ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES

Role of faith and traditional healing practices in the care of Severe Mental Disorders and impact on patient level outcomes

A population based study in Sodo District, Southern Ethiopia

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PhD Dissertation Research Proposal submitted to Addis Ababa University, College of Health Sciences, School of Medicine and School of Public Health

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PhD Dissertation Research Proposal Submission Form

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List of abbreviations

BMPs	BioMedical Practitioners
BPRSE	Brief Psychiatric Rating Scale Expanded version
CMD	Common Mental Disorders
CSRI	Client Service Receipt Inventory
DALYs	Disability Adjusted Life Years
EMs	Explanatory Models
FAST	Fast Alcohol Screening Test
FGD	Focus Group Discussion
FTHs	Faith and Traditional Healers
FTPs	Faith and Traditional Practices
GBD	Global Burden of Disease
MNS	Mental, Neurological and Substance use
OPCRIT	Opretional Criteria for Research
OSS	Orientation of Social Support
PRIME	Programme for Improving Mental Health Care
SCID	Structured Clinical Interview for DSM Disorders
SEMI	Short Explanatory Model Interview
SMDs	Severe Mental Disorders
SNNPR	Souht Nation Nationalities People Region
TPB	Theory of Planned Behavior
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule

Executive summary

***Title*:** Role of faith and traditional healing practices in the care of Severe Mental Disorders and impact on patient level outcomes: A population based study in Sodo District, Southern Ethiopia

***Introduction*:** Mental disorders are common and are associated with severe disability, cost and mortality. The burden of mental disorders in low income countries like Ethiopia is compounded by the huge treatment gap, which is over 90% for Severe Mental Disorders (SMD) such as schizophrenia, bipolar disorder and major depressive disorder.

The current strategy of the Federal Ministry of Health to narrow the treatment gap focuses on integration of mental health care into primary care. This agenda of integration has been advocated by the World Health Organization (WHO), and relies on training primary care staff to provide evidence-based interventions for selected (priority) disorders. However, neither the WHO nor the Ministry of Health provided explicit suggestions on how the integration would occur. Although Faith and Traditional Healers (FTHs) are key for the success of such integration, there is no direction on how they may be engaged or support care provision.

Understanding treatment practices, attitudes, cultural factors and explanatory models that influence community utilization of FTHs and the link of these factors with utilization of bio-medical services may allow development of strategies to support collaboration between the FTHs and the biomedical sector. It may also improve access to timely bio-medical care. This proposed study will explore the role of FTHs in the care of patients with SMD and the impact on bio-medical service utilization and patient level outcomes. The study hypothesizes that most patients with SMDs will use FTHs before accessing biomedical care and these patients are likely to have longer duration of untreated psychosis resulting in poorer clinical, social and economic outcomes.

***Objectives*:** the main objective of the study is to explore the pattern and determinants of the use of FTHs practices for the care of SMDs, and impact on patient level outcomes.

Methods: four complementary studies will be conducted using a mixed quantitative and qualitative research design.

- Study I will have two components
  - The first component will be a cross-sectional community based study on 1,500 randomly selected sample of community members in Sodo district to determine community attitude towards FTHs and describe the prevalence and pattern of use of FTHs by the community.
  - The second part of the initial cross-sectional survey will describe the profile of FTHs, their EMs about SMDs as well as define types of use of available service (predominant use)
- Study II will have two components
  - The first component will be to explore the prevalence, pattern and determinants of use of FTHs among community (Key informant) identified *persons with SMD*, completed using all available information (Butajira Case Detection Method BCDM);
  - The second component to determine baseline clinical, social and economic profiles in the three groups of *patients with SMD* basedon their level of service utilization: predominantly FTH users, Predominantly Boimedical service users and those who use both sercvices
- study III will be a follow up of participants in study II to examine short-term (six months) patient level outcomes (clinical, social and economic) and pathways in care in relation to baseline FTH use pattern; and

- study IV will examine, on purposively selected sample of FTHs and BMPs, behavioral determinant of collaboration between FTHs and BMPs (beliefs, attitudes, subjective norms and perceived behavioral control as well as intention towards collaboration) and the changes in these determinants.

***Assessments**:* A set of assessment tools will be used to establish diagnosis, symptomatic and functional state as well as costs. Qualitative assessment will consist of face-to-face interview using semi structured questionnaire, Focus Group Discussions, In-depth interview and observations using guides and checklists. Quantitative data will be entered in epiData version 3 and analyzed using SPSS version 17 and STATA 8. Thematic content analysis will be used for qualitative data.

Ethical consideration: Ethical approval will be sought from the Scientific Committee of the Department of Psychiatry and the Institutional Review Board of the College of Health Sciences, Addis Ababa University. Official permission will be secured from the Sodo district health office and health institutions. Every selected respondent will be briefed about the purpose of the study and informed written consent will be sought from each participant. All papers, computers, external hard drives, and USB memory sticks containing data will be password protected and kept in secure (locked) locations to ensure confidentiality of information.

Expected outcome: The results of the study would provide more objective determination of the impact of FTHs utilization on patient level outcomes. The findings would allow development of possible models of broader collaboration and interventions to improve access to quality mental health care and hence improve the mental health status of people with SMDs.

Budget: Part of the cost for the study will be covered by a PRIME fellowship to the candidate. But the study will be nested within the larger PRIME (‘PRogramme for Improving Mental health carE) project.

Research plan: The research proposal will be submitted in March 2013 for ethical approval and data collection is expected to begin in May2013. The whole research work will be finalized in early 2015.

1. Introduction

1.1. Background

Global context: Mental well-being is part of an individual's capacity to lead a fulfilling life; the ability to study, work or pursue leisure interests, and to make day-to-day personal or household decisions about educational, employment, housing or other choices (1, 2) . Mental disorders are of major public health importance pertaining to their relatively high prevalence, association with serious disability and mortality and high cost.

An estimated 450 million people worldwide have mental disorders and at least 40 million people suffer from severe forms of mental disorders, such as schizophrenia and dementia (3). Mental disorders affect 1 in 4 people around the world (4). At any given time, approximately10% of adults experience mental disorders, and about 25% will develop one at some point during their lifetime (5). Generally the prevalence rate of mental disorders ranges from 10% to 25% among the general public, and among patients attending primary health care the prevalence may go as high as 30%. The overall one-year prevalence of mental disorders ranges from 4% to 26% among different countries with the same rate among men and women (6-11). Mental disorders account for 13% of the global burden of disease, and the burden is estimated to rise to nearly15% by 2030 (12). Mental disorders are associated with more than 90% of the one million suicides that occur annually (13).

The enormity of this disease burden is caused by the relatively high prevalence of mental disorders, the often chronic or recurring nature of these disorders and the severity of disability associated with many of these disorders (10, 14). People with mental disorders have a heightened risk of suffering from physical illnesses because of diminished immune function, poor health behaviour, poor adherence to medical treatments, and social barriers to obtaining treatment (4). Furthermore, mental disorders often coexist with substance abuse and the harmful use of alcohol, and, in the case of women and children, greater exposure to domestic violence including sexual violence and abuse that may lead to higher risk for sexually transmitted infections including HIV and AIDS (15, 16).

Complex aetiologies and interactions among multiple genetic and environmental factors are assumed to be involved in the development of mental disorders. Gender, early developmental factors, biochemical and morphological abnormalities are associated with various mental disorders. Cultural factors, including traditional and social structures may play a role in the onset and prognosis of mental disorders (1, 10). Many people consider mental disorders to be consequences of magical or supernatural events related to spirits that take over the body. Thus people with mental disorders are presumed to be dangerous and their illnesses to be contagious. As a result, vulnerable patients suffer a great deal. They are physically removed from society, are chained to tree trunks, abandoned and hidden away from the society. Abuse and beatings are common even as part of the treatment that mandates purging the evil spirits through physical suffering. They live at the bottom of social rankings with little job or educational opportunities (17).

While it is true that help is available and most people with mental disorder can return to normal life if they are diagnosed early, receive early and appropriate treatment with medication, psychotherapy or a combination of both, provision of this type of gold standard treatment and care is not without challenge (4). Mental health interventions encompass a wide range of possible actions, including legislative and regulatory frameworks, prevention and promotion, treatment and rehabilitation. However, such effective system is not available in most developing countries and usually less backed with policy and legislation, poorly organized, funded and staffed (4).

According to WHO report only sixty percent of countries report having a dedicated mental health policy; 71% possess a mental health plan; and 59% report having dedicated mental health legislation (18). Stigma and discrimination associated with mental disorders negatively affect access to care, as well as the social integration of those suffering from mental disorders (19). However, although most countries ratify important laws and conventions, there are still all kinds of violations of rights seen on the ground (4, 18). In low income countries, only few countries have a specific budget dedicated for mental health care and institutional care in psychiatric hospitals is less accessible and affordable for the majority.

Access to mental health services is further limited by the shortage of health professionals with mental health expertise (18, 20, 21). Treatment gap for common mental disorders is unacceptably huge all over the world, where it remains over three-quarters , In the US about 64% of people suffering from mental disorder are not receiving treatment (22) and this proportion is even high, 74% in Europe (23). For example, most of those suffering from epilepsy receive no treatment although provision of such treatment is cheap, simple and effective (3, 24-26). The treatment gap for SMDs is very high in low – and middle-income countries, where in some countries, the lifetime treatment gap reaches 90% (16).

In this context, the strategy to improve access to care for the majority living in low income countries is through integration of mental health care in to primary care in which the primary providers will be general health professionals (27, 28).

In an effort to address challenges towards ensuring mental health for all, 25 grand challenges were identified, among which: reducing the delay for treatment through culturally sensitive interventions; provision of effective and affordable community-based care and rehabilitation; and implementation of culturally informed methods to eliminate stigma, discrimination and social exclusion of patients and their families are included (24). These challenges may be addressed more effectively through a locally informed strategy, which involves all key staekholders, including FTHS (29).

In many parts of the world, FTH practices (called alternative medicine in the West), constitute an important part of the health system and coexist with modern biomedical practices. People often use traditional healing with or without biomedical care, for all kinds of health problems including mental disorders(5, 30, 31). Among the many reasons that attracts people to traditional care is the accessibility and availability of the services, having shared social norms, traditions and beliefs about the cause and treatment of diseases with FTH practitioners are important considerations (5, 30, 31).

Furthermore, many people attribute mental illness to some sort of supernatural phenomenon hence faith and traditional healers are viewed as having the expertise to address the problem than biomedical practitioners (32, 33). Peoples' traditional belief systems and culturally specific explanations of mental illness will influence acceptance by the patient (and careers) of the care being provided and whether other individuals are accepting and supportive to individuals suffering from mental disorder (34). Therefore, establishing collaboration between the traditional and biomedical health services may help improve access to mental health care (35) and may also have the potential to reduce stigma, which also has an impact on access to mental health care.

The Ethiopian context: In Ethiopia, mental health contributes to over 12% of the burden of disease (36) and mental disorders are wide spread problems prevalent in primary care, hospital and community settings. In primary care, 6.5% to 18% of primary care and outpatient attendees have psychiatric morbidity (30), while 0.7% to 2.3% of inpatients were identified to have psychiatric diagnosis. Community surveys since the 1960s have consistently found a prevalence of 8% to 20% (37, 38).

More severe disorders, for example schizophrenia and bipolar disorder affect about 1% of the general population (39). Most of the systematic studies have focused on severe mental disorders. These studies have confirmed that SMDs are associated with high level of family burden, stigma, cost and mortality.

On the other hand the treatment gap for SMDs is more than 90% and for less severe disorders, it is likely to be nearly 100%. There is no mental health legislation or mental health policy although a national mental health strategy has been recently approved by the Federal Ministry of Health. There is no dedicated fund for mental health and virtually all the money is allocated to Amanuel hospital (18) (28). There is serious shortage of professionals trained in mental health and the pace of service scale up through integration into primary care has been very slow. Along with the proposed plan of integration of mental health care into primary care, use of available resources within the community is crucial. The overall aim of this study is to explore the role of FTHPs, as key community resources, in the integration of mental health care into the primary care system.

1.2. Statement of the problem

Severe Mental Disorders (SMDs) are relatively rare conditions but cause considerable suffering and disease burden (4); moreover, most with SMDs, despite the availability of effective treatments, remain untreated leading to substantial treatment gap (16, 22, 23). The greatest challenge in addressing the treatment gap is making the service available, acceptable and affordable to all on the basis of social justice, equity and fairness (4).

On the otherhand, peoples' explanatory model of SMDs highly influences the pathway to care and determines why and when they use available care (40, 41). Many people worldwide attribute SMDs to spiritual problems influenced by ancestral spirit and bewitchment (42). These explanatory models are largely shared by FTHs, who are viewed as having the expertise to address SMDs than biomedical practitioners (40). FTHs are widely available and used by majority (over 80%) of the population, especially in resource limited countries (32, 43, 44). However little is known about the impact of traditional mental health practices on the outcome of SMDs (40, 45) and how, if at all, they collaborate with biomedical practitioners. The key strategy to scale up services by the Federal Ministry of Health and the mhGAP programme of the WHO is integration of mental health care into primary care. However, neither the WHO nor the Ministry of Health provided explicit suggestions on how the integration would occur.

Moreover, there are evidence that suggest the inability of modern biomedical approach alone to address people's mental health needs adequately despite its effectiveness. Consequently, it is important to understand the complementarities of traditional care approach with bio-medical care (32, 46, 47).

1.3. Rationale of the study

Most Ethiopians attribute mental health problems to the influence of supernatural forces and they use traditional and spiritual healers to address these causes. However, little is known about pattern as well as determinants of use of traditional healing practices in Ethiopia in general and in the study area in particular. Furthermore, there is limited information about people's explanation of the cause of SMDs, which may have direct impact on the utilization of bio-medical services and outcome of illness. This study, therefore, tries to use explanatory model approach to explore meanings and determinants of use of faith and traditional practices for SMDs, whether biomedical care is available or not.

Similarly, while the role of FTHs in the treatment of SMDs has long been recognized by the public as well as by the government, there is limited knowledge of their distribution, their perception and belief as well as treatment practice of SMDs. This study strives to explore the distribution, profile and explanatory models of FTHs and their beliefs and practices to fill this gap of knowledge.

Existing evidence suggest limited availability and utilization of modern mental health services and there is a growing recognition of the need to improve mental health care through greater involvement of the community and FTHs. However, there is lack of evidence to inform how to involve FTHs in the care of SMD. This may require establishing a functioning system of collaboration between FTHs and modern mental health care services. Hence, there is a need to explore the role of FTHs in the care of SMDs, explore potential obstacles to, and enabling factors for such collaboration and suggest mechanisms on how to best establish this collaboration to improve mental health care service. There is also recognition for the need for both traditional and biomedical services for effective care in traditional communities as is the case in most rural settings in Ethiopia, where the majority of the population lives.

