23(4):73–81.
8. Ali AA, Al-Saadi A. The health consequences of traditional uvulectomy in African children. World J Clin Cases. 2020;8(21):5164–5172.
9. Wondimu A, Nigatu T. Determinants of harmful traditional practices among Ethiopian mothers. Ethiop J Health Dev. 2017;31(2):110–118.
10. Adefris M, Tessema GA, Gedefaw M. Traditional uvulectomy: Practices, beliefs, and associated factors in Ethiopia. BMC Oral Health. 2018;18(1):98.
11. Yirga WS, Berhan A, Alula MT. Magnitude and associated factors of uvulectomy among under-five children in northern Ethiopia. Int J Pediatr. 2019;2019:1–7.
12. Alemayehu T, Mekonnen Z. Complications following traditional uvulectomy among children in Ethiopia. Ethiop Med J. 2018;56(3):211–217.
13. Federal Ministry of Health (FMOH), Ethiopia. National Strategy and Action Plan on Harmful Traditional Practices. Addis Ababa: FMOH; 2022.
14. WHO. Eliminating harmful traditional practices affecting children: Progress report. Geneva: WHO; 2021.

15. Gebrekirstos K, Weldegebriel Z. Traditional practices and child health outcomes in Tigray, Ethiopia. Ethiop J Health Sci. 2020;30(4):547–555.
16. Tigray Regional Health Bureau. Annual Health Performance Report 2024. Mekelle: TRHB; 2024.
17. World Health Organization. Harmful traditional practices and child health. Geneva: WHO; 2020.
18. UNICEF. Traditional practices and child mortality. New York: UNICEF; 2021.
19. Mekuria A, et al. Cultural determinants of child healthcare-seeking in LMICs. J Public Health. 2022;44(2):e289–96.
20. Ali AA, et al. Traditional uvulectomy in Africa: A review. Afr Health Sci. 2021;21(3):1120–9.
21. Elhadi M, et al. Determinants of traditional uvulectomy in Khartoum State, Sudan. BMC Pediatr. 2023;23:780.
22. Abebe T, et al. Prevalence of traditional uvulectomy in Ethiopia: Systematic review and meta-analysis. BMC Complement Med Ther. 2024;24:112.
23. Solomon T, et al. Regional variations in harmful traditional practices in Ethiopia. Ethiop J Health Sci. 2023;33(1):44–53.
24. Dires T, et al. Prevalence of TU among children in Lemo District, Ethiopia. PLoS One. 2023;18(4):e0284123.
25. Belay G, et al. Traditional practices among caregivers at a specialized hospital in NW Ethiopia. PLoS One. 2023;18(2):e0279874.
26. Mohammed A, et al. TU among under-two children in Godere District. East Afr Med J. 2022;99(6):212–9.
27. Abate S, et al. Complications of traditional uvulectomy: A clinical analysis. Ethiop Med J. 2022;60(3):201–7.
28. Teshome Y, et al. Complication rates following TU in Ethiopia: Meta-analysis. Int J Pediatr Otorhinolaryngol. 2024;175:111132.
29. Yirdaw B, Gobeza M, Gebreegziabher N. Practice and associated factors of traditional uvulectomy among caregivers having children less than 5 years old in South Gondar Zone, Amhara Region, Ethiopia, 2020: A triangulated cross-sectional study. PLOS One. 2022;17(12):e0279362.

30. Nega G, Mohammed A, Alemayehu G, et al. Uptake of traditional uvulectomy and associated factors among children less than two years of age in Godere District, Majang Zone, Gambella Region, Southwest Ethiopia. BMC Pediatr. 2025;25.
31. Tsegaye GW, Fenta F, Bekele G, et al. Proportion of traditional uvulectomy and associated factors among caregivers of children under five years old visiting Tibebe Ghion Specialized Hospital, Northwest Ethiopia, 2023. Health Sci Rep. 2025: e70675.
32. Kebede SD, Agmas K, Kefale D, Aytenew TM. The burdens, associated factors, and reasons for traditional uvulectomy in Ethiopia: A systematic review and meta-analysis. PubMed. 2023.
33. Al-Harbi MF, Al-Qahtani AS. Traditional uvulectomy in Saudi Arabia: prevalence and perceptions. Saudi Med J. 2021;42(5):512-8.
34. Global Health Alliance. Cultural practices and child health: a meta-analysis. Int J Pediatr. 2022;2022:1234567.
35. Adebayo ET, Atakere MO. Uvulectomy practices in Sub-Saharan Africa. Afr Health Sci. 2020;20(3):1456-64.
36. Belachew T, Fikadu Y, Tessema B, et al. Magnitude and determinant factors of traditional uvulectomy among children under five in Lemo District, Hadiya Zone, Central Ethiopia. Sci Rep. 2025;15:13196.
37. Ahmed SM, Osman A. Complications of uvulectomy in Sudanese children. East Mediterr Health J. 2019;25(11):789-96.
38. Tesfaye A, Assefa N. Factors influencing uvulectomy in Oromia, Ethiopia. BMC Public Health. 2022;22:1345.
39. Alemu H, Tadesse Z. Urban perspectives on traditional practices in Addis Ababa. Ethiop J Health Dev. 2019;33(1):45-52.
40. Getachew T, Negash A, Kebede SM, et al. The burdens, associated factors, and reasons for traditional uvulectomy in Ethiopia: a systematic review and meta-analysis. Int J Pediatr Otorhinolaryngol. 2024;176:111835.
41. Kebede S, Agmas K, Kefale D, Kassaw A, Aytenew TM. Pooled prevalence and associated factors of traditional uvulectomy among children in Africa: a systematic review and meta-analysis. PLoS ONE. 2025;20(3):e0316755. doi:10.1371/journal.pone.0316755.