This study will look at this issue from three perspectives: community, FTHs and modern biomedical health care providers. The study, therefore, is believed to generate local strategic evidence to assess the impact of primary-care and community level intervention of PRIME project. Thus the project is aimed at providing evidence on the 'integration of mental health care into primary care'.

2. Literature review

Medical pluralism (MP) or *pluralistic medical system* is application of more than one medical tradition, and is found in most contemporary societies where there are different, coexisting or competing medical traditions arising from different ideas, beliefs, practices and bodies of knowledge (48-50). It may include both internalizing and externalizing medical traditions, and implemented by traditional healers, faith healers, modern biomedical care providers, self-treatment or folk medicine. This system is not limited to the technologically less developed countries and remained persistent alternative therapeutic system, thus regarded as global phenomenon. This is true for Africa too, where the delivery of health care has undergone dramatic changes in the past decade, with significant involvement of private and non-formal care providers making up the system (51).

Modern medicine is a generic term for a specific mode of treatment of healing therapies characterized by the assumption that disease is materially generated by specific etiological agents such as bacteria, and the use of invasive manipulation to restore/maintain the human organism at a statistically derived equilibrium point (health). It is based on Western explanatory model of concept or health and disease, science and technology, and is of recent development in the greater part of Africa. Modern medicine is believed to have several limitations specially for resource limited countries because of their limited accessibility, high cost, emphasis on curative services and socio-cultural insensitivity (3).

2.1. Traditional health care system

Traditional medicine also called *alternative medicine* is defined as all forms of health care provision which "usually lie outside the official health care sector" (52) which is generally called the 'local health system', (53) also referred as "indigenous", "folk" or "ethnomedicine". It comprises practices that have evolved in a particular cultural setting, where practitioners rely on indigenous medicine and/or rituals to treat the sick. Yet another definition of traditional medicine is 'the sum of all knowledge and practices – whether they can be explained or not- used in the prevention, diagnosis and elimination of physical, mental or social imbalances, and relying exclusively on past experiences and observations handed down from generation to generation, whether orally or in writing (54, 55).

According to the World Health Organization (WHO) traditional medicine is 'health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses and maintain well-being (52).

"*Traditional healer*" is a "person who is recognized by the community in which he lives as competent to provide health care by using vegetables, animal and mineral substances and other methods based on the social, cultural and religious background, as well as on the knowledge, attitude and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability" They are an integral part of the society and the people, and are believed to share similar beliefs and attitude towards all life events (health and ill-health) as well as expectations with the people they are living (52).

History of traditional medicine: Traditional healers have been serving communities since time immemorial in many societies. The earliest recorded history was in China around 1800 BC and latter the practice spread to other parts of the world (53). Traditional practice was documented in South Africa in the 17th century (56).

There were times when traditional practices were prohibited and hardly condemned and healers were regarded as "witchdoctors" who exploit the ignorance and superstitiousness of the unenlightened local people (57); for instance in South Africa there has been attempt to ban (1974 Health Act) traditional healing practices completely (58) though the system continued to exist. In 1929 the government of China tried to ban traditional practice but soon failed largely because of people's belief and satisfaction on the traditional medicine, readily availability of medicinal herbs at low cost, their convenience and simplicity of use with side effects presumed to be fewer (53).

In many rural communities of low-income societies, informal and traditional systems may be the main method of health care provision, even when allopathic health services are available, local populations may prefer to turn to local and traditional help for mental and physical health issues. Such help may be cheaper, more accessible, more socially acceptable and less stigmatizing and, in some cases, may be potentially effective (59).

Traditional health care systems survive because they satisfy at least four basic requirements: accessibility, availability, acceptability and dependability. The effectiveness of the healing practices in terms of the wellbeing of the whole person is also reassured in the context of the 1978 primary health care strategy initiated by the Alma-Ata Declaration (52).

Entrance in to Traditional practice: The entrance into traditional practice varies widely, and is facilitated through four routs: inheritance from family kinship; communication by ancestral spirit through dreams to take up the responsibility; driven by personal healing experience; individual conviction and appreciation of the practice followed by training to be traditional healer (60, 61).

A study conducted in east London showed that traditional healers averred that they have a long lineage mapping out the same practice as far from their grand fathers (62). In Uganda many healers reported to have some kind of emotional disturbance before they joining the practice and greater majority had at least one traditional healer in their family (33).

In South Africa, diviners are believed to be called by their ancestors and granted access to supernatural power to receive ability to do good or evil things. They get into the process of diviner training and start to participate in rituals of the healers and trainers (called *abaqwetu*) to become a member of mutually supportive healing network (34).

Types of Traditional healers and practice: Traditional healers are not a homogeneous group (45) in terms of religion; sex and level of education, and their entrance in to the practice differs greatly (60, 61). Grossly based on their primary practice they can conveniently be divided in to two types: those who deal with the psychological aspects called *spiritual healers* (believed to have access to supernatural powers) and those who dispense medicines called *secular healers (Herbalists). Herbalists* treat patients using herbs or plant remedies and in most countries, including in the western, they are not officially authorized but tolerated. However, since in most cases there is a great deal of overlap in the functions and healing methods of these practitioners, and usually they integrate more than one orientation into their practices, the grouping of healers into four seems the most convincing classification: Faith healers (practicing in *churches, mosques, holy water places*), Divine healers (spiritualists *kalechas, and Tenquay in the case of Ethiopia, who practice astrology, read zodiac sign*, etc), Herbalists and Herbalist-Ritualist (healers who use both rituals and herbal medicine).

Spiritual healing encompasses healing practices either or both by *general religious leaders* using prayer, recitation or sprinkling of holy water, and *healing by specialized healers* sanctioned by the religious community using similar methods or those operating within the local cultural framework. The

latter may involve the use of herbs or other natural substances, massage (from holy spirit in case of Christian faith) or other physical manipulation, rituals and/or magic, as well as rituals dealing with spirits (59).

Some spiritual healers hypnotize patients to exorcise (63), and the method used by spiritual healer's is sometimes considered as psychotherapy. Spiritual healers and diviners may be similar and they are said to enter in to an altered state of consciousness to communicate with spirit during their healing practice (63). Traditional healers, for example in some West African countries, practice of using local herbs for the treatment of diseases (64) and Faith healers or pastors/imams are religious leaders who base their treatment on the powers of God to heal sickness (56).

In South Africa, at least three types of traditional practitioners are identified Inyangas, Isangomas and Umthandazi. Inyangas are herbalists and possess extensive knowledge about curative herbs and medicines of animal origin and majority are male. Isangomas, majority being female, are diviners and can determine the cause of illness by using ancestral spirits, whereas Umthandazi are faith healers and heal by prayer, by using holy water or ash, or by touching a patient. Only a person "called" by the ancestors can become diviner (56).

In South-East Asia, the major system of traditional medicine being prescribed can be classified as formalized system of indigenous medicine, which includes Ayurveda, Siddha, Unani-Tibbi, the Chinese system of medicine, the Amchi (Tibetan) system of medicine and Burmese medicine; and non-formalized traditional system of medicine by herbalists, bonesetters, practitioners of *thaad* (element system), and spiritualists (53).

Almost all traditional practices are private practices and are entirely financed by patients or caregivers. Fees vary greatly and usually affordable by majority of the people, and can be made either monetarily or in kind. In addition, there are instances where patients make payments after being treated or cured (credit mode). Among the secular healing practices *Neuropathy, Osteopathy and chiropractic, Homeopathy and Balneotherapy* are few to mention (52, 53, 56) In a Tanzanian study that looked at kind of traditional practice, more than 50% of practitioners deliver services in a full time base specially if they are men and young (60).

Distribution of traditional healers: Traditional healing systems exist virtually in all countries though the practice and their position varies according to their particular socio-cultural heritages. In general, the number of traditional healers outweigh that of medical practitioners (32, 43, 44, 46, 53, 56, 65).

Characteristics of users of Traditional healing: There are various ways in which people get acquainted with and seek help from traditional healers; word of mouth, advice from friend and families, referral from fellow traditional healers and modern health facilities are the most common ways. Different patterns of use of traditional practice are reported: simultaneous or sequential, and exclusive. Many see healers prior, during, or after receiving biomedical care, and even while they are under inpatient medical treatment to make the care complete (61). The order in which these services are accessed may also vary. For example, for first time users, a Nigerian study noted that spiritual healers, traditional healers and general practitioners were the first to be contacted by 13%, 19% and 47% of patients respectively (66).

Commonly identified factors associated with the use of traditional practice are the user's socio-demographic characteristics, explanatory model of cause illness and treatment, prevalence of traditional healing practices, availability and accessibility of biomedical care and other factors such as personal or family experience of a particular care system. People are either self-referred or referred by someone

else, and in fact, there may even be cross-referral between traditional healers (48). Residence also seems important, for example, majority of users belong to the poorer sections of South African society (56).

2.2. Utilization of traditional healing practice

The World Health Organization estimated that at least 80% of the population in most developing countries, including Africa, rely on traditional form of health care (43, 44). Studies from Africa have supported this figure from the WHO. In Ghana, 71% had consulted traditional healers in the previous one year while only 53% consulted modern care system (67). A study from rural Ghana indicated 70% consult traditional healers for mental health problems (68).

A one year prevalence of use of traditional healers services was found to be 61% among South Africans (69). This study also documented reported level of satisfaction by users with the various kinds of healers. The highest level of satisfaction was for herbalists followed by faith healers and there was dissatisfaction with diviners due to their cost and perceived failure to cure illnesses. Concurrent use of biomedical care was also reported in South Africa, with 80% of users reporting use of modern health services concurrently (70). A high prevalence of psychological distress is also reported by those using traditional healers. For example, the prevalence of psychological distress among those who attended traditional healing services in in two districts of Uganda was 65.1%. (42).

The proportion of individuals visiting traditional healers (alternative therapist) in other parts of the world, even among biomedical practitioners similar. For instance 75 percent of physicians in Germany reported use of alternative medicine, and 77 percent of pain clinics provide acupuncture treatment (52).

In China, traditional herbal preparations account for 30%-50% of the total medicinal consumption (71). Traditional practices can be found in individual households all over the continent of Europe especially in rural areas. In fact, studies showed that not all traditional healing practices used in Europe are of European origin, however most healers like acupuncturists, are either tolerated or partly accepted by the system (53). In some parts of Europe, not only the ordinary people but also modern care practitioners were found to use alternative medicine.

The use in the United States may not be as high. In a trend analysis on use of alternative medicine over seven years (1990-7), Eisenberg and colleagues documented that about 4% and 25% of the population reported using spiritual healing and healing prayer respectively (72), and in 2004 another report showed a 13.7% national prevalence of past 12 months use of spiritual healing or prayer (73). A study looking at life-time use of faith healing found a prevalence of 3.7% while lifetime use of psychic (divine) healing was 6.1%. Women than men, more educated than less educated, previously married than currently married were more likely to use psychic healing (74).

Reason for use of Traditional practice: Different factors operate in the decision-making process in choosing between consulting biomedical and traditional care. Client-provider interaction/communication, the amount of explanation provided, socio-cultural and spiritual sensitivity of explanation, type of treatment given, affordability and acceptability of treatment, accessibility of provider, previous experience of self or others in terms of satisfaction are among the reasons. One South African study cited by BA Robertson documented traditional service users perspective where about two-thirds reported the practice fully was effective (69).

In China, people use traditional medicine for many reasons, but the main once cited are intense belief of the vast majority of people in traditional medicine; reported experience of improvement; ready availability of medicinal herbs at low cost and their convenience and simplicity of use with few side effects experienced (53).

Seeking help from a mental health specialist (psychiatrist or psychologist) is quite improbable among rural inhabitants, mostly due to difficulties in accessing these services (geographical location, distance, transportation, overall cost, and cultural distance between the health providers and the patient) (65, 75).

2.3. Overview of traditional healing practice in Ethiopian

Ethiopians conventionally understood health as a state balance between physiological, spiritual, cosmological, ecological and social forces (76). The knowledge of traditional medicine owes much to the existence of a small but important corpus of medico-religious and medico-magical literature, written in both Ge'ez and Amharic, dating back to the second half of the eighteenth century and containing thousands of prescriptions for a wide range of diseases (77). The diversity and unity of themes in Ethiopian culture and traditional medical beliefs are the result of a long and dynamic interaction among the many groups constituting Ethiopian society and between others across the Red Sea and the Mediterranean Sea. The result has been the evolution of complex cultural themes that are neither fully African nor wholly exotic (78).

Ethiopians still rely on traditional medicine for their primary health care needs, especially in the rural areas due to poor access to health services (31) and others even in cities where modern health services are more accessible and specialized (79). The 1982-83 rural health survey indicated that more than half of health care seekers used traditional healers, lay providers or self-treatment (80).

A policy review on traditional medicine documented that there is no single system of traditional medicine in Ethiopia perhaps due to cultural diversity and social complexity, even though themes that are common to the many cultural groups constituting the society have been described.. Most Ethiopian traditional medicine systems have holistic approach employing both 'mystical' and 'natural' explanations of ill-health and other misfortune. Among most cultural groups, distinction between illness and other personal misfortune are blurred or nearly absent. Along with the adoption of the Primary Health Care strategy in 1978, there was a noticeable improvement in the official attitude toward the promotion and development of traditional medicine in the country although there is uncertainty about the translation of this official commitment in to actual practical implementation (78).

In Ethiopia up to 80% of the population uses traditional medicine and the reasons are similar to those in other countries: cultural acceptability, , relatively low cost of traditional medicine and difficulty of accessing modern health facilities (31, 79). However, the practice has not been entirely free of harmful and fraudulent practices (81). A study conducted in one district of Ethiopia showed that most of traditional as well as modern heath care providers had reported use of traditional medicine at least once in their life time (82).

Traditional medicine in the country, in many cases, is concerned with both the prevention, such as inoculation for the prevention of smallpox, and the cure of disease with the use of traditional pharmacopoeia. The great expectations are focused on the supernatural, for both as a cause and treatment; hence supernatural intervention with innumerable prayers would be sought for almost all conditions. Magical texts of all kinds enjoy great popularity (77).

Healing in traditional medicine goes beyond curing of the disease and involves protection and promotion of human physical, spiritual, and material well-being. Since illness and other personal misfortunes are often perceived as resulting from a combination of 'natural' and 'supernatural causes, the diagnostic and therapeutic strategies employed are both 'empirical' and 'spiritual' at one and the same time. Therapy follows three fundamental strategies, consisting of the manipulation of the sick person's body, the expulsion or neutralization of the illness-causing agent, and the exorcizing or appeasement of malign spirits(78).

Secular healers' are those involved in manipulation of body using a variety of techniques such as bonesetting by the*wegesha* (a physiotherapist/orthopedic surgeon) or assisting births by the *Yelimd awalaj* (traditional mid-wife), dressing wounds or excising affected (often painful) body parts, drainig abscesses, pulling out 'bad' teeth (tooth extractors), or cutting out the uvula or tonsils, inoculation, and provision of remedies such as herbs, minerals, animal products and thermal waters by the *medhanit awuqi* (herbalist) (78, 83).