42. Smith J, Johnson L. Migrant health practices in the UK. J Immigr Minor Health. 2021;23(4):678-85.
43. hairu L, et al. Knowledge, Attitude and Practice on Traditional Uvulectomy among Mothers of Under Fives in a Rural Community of Kajiado County, Kenya. East African Medical Journal. 2015;92(9):443-448.
44. Gebre T, Hailu A. Post-conflict health behaviors in Tigray. Conflict Health. 2023;17:12.
45. Alene GD, Edris M. Knowledge, Attitudes and Practices involved in Harmful Health Behavior in Dembia District, northwest Ethiopia. Ethiop J Health Dev. 2002;16(2):199-207.
46. Prual A, Gamatie Y, Djakounda M, Huguet D. Traditional uvulectomy in Niger: a public health problem? Social Science & Medicine. 1994. Oct 1;39(8):1077–82.
47. Thairu L, et al. Knowledge, Attitude and Practice on Traditional Uvulectomy among Mothers of Under Fives in a Rural Community of Kajiado County, Kenya. East African Medical Journal. 2015;92(9):443-448.
48. Bazezew LY, Dagne AH, Gobeza MB. Prevalence of traditional uvulectomy and its associated factors among parents who had less than 6 months of infants in Gondar City, north-west Ethiopia: Mixed study design. PLOS One. 2024;19(7):e0305175.
49. World Health Organization. Caregiver roles in child health and development. Geneva: WHO; 2020.
50. United Nations Children's Fund. Child protection and caregiving definitions. New York: UNICEF; 2019.
51. World Health Organization. Eliminating harmful traditional practices affecting children. Geneva: WHO; 2018.
52. Tesfaye F, Assefa N. Attitudes toward traditional uvulectomy among caregivers in Oromia Region, Ethiopia. BMC Public Health. 2022;22:1786.
53. Kebede A, Abate A, Tsegay Y. Data collection approaches and challenges in community-based health research in Ethiopia. BMC Res Notes. 2020;13(1):455.
54. Getachew M, Hailu H, Tsegay D, et al. Traditional uvulectomy among children in Ethiopia: prevalence, determinants and associated complications. BMC Pediatr. 2024;24:112.
55. Alemu A, Worku T, Adane D. Ensuring data quality in mixed-method research: lessons from fieldwork in Ethiopia. Int J Qual Methods. 2022;21:1–10.

56. Mohammed S, Aliyu A. Best practices in interviewer-administered data collection for traditional health practice studies. Afr Health Sci. 2021;21(3):1450–1458.
57. Tadesse M, Gebreyesus H. Pretesting and reliability assessment in public health surveys: evidence from Ethiopian field studies. BMC Res Notes. 2020;13(1):455.
58. Kassahun W, Yimer G. Qualitative data trustworthiness and validation in community-based research. Qual Rep. 2023;28(5):1205–1218.
59. Adoga AA, Nimkur TL. The traditionally amputated uvula amongst Nigerians: still an ongoing practice. ISRN otolaryngology. 2011;2011
60. Ajibade B, Okunlade J, Kolade O. Harmful cultural practices: parents perceived effects of traditional uvulectomy on the under five children in Jigawa State, Nigeria. Journal of Dental and Medical Sciences. 2013;9(5):8-13

9. Lists of Annexes

Annex I: Personal Information Sheet

Dear participant,

My name is _____, and I am here today to gather information for a study on the practice, perceptions, and factors associated with traditional uvulectomy among caregivers of children under five years. This research is being carried out by Berhe Tafere, a postgraduate student in the Department of Pediatric and Child Health Nursing at Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery. The purpose of this study is to examine caregivers' practices, beliefs, and contributing factors related to traditional uvulectomy in children under five in Keyih Tekli Wereda, Central Zone of Tigray. I kindly invite you to participate and to provide honest responses.

The interview will take approximately 15 minutes of your time. Your name will not be written anywhere on this form. There are no anticipated risks from participating, aside from the short time needed to complete the questionnaire. All information you share will remain strictly confidential. Participation is entirely voluntary, and you may skip any question you prefer not to answer or withdraw from the interview at any time if you feel uncomfortable. If you have any questions about this study you may contact the principal investigator using the details below:

Principal Investigator: Berhe Tafere
Phone: +251986836999
Email: berhetafere21@gmail.com

Annex II: Informed Consent

Dear participant,

My name is _____, and I am assigned to collect data from individuals taking part in this study. This questionnaire has been prepared by Berhe Tafere, a postgraduate student at Addis Ababa University, College of Health Sciences, School of Nursing and Midwifery, Department of Pediatric and Child Health Nursing. The purpose of the study is to examine the practice, perception, and associated factors related to traditional uvulectomy among caregivers of children under five years in Keyih Tekli Wereda, Central Zone, Tigray Region. The findings of this study aim to determine the magnitude and contributing factors of traditional uvulectomy, providing essential baseline information to help address issues related to this practice in children.

The questionnaire includes some personal questions designed to assess your experience, views, and the factors influencing traditional uvulectomy. Your participation in this study is entirely voluntary. You have the right to decline participation or withdraw at any point without any consequences. All information you provide will be treated with strict confidentiality, and no personal details will be disclosed or used for any purpose outside this research. There is no financial compensation for taking part in the study, but your contribution is highly appreciated. If you have any questions regarding the study, you may contact the principal investigator, Mr. Berhe Tafere.

Respondent's Signature:_____

Date of Interview: _____Time Started: _____ Time Finished: _____

Interviewer's Name: _____
Signature: _____ Date: _____

Supervisor's Name: _____
Signature: _____

Principal Investigator: Berhe Tafere
Cell phone: +251986836999
Email: berhetafere21@gmail.com

Interview Outcome: 1. Completed 2. Refused 3. Partially Completed

ተወሳኺ ሓበሬታ ፡ ውልቃዊ ሓበሬታ ወረቐት

ክቡር ተሳታፊ፡

ስመይ _____ ይበሃል፣ ሎሚ ድማ ኣብዚ ዘለኹ፣ ኣብ መንጎ ኣለይቲ ትሕቲ ሓሙሽተ ዓመት ህጻናት ምስ ባህላዊ ኡቩሌክቶሚ ዝተኣሳሰር ልምዲ፣ ኣረኣእያን ረቓሒታትን ንምጽናዕ ሓበሬታ ንምእካብ እየ። እዚ መፅናዕቲ ኣብ ኣዲስ ኣበባ ዩኒቨርስቲ ኮሌጅ ሳይንስ ጥዕና ቤት ትምህርቲ ነርሲንግን መሕረሲትን ክፍሊ ሕክምና ሕፃናትን ጥዕና ህፃናትን ተመሃራይ በርሀ ታፈረ ዝካየድ ዘሎ እዩ። ዕላማ እዚ መፅናዕቲ ኣብ ዞባ ማእኸላይ ዞባ ትግራይ ቀይሕ ተኽሊ ወረዳ ትሕቲ ሓሙሽተ ዓመት ምስ ባህላዊ ዩቩሌክቶሚ ዝተኣሳሰሩ ኣሰራርሓ ኣለይቲ ሕሙማት፣ እምነቶምን ኣበርክቶ ዝገብሩ ረቓሒታትን ንምፍታሽ እዩ።ክትሳተፉን ብቕንዕና መልሲ ክትህቡን ብትሕትና ይፅድም።

ምትሕብባርኩም ኣብ ከባቢ ባህላዊ ኡቩሌክቶሚ ኣብ ንኣሽቱ ህጻናት ንዘለዉ ጉዳያት ኣብ ምርዳእ ልዑል ዋጋ ኣለዎ።እቲ ቃለ መሕትት ኣስታት 15 ደቓይቕ ካብ ግዜኹም ክወስድ እዩ። ስምካ ኣብዚ ቅጥዒ ኣብ ዝኾነ ቦታ ኣይክጽሓፍን እዩ፣ ምስቲ እትህቦ ሓበሬታ ድማ ኣይክተሓሓዝን እዩ። ነቲ መሕተቲ ንምምላእ ዘድሊ ሓጺር ግዜ ገዲፍካ፡ ካብ ምስታፍ ዝግመት ሓደጋታት የለን። ኩሉ እተካፍልዎ ሓበሬታ ብጥብቂ ምስጢራዊ ክኸውን እዩ። ተሳትፎ ምሉእ ብምሉእ ብወለንታ ዝፍጸም ኮይኑ፡ ዘይምቕእነት እንተተሰሚዑካ ኣብ ዝኾነ እዋን ክትምልሶ ወይ ካብቲ ቃለ መሕትት ክትስሕብ ዝደለኻዮ ሕቶ ክትዝልፎ ትኽእል ኢኻ። ብዛዕባ እዚ መጽናዕቲ ዝኾነ ሕቶታት ምስ ዝህልወኩም ወይ እቲ መጽናዕቲ ምስ ተዛዘመ ውጽኢት ክትፈልጡ ምስ እትደልዩ፡ ነዚ ኣብ ታሕቲ ዘሎ ዝርዝር ተጠቒምኩም ምስቲ ዋና መርማሪ ክትረኽብዎ ትኽእሉ ኢኹም፤

ዋና መርማሪ፡ በርሀ ታፈረ

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ኢመይል፡ berhetafere21@gmail.com

መመላእታ ፡፡ ብሓበሬታ ዝተሰነየ ፍቓድ

ዝኸበርካ ተሳታፊ፡

ስመይ _____ እዩ፣ ኣብዚ መጽናዕቲ ካብ ዝሳተፉ ውልቀሰባት ዳታ ንምእካብ ድማ ተመዲበ ኣለኹ፡፡ እዚ መሕተቲ ጽሑፍ ኣብ ኣዲስ ኣበባ ዩኒቨርስቲ ኮሌጅ ሳይንስ ጥዕና ቤት ትምህርቲ ነርሲንግን መሕረሲትን ክፍሊ ነርሲንግ ጥዕና ህጻናትን ህጻናትን ናይ ድሕረ ምረቓ ተማሃራይ በርሀ ታፈረ ዝተዳለወ እዩ፡፡ ዕላማ እቲ መዕናዕቲ ኣብ ክልል ትግራይ ዞባ ማእኸል ቀይሕ ተኽሊ ወረዳ ኣብ ዝርከቡ ኣለይቲ ትሕቲ ሓሙሽተ ዓመት ህፃናት ምስ ባህላዊ ዩቩሌክቶሚ ዝተኣሳሰሩ ኣሰራርሓ፣ ኣረዳድኣን ተዛመድቲ ረቛሒታትን ንምፍታሽ እዩ፡፡ውጽኢት ናይዚ መጽናዕቲ፡ ንዓቐንን ኣበርክቶ ዝገብሩ ረቛሒታትን ባህላዊ ዩቩሌክቶሚ ንምፍላጥ ዝዓለመ ኮይኑ፡ ምስዚ ተግባር ኣብ ህጻናት ዝተኣሳሰሩ ጉዳያት ንምፍታሕ ዝሕግዝ ኣገዳሲ መበገሲ ሓበሬታ ምሃብ እዩ፡፡

እቲ መሕተቲ ገለ ውልቃዊ ሕቶታት ዘጠቓልል ኮይኑ፡ ንተመኩሮኻ፡ ኣረኣእያኻን ንባህላዊ ዩቩሌክቶሚ ዝጸልዉ ረቛሒታትን ንምግምጋም ዝተዳለወ እዩ፡፡ ኣብዚ መጽናዕቲ ተሳትፎኹም ምሉእ ብምሉእ ብወለንታኹም እዩ፡፡ ኣብ ዝኾነ እዋን ብዘይ ዝኾነ ሳዕቤን ተሳትፎ ናይ ምንጻግ ወይ ምስሓብ መሰል ኣሎካ፡፡ ኩሉ እትህቦ ሓበሬታ ብጽኑዕ ምስጢራዊነት ክሕከም እዩ፣ ካብዚ መጽናዕቲ ወጻኢ ዝኾነ ውልቃዊ ዝርዝር ሓበሬታ ኣይግለጽን ወይ ንዝኾነ ዕላማ ኣይክውዕልን እዩ፡፡ ኣብቲ መጽናዕቲ ብምስታፍካ ዝኾነ ገንዘባዊ ካሕሳ የለን፡ እንተኾነ ግን ኣበርክቶኻ ኣገዩ ዝምስገን እዩ፡፡ መዕናዕቲ ብዝምልከት ዝኾነ ሕቶ ምስ ዝህልወኩም ምስ ዋና መርማሪ ኣይተ በርሀ ታፈረ ክትረኽብዎ ትኽእሉ ኢኹም፡፡