The second type of traditional healers are *spiritual healers.* Malign spirits such as *buda* (evil eye) and *ganen* (devil) are exorcised by such healers. Practitioners of such healing include the *debtera* (cleric-deviner-healer) and at*'maqi* (baptizer-exorcist). The *balezar* (zar shaman) appeases the *zar* spirits considered to be inherently benign and even potentially useful (78), while the *'Debtera*', '*Tenquay*' (witch doctors), and spiritual healers such as '*Weqaby*' and '*Kalicha*' (84, 85) function as spiritual healers. '*Debtera*', '*Tenquay*', '*Kalicha*' and "*Tila-Wegi"* are individuals/healers believed to have certain magical power, usually governed by either good or bad spirit, to make a person ill or protect form developing a psychotic illness. These people often use incantation, sorcery, enchantment and certain rituals (86).

Danqara/Metet are items (such as food items, dead mouse, chicken, cat or other animals) on which the incantation of magicians is effected, and when the items are thrown on the roof, or the gate, or in the compound of person's home or across the path of another person, they can bring misfortune including mental illness (86). The magicians carry out these curses when requested, usually paid, by someone who wants to harm another person. It is also believed that people who ate or drank the cursed items will be afflicted with mental illnesses, and/ or with physical illnesses and even death.

Molvaer has the following typology for the healing practices of the traditional medical sector in Ethiopia: Magical, Astrology and Naturalistic (87).

The average traditional healer in Ethiopia would be in a middle age person and mostly practicing on a part-time basis with flexible pay arrangement. On average He sees about seven patients per week and often prescribes herbs in liquid form (88). The skill is believed to be God given and their knowledge on traditional medicines is passed orally from father to a favorite child, usually a son or is acquired by some spiritual procedures (16). Concurring with, a study conducted in Uganda, almost all traditional healers inherited the practice from their parents and had a family member who was also a traditional heale (33).

According to Alem et al, both Muslims and Christians showed similar attitude towards biomedical and traditional methods. But when it comes to the treatment of spirit possession by traditional methods, Muslims preferred witchcraft and herbalists while Christians preferred holy water (32).

Mental disorders are generally explained as resulting from disturbances in the relationship between people and divinity, and possession by evil spirits. Spiritual healers, *debteras* and *kalichas*, usually treat patients through exorcism, a procedure that involves conducting special ceremonies, burning incense

such as myrrh, and frankincense, praying, using holy water , and advise to put amulets containing a written script (33) .

According to the Federal Ministry of Health's guideline used for the registration of traditional medicines, "Traditional Medicine" is defined as any plant, animal or mineral product that can be used independently or in combination for the treatment of human or *animal disease.* Products are divided into two categories according to the claim: traditional use claims; and non-traditional use claims. The guideline adopted the WHO's definition of traditional medicine, and requests applicants to submit evidence from all relevant sources to support the safety and efficacy of their products according to its recommended indications of use. The evidence must come from human use; animal or in vitro experimental evidence may be considered as additional, supporting information but cannot be the basis for approval. The required evidence will vary depending on the product and type of claim being made (89).

Although traditional healers are an important part of Ethiopia societies, unfortunately the information about the extent and character of traditional healing and the people involved in the practice is limited and vague. More importantly, understanding of the basic concept and explanation of illness and disease as well as healing and healer's preference is lacking. However, it is believed to have wide variation and is shaped by the ecological and socio-cultural diversities as well as historical developments related to migration and introduction of foreign culture and religion(45) .

2.4. Explanatory models

2.4.1. Community's explanatory models of health and disease

Explanatory modes refer to an individual's ideas about the nature, etiology, possible treatments that are likely to work and the outcome of illness. Explanatory models are culturally constructed, and determine help seeking behavior, care preference, satisfaction in care, treatment adherence, coping mechanism and treatment outcome (90). Understanding of explanatory model is not only important but also crucial in designing and implementing any given public health and clinical intervention. The knowledge on it informs policy and program development as well as strategies in rolling out intervention activities (41).

The lay people's understanding of health and ill health tend to differ from that of the modern biomedical viewpoints. While modern medicine regards 'disease' predominantly as abnormalities of body functions, lay people conceptualize the conditions as 'illness' based on local perceptions of the sign and symptoms, causes, routes of transmission, prognosis and alternative measures for cure and prevention. This simplistic dichotomy is often expressed as the 'etic' (ideology of biomedical professionals outside local community) as opposed to the 'emic' (ideology of local community) perspective (91).

Conceptually, the practices of curing and healing are different where *curing* is the modern biomedical perspective while *healing* is seen as people's perspective. This also influences the 'perceived capacity of the practice' to affect the sickness or efficacy of the practice, where in the biomedical system the efficacy of curing is predicted and judged by the 'knowledge accumulated' or universalistic claim whereas the efficacy of healing is predicted by particularistic perceptions and expectations of the patient. A given intervention or practice can be solitary i.e. either curing or healing or can be a combination of healing and curing components (50).

In African belief systems, good health is holistic and extends to the person's social environment, even wider from family and close relatives (64), and regarded as the net result of a delicate and intricate

balance between a person and his relationship with others including both natural and supernatural being such as the ancestral spirit.

2.4.2. Community's explanatory models of mental illnesses

When it comes to mental health and illness, people may have different belief system regarding the cause of mental illness, including spiritual, psychological, biological, and social/cultural beliefs, which are distinct but not mutually exclusive. Many people in developing world often have an explanatory model of conceptualizing mental disorder as being related to stress, social and economic problems, and not as disturbance in health they are less likely to acknowledge a role for biomedical and physiological interventions, which in turn influence the acceptability of such interventions (92, 93).

In any ethnic or religious group, supernatural powers are given the attribute of controlling the well-being of the individual's mind, and when a person's mental condition is disturbed supernatural causes are credited. When a person sins, do what is forbidden, confronting these supernatural power are some of the reasons believed to provoke them to negatively direct them against a person. If a person seeks for help believing that the ill-health he is suffering from is due to '*supernatural'* force, he certainly expects remedy that targets and acts supernaturally, such as religious or spiritual method. For instance, in South Africa, according to Kale, people's belief that disease is a supernatural phenomenon is their justification to their choice of treatment (56).

Simon and his colleagues did an exploratory study among Bangladeshis living in east London in 2008. They documented that in Islam there are various groups of beings all over the universe including *Jinn* (spirit), *shaytaan* (satanic being), *marrid* (demons), *bhut* (evil spirits) and *farista* (angels). *Jann* is literally to mean something like protecting, shielding or concealing in Arabic language from which the word *Jinn* came from. *Jinn* are intelligent being and accountable for their actions and as human being they do everything a person can do (eat, marry, produce children, etc) but unlike human they have extraordinary power to take different shape such as hyena or bird, move swiftly from one place to another, carry incredibly heavy object summarily etc. They are believed to usually station in a dark dirty places and burial grounds and greatly influence people in some sort of '*transitional state*' such as during celebration, menstruation, honeymoon, pregnancy, delivery or post partum. *Jinn* are believed to cause unpredictable moods and bizarre behavior in person's word or action either by possession (occupying space in one's body) or influence from outside. They also thought to bring both physical and mental illnesses. Furthermore, it is believed that a person can protect from *jinn* possession or influence by obeying Allah's commands or being good person (62).

Jinni in Hinduism, a supernatural evil being when possess an individual may separate the person from God, brings all kinds of physical as well as mental ailments including fits and altered personality. Another such spiritual belief is the so called '*evil eye*' which is believed to happen when an envious person call upon trouble on another individual (94) through the jealous glance of his eye. Sometimes such *'evil eye'* phenomenon can be unintentional and uncontrolled.

The Saudi study that was conducted on 275 patients may well demonstrate the 'power of belief' on the cause and treatment expectations, where for about two-third of them religious methods were the only mean to treat mental illnesses including depression and anxiety caused by evil-eye. The same study also documented the significantly higher proportion (34%) of patients preferred help from a combination of traditional and modern care compared to only modern care (4%) (94).

In South Africa such supernatural phenomenon is governed by a hierarchy of vital powers beginning with a most powerful deity followed by lesser spiritual entities, ancestral spirits, living persons,

animals, plants, and other objects. These powers can interact, and they can reduce or enhance the power of a person, and at the same time their disharmony can cause illness. Ingredients obtained from animals, plants, and other objects can restore the decreased power in a sick person and therefore have medicinal properties (56). Zabow reveled the three categories of mental disturbances, *Ukuthwasa* (calling to be a healer), *amafufunyana* (possession by evil spirit), and *ukuphambaba* (madness) by the South African traditional healers (34).

A case vignette study conducted in Uganda in 2011 by Abbo indicated that all study participants have had observed people with severe mental illnesses and distinguish these illnesses by their local names. They name schizophrenia as *eddalu* or *ilalu* and labeled as more serious than mania; mania named as kazoole which they describe as illness with symptom fee interval; and psychotic depression as a manifestation of 'thinking too much' due to social difficulties. Participants also ascribed 'family or clan issues such as ancestral spirit or witchcraft for schizophrenia and psychotic depression while physical problems and illness cited as a causes of mania. With regard to care or treatment performance of rituals was the declared remedy for schizophrenia and psychotic depression whereas traditional herbal as well as modern medical treatments are mentioned for mania (70).

Traditional healer's approach to illness depends on how '*causation'* is perceived and dictates the healing process which involves the identification of the cause of the affliction and removal of the hostile source, either through seeking ancestral forgiveness with rituals and scarifies, or prescribing certain medications. In all the cases healing involves the whole person, his/her physical, psychological, spiritual and social aspect within the emotional environment of the past and present; and the family (as extended patient) is almost always actively involved in the process of helping the patient to live at peace with family, clan, village, tribe and inner-self (95), this view was also acknowledged by Asians living in the UK in the mid 80^{th} when they argued that traditional remedies reach to the core of the problem, according to Bhopal (96) with no language or cultural barrier.

Another study in South African by Campbell H, in 2010, many people believed that traditional healing brings emotional strength to the patient and care givers that enhance quick recovery (93). People go to biomedical practitioners for relief of symptoms and to the traditional practitioners to discover the cause of the illness and get read of it. This rationale underlying traditional medicine is essentially similar in many traditional communities with minor variation across different socioeconomic and ethnic diversity.

Awareness of explanatory model is also help modern medical care practitioner to make proper diagnosis and provide treatment that is acceptable to the local community with a greater chance of adherence by the patient (97), that is why 'cultural formulation of culture-bound syndrome' is introduced in the current DSM-IV, which demands the clinician to understand and take account of how the individual patient and families perceive and interpret their ill health experience within their own cultural context, assist them to apply diagnosis schedules as well as help to establish a good rapport with clients for effective management.

2.4.3. Traditional healers explanatory model of mental disorders

Many traditional healers regard heredity, witchcraft, sorcery and spirit possession (which included the call to become a traditional healer) as the causes of mental illness.

A Zimbabwean study that aimed at developing an 'emic' case-finding instrument, a 'change in behaviour or ability to care for oneself' emerged as the central definition of 'mental illness' and both the head and the heart were regarded as playing an important role in the mediation of emotions the types of mental illness described were intimately related to beliefs about spiritual causation. All case

vignettes were recognized by the traditional care providers in their communities though many felt that the descriptions did not reflect 'illnesses' but 'social problems' and that accordingly, the treatment for these was social, rather than medical (35).

Mufamadi from South Africa said most traditional healers considered 'aggression, uttering incoherently, isolation, shouting, confusion and strange behaviour' as common symptoms associated with mental illness. She found that traditional healers commonly use bone throwing and observation and history-taking in the diagnosis of mental illness. Common intervention strategies used by traditional healers included steaming, taking medicine – prepared as powder, solution and soup nasally and orally. This was to induce vomiting, sneezing and the release of mucus which was regarded as an indication that the illness was leaving the body. "This will arouse anticipation that the patient will be cured and is in itself psychological in nature."(98).

An explanatory model to elicit traditional healers' view on mental illness in South Africa demonstrated that healers held multiple explanatory models for psychotic and non-psychotic disorders. Traditional healers were readily able to identify mentally ill patients based on their behaviors (e.g. wandering away from home; eating or smearing feces; laughing at inappropriate times; impaired self-care such as not washing; and eating dirty food). However, most found that the case vignettes for CMDs did not reflect an illness, but rather suggested psychological difficulties resulting from a number of external factors (such as poverty, alcoholism, or poor marital relations) (99).

There are several studies conducted to see the perception of traditional healers on the success of managing problems. On this area of perceived effectiveness, Emilio from Uganda documented that about 87% of those who treat all kind of illnesses, including mental problems, believed that they succeeded in managing client's problem and this success is due to their wealth of knowledge and skills in health and social problem handling through experience (33). A study conducted in Nigeria demonstrated that about 86.6% of traditional healers claim complete cure of psychiatric illness among treated patients while the remaining (13.4%) acknowledge possible relapse (100).

2.5. Outcomes of traditional healing practice for SMDs

Unfortunately, there are not many studies on the effectiveness and efficacy of traditional healing practices (45), at least measured against certain gold standard (99). Even though there might be no direct scientific proof for the effectiveness of faith healing, anecdotal evidence suggests that certain people benefit from faith healing, either in conjunction with allopathic medication or without, at least as perceived by patients (69).

A follow-ups study done in Uganda among patients with SMDs attending traditional healers documented a reduction in symptom scales at the third and sixth month of follow up treatment using Positive And Negative Syndrome Scale (PANSS), where about 30.7% of schizophrenic patients showed an improvement at 6 months of follow up. Poor economic status, early age of onset, longer duration of symptoms, previous episodes, positive family history, current illness severity, and co-morbidity (bivariate analysis) and combined use of biomedical services and traditional healing, and poor socio-economic status i.e. worrisome debt (multivariate analysis) were factors significantly associated with poor outcome (70).

A prospective cohort study conducted in central Sudan among traditional healing service attendees for their SMDs also showed a significant reduction after a mean period of stay of 4.5 months where the mean for the overall PANSS score was 118.36 on admission and 69.36 on discharge (101).

Another follow up study done in Bali comparing the outcomes of schizophrenic patients with and without modern treatment demonstrated no significant differences in any of the individual subscale scores or the total score of the PANSS between the groups (Mann-Whitney *U* test). Furthermore, patients in the non-treated group showed a greater tendency to be classified into either the best or worst outcome categories in the PANSS and (Eguma's Social Adjustment Scale) ESAS assessments than subjects in the treated group. The study also showed no significant difference in both the ESAS classifications and the PANSS scores between either gender or marital status in both groups (102).

A 6 years follow up study aimed at determining the clinical course and outcome of 321 Schizophrenic patients in rural Ethiopia documented a psychotic episode, partial remission and complete remission in 54%, 17.6% and 27.4% of patients at the final follow-up assessment (mean duration of 3.4 years (range 1–6 years) with first-generation psychotropic medication. The study also showed living in a household with 3 or more adults, later age of onset, and taking antipsychotic medication for at least 50% of the follow-up period predicted complete remission (103).

2.6. Biomedical care provider's perception towards traditional practice

Dr. Brigitte Sebastia from India elaborated on the problems clients had with psychiatrists, perhaps why clients may prefer traditional practice over modern: psychiatrists talking only to the care giver and not the client with their limited repertoire of questions therefore not exploring the symptoms completely, give prescription to the family member, and little or no information was provided to the client on their illness or medication (104).

Traditional healers are a very caring people, and extraordinarily skilled in psychotherapy and counseling although there are some who do things that may harm patients (56). Modern day psychiatrists, while not disputing the role of traditional healers many show concern about the effect of certain practices such as vomiting in patients were already taking prescribed psychiatric drugs. Errors or harming or controversial practices of traditional healers are also a concern of many professionals. A research paper produced in South Africa reported that seeing a traditional healer before seeking modern treatment may result in delay in diagnosis and treatment that may be fatal; receiving treatments simultaneously may bring drug interactions, and seeing a traditional healer after modern treatment could interfere with follow up care. Some prescribed ingestible remedies may have profound effects on the mouth, tongue, stomach, duodenum, and jejunum (56).

Catherin A, in her follow-up study of patients with psychosis who attended traditional healing services suggested that combining modern and traditional healing may have some positive effects for patients (70).
A study done in Taiwan also indicated that traditional practitioners were associated with medical pluralism, and people who had factors associated with the adoption of medical pluralism may be at risk for adverse health effects from interactions between traditional herbal medicine and modern pharmaceuticals (48). Furthermore, the dual use and frequent shifting between the two system of treatment by patients were discomforting for many modern care practitioners for the potential of reducing treatment adherence (93).

However, there are areas where traditional practices often had limitations – mainly that there was no clear definition of what they regarded as mental illness, individualized the illness, often satisfied that a patient was well based on the domestic tasks he or she performed or whether they conducted meaningful conversations with others. "This would imply that traditional healers are mainly concerned with maintaining social stability and may not consider the issue of personal happiness or well-being."

There was also a lack of clear distinction among traditional healers between the different types of mental illness. "Traditional healers' assessment techniques are also too simplistic to be utilized in all cases of mental illness. Some types of mental illness might require more complex assessment techniques" (98). In this line, the commonest method of recognition and reaching in to diagnosis of mental illnesses by traditional healers is simple observation of varieties of signs for hours as presented by patient related to speech, clothing, carrying rubbish and suspicious attitude (33).

2.7. The pathways to care for mental care

Knowledge of 'pathway to a given health care' is instrumental in understanding the individual components of the overall care system, the interconnection between the various care components, the way the system is functioning, overview of functionality of components of care (effectivity), users profile and utilization pattern, show the various referral routes, help in picturing out service accessibility, and inform rational allocation of resource. Pathway to care is influenced by various factors, among which explanatory model of an illness assumed to be treated by a given system, cultural and socio-economic factors including support mechanism as well as availability of that particular care at individual, family and community level (105). Besides perception of illness and disease, health seeking behavior, availability, affordability and accessibility to care, perceived ability of care providers in making a diagnosis of psychiatric illnesses as well as the availability and relationship among the various care givers influence the pathways to care (40, 41).

People take different paths as they single out and choose a particular course from the time of deciding to seek help from the available care providing sectors. They may prefer one medical tradition or system to start and either remains there or consult another different system or sector at the same time i.e. *simultaneously*, or move to another sector after exhaustively used the first one, i.e. *sequentially*. In general these 'patterns of resort' or pathways are different for different society as they are grounded in people's explore belief model which in turn is embedded in their socio-economic and cultural settings, and in a society where the medical system is pluralistic, 'pathway' exhibit heterogeneity within the society (41) (40).

Lack of adequate training on mental health issues, prejudice against mentally ills people, lack of attention, interest and reluctance to see mentally ill patients, were some of the common factors related to health workers that may hinder people to access professional mental services. Tobin also identified inappropriate intervention strategies at system level and inadequate cross-cultural skills and orientation by professionals as factors that make mental health services less user-friendly to clients so that hinder utilization (40).

Moreover, language barriers, concept of mental illness, shame and stigma, unfamiliarity with services, forming a trusting doctor–patient relationship, and incompatibility between treatment expectations of both doctor and patient were among the most common community related obstacles to modern mental care, according to WHO (106).

In a study that looked at factors influencing mental-health help-seeking, Jacqueline found that shame and stigma were the most important obstacles to utilize modern mental health care reported by Arabic speaking residents in Australia. This was emanated from fear of cultural exclusion for exposing a personal matter to outsider as they perceived that mentally illness has a negative outcome on social institutions, such as established marriage as well as marital prospect. Further, due to lack of trust and fear of bridging confidentiality by modern care providers they preferred faith healers as main mental-health care provider (107).

A study done in the UK to examine the extent of medical pluralism among the Chinese in London showed that they used both systems concurrently with varied utilization pattern, and the modern care system was generally perceived as difficult to use, with concerns over the language barrier, and communicating with and being able to trust health providers (48, 49). Culture also plays a role in the diagnosis of mental conditions; however, the treatment is more likely to be influenced by factors such as awareness and availability of effective interventions. According to Patel V, cultural factors may play a role in the acceptability of certain interventions, in particular psychological interventions in non-industrialized countries (92).

According to the Mexican study the pathways models suggest that the first attempt a person does to solve a symptom is self-care. When such strategies are not sufficient to relief the symptom, the person turns to the members of his/her *social network* for help, who in addition to providing information about remedies; offer their emotional and instrumental support. If after consulting the social network, the symptom is not relieved, the individual seeks help from other *external resources*, such as the members of the *ethno-medical* local system. Inhabitants of rural communities tend to seek help from physicians, only when the symptom persists and the suffering associated with it seems to be out of the individual's control, or if members of the social network or the ethno-medical local system refer the patient to the physician (108)

On the other hand, other studies from Zimbabwe (109, 110), South Africa (111) and Saudi Arbia indicated that most patients consulted more than one care provider from both traditional and biomedical care providers either concurrently or sequentially. Some prefer the biomedical firstly while others choose to use traditional first (34, 41).

In some of these studies, unlike other diseases, depression is rarely considered to be a mental disorder in many non-industrialized countries and thus mental health professionals are perceived to have a limited role in its management (112) hence self-care is the commonest type of management for depression. The Saudi study prevailed that most patients preferred help from only religious methods compared to a combination of traditional and modern care and only modern method (94).

2.8. Framework for collaboration

Cognizant of the burden of mental illnesses associated with huge treatment gap, and the use of traditional healers by vase majority of the population in resource limited world and the fact that modern health care alone could not meet the health need of the entire population of the world in 1978 Alma-Ata declaration the WHO urged member states to promote and integrate traditional medicine into their national health care systems (113). In 2002, the organization again made an international commitment to promoting the inclusion and integration of traditional practitioners in national and donor-specific health programs (106).

Several governments has put effort to integrate traditional medicine with modern care system so that provided room for complementarities between the two systems for instance in China(53), South African (69, 114), Zimbabwean (56), and Ethiopian Ministry of Health (115).

The *WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health*, is a model that help to integrate other levels of care including community based and informal community care, such as care by traditional healers (116). There are several convincing evidences that greater social cohesion and community support can prevent some mental illnesses and assist people with mental illness to recover more easily (3, 4, 116).

Two system models of liaison between primary health care services and traditional healers can be considered: a *simultaneous model* whereby the traditional healers *work side-by-side*, perhaps in the same premises, and a *sequential model* in which the medical workers and traditional healers *by directionally refer* their patients (33). Several studies has documented cross referral practices for different kinds of illnesses such as for HIV/AIDS (117)

2.9. Perception of users, healers and modern care providers towards collaboration

In general there is growing evidence that practitioners of both systems are optimistic towards collaboration for the benefit of patient care, although there are concerns from both sides.

The modern providers feel that healers practice may be dangerous and harming clients so are uncertain about which practice to work together; where as traditional healers may felt that integration may lead modern system to dominate the practice (118, 119). The need to engage community opinion leaders as well as traditional healers was also emphasized to improve people's acceptability of modern mental health care (47).

While the role of traditional healers in the treatment of mental illness has been reported in Uganda, this role is undermined by the lack of a functional system of collaboration and liaison between healers and modern mental health care services in the country (118-121).

Dein and his colleagues in 2008 identified how collaboration benefits both traditional as well as modern care systems. According to him, if not all some traditional practitioners may lack some basic knowledge on how to recognize early sign and symptoms of mental illnesses and perhaps where and when to refer such cases. On the other hand modern care practitioners also lack spiritual belief related to the cause and treatment of mental disorders. This may indicate that there is a need to bring the two groups together and learn from each other in a mutually benefiting manner. The same researchers also showed that there is no significant difference in the cost of their services (122).

Rajendra Kale suggested three principles that modern health would benefit from traditional, giving enough time to learn the client and their symptoms so that brings complete satisfaction and discharge their fear, learning the patient as a whole without splitting the body and mind as two entirely separate entities, and not considering the patient as an isolated individual but as an integral component of a family and a community (56).

Traditional healers, in one Ugandan study, almost all healers reported that they referred patients to the district hospitals and were willing to work with government health services (33), while in Tanzania all traditional healers reported that they refer patients to the hospital in cases they failed with their own treatment or when they knew that the patient would be better treated in the hospital or dispensary (60). A qualitative study done in South Africa using Theory of Planned Behavior (TPB) to look at traditional healer's referral practice, documented that healers refer mentally ill patients to modern care either as a temporary measure or as a last option, and about 88% of them were willing to collaborate with the modern system, even working together in a single setting, such as in hospital. The study recommended providing training to healers so that they will be able to recognize referral cases of mental problems (99).

Willingness to collaborate with formal medical services was noted by Zimbabwean and Nigerian healers (110, 123) as well, and in Ethiopian study to sustainably reduce the drawbacks and promote traditional practices positive elements, both types of practitioners expressed their willingness to

collaborate and demanded government support to facilitate the collaboration (82). In Ethiopian professionals acknowledge the practices of traditional healers and birth attendants, and the need to work together (31).

An exploratory study on perceptions of clients and service providers towards collaboration conducted in South Africa demonstrated that although majority of patients held traditional belief of cause of mental illness they were found to use both systems of care concurrently, with frequent shifting between treatment modalities causing problems with treatment adherence. Furthermore, traditional healers perceived lack of approval by modern practitioners through they were willing to collaborate and receive biomedical training. However modern care professionals were less interested in such collaborative relationship (93, 99).

Another South African qualitative study explored information by in-depth interviewing of traditional healers on the notion of working together with modern system in the treatment of mental illnesses has documented that majority of clients still have traditional belief while using both care systems simultaneously. Furthermore, many traditional healers showed greater positivity towards collaboration by welcoming the modern belief of environmental stressors as cause of mental illness without, in fact, losing their traditional belief of supernatural being as responsible entity. Moreover, traditional healers showed their discontent for lack of acknowledgment by modern practitioners and this created sense of wariness of being exploited unless otherwise any collaboration anchored on respectful cross-referral mechanism (93).

From various studies one can reasonably conclude that collaboration of the two systems is fairly accepted by practitioners of both systems, as long as their beliefs are acknowledged and client's socio-cultural perspectives are incorporated in the care practices. However, the issue of concern remains to be how to bridge the difference in the way of reaching in to a diagnosis, modalities of treatment and follow up, and the power relationship in establishing a convenient forum on the bases of mutual trust, respect and learning. The formal integration of traditional and modern care systems will build upon an ancient and acceptable cultural heritage, and provide a level of health care to all citizens that will be reflected in future social and economic prosperity (31).

However, before supporting or collaborating with traditional healing practices, it is essential to outline a package with those practices that can be included and determine whether those identified activities are potentially beneficial, harmful or neutral in the universally accepted mental care component. Whether or not traditional healing approaches are biomedically continual face to face discussion with traditional healers respecting their cultural beliefs on the cause and treatment of mental illness should be held to bring a positive outcomes (59). It is wise to note that there were countless efforts made with little or no meaningful change on the ground, largely because they were executed in the absence of sufficient cultural and contextual knowledge and understandings, being informed by either 'uninformed skepticism' or 'uncritical enthusism'(124)

In the view of collaboration, in fact, some types of activities seems simple to implement without going any step of approval, such as training, education sessions, whereas others which are more controversial ones are likely to bring hesitancy and needs more detailed work before making to decision (125). A South Africa exploratory study suggested interventions targeting both types of care providers: to acquaint traditional practitioners with biomedical approaches to the treatment of mental illness; and orientation of modern care practitioners towards a culture-centered approach to mental health care, as well as the establishment of fora to facilitate the negotiation for respectful collaborative relationships between the two systems of healing to promote access to equitable mental care (93). Another researcher

from the same country by BA Robertson promoted collaboration but, at the same time, suggested the need for further knowledge and research to find the best locally appropriate way of doing it (69).

Furthermore, the scope of trust among providers of the two systems as well as between the care system itself have also influence the moral obligations to establish a functioning networking within themselves to provide quality care. In this regard Campbell and his colleagues suggested three steps in establishing such collaboration: identifying the crossroads that are reciprocally reinforcing rather that disallow superior position of one over the other; mutual learning-undertakings that modify orientation of both practitioners, modern practitioners towards culture-centered approach and traditional healers towards acquaintance of modern treatment modalities; and transparent and broad base planning process of designing locally appropriate modality of collaboration with proactive engagement of both systems (93).

Summary of the Literature Review: This section tried to document information from relevant documents (books, journals, relevant policy, legal documents, policy papers, reports, program documents, research publications) on mental health issues in general and traditional medicine in particular. Lliterature on conceptual issues related to mental health as well as treatment of SMDs, global and regional experiences, as well as relevant research outputs by academics, practitioners, multi- and bi-lateral agencies, were consulted. More importantly literature that could provide insights to global level experiences in responding to growing mental health problems, and bi-sectoral collaborative interventions and best practices worth replicating as well as obstacles were reviewed. Documents produced and published since 1960 from various electronic data bases were reviewed.

To summarize the literature review, mental health services, which are simple and relatively inexpensive, are very much inadequate. Cognizant to the magnitude of mental disorders along with the individual suffering, the burden to families and the cost of treatment, modern mental health care alone cannot bring any significant impact on the problem of such dimension. The greatest challenge in addressing mental health needs is how to make mental health diagnosis and treatment services available to all on the basis of social justice, equity and fairness.

However, beyond the notion of accessibility, acceptability and affordability, people's explanatory model is believed to highly influence the pathway to care and preferential use of available service, be it traditional or modern, either *simultaneously* or *sequentially.* The pathways to care for mental illness are diverse and are dependent on socio-cultural and economic factors, as well as attitudes and beliefs about illness causation, and trust on health care providers and system.