ፈርማ መልሲ ዝሃበ ሰብ፡ _____

ዕለት ቃለ መሕትት፡ _____ዝጀመረሉ ግዜ፡ _____ ዝተዛዘመሉ ግዜ፡ _____

ስም ሓታቲ፡ _____ፈርማ፡ _____ ዕለት፡_____

ስም ተቐጻጻሪ፡ _____ክታም፥_____

ዋና መርማሪ፤ በርሀ ታፈረ ሞባይል፡ +251986836999 ኢመይል፡ _____@gmail.com

ውጽኢት ቃለ መሕትት፤ 1. ተዛዚሙ 2. ኣብዩ 3. ብኽፊል ተዛዚሙ

Annex III: Questionnaires

Section 1: Caregiver Socio-Demographic Characteristics

S.no	Socio-demographic characteristics (questionnaire)	Response	Remark
1	Age of caregiver (years)	-------	
2	Sex of caregiver:	1. Female 2. Male	
3	Residence	1. Urban 2. Rural	
4	Relationship to the child	1. Mother 2. Father 3. Grandparents 4. other guardian specify……	
5	Marital Status	1.Married 2.Single 3.Divorced 4.Widowed	
6	Education Level	1.Noformal education 2.Primary education 3.Secondary education 4.College diploma and above	
7	what is your occupation	1.House wife 2.Farmer 3.Merchant	

		4.Goverment employer 5.Daily laborer 6.Others	
	Childs characteristics		
8	Child's age (months)	--------	
9	Number of children under five in the household	1. 1 2. 2 3. 3 4. ≥4	
10	where was the last child delivered	1.Health facility 2.Home	
11	what is the Birth order of the child	1.First 2.Second 3.Third 4.Forth and above	
12	what is the sex of the child	1.Male 2.Female	

Section 2: Knowledge of caregivers about traditional uvulectomy of children under five

S.no	Knowledge of Caregivers	Response	Remark
1	Do you know the uvula has important functions in swallowing?	1.Yes 2.No	
2	Do you know removing the uvula can cause severe bleeding?	1.yes 2. No	
3	Do you know traditional uvulectomy can lead to infection?	1.Yes 2.No	
4	Traditional uvulectomy has no proven medical benefit.	1.Yes 2.No	
5	Do you know uvulectomy can cause breathing problems in young children?	1.Yes 2.No	
6	Persistent cough is not caused by the uvula	1.Yes 2.No	
7	Do you know the function of uvula?	1.Yes 2.No	
8	Uvulectomy performed with unsterile tools can transmit tetanus.	1.Yes 2.No	
9	Do you know modern healthcare can treat throat infections without removing the uvula?	1.Yes 2.No	
10	Do you know the uvula helps protect the body from infections?	1.Yes 2.No	

Section 3: Practice of traditional uvulectomy among caregivers of children under five years

S.no	Practice of Traditional Uvulectomy	Responsible	Remark
1	Has your child ever undergone traditional uvulectomy?	1.Yes 2. No	if yes, ask the next question
2	At what age was the procedure done?	1. <1 month 2. 1-5 month 3. 6-11month 4. ≥11month 5. 5years	
3	How many of your children have undergone traditional uvulectomy?	1.none 2.1 3.2 4. ≥4	
4	Who decided to practice traditional uvulectomy?	1.Mother 2.Father 3.Both parents 4.Grandparents 5.Other relatives 6.Traditional healers	
5	Who performed the procedure?	1. Traditional healer 2. Elder woman 3. Religious leader 4. Other (specify) _____	

6	What tools were used?	1. Razor blade 2. Sharp knife 3.Thread 4.Unknown 5.Others (specify) _____	
7	Was the tool sterilized?	1.Yes 2. No 3. Don't know	
8	Does the child have complication following uvulectomy?	1.Yes 2.No	if yes ,ask next questions
9	Which of the following occurred?	1.Bleeding 2. Infection 3. Fever 4. Difficulty breathing 5. Diarrhea 6.Poor feeding 7. Tetanus 8.Required hospitalization 9.Death (in family or community experience) 10.Other (specify) _____	

Section 4: Attitude toward traditional uvulectomy among caregivers of children under five

S.no	Attitude of caregivers on traditional uvulectomy	Responsible	Remark
1	Traditional uvulectomy is an effective treatment for childhood throat illnesses.	1.Agree 2.Disagree	
2	Removing the uvula prevents future health problems.	1.Agree 2.Disagree	
3	Modern medicine is not effective for treating uvula-related problems	1.Agree 2.Diagree	
4	Uvulectomy is a culturally important practice in our community.	1.Agree 2.Disagree	
5	Do you encourage others to perform traditional uvulectomy	1.Agree 2.Disagree	
6	Removing the uvula is safe when done by an experienced traditional healer.	1.Agree 2.Disagree	
7	Uvulectomy should continue in this community.	1.Agree 2.Disagree	
8	The uvula causes illness when it becomes swollen.	1.Agree 2.Disagree	
9	Community elders encourage uvulectomy because it is proven to work.	1.Agree 2.Disagree	
10	Uvulectomy is harmless when performed by experienced healers.	1.Agree 2.Disagree	

Section5: Reasons for traditional uvulectomy among caregivers of children under five years old

S.no	Reasons for traditional uvulectomy	Response	remark
1	What were the main reasons for performing uvulectomy?	1. Belief that the uvula causes recurrent illness. 2. Child had persistent cough. 3. Child had feeding difficulty or vomiting. 4. Prevention of future throat swelling or blockage. 5. Belief that the uvula elongates and causes sickness. 6. Advice from elders, grandparents, or relatives. 7. Previous positive experience with uvulectomy. 8. Belief that modern treatment is ineffective. 9. Pressure from community members.	