People worldwide use FTHs care system, either as the only care system or combined with modern system concurrently or sequentially, for SMDs. Several factors influence the use of these traditional systems, such as socio-economic and demographic characteristics, individual or societal explanatory model of health and disease, traditional and cultural values, access to basic infrastructure including health care and others. The FTHs care system is deeply embedded with and respects the traditional and cultural belief of cause and treatment of mental illness. Traditional healers share traditional and cultural values, meaning and explanation about health, disease, life and death with the community with which they are living. Patient's explanatory model of SMDs is embedded within supernatural force and FTHs (faith, diviners and herbalists) are viewed as having expertise in addressing the illness hence patients utilize FTHs services

The traditional healing system influence the clinical, social and economic outcome of patients with SMDs. Traditional healing system contributes a lot to the delay of professional treatment seeking hence

disease outcome. FTHs healer's mode of management usually brings both physical harms to patients and delays the time to seek professional treatment at modern mental care facilities.

FTHs are likely to make substantial contribution to improve access mental health care through enhanced community awareness towards mental illness, reduced stigma against mentally ill people, early recognition of SMDs, early help seeking behavior (*reduce treatment delay and treatment gap)*, cross-referral to care systems for therapeutic alliance and adherence to professional treatment, reintegration and rehabilitation of mentally ill individuals. Hence establishing collaboration between traditional and modern health care systems is important step towards improve community mental health status. However, it is important to differentiate types of health problems as well as the stages of the problem that can be managed at each level of care. It is also important to regulate the kind of care practice each level should execute.

3. Theoretical framework

Factors that are conceptually believed to influence treatment outcomes of patents with SMDs are categorized into three levels based on their proximity to the anticipated outcome: level 1 relates to the national and policy factors, level 2 related to the underlying factors, and level 3 relates to the immediate factors.

Level 1: Factors at national level include aggregated figures or indexes at national level like level of education, health status, economic status and variables used directly like gross national income or GDP, government health expenditure and presence or absence of national level mental policies, Promotion of FTHs and collaboration with modern care system at various levels etc.

Level 2: District and community level factors include availability and access to community infrastructures and resources, community traditions related to mental disorder.

Care or service facility level is grouped under the two care systems, FTHs and modern biomedical care system. Within the FTHs system, traditional care providers' characteristics (socio-demographics); attribution style (belief and attitude regarding cause and treatment); perceived personal role on mental care, competence (experience); perceived cost-benefits of treating MD; perceived socially and culturally determined acceptability of this system of care. Moreover, traditionally those facility related factors such as access to and availability (type, number, distance, time), quality (performance, practice, supplies), comprehensiveness (continuum of care component) will influence the community acceptance and utilization of traditional care system. On the other hand the level of readiness (to support) and willingness to work together with bio-medical services (referral, community level education interventions, etc) as well as perceived benefit of collaboration will determine whether the two systems can collaborate.

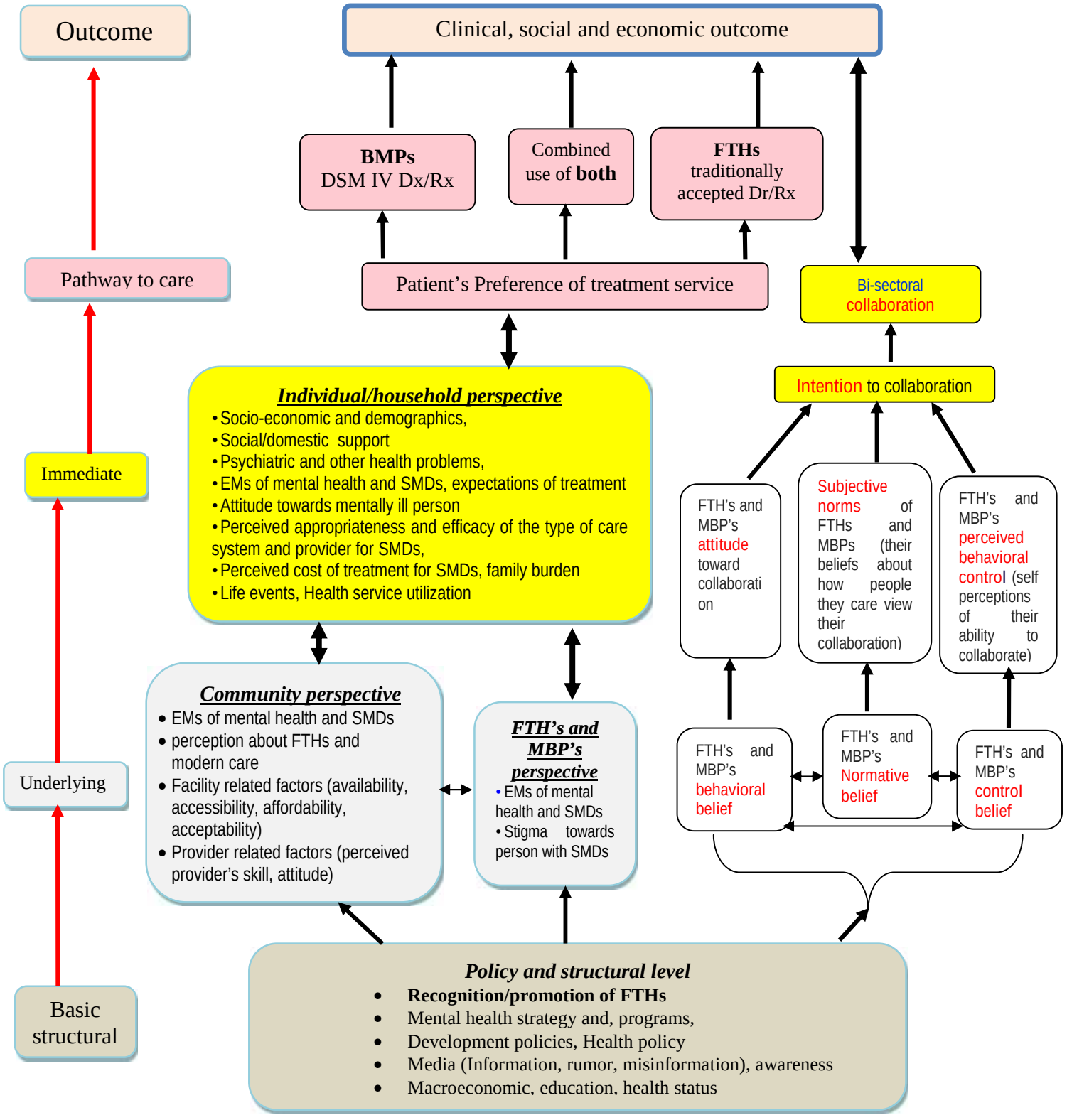
Level 3: Factors at individual/household level: Factors included at this level are expected to influence outcome through direct influence on service preference and utilization. Included in this category are: socio-demographic factors (age, education, occupation, income, religion, marital status, health status, history of mental illness etc); Psychiatric conditions including type of disorder, duration and frequency of illness; support mechanisms; knowledge, attitude and belief about the cause, consequence (medical, social, emotional), treatment (type, provider, quality) as well as perception of susceptibility and risk.

Furthermore, individual's perception of seriousness and prognosis of MDs, perception of efficacy of the type of the care system and provider for the type of the MD and the patient, the cost-benefit perception of treatment, as well as perception of culturally and socially determined appropriateness of the kind of treatment and practitioner; and previous experience of the type of medical system are assumed to interplay to determine the path through which an individual would take to see for diagnosis, treatment and other kinds of medical services. These individual/household factors while influenced by community level factors determine the health seeking behavior, preference of service type or provider and acceptance of type of care system.

On the other hand, FTH's and BMP's intention to collaborate is strong predictor of collaboration between the two practice systems, and the more favorable their attitude towards collaboration and their subjective norm, as well as the greater their perceived control the stronger should the their intention to collaborate.

Figure 1: *Diagrammatic presentation of the theoretical framework.*

The role of FTHs in the recovery process of persons with SMD in the context of individual and household (immediate), community, facility (underlying) and structural (basic) factors. Variables indicated in the conceptual framework (schematic presentation below) will be translated in to questions and presented in the various questionnaires and guides specific to specific respondent groups.



4. Research questions

Primary research question: What is the impact of patients' utilization of FTHs practices on patient level outcomes (clinical, functional and economic)?
Secondary research questions:

1. What is the distribution and characteristics of FTHs and what determines utilization of FTHs in the care of SMDs?
2. Do FTHs & BMPs differ in EMs of SMDs (such as attribution and classification system of SMDs) that brings about differences in the outcomes of their treatment practice?
3. What is the practice and intention of collaboration between FTHs and BMPs?
4. What is the short term change in the behavior of collaboration between FTHs and BMPs?

5. Objectives

General objective: To explore the pattern and determinants of the use of FTH practices for the care of SMDs, and impact on patient level outcomes

Specific objective: there will be four specific objectives that relate to the specific studies that are referred to in the body of the methods of the proposal

- To describe availability (distribution and characteristics) of FTHs, and community utilization pattern (general community and persons with SMDs) of FTHs practices and to understand explanatory models of FTH's and community opinion leaders about SMDs
- To examine factors that determine utilization of FTHs services by patients with SMDs (example: patient's explanatory model of SMDs, demographic factors)
- To determine the impact of FTHs utilization on patient level outcomes for SMDs (clinical, social, and economic)
- To explore experience and behavioral determinant of collaboration between FTHs and BMPs (beliefs, attitudes, subjective norms and perceived behavioral control as well as intention towards collaboration) and the short term changes in the cross-sector collaboration

6. Research Hypothesis

Primary hypothesis: Patients with SMDs use FTHs before accessing bio-medical care and these patients will have longer duration of untreated psychosis resulting in patient's poorer clinical, social and economic outcomes.

Secondary hypothesis:

- FTHs share similar EMs of SMDs with the people they are serving. Patient's EMs of SMDs is embedded within supernatural force and FTHs (faith, diviners and herbalists) are viewed as having expertise in addressing the illness hence majority of patients utilize FTHs services as primary care system
- FTHs and bio-medical practitioners have different explanatory models of SMDs, little acknowledgement and appreciation of each other's treatment practices, which will influence collaboration between the two practices.
- Given most patients and carers are likely to have a more traditional explanatory model, using both biomedical and FTHs is likely to lead to the best outcome.

7. Methodology

Context: This research is a nested study within the wider project called 'PRogramme for Improving Mental health carE (PRIME)'. PRIME is a study that aims to generate evidence on the integration of mental health care into primary care. The PRIME project encompasses three components: Inception phase, implementation phase and scale up phase. This PhD project will be conducted during the implementation phase of the PRIME study.

We consider that FTHs will make substantial contribution to the integration of mental health care into primary care and that dialogue, mutual respect, understanding and collaboration between FTHs and bio-medical practitioners (BMPs) will improve the quality of care and uptake of mental services.

Issues identified in the specific objectives will be explored from the perspective of traditional and faith healers, BMPs, the community, persons with SMD and their caregivers and other relevant stakeholders. The most important methodological issue in this research is how to understand the *explanatory model of SMDs and treatment practices* of the community and FTHs, and develop a model that engages FTHs to support the establishment of a collaborative mental health service responsive to the community need which is accessible, affordable and acceptable. The study will also look at the bigger policy and programmatic aspect of traditional health care system.

As this work is also a social research, beyond its epidemiological component, it strives to explore socio-cultural and traditional 'health and ill-health beliefs' of the community and practitioners in their social setting. Cognizant of the complex, diverse and pluralistic nature of social research with epidemiological element, the study will utilize a mixed qualitative and quantitative research designs. Triangulating the two methods in a single research has got a synergic effect in a way that the overall validity of the study is greater than the sum total of the individual methods (126, 127).

SMDs was chosen for this study because of its serious disabling nature in terms of clinical, social and economic outcomes, relatively easy to diagnose and treat, and amenability to treatment thus allowing assessment of outcomes.

7.1. Study area and setting

The study will be conducted in Sodo district of the Gurage Zone in the Southern Nation Nationality and Peoples region (SNNPR) of Ethiopia. While the traditional health in the context of the overall health policy analysis will be made at national and zonal level, the population and facility based as well as FTHs specific study will be limited to the Sodo district.

Sodo district is found at the northern tip of the SNNPR with a total area of around 830.63 square kilometers and with a three geographic and ecological zone: Dega is situated at an altitude between 3000-2300m, Weyna Dega is situated at an altitude between 2300-2000m, and Kolla is situated at an altitude between 2ooo-1800m. Bue, the capital of the district, is located 103km south from Addis Ababa. The district is home for the '*Medrekebd Abo monastery'* a 15th century monastery which is a burial place of *Abuna Gabre Manfas Qeddus*. There are also several tourist attraction spots including the famous stelae at *Tiya*.

Total population of the district is 161,952 with an average population density of 187 population per square km, with very slight dominance of female at 1:1.04 male (n=79,356 (49%)) to female (n=82,596 (51%) ratio. Ethnically Sodo Gurage accounts for the majority (85.3%) of the population, followed by

Oromo (11.6%) and Amhara (1.5%). About 97% of the population are followers of the Christian religion and 2.3% are Moslems. The official language of the district is Amharic, which is widely spoken within the district (128).

Administratively the district is divided in to 58 sub-districts (*kebeles*; smallest administrative unit), 4 of which are urban and 54 rural kebeles. Subsistence farming is the main source of living for greater majority of rural community although most have one or more family members living outside the district, habitually in Addis Ababa, the capital of the nation, involved in business such as trade. Most houses in the rural areas are made with mud/straw houses with thatched roofs. About 3.2% of rural residents and 25.2% of urban residents have home with sanitation facilities and 12.5 and 82.2% homes have clean water in rural and urban areas respectively

There are seven public health centers and over 50 health posts to provide outpatient comprehensive primary health care services including delivery. Christian Children Fund and Self-help Ethiopia are the only non-governmental organizations operating in the area of health and agriculture.

The overall health status is said to be poor with all kinds of diseases of poverty and largely attributed to preventable infectious ailment and nutritional deficiencies. According to the report of the district health office malaria, upper respiratory tract infection, diarrhoeal diseases, pneumonia, intestinal parasitic infestation, skin infections, trauma (accidents), gastritis, urinary tract infection and non-specific rheumatic conditions are the top ten diseases seen at outpatient units of health facilities in the district. Cutaneous leishmaniansis is also reported to be an important health concern of the district.

With regard to mental health related activities there is no recorded information available about any kind of mental health promotion or illness prevention activities at the district level. There is no modern mental health diagnosis and treatment service providing institutions in the district. The nearest modern heath facility that provide mental health diagnosis and treatment service available is a general hospital in Butajira town which is about 30kms away that took about half an hour. The facility provides out-patient service for adults with epilepsy and mental disorders mainly psychosis treatment but no psychosocial intervention. The next nearest modern mental health service is in Addis Ababa where of all kinds of psychiatric problems are managed by professionals such as psychiatrists
(prime-ethiopia situational analysis, unpublished)

7.2. Study design

There will be four overlapping studies using a mixed qualitative and quantitative study design and based in both the community and facility.