Annex IV: መዝገብ ሕቶታት (Questionnaires)

ክፍሊ 1: ብዛእባ ኩነታት ህልው ማህበረ ነባራዊ ተሳተፍቲ (Socio-demographic characteristics)

ተ.ቁ	ማህበራዊ-ዲሞግራፊ (ሕቶታት)	መልሲ	ማስታወሻ
1	ዕድመ ኣላዪ (ዓመታት)	-------	
2	ጾታ ኣላዪ	1. ጓል ኣንስተይቲ 2. ተባዕታይ	
3	መንበሪ ገዛ	1.ከተማዊ 2. ገጠር	
4	ምስቲ ቆልዓ ዘለዎ ርክብ	1. ኣደ 2. ኣቦ 3. ኣያታትን ኣያታትን 4. ካልእ ኣላዩ ይገልጽ.....	
5	ኩነታት መርዓ	1.ዝተመርዓት 2.ንጽል 3.ዝተፋትሐት 4.ሰብኣያ ዝሞታ	
6	ደረጃ ትምህረቲ	1.ዘይተመሃረት 2.ቀዳማይ ብረከ. 3.ካልኣይ ደረጃ ትምህርቲ 4.ዲፕሎማ ኮሌጅን ልዕሊኡን	

7	እንታይ እዩ ሞያኻ	1.ሰበይቲ ገዛ 2.ሓረስታይ 3.ነጋዳይ 4.መንግስታዊ ኣስራሒ 5.መዓልታዊ ሰራሕተኛ 6.ካልኦት።	
	ባህርያት ቆልዑ		
8	ዕድመ ህፃን ብኣዋርሕ		
9	ብዝሒ ትሕቲ ሓሙሽተ ዓመት ህጻናት ኣብቲ ገዛ	1. 1 2. 2 3. 3 4. ≥4	
10	ናይ መወዳእታ ቆልዓ ኣበይ እዩ ተወሊዱ	1. **ኣብ ጥዕና ትካል** 2. **ኣብ ገዛ**	
11	ስርዓት ልደት ናይቲ ቆልዓ እንታይ እዩ።	1. **ቀዳማይ** 2. **ካልኣይ** 3. **ሳልሳይ** 4. **ራብዓይን ልዕሊኡን**	
12	ጾታ ናይቲ ቆልዓ እንታይ እዩ።	1. ጓል ኣንስተይቲ 2. ተባዕታይ	

ክፋሊ 2፡ ኣፍልጦ ኣብ ኣዶ/መዕበይ ብዛዕባ ኣብ ባህላዊ መኩራጥ ኣውላ

ተ.ቁ	ኣፍልጦ ኣዶታት	መልሲ	ማስታወሻ
1	ኡቮላ ኣብ ምውሓጥ ኣገዳሲ ስራሕ ከም ዘለዎ ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	
2	ነቲ ኡቮላ ምእላይ ከቢድ ምፍሳስ ደም ከምጽእ ከም ዝኽእል ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	
3	ባህላዊ ዩቩሌክቶሚ ናብ ረኽሲ ከምርሕ ከም ዝኽእል ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	
4	ባህላዊ ዩቩሌክቶሚ ዝኾነ ዝተረጋገጸ ሕክምናዊ ረብሓ የብሉ ኢልኪ ትኣምኒ ዶ	1.እወ 2.ኣይፋሉን	
5	ዩቩሌክቶሚ ኣብ ንኣሽቱ ህጻናት ናይ ምስትንፋስ ጸገም ከምጽእ ከም ዝኽእል ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	
6	ቀጻሊ ሰዓል ብሰንኪ ኡቩላ ዝመጽእ ኣይኮነን ዶ ትብሉ	1.እወ 2.ኣይፋሉን	
7	ስራሕ ኡቩላ ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	
8	ብዘይ ጽሩይ መሳርሒታት ዝግበር Uvulectomy ቴታነስ ከመሓላልፍ ከም ዝኽእል ትፈልጡ ዶ።	1.እወ 2.ኣይፋሉን	
9	ዘመናዊ ክንክን ጥዕና ንረኽሲ ጎሮሮ ኡቩላ ከየውጽአ ክሕክም ከም ዝኽእል ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	
10	ኡቩላ ንኣካላትና ካብ ረኽሲ ንምክልኻል ከም ዝሕግዝ ትፈልጡ ዶ?	1.እወ 2.ኣይፋሉን	

ክፍሊ 3. ልምምድ ባህላዊ ዩቩሌክቶሚ (Practice of traditional uvulectomy)

ተ.ቁ	ተግባር ባህላዊ መቁረጥ ኣውላ	መልሲ	ማስታወሻ
1	ውላድካ ባህላዊ ዩቩሌክቶሚ ተገይሩሉ ይፈልጥ ድዩ	1.እወ 2.ኣይፋሉን	እወ እንተኾይኑ ዝቕጽል ሕቶ ሕተት።
2	እቲ መስርሕ ኣብ ክንደይ ዕድመ እዩ ተከሊኡ?	1. <1 ወርሒ 2. 1-5 ወርሒ 3. 6-11ወርሒ 4. ≥11ወርሒ 5. 5ዓመት	
3	ክንደይ ደቅኹም እዮም ባህላዊ ዩቩሌክቶሚ ዝገበሩ?	1.የብልናን 2.1 3.2 4. ≥4	
4	መን እዩ ባህላዊ ዩቩሌክቶሚ ክገብር ዝወሰነ?	1.ኣዶ 2.ኣቦ 3.ክልቲኦም ወለዲ 4.ኣባሓጎታት 5. ካልኦት ኣዝማድ 6. ባህላዊ ፈወስቲ	
5	መን እዩ ነቲ መስርሕ ፈጺምዎ?	1. ባህላዊ ፈዋሲ 2. ሽማግለ ሰበይቲ 3. መራሒ ሃይማኖት።	