Table 1: Summary table of the study protocol

General objective: To explore the pattern and determinants of the use of FTH practices for the care of SMDs, and impact on patient level outcomes in Sodo District, Southern Ethiopia.				
Hypothesis: Patients with SMDs use FTHs before accessing bio-medical care and these patients will have longer duration of untreated psychosis resulting in patient's poorer clinical, social and economic outcomes.				
Issues	**Study I**	**Study II**	**Study III**	**Study IV**
Objective	To describe availability (distribution and characteristics of FTHs),) and communityattitude & utilization pattern (profile of SMDs treated) of FTHs and describe profile of FTHs & their EMs of healers	To examine utilization patern & factors influencing use of of FTHs by patients with SMDs; and establish baseline clinical, social and economic status based on their use of available mental health services	To determine the impact of FTHs utilization on patient level outcomes for SMDs (clinical, social, and economic)	To explore experience, intention and determinants of cross-sector collaboration between FTHs and biomedical care system
Key questions	Utilization pattern Factors for use of FTHs Type of FTHs FTH's EM for SMDs FTHs Rx practice	Utilization pattern Factors for use of FTHs Paitiens' baseline clinical, social & economic status	Clinical, social and economical outcomes Pathway to care	Attitude and perception towards each other Experience, intention and attitude for cross-collaboration
Source population	General population and all FTHs (faith healers, diviners, herbalist, mixed)	Patients with SMDs in the district	Patients with SMDs in the district	All FTHs and DM practitioners in the district
Study population	Sample from general population and all FTHs	Patients with SMDs identified by BCDM & OPCRIT	Cohort of patients with SMDs used in study II	Sample of FTHs and DM in the district
Primary respondent	Adult community members FTH facilities and FTHs	Patients or their care giver (family)	Patients or their care giver (family)	FTHs and MB practitioners
Study design	Cross-sectional, mixed quantitative and qualitative)	Comparative cross-sectional, quantitative study	Comparative cross-sectional, quantitative sttudy	Comparative cross-sectional, quantitative sttudy
Data collection technique	Face-to-face interview In-depth interview	Face-to-face interview	Face-to-face interview	Face-to-face interview In-depth interview
Instrument	***Comm***: Semi-structured ques., ***FTH***: Semi-structured ques., In-depth guide	Semi-structured ques., (SEMI, FAST, OSS, LTE, FIS, BPRS, WHODAS, CSRI, stigma)	Same as study II	TPB Semi-structured ques., In-depth guide,
Predictor Variables	Demographic, health status, medical Hx & Dx, EMs of SMDs, perceived severity; reason of use, perception on accessibility, availability, affordability, quality, autonomy, credibility, comprehensiveness; satisfaction of care; family & social support. SE-D status; EMs of SMDs; means to obtain remedies, cost of services, respect to basic human rights, abuses and harm, Dx modalities and Rx practices	Patient's SE-DS, health experience and status, service utilization, patient's EM of SMDs, clinical data, current illness severity, social and functional status; substance use, life event, social support, family burden, modern care service receipt, livelihood, stigma,	Health experience and status, service utilization, endorsement and adherence to FTHs practice, clinical data, current illness severity, social and functional status. substance use, life event, social support, family burden, modern care service receipt, livelihood, stigma, clinical outcome, social and economic impact	Self-rated role and competence in MHC; identification, classification and naming of MDs; SMDs related practice, Perceived competence & acknowledgment of each other; referral; perceived role and willingness for collaboration; perceived risks and benefits of collaboration; perceived competence required
Outcome variable	Prevalence and pattern of use by type of FTHs used Ddistribution of FTHs and by type of practice	Prevalence and pattern of use of FTHs by patients, Clinical, social & economic pforile	Clinical, social, economic outcomes Pathway to care	Attitude towards each other intention for collaborate
Data collector	HEWs, Trained young people Research assistants Principal investigator	Research assistants Principal investigator Psychiatric nurse Psychaiatris	Research assistants Principal investigator Psychiatric nurse	Research assistants Principal investigator

Study I: To determine community attitude towards FTHs and utilization pattern of FTHs practices, as well as describe profile of FTHs and their EMs about SMDs

This study will have two components: community component and FTHs component

A. Community component*:*

***Study design*:** Cross-sectional community based quantitative survey with internal comparison between FTHs service users and non-users supported with qualitative technique including FGDs and Key informant In-depth interview.

***Source population*:** General population of the Sodo district, SNNP region, Ethiopia.

A1. Survey: The candidate will use secondary data collected as part of the PRIME situational analysis. Close ended questionnaires were prepared in English and translated in to Amharic. The questionnaires explored in detail the lifetime and 12-months utilization of FTHs and their recommendations for the treatments participants would recommend for different physical conditions and mental disorders. Data on sociodemographic status, social risk factors and mental health status was also collected.

Study units and participants: Participants were adults (age 18 and above) residing in Sodo District of Gurage Zone randomly selected using multi-stage sampling technique.

Sample size determination: 1500 adults were interviewed, which was adequate sample to estimate the service utilization patterns based on the following assumptions:

- the prevalence of community FTHs utilization to be 50%--figure chosen because of the lack of available data on the subject
- 95% confidence level
- Margin of error of 0.03
- 80% power

Using a single population proportion formula

$$n = \left(\frac{2z_{\alpha/2}}{w}\right)^2 \cdot p^*\left(1-p^*\right)$$

⇒ 1056 participants would be required. The sample size of 1500 would allow estimation of factors associated with service utilization and also non-response rate as high as 30%.

Selection of participants: The study employed a two-stage sampling procedure. Based on the total required sample size, number of adults required per kebele was determined proportional to the size of the kebeles. Then households were randomly selected. In the second stage a respondent was selected through a by simple random sampling method from the adult respondents of the household fulfilling inclusion criteria. The kebele household number and the one-to-five household listing were used as a 'sampling frame' for identification of eligible respondents.

***Measurement*:**

- *Service utilization pattern:* Structured questionnaire iteratively developed through expert discussion was used to establish FTH utilization patterns, prevalence of use of FTHs;
- *Exposure variables:* potential determinant of use of FTHs including socio-demographic characteristics (such as age, sex, educational level, marital status, occupation/profession, household

income, religion, ethnicity), health status, access to health care, self-rating (perceived) of health condition/status and severity (state) of health problem; reason/purpose of use (perceived access/distance, availability, affordability, quality, comprehensiveness of care); satisfaction with provided care, other specific purpose (maintaining health, prediction), coping mechanism (family support) will be measured.

Data collection: Data was collected by trained health extension workers.

A2. Qualitative: *Focus Group Discussion (FGD) using case vignettes*: community opinion leaders will be identified to generate information on determinants and pattern of use of FTHs service for SMDs as well as explanatory models of SMDs using a discussion guide. Such group discussions are believed to provide group norms, traditions as well as meanings that underlie those norms. FGDs will be facilitated by research assistant and the principal investigator who have basic training on the technique and experience in performing similar interviews in the past.

B. FTHs component*:* Describe the distribution and characteristics of FTHs and their explanatory models of SMDs

Study design: Cross-sectional facility based mixed qualitative and quantitative exploratory design.

***Source population*:** Population of Faith and Traditional healers in the Sodo district, SNNP region.

Study units and participants: all faith and traditional healing facilities and chief healers in the respective facilities in the Sodo district will be involved. Traditional care facility survey will be linked to population based survey in study area and the population based survey clusters will be the bases to identify these facilities.

The initial resource mapping exercise will begin with identification of all FTHs within the study area. For complete ascertainment of all healers we will employ the snow-ball technique. Based on this, we will develop a list of available healers, which will serve as the *sampling frame* for all faith and traditional healing facility and providers.

The faith and traditional healing facility will be stratified in to groups according to the type of traditional healers dominant way of diagnosis and treatment practice. For example faith healing facilities (*churches, Mosques, holy water places*), divine healings (*kalechas, Tenquay, who practice astrology, read zodiac sign*, etc), herbalists (who provide medicinal remedies prepared from plant, sometimes animal, part locally called *balemedhanit*) and herbalist-ritualist (healers who use both rituals and herbal medicine) within the study areas. Basic information are facility (supply) related determinants from faith and traditional care facilities and FTHs themselves.

Measurement:

- *Outcome measure*: Prevalence and distribution of FTHs; pattern of use of FTHs for SMDs by patients with SMDs; FTH's explanatory models of SMDs

- *Independent variables:* socio-demographic characteristics including age, sex, educational level, marital status, occupation, household income, religion, ethnicity; education, residence (current, duration in current locality), treatment practice (years of training, years of service, way of entry in to the practice, specialization, kinds and state of health problems handled, client handling), means to obtain remedies, cost of services (income related to their healing practice), issue of capacity to

consent for treatment, respect to basic human rights, abuses and harm to patients during treatment practice, etc

Data collection: Facility based survey have two study populations – facilities and providers

- *Facilities*: Simple descriptive mapping of healing facilities where all available traditional healing facilities within the district will be assessed to determine the distribution of the healing facilities. Each facility is treated as a "unit" of observation for studying type and predominant modalities of treatment practices within facilities, and with regard to the type and state of conditions of the individual service user. Data will be solicited through observation check-list and informal interview technique.
- *Providers*: structured questionnaire will be used to interview FTHs

***Data collection Instruments and procedure*:** There will be two kinds of tools, one for quantitative survey and another for qualitative data collection

B1. Survey:

Data will be collected through face-to-face interview and discussion at their home or care facility using semi-structured questionnaire with close and open ended questions will be prepared in English and translated in to Amharic.

B2. Qualitative:

In-depth interview: FTHs who are treating patients with SMDs will purposely be identified to generate information on EMs of SMDs using a discussion guide including case vignette for SMDs. In-depth interviews will be conducted by research assistant and principal investigator. Details about the healer, their healing practice and past experience of such treatment were obtained

Study II: To explore the prevalence, pattern and determinants of use of FTHs among community (Key informant) identified *persons with SMD* and determine baseline clinical, social and economic profiles s of *patients with SMD* based on their available service utilization: predominantly FTH users, Predominantly Boimedical service users and those who use both sercvices

***Study Design**:* cross-sectional quantitative design with internal comparison will be employed.

***Source population*:** Patients with SMDs in Sodo district of Gurage zone, SNNP region.

***Study unit and participants*:** identification of patients with SMDs will be done in a 2-stage sampling design.

- First (screening) stage: individuals with potential SMDs will be identified by community key informants (Butajira Case Detection Method BCDM) selected from each village.
- Second stage: (confirmatory stage), persons with suspected SMDs will be assessed by a trained clinician using the Operational Criteria for Research OPCRIT (129).

The OPCRIT is an operational criteria checklist for psychotic illness and designed to be used with a computer program. The instrument uses some of the rating styles of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) (129) but is briefer and simpler to administer. It has established reliability and allows application of multiple diagnostic criteria (130). The OPCRIT also allows diagnosis of co-morbid substance abuse and personality disorder. It has both a checklist of symptoms, which can be printed out (a paper and pencil version) and computerized version, which

together form the OPCRIT system. The paper version will be administered in a face to face interview and data will then be transferred into the computer program. The checklist is linked with extensive definitions that standardize each item to be rated.

Sample size calculation and procedure:

Comparison groups: Based on the intensity of use of FTHs, patients will be grouped in to three: those who predominantly used FTHs, those who used BMPs predominantly and those who use both. The various intensities of use will be determined through expert group discussions, which will involve community leaders, service users and providers.

*Sample size calculation**:*** The participants in this part of the study will form the cohort study and the sample size determination for this cross-sectional evaluation of service utilization and associated factors is based on the cohort study. The STATA statistical program, version 11 (StataCorp 2009) will be used for sample size calculation. Based on a previous study in the neighboring district of Butajira, we assumed the average means (SD) of persons with SMDs to be 79 (16.3). Furthermore, we assumed that a six point difference between the BMPs users and FTHs practice users will be clinically meaningful. With a correlation coefficient of 0.7 and a mean change of six points on the BPRS-E using analysis of co-variance (ANCOVA) method with two measurement points at six month interval, at 95% confidence, 80% power, and adjusting for 10% loss to follow-up, a total of 256 participants will be needed.

Sampling procedure: the list of all patients diagnosed with SMDs (using OPCRIT) will be used as 'sample frame' from which patients will be interviewed to learn about their mental health care utilization so that those who predominantly used FTHs (arm I), those who predominantly used biomedical service (Arm II) and those who use both methods equally (Arm III) will be enrolled to the study. Patients in the first and second group will be the study participant, and will be selected either using systematic random sampling (if their number exceeds the required sample size per group) or all patients will be enrolled if their number is less than the required sample size per group.

***Measurement*:**

- *Outcome measure*: baseline information on clinical (clinical symptoms will be evaluated using **BPRS**), functioning status (**WHODAS**), and economic outcomes of patient with SMDs using Client Service Receipt Inventory (**CSRI**) and pattern of available mental health service use.
- *Exposure variables*:
  - *Primary exposure* is receipt/utilization of FTHs services (a series of questions on patients' contact with traditional healers).
  - *Secondary exposure* includes type of supervision, basic socio-economic and demographic variables (age, sex, education, income, marital states, occupation), past medical history, social support (**OSS**), alcohol and substance use (**FAST** Fast Alcohol Screening Test), explanatory model (**SEMI**), baseline family burden (**FIS**), stigma (stigma and discrimination scale), duration of illness, biomedical service receipt etc.

Data collection Instruments and procedure: baseline information on clinical, functional/social and economic profile, their explanatory model of SMDs as well as available mental health service utilization will be collected using semi-structured questionnaire through face-to-face interview.

Data collector: The trained data collectors, primary investigator, psychiatrist, experienced psychiatric nurse practitioners using the BPRS.

Study III: To determine short-term (six months) patient level outcomes (clinical, social and economic) in relation to baseline status and compare outcomes in the three arms of the study.

Study design: Prospective quantitative study supported with qualitative exploratory design to search for patient level outcomes of FTHs services for SMDs

Source population: patients with SMDs in Sodo district of Gurage zone, SNNP region.

***Study participants*:** Cohort of patients with SMDs identified and used in study II

***Measurement*:**

- *Outcome measure*: patient level outcomes compared between those three airms of the study II. Outcomes will be measured at six months.