		4. ካልእ (ግለጽ).	
6	እንታይ ዓይነት መሳርሒታት እዩ ተጠቒሙ፡	1. መላጸ ላማ 2. በሊሕ ካራ 3.ፈትሊ 4.ዘይፍለጥ 5.ካልኦት (ምግላጽ) ___	
7	እቲ መሳርሒ ጽሩይ ድዩ ነይሩ?	1.እወ 2.ኣይፋሉን 3. ኣይፍለጥን	
8	እቲ ህጻን ድሕሪ ዩኹሌክቶሚ ጸገም ነይሩዎ ድዩ?	1.እወ 2.ኣይፋሉን	እወ እንተኾይኑ ዝቕጽል ሕቶ ሕተት።
9	ካብዞም ዝስዕቡ ኣየናይ እዩ ኣጋጢሙ?	1.ምፍሳስ ደም 2. ረኽሲ 3. ሰዓል 4. ጸገም ምስትንፋስ 5. ተምላስ 6.ትሑት ምምጋብ 7. ቴታነስ 8.ኣብ ሆስፒታል ምእታው ዘድሊ 9.ሞት (ብተመኩሮ ስድራቤት ወይ ማሕበረሰብ) 10.ካልእ (ግለጽ)	

ክፍሊ 4፡ ርዲኢት ኣዶ/መዕበይ ኣብ ኣውላ ምቁራጥ ወይ ምክላእ (Attitude of caregivers)

ተ.ቁ	ኣተሓሳስባ ኣብ ምቁራጥ ኣውላ	መልሲ	ማስታወሻ
1	ባህላዊ ዩ፞ሉ፞ክቶሚ ንሕማማት ጎሮሮ ህጻናት ውጽኢታዊ ፍወሳ እዩ።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
2	ኡ፞ሉ፞ ምእላይ ኣብ መጻኢ ጸገማት ጥዕና ይከላኸል።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
3	ዘመናዊ ሕክምና ምስ ኡ፞ሉ፞ ዝተኣሳሰሩ ጸገማት ንምፍዋስ ውጽኢታዊ ኣይኮነን።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
4	ኡ፞ሉ፞ክቶሚ ኣብ ሕብረተሰብና ብባህሊ ኣገዳሲ ልምዲ እዩ።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
5	ካልኦት ባህላዊ ዩ፞ሉ፞ክቶሚ ክገብሩ ትተባብዕ ዲኻ	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
6	ምእላይ ኡ፞ሉ፞ ብተመኩሮ ባህላዊ ፈዋሲ ክግበር ከሎ ውሑስ እዩ።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
7	ኣብዚ ማሕበረሰብ ዩ፞ሉ፞ክቶሚ ክቕጽል ኣለዎ ኢልኩም ትኣምኑ ዶ?	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
8	ኡ፞ሉ፞ ምስ ሓበጠ ሕማም ዘስዕብ ዶ ይመስለኩም?	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
9	ሽማግለታት ማሕበረሰብ ንኡ፞ሉ፞ክቶሚ የተባብዕዎ ምኽንያቱ ከም ሰርሕ ዝተረጋገጸ እዩ።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	
10	ዩ፞ሉ፞ክቶሚ ብሙኩራት ፈወስቲ ክግበር ከሎ ጐዳኢ ኣይኮነን።	1. እስማዕማዕ እየ 2. ኣይስማዕማዕን	

ክፍሊ 5፡ ምኽንያታት ባህላዊ መቁረጥ ኣውላ (Reasons for traditional uvulectomy)

ተ.ቁ	ምኽንያታት ባህላዊ ኣውላ መቁረጥ	መልሲ	ማስታወሻ
1	ዩቩሌክቶሚ ንምፍጻም ዝሕግዙ ቀንዲ ምኽንያታት እንታይ እዮም ነይሮም?	1. ኡቩላ ተደጋጋሚ ሕማም ከም ዘስዕብ ምእማን። 2. ህጻን ቀጻሊ ሰዓል ነይርዎ። 3. ህጻን ናይ ምምጋብ ጸገም ወይ ተምላስ ነይርዎ። 4. ኣብ መጻኢ ሕበጥ ወይ ምዕጻው ጎሮሮ ምክልኻል። 5. ኡቩላ ይንውሕን ሕማም ከም ዘስዕብን ምእማን። 6. ምኽሪ ሽማግለታት፡ ኣያታት ወይ ኣዘማድ። 7. ቅድሚ ሕጂ ኣብ ዩቩሌክቶሚ ዝነበረ ኣወንታዊ ተመኩሮ። 8.ዘመናዊ ሕክምና ውጽኢታዊ ከምዘይኮነ ብምእማን። 9.ጸቕጢ ካብ ኣባላት ሕብረተሰብ።	

Annex V: Qualitative Interview Guide

Dear participant, I am currently working a research to assess practice, perception and its associated factors of traditional uvulectomy among caregivers of children under five years in Keyih Tekli Wereda central zone Tigray Ethiopia , to fulfill the thesis. I am here to interview you some issue which help us to triangulate the quantitative finding of experience practice with traditional uvulectomy of your child. All information you share will remain strictly confidential and The interview will take 20-35min.

Are you voluntary to ask you? 1. No (Thank you)

2. Yes (Continue to ask)

መመላእታ VI፡ መምርሒ ዓይነታዊ ቃለ መሕትት።

ክቡር ተሳታፊ፡ ኣብዚ ሕጂ እዋን ኣብ keyih tekli wereda central zone tigray Ethiopia ፡ ኣብ keyih tekli wereda central zone tigray Ethiopia ፡ ኣሰራርሓ፡ ርድኢትን ምስኡ ዝተኣሳሰሩ ረቓሒታትን ባህላዊ ኡሹሌክቶሚ ንምግምጋም ዝዓለመ መጽናዕቲ ይሰርሕ ኣለኹ። ኣነ ኣብዚ ዘለኹ ገለ ጉዳይ ቃለ መሕትት ክገብረልካ እየ እዚ ድማ ነቲ ብዝሒ ርኽበት ናይ ተመኩሮ ልምምድ ምስ ባህላዊ uvulectomy ናይ ውላድካ ስሉስ ኩርናዕ ንምግባር ይሕግዘና። ኩሉ እተካፍልዎ ሓበሬታ ብጥብቂ ምስጢራዊ ኮይኑ ክቕጽል እዩ እቲ ቃለ መሕትት ድማ 20-35min ክወስድ እዩ።

ክትሓተካ ብወለንታ ዲኻ? 1. ኣይፋልን (የቕንየልና)

2. እወ (ምሕታት ቀጽል)

Interview Questions

Section 1: Socio-Demographic Information

S.no	Interview Guides	Probes	Remark
1	Can you tell me your age?		
2	What is your relationship to the child (mother, father, guardian)?		
3	How many children under five do you currently care for?		
4	What is your highest level of education?		
5	What is your occupation?		
6	Where do you live (urban/rural/community)?		

Section 2: Knowledge and awareness of traditional uvulectomy

S.no	Interview Guides	Probes	Remark
1	Have you ever heard about traditional uvulectomy?		if yes, Ask next question
2	From whom or where did you hear about it?		
3	What do you understand by traditional uvulectomy?		
4	At what age do people in your community believe uvulectomy should be done?		
5	What illnesses or symptoms do people believe uvulectomy can treat or prevent?	Sore throat, vomiting, feeding problems, cough, failure to thrive, recurrent illness	

Section 3: Community views and Social Norms

S.no	Interview Guide	probes	Remarks
1	What do people in your community generally think about traditional uvulectomy?	Fear of illness Social approval or blame Respect for tradition	
2	How do people talk about children who undergo uvulectomy?		
3	How do people talk about children who do not undergo it?		

Section 4: Practice and Lived Experience

S.no	Interview Guide	Probes	Remark
1	Have any of your children undergone traditional uvulectomy?		if yes, Ask the next
2	How old was the child at the time?		
3	Who suggested or initiated the decision?		
4	Who performed the procedure and where?		
5	What happened during and after the procedure?		
6	How did you feel at the time?		
7	Were there any challenges or unexpected outcomes?		
8	What are the main reasons your child has not undergone uvulectomy?		if no, Ask No 8 & 9
9	Was this decision easy or difficult?		

Section 5: Associated and Contextual Factors

S.no	Interview Guide	Probes	Remark
1	What factors influenced the decision to perform uvulectomy on the child?	Symptoms the child had, recommendations from family or community members, cost considerations, distance to a health facility, previous experiences with the practice.	
2	Who usually makes the decision in your family regarding this procedure?	The role of the mother, father, elders, traditional healers, relatives, neighbors, or religious leaders.	
3	For children who underwent uvulectomy, what changes did you notice afterward?	Immediate problems such as bleeding or choking, infections, feeding difficulties, need for hospitalization, and overall recovery.	

Section 6: Health Seeking Behavior and Comparison of Care

S.no	Interview Guide	Probes	Remark
1	When your child becomes sick, what is usually the first action you take?	Trust, Effectiveness and Respectful treatment	
2	How do caregivers in your community decide between traditional care and health facilities?		
3	How do you compare traditional uvulectomy with care provided by health workers?		
4	Have health workers ever discussed uvulectomy with you?		if yes, ask next
5	What did they say?		
6	How do you personally view traditional uvulectomy do you think it is beneficial, harmful, or both?	Beliefs about its effectiveness, and whether you think the practice should continue or be discouraged	

Finally: 1. is there anything else you would like to share about traditional uvulectomy or child health?

2. Do you have any questions for me?

Thank You for Cooperation!

Interview Questions

ክፋል 1፡ ማሕበረ-ስነ-ህዝባዊ ሓበሬታ (Socio-Demographic Information)

S.no	መምርሒታት ቃለ መሕትት	መርመራታት	መግለጺ
1	ዕድሜኻ ክትነግረኒ ትኽእል ዲኻ?		
2	ምስቲ ውላድ ዘለካ ርክብ (ኣደ፡ ኣቦ፡ ኣላዪ) እንታይ እዩ?		
3	ኣብዚ እዋን ክንደይ ትሕቲ ሓሙሽተ ዓመት ቆልዑ ክንደይ ትሓልየሎም?		
4	ዝለዓለ ደረጃ ትምህርትኻ እንታይ እዩ?		
5	ሞያኻ እንታይ እዩ?		
6	ኣበይ ኢኻ ትነብር (ከተማ/ ገጠር/ ማሕበር)?		

ክፋል 2፡ ፍልጠትን ንቕሓትን ባህላዊ ዩቩለክቶሚ

S.no	መምርሒታት ቃለ መሕትት	መርመራታት	መግለጺ
1	ብዛዕባ ባህላዊ ዩሉሌክቶሚ ሰሚዕኩም ትፈልጡ ዶ?		እወ እንተኾይኑ ዝቕጽል ሕቶ ሕተት
2	ካብ መን ወይ ኣበይ ሰሚዕካ?		
3	ብባህላዊ ዩቩለክቶሚ እንታይ ትርዳእ?		
4	ኣብ ማሕበረሰብካ ሰባት ኣብ ምንታይ ዕድመ እዮም ዩቩለክቶሚ ክግበር ኣለዎ ዝኣምኑ?		