Primary outcome:

- Change in clinical outcomes (change in BPRSE score) including symptom severity, persistence of illness (presence or absence of psychotic symptoms), rate of remission and relapse (whether patients were in episode or remission, complete or partial).
- Functional outcome: (WHODAS) change in level of stigma and carer burden,
- Economic/cost: (CSRI) estimated costs of treatments, including opportunistic costs and outcomes

Secondary outcome:

- Service related outcomes: pathway to care, pattern of use/treatment adherence, human right, service satisfaction

- *Exposure variables:*
  - *Primary exposure*: service receipt/utilization (use of medication),
  - *Secondary exposure* includes type of supervision, basic socio-economic and demographic variables (age, sex, education, income, marital states, occupation), service utilization pattern, past medical history, adherence to FTHs practice, social support (**OSS**), alcohol and substance use (**FAST** Fast Alcohol Screening Test), explanatory model (**SEMI**), baseline family burden (**FIS**), stigma (stigma and discrimination scale), duration of illness, service receipt (delay to professional care).

Data collection Instruments and procedure: instrument used in study II will be utilized in determining patient level outcomes and pathway to care.

Data collector: The trained data collectors, primary investigator, experienced psychiatric nurse practitioners using the BPRS.

Study IV*:* To explore experience and behavioral determinant of collaboration between FTHs and BMPs (beliefs, attitudes, subjective norms and perceived behavioral control as well as intention towards collaboration) and the short term changes in the cross-sector collaboration

Study design: Interventional prospective cohort using 'Theory of Planned Behavior (TPB)'

***Source population*:** all FTHs and all MBPs practicing in health facilities in Sodo District of Gurage zone, SNNP region.
***Study participants*:** Sample of FTHs from the four main groups (herbalists, diviners, mixed herbalist-diviners and faith healers) as well as sample of MBPs who are involved in caring patients with SMDs.

***Sample size determination and sampling procedure*:**
Actual sample size will be calculated using the primary outcome: cross-sectoral collaboration, for the two groups.

Faith and Traditional healers: traditional healing facilities from each of the four groups (faith healers, diviners, herbalists and mixed) will purposively selected from the sample frame of traditional healing facilities constructed during the initial resource mapping exercise.

Selection of modern health care providers: service providers in randomly selected health centers within the district will be purposively selected to participate in the study.

The study involves two stages: formative and formal study, which involves a base-line and post intervention follow up.

Formative research: a qualitative exploratory study will be conducted among purposively selected FTHs and BMPs. Participants will be given a *description of the behavior (cross-referral)* and asked a series of questions designed to elicit accessible beliefs. The purpose of this research will be to generate constructs of TPB by identifying accessible (ready in memory) beliefs (behavioral, normative & control), i.e. *personal accessible beliefs*, i.e., the unique beliefs of each research participant, or to construct a list of *modal accessible beliefs*, i.e., a list of the most commonly held beliefs in the research population.

Formal study: Once accessible beliefs have been identified, questionnaire will be developed to assess behavioral beliefs (beliefs strength & outcome evaluations), normative beliefs (strength & motivation to comply), and control beliefs (strength & perceived power), attitudes, subjective norms, perceptions of behavioral control, intentions, and actual behavior using Theory of Planned Behavior (TPB) that helps to identify determinants of behavior.

A) **Baseline**: document baseline determinants of cross-collaboration (behavior) defined as 'referral of patients with SMDs', in terms of beliefs, attitudes, subjective norms and perceived behavioral control as well as intention; and past experience.

B) **Intervention:** based on the finding of the baseline study targeted education-communication program will be designed for each types of providers during which time educational material will be developed with which provides will be trained.

C) **Post intervention follow up**: the short term changes in determinants of cross-sector collaboration (behavior) defined as 'referral of patients with SMDs.

***Measurements*:**

- *Outcome measure*:
  - *Primary outcome*: cross-referral
  - *Secondary outcome*: intention for cross-referral
- *Predictor variables:* determinants of cross-sectoral collaboration including **provider's behavioral belief** (how likely collaboration will improve outcomes of SMDs, value attached to the treatment of SMDs), **attitude towards collaboration, normative beliefs** (perceived behavioral expectation of community, patients, coworkers and government about collaboration, provider's motivation to comply with these people), **subjective norms** (perceived social pressure to engage or not to engage in the collaboration), **control belief** (perceived presence of factors that positively or negatively

affects the collaboration, and perceived power (potential strength) of each control factor), **behavioral control** (provider's perceptions of their ability to collaborate).

Data collection Instruments and procedure: structured questionnaire based on the TPB will be used for face-to-face interview will be developed in English and translated in to Amharic or to the local language, if applicable.

Two models will be developed, one for the FTHs and one for MBPs. The behavior for the FTHs model will be 'referral of SMDs to MBPs for initial diagnosis and initiation of modern psychiatric treatment' while the behavior for the BMPs model will be 'referral of SMDs to FTHs for reintegration as well as adherence to modern psychiatric treatment'.

Data collector: Principal investigator and research assistants

7.3. Qualitative data collection tools and techniques

Various qualitative information collection techniques including document and literature reviews, key informant in-depth interview, and focus group discussions with different groups will also be employed. Unstructured and semi-structured guiding questions and observation checklists of topics for the different categories of informants/stakeholders will be used for the latter.

While the literature review and case studies will be exclusively done by the principal investigator, key informant in-depth interviews, focus group discussions and observations will be done by health professionals, either health officers or nurses, who have experience in the technique and received additional training for this purpose, will serve as primary data collectors. The principal investigator will be supervising and provide onsite support during the whole course of data collection.

Key informant In-depth Interview: The kind of information desired to acquire is related to the culturally embedded community traditional values of health and ill-health, perceptions and beliefs regarding cause and treatment of SMDs as well as traditional practices in the day-to-day lives of people. Furthermore, information on the conceptual and practical validity of FTHs belief and practice; the potential roles of FTHs in the promotion of mental health, early diagnosis and treatment of SMDs will be solicited. Potential obstacles and opportunities to engage FTHs in a bi-sectoral collaborative approach, and the success or shortcoming of such modalities and achievements will be investigated within the broader socio-traditional and cultural perception of the society.

Thus, key informants in this study will include community/opinion leaders, FTHs, BMPs, health officials from federal to district levels, relevant stakeholders such as representatives of associations (mental health association), representatives from CSOs, etc. In-depth interview will be facilitated using semi-structured topics guides to generate detailed qualitative information on the various issues related to mental health, mental disorder, FTHs, BMPs mental health care, collaboration approach etc will be recorded and transcribed by the researchers for thematic analysis.

Case vignette: Case vignette based discussion to solicit explanatory model will be conducted with FTHs, patients with SMDs and community opinion leaders. During the discussion the moderator will read case vignette for SMDs slowly for respondents to hear clearly and understand, and clarified anything that was uncertain before initiating the discussion. This was done in order to ensure the uniformity and clarity of the symptoms presented in the vignette, and also to allow participants who could not read the material to participate in the study. In-depth interviews will be conducted

predominately in Amharic language (with translators when ever applicable). All participants will be asked to provide verbal informed consent prior to inclusion in the study.

7.4. Data Processing and Management

Quantitative data: on-site and central editing will be done to ensure that the questionnaires have the required quality in terms of completeness and consistency. Then manual editing and coding will be done before entry to computer in Addis Ababa. Editors will be highlighted on the key elements of the editing and coding, and briefed on the variables that may need thorough scrutiny. The processing of data will begin soon after the survey in the field is completed. The investigator will keep track of all the data, closely supervise the data entry operations and monitor data quality parameters.

Qualitative data: Field notes and transcripts obtained from observation, interviews and FGDs will be translated into English and back translated into the Amharic to ensure that the words used during the discussions maintain their original meaning. Data will be entered and organized by the investigator using appropriate qualitative data analysis software for coding and analysis. A thematic content approach focusing on study questions will be used for the qualitative analysis.

7.5. Data Analysis

Quantitative data: After appropriate coding, the quantitative data will be entered in epiData version 3.0 (Epidata Association, Odense, Denmark, http://www.epidata.dk) software, and exported to STATA 8 (Stata Corporation, Texas, Unkted States of America) software for analysis. Response frequencies will be calculated (A chi-square analysis and a 2-tailed *t* test as appropriate) to assess within and between group differences in socio-demographic and clinical data (sex, marital status, age, age at onset, length of first admission, DUP, number of family members, educational period, time required to go to the treatment service) and analyzed univariate, bivariate, and multivariate levels to determine the association between use of FTHs service and potential determinates of use; and patient level outcomes will be analyzed with type of service use (FTHs or BMPs) in study III using a one-way ANOVA for independent samples.

Analysis for the TPB: multiple regression or structural equation analyses, standardized regression coefficients or by path coefficients will be used to determine the relative contributions of attitudes, subjective norms, and perceptions of behavioral control to the prediction of intentions; and to determine the relative contributions of intentions and perceptions of control to the prediction of behavior.

Qualitative data: analysis will be done using the thematic content approach in five stages (Familiarization, Identifying a thematic framework, Indexing, Charting, Mapping and Interpretation) using OPEN code software. Qualitative responses will be read for emergent themes and then be coded. Maximum care will be taken so that codes capture the meaning of each respondent as accurate as possible, and to ensure validity of the categories a second independent coding of interviews may be considered.

Stakeholders Analysis: Information on the roles played by different actors (government bodies, NGOs, faith-based institutions, indigenous social organizations, mental health service users etc) that have stake in mental health issue at the implementation and policy levels, will be collected so as to have a comprehensive understanding of what is being done, where and how, by whom and what has been so far achieved, etc.

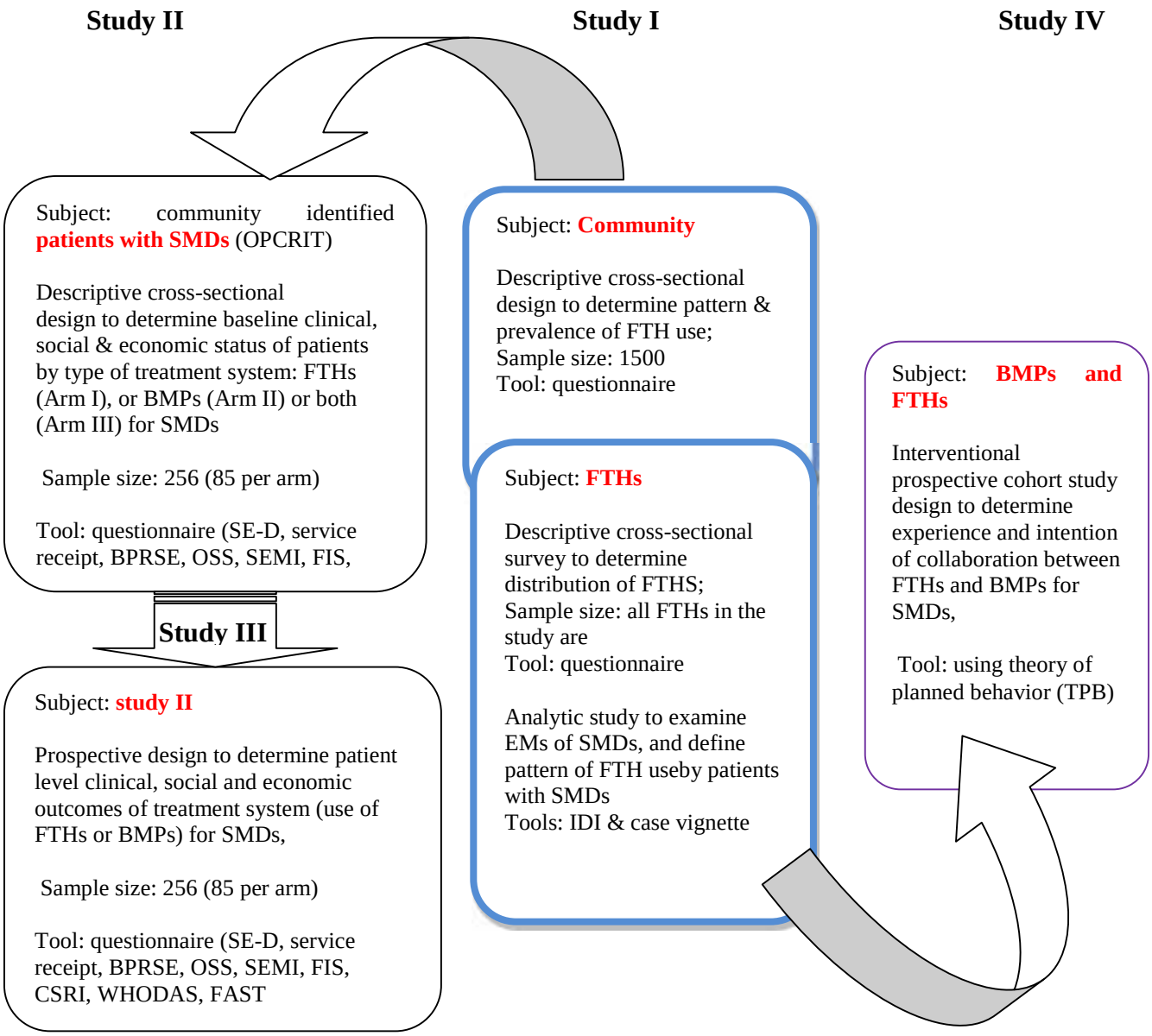
Finally, quantitative and qualitative data will be triangulated to improve validity as well as to complement the quantitative findings.

7.6. Quality assurance mechanisms

Quality will be assured through the following measures:

- The study will utilize a well reviewed and commented methodology by experts in the field of psychiatry, public health and health service management
- Data collection instruments (questionnaires, guides, check-lists) will be developed by adapting standard data collection tools used in relatively similar settings and pretested for possible modification to ensure their social and cultural sensitivity
- Selection of data collectors based on solely their knowledge and experience on data collection.
- Assignment of graduates or master students as research assistants to assist the qualitative data collection and overall work supervisors.
- Provision of well structured and organized pre-data collection training to all research team including data collectors, supervisors and research assistances.
- Preparation, distribution and strict utilization of training and field-work manuals by all members of the research team
- Enhancing privacy of respondents to ensure a high comfort level, and in turn, the most accurate responses and ensuring confidentiality of information
- Close supervision of data collection procedures by research assistants and principal investigator on top of field supervisors, and checking all questionnaires for completeness every day and taking immediate actions
- 10% of questionnaires will be re-entered to evaluate mistakes during data entry
- Use of advanced techniques and appropriate modeling during analysis
- Use of quality tape recorder to ensure quality of FGDs. Regular checking of recording levels, battery status etc beforehand.