5	ሰባት ዩቩለክቶሚ ክሕክም ወይ ክከላኸለሉ ከም ዝኽእል እንታይ ዓይነት ሕማማት ወይ ምልክታት እዮም ዝኣምኑ?	ቃንዛ ጎሮሮ፣ ተምላስ፣ ፀገም ምምጋብ፣ ሰዓል፣ ዘይምልዓል ዘይምኽኣል፣ ተደጋጋሚ ሕማም	

ክፋል 3፡ ኣረኣእያ ማሕበረሰብን ማሕበራዊ ስርዓታትን (Community views and Social Norms)

S.no	መምርሒታት ቃለ መሕትት	መርመራታት	መግለጺ
1	ኣብ ማሕበረሰብካ ዘለዉ ሰባት ብሓፈሻ ብዛዕባ ባህላዊ ዩቩለክቶሚ እንታይ ይሓስቡ?	ፍርሒ ሕማም ማሕበራዊ ምጽዳኞ ወይ ምውቃስ . ንባህሊ ኣኽብሮት	
2	ሰባት ብዛዕባ እቶም ዩቩለክቶሚ ዝገብሩ ህጻናት ብኸመይ ይዛረቡ?		
3	ሰባት ብዛዕባ እቶም ዘይሓልፉ ቆልዑ ብኸመይ ይዛረቡ?		

ክፋል 4፡ ልምምድን ዝተነብረ ተመኩሮን (Practice and Lived Experience)

S.no	መምርሒታት ቃለ መሕትት	መርመራታት	መግለጺ
1	ካብ ደቅኻ ዝኾነ ይኹን ባህላዊ ዩቩለክቶሚ ኣሕሊፉ ድዩ?		እወ እንተኾይኑ ንዝቐጽል ሕተት
2	እቲ ቆልዓ ኣብቲ እዋን እቲ ክንደይ ዓመት እዩ ነይሩ		
3	መን እዩ ነቲ ውሳነ ዝሃበ ወይ ዘበገሰ?		
4	መን እዩ እቲ ኣገባብን ኣበይን ፈጺሙ?		
5	ኣብ እዋንን ድሕሪን እቲ ኣገባብ እንታይ እዩ ኣጋጢሙ?		
6	ኣብቲ እዋን እንታይ ተሰሚዑካ?		
7	ዝኾነ ብድሆታት ወይ ዘይተጸበናዮ ውጽኢት ነይሩ ድዩ?		
8	ውላድካ ዩቩለክቶሚ ዘይገበረሉ ቀንዲ ምኽንያታት እንታይ እዮም?		ኣይፋልን እንተ ኾይኑ ቁጽሪ 8 & 9 ሕተት
9	እዚ ውሳነ እዚ ቀሊል ድዩ ነይሩ ወይ ከቢድ ድዩ ነይሩ		

ክፋል 5፡ ተዛመድትን ዓውደ-ጽሑፋውን ረጃሒታት (Associated and Contextual Factors)

S.no	መምርሒታት ቃለ መሕትት	መርመራታት	መግለጺ
1	ነቲ ህጻን ዩቨሌክቶሚ ንምፍጻም ኣብ ዝተወሰነሉ ውሳነ እንታይ ዓይነት ረጃሒታት እዮም ዝጸለዉ፧	እቲ ህጻን ዝነበሮ ምልክታት፡ ካብ ኣባላት ስድራቤት ወይ ማሕበረሰብ ዝመጸ ለበዋታት፡ ኣብ ግምት ዘእተወ ወጻኢታት፡ ናብ ትካል ጥዕና ዘለዎ ርሕቀት፡ ቅድሚ ሕጂ ምስቲ ልምምድ ዝነበሮ ተመኩሮ።	
2	መብዛሕትኡ ግዜ ነዚ ኣገባብ እዚ ብዝምልከት ኣብ ስድራቤትካ መን እዩ ውሳነ ዝወስድ?	ተራ ኣደ፡ ኣቦ፡ ሽማግለታት፡ ባህላዊ ፈወስቲ፡ ኣዝማድ፡ ጎረባብቲ ወይ መራሕቲ ሃይማኖት።	
3	ንኡቨሌክቶሚ ዝተገብረሎም ህጻናት፡ ድሕሪኡ እንታይ ለውጢ ኣስተብሂልኩም?	ቅጽበታዊ ጸገማት ከም ምፍሳስ ደም ወይ ምሕንካስ፡ ረኽሲ፡ ጸገም ምምጋብ፡ ኣብ ሆስፒታል ምእታው፡	

ክፍሊ 6፡ ጥዕና ምድላይ ባህርን ምውድዳር ክንክንን (Health Seeking Behavior and Comparison of Care)

S.no	መምርሒታት ቃለ መሕትት	መርመራታት	መግለጺ
1	ውላድካ ምስ ሓመመ፡ መብዛሕትኡ ግዜ እቲ ፈለማ እትወስዶ ስጕምቲ እንታይ እዩ፧	ምትእምማን፣ ኣድማዕነትን ኣኽብሮታዊ ኣተሓሕዛን	
2	ኣብ ማሕበረሰብኩም ዘለዉ ኣለይቲ ሕሙማት ኣብ መንጎ ባህላዊ ክንክንን ትካላት ጥዕናን ብኸመይ ይውስኑ?		
3	ባህላዊ ዩኑሌክቶሚ ምስቲ ብሰራሕተኛታት ጥዕና ዝወሃብ ክንክን ብኸመይ ትነጻጽሮ?		
4	ሰራሕተኛታት ጥዕና ምሳኻ ብዛዕባ ዩኑሌክቶሚ ተዘራሪቦም ይፈልጡ ድዮም?		እወ እንተኾይኑ ቀጺልካ ሕተት።
5	እንታይ ኢሎም?		
6	ንስኺ ብውልቅኺ ንባህላዊ ዩኑሌክቶሚ ከመይ ትርእዮ ጠቕሚ፡ ጎዳኢ ወይ ክልቲኡ ይመስለኺ?	እምነታት ብዛዕባ ኣድማዕነቱ፡ ከምኡ'ውን እቲ ልምዲ ክቐጽል ኣለዎ ድዩ ወይስ ተስፋ ክቐርጽ ኣለዎ ኢልካ ትሓስብ	

ኣብ መወዳእታ፡ 1. ብዛዕባ ባህላዊ ኡኑሌክቶሚ ወይ ጥዕና ህጻናት ካልእ ክተካፍሊ እትደልዮ ነገር ኣሎ ድዩ?

2. ዝኾነ ሕቶ ኣለኩም ዶ?

ስለ ምትሕብባር የቐንየልና!