Figure 2: Interconnectedness of the four studies



7.7. Operational definitions

- *Behavior*: an individual's observable response in a given situation with respect to a given target. Behavior is a function of compatible intentions and perceptions of behavioral control in that perceived behavioral control is expected to moderate the effect of intention on behavior, such that a favorable intention produces the behavior only when perceived behavioral control is strong.
- *Behavioral intention*: an indication of an individual's readiness to perform a given behavior. It is assumed to be an immediate antecedent of behavior (Ajzen, 2002b). It is based on attitude toward the behavior, subjective norm, and perceived behavioral control, with each predictor weighted for its importance in relation to the behavior and population of interest.
- *Biomedical**:*** Medical beliefs, and the clinical practices that are based on scientific evidence
- *Bi-sectoral collaboration:* a formal arrangement or mechanism that allow traditional healers and modern biomedical practitioners in areas related to mental health care manifested by smooth, respectful communication, joint educational and training activities and cross-referral.
- *Diviners:* these include traditional diagnosticians and spiritualists, the consult with spirits who may identify the type and cause of the illness. Sometimes also called *spiritist*
- *Explanatory model:* explanatory model of an illness is 'how a person interprets their illness in relation to causation, precipitating events, initial symptoms and signs, expected course of the illness, short and long term consequences as well as treatment options

  According to Kleinman 1984 EM is the "notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process". These models are linked to particular categories of illness and reveal labels and cultural idioms for expressing the experience of illness. In this study the choice of EM over other frameworks such as critical medical anthropology, the health belief model, theories of reasoned action, attribution theories, was to focus more on cognitive orientation of the community rather than on structural factors, such as economy, power or status.

- *Faith healers:* these are religious leaders such as priests, pastors, imams, sheiks ordained by their respected religious institutions such as *Mosques, churches, synagogues, congregations,* etc to preach, teach and other religious specific activities and rituals, and who base their treatment on the powers of God to heal sickness in certain practices such as prayer and holy water and without any formal type of indigenous medical training.
- *Mental health:* a state of well-being in which the individual realize his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO)
- *Modern health care*: largely overlapping term of mode of healing used interchangeably with biomedical, Western, modern, orthodox, allopathic, scientific, conventional or cosmopolitan medicine
- *Pathway in care:* Service utilization pattern once patients are referred for care
- *Severe mental disorders:* severe and persistent, serious, disabling, or chronic mental illness, for the purpose of this study schizophrenia is considered SMD,
- *Traditional healers:* is a "person who is recognized by the community in which he lives as competent to provide health care by using vegetables, animal and mineral substances and other methods such as divine healing based on the social, cultural and religious background, as well as on the knowledge, attitude and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability"

8. Ethical considerations

The research proposal, before the commencement of the study, will be reviewed by the Scientific Committee of the Department of psychiatry, and the the Institutional Review Board of the College of Health Science, Addis Ababa University.

Official permission letters from officials of the Sodo district Health Office will be obtained before starting data collection. The management of each participating health facilities will be given orientation by the principal investigator to ensure their support and facilitation of the data collection process. Orientation will focus on the purpose, methodology, procedure and expectations of the study.

Participation into the study will require informed consent from all participants (please see annex).

Anonymity and Confidentiality:

Collecting data: five types of data set will be collected: audio recordings (of in-depth interviews and focus groups discussions), transcripts of audio recordings, photographs, field notes, and survey data. The data will be collected by trained HEWs, research assistants and the principal investigator. All data will be converted into electronic formats (e.g., .mp3, .doc, .xls, .pdf) and shared between the primary investigator and PRIME project. Photographs will never be linked to specific interview or survey responses. Participants will be informed that they can refuse to have their photo taken and to have their interview voice-recorded. *Data storage, analysis, and reporting:* All computers, external hard drives, and USB memory sticks containing data will be password protected and kept in secure (locked) locations. All data on paper (for example, survey responses) will be given specific code numbers (alphanumeric IDs) and will be kept in secure, locked locations within the PI's and PRIME project office. In reporting research findings, pseudonyms will be used in all cases, unless a research participant requests to be identified by his or her real name. Audio recordings and photographs will not be publicly connected to specific interviewees' identity. We will retain a link between study code numbers (alphanumeric IDs) and direct identifiers (names) after the data collection is complete in order to enable future research efforts to follow-up with the same participants. We will not provide the link or identifiers to anyone outside the research team. All audiorecords will be destroyed once the recordings are transcribed.

Data availability: Researchers may request the data (qualitative and quantitative) from the principal investigator and PRIME project, who will consider sharing the data according to the negotiated terms of a data sharing agreement. Paper forms containing survey data will be destroyed once all the data have been entered electronically, cleaned, and backed-up.
Costs: There are no costs besides opportunity/time costs associated with participation in the study.

Drugs or Biologics: No drugs, dietary supplements, medical devices or services, radiation, biological samples, or other biologics will be collected for the proposed research.

Risk: For participants involved in interviews and surveys, there is minimal psychosocial risk involved in the study. Interviewers will be trained to pose questions related to stressful life events in a sensitive manner. In case when a respondent gets upset during an interview or observation or discussion, he or she will be allowed to discontinue the interview or observation or discussion. In such instance, the interviewer makes sure that the respondent is not left alone, but rather accompanied by neighbors or family whenever feasible.

There will be minimal risk that would jeopardize participant's employment or employability. Only "anonymized" or de-identified results of the study, and specifically the feedback on the program we collect from participants, including the health workers and traditional healers in the study, will be

communicated to high-level officials and policy makers. Given the nature of the study, accidental disclosure of a person's involvement in this study is unlikely to be upsetting or stigmatizing. Accidental disclosure of a person's responses to specific questions has the potential to have more serious effects, and thus we will take confidentiality extremely seriously, as described above.

9. Dissemination and utilization of results

Findings of the study will be compiled and presented at defense and then final report will be prepared after incorporating important comments.

1. Presentations will be prepared at scientific seminars and conferences.
2. Efforts will be made to publish and widely disseminate findings of the research in academic journals, newsletters, even on book chapters, with all personal identifying information removed.
3. Electronic and hard copies will be provided for partners involved in mental health service programs.
4. A PRIME project may make available summaries of data, key findings, and survey and interview protocols.

9.1. Beneficiaries

- The community: improved mental health services and improved mental health status through the intervention of the PRIME project
- Traditional practitioners: improved recognition by the health system; improved competency in managing mental health problems; improved acceptance by the community
- Modern health system: improve early detection, referral and treatment compliance of mentally ill individuals through established bi-sectoral collaboration
- Health authorities: an input for policy decision, planning and designing strategies to improve mental health services; lessons can be learned for other program collaborative efforts
- University: improve evidence base and knowledge transfer; teaching purpose by using the dataset as well as findings

9.2. Contribution to the project

This study will provide evidence on how to better facilitate collaboration between AHCPs and modern biomedical care system so that improve the mental health care services through

- Developing appropriate community mental health care intervention package
  - To explore professionally and technically sound and socio-culturally acceptable attitude and practice shifting tools (set of messages/materials) that help to bring change upon FTPs' and modern health care system towards improved mental health status of the community
- Develop well-informed action-focused program models to accelerate transformation of bi-sectoral collaboration to improve early recognition, help-seeking behaviour, and treatment adherence for common mental disorders
- Piloting the model of Community Intervention Team (CIT) in which traditional healers and mental health professionals are able to collaborate and work jointly so that improve access and coverage to mental health care

10. Presentation of study reports

The presentation of reports will follow standard way of formatting with sections of Introduction and background, Literature review, Objectives, Methodology, Findings, Discussions, Conclusions and Recommendations. Important findings of each study will be analyzed, discussed and presented accordance to the specific aims of individual studies.

There will be four publications one for each study with the following prospective titles:

- *Paper one*: Community utilization of FTHs (lifetime and 12-months) : pattern and determinants of use. Describing community attitude towards FTHs, user's characteristics, the prevalence and pattern of use of FTHs by the community, distribution of FTHs by type of practice, as well as user's and FTH's explanatory model of SMDs.
- *Paper two*: Utilization of FTHs mental health care by patients with SMDs. Demonstrating patient's characteristics, determinants of use including clinical, functional and economic status as well as their explanatory model of SMDs.
- *Paper three*: Clinical, functional and economic profile of patients with SMDs
- *Paper four*: short term changes in clinical outcome of SMDs by type of available service use.
- *Paper five*: short term changes in functional outcome of SMDs by type of available service use.
- *Paper six*: short term changes in economic outcome of SMDs by type of available service use.
- *Paper seven:* Baseline Experience, intention and determinants of cross-sector collaboration between FTHs and BMP care systems. The study will describe the existing as well as the changes in beliefs, attitudes, subjective norms and perceived behavioral control of biomedical and traditional care providers as well as their intention towards collaboration with each other.
- *Paper eight*: Change in the intention (impact of the intervention) and behavior (cross-sector collaboration between FTHs and BMP care systems).

Out of these six papers, four of them: paper three to six will included in the PHD dissertation work while the remaining will be published as separet papers in international and local credible journals.

11. Proposed budget

Table 3: Proposed budget

Category	Personnel	Qualification/description	No. of persons	Duration of work	Payment per day (ETB)	ETB
Survey						
Training	Data collection team	HEWs, Lay and HWs	130	3	150	58500
Data collection						
Community	Data collectors	HEWs	114	7	200	159600
FTHs	Data collectors	Lay youth	5	6	200	6000
	Supervisor	Degree holders	10	15	250	37500
Qualitative	Research Assistant	MPH graduates	4	10	600	24000
Longtudenal						
Training	Data collectors	Helath workers	6	3	150	2700
	Supervisor	Senior Health workers	3	3	200	1800
Data collection	Data collectors	Helath workers	6	10	250	15000
	Supervisor	Senior Health workers	3	10	300	9000
Refresher training	Data collectors	Helath workers	6	1	150	900
	Supervisor	Senior Health workers	3	1	200	600
Data collection	Data collectors	Health workers	6	10	250	15000
	Supervisor	Senior Health workers	3	10	300	9000
Collaboration						
Training	Data collectors	Lay youth	6	2	150	1800
	Supervisor	Degree holders	3	2	200	1200
Data collection	Data collectors	Health workers	6	5	250	7500
	Supervisor	Degree holders	6	5	250	7500
Qualitative	Research Assistant	MPH graduates	2	4	600	4800
Data entry	Data entry clerk	Diploma	2	1	2000	4000
Sub Total						366400
Transportation	PI	Field work	1	40	1000	40000
Accommodation	PI	Field work	1	40	200	8000
	Advisors	Field work	4	10	200	8000
Sub-total						56000
Stationary	Items	Unit	Amount	Unit price		ETB
	Paper A4 size	Ram	30	80		2400
	Toner(4100)	Pcs	2	1300		2600
	Pencil	Pcs	300	2		600
	Pen	Pcs	200	2		400
	Note book	Pcs	40	10		400
	Eraser	Pcs	200	1		200
	Clip board	Pcs	13	10		130
	CD- rewritable	Pak	4	100		400
	External hard disc	Pcs	1	2000		2000
	Tape recorders	Pcs	6	300		1800
	Tape cassettes	Pcs	30	10		300
	For duplication	Bulk	1	10000		10000
	Binding cost	Pcs	160	8		1280
	Communication services	Bulk	1	5000		5000
Sub-total						27510
Grand total						**449910**

12. Proposed work plan

Table 2: proposed work plan

No.	lists of Activities	2012	2013				2014				2015
		Quarter 4	Q 1	Q 2	Q 3	Q 4	Q 1	Q 2	Q 3	Q 4	Q1
1	Presenting the draft proposal to advisor(s)	x									
2	-Finalizing the proposal incorporating comments of the advisor(s) -Presenting and defending final proposal	x x									
3	Submitting the proposal to the PHD coordinator of the joint SPH-Psychiatry academic commission, send to IRB	x									
4	-Securing ethical clearance -Securing supporting letters	x x									
5	Initial communication with local officials	x									
6	-Identifying and recruiting data collection team -Training of data collectors collection team Pretesting of the data collection instruments -Finalizing the data collection instruments incorporating comments from the pretest -Finalizing sampling frame for data collection	x	x x x x								
7	Data collection		x	x	x	x					
8	-Data entry and cleaning -Data analysis		x	x	x	x	x				
9	Write up of the draft report			x	x	x	x	x			
10	Submission of draft report to advisor(s)				x	x	x	x	x		
11	Finalizing the report incorporating comments of the advisor(s)				x	x	x	x	x		
12	Finalizing and submitting the approved research report					x	x	x	x	x	
13	Presentation to focused audience (scientific)					x	x	x	x	x	
14	Finalizing and submitting the approved research report					x	x	x	x	x	x
15	Dissemination of report Scientific journal Scientific conferences					x	x	x	x	x	x

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14. ANNEXES

ANNEX 1: Study Instruments

Tool for Study I:

1.1. FGD (#2) or In-depth guide with community/opinion leaders (# 5)

- Worm up questions
  - Can we talk about the health problems in this area
  - Where do people go to seek health services for these problems
  - Depending on the response if they say modern healer, are there times when people seek health care from people like you?
- What kind of people prefer to use FTHs?
  - Probe for:
    - age, sex, status: marital, economic, educational
    - Availability: distance, working days & hours (full- or part-time;
    - Affordability: amount & type of payment by kind of services;
    - Provider factors: practitioners characteristics;
    - Problem factors: type of illness, etc)
- What kind of FTHs exists in your area:
    - Probe for
    - Faith, Diviners, Herbalist, other
- What kind of health conditions are treated by FTHs?
  - Probe for
    - Type of healers;
    - Type of health problems?
- When do you call a person 'FTHs user'
  - Probe, in terms of
    - Frequency of use
    - Duration of use
    - Exclusive or mixed use
- Is mental health problem common in your area?
  - What kinds of mental illness do you think are common?
  - What local name you have for mental illnesses?
    - Does this differ by type
    - Can you give an example
    - What conditions or symptoms are commonly associated with mental illness?
  - Which one is serious?
    - What kind of symptoms do people with severe mental disorder exhibit?
    - Can you tell me a story about a severe mental problem you have faced
    - Can you also tell me a simple one?
  - What do you think is the cause of mental illness?
    - Probe for family history,
    - Belief system
    - Curse
    - Ancestral heritage
  - What are the consequences of mental illness?
  - What is the treatment of mental illness?
  - What is the prognosis of mental illness?

Psychosis:

[READ OUT PSYCHOSIS VIGNETTE]

A previously normal person has changed over the past 1-2 weeks. He or she has become extremely restless, looking frightened, and trying to do unreasonable or dangerous things - starting a fire, smashing objects, undressing, tearing clothes, or even attempting to harm people for no reason. Sometimes such a person may behave as if hearing voices that no one else can hear, or seeing things which are not real. Such a person may be very difficult to stop or talk to, but may say that he/she is receiving orders from God, or is communicating with spirits. Usually this sort of state lasts for days or a few weeks after which the person either returns to normal, or continues to say strange things and look about strangely but is no longer excited and difficult to manage.

- Have you experience of people who have this kind of condition?
  If yes,
    - Does this condition have a name? What do you call this kind of problem?
    - What do you think is the cause of such a condition?
    - Why do you think it started when it did?
    - Without treatment, what would happen to the person?
        - What does this sickness do to the patient?
        - How does it work?
        - How severe is it?
        - Will it have a short or long course?
    - What do you fear most about this sickness?
    - What are the chief problems this sickness has caused for the patient?
    - What kind of treatment do you think such patients should receive?
    - What are the most important results patients hope to receive from the treatment?
    - Where do people with this kind of condition get help?
        - Do you think traditional healers could offer anything for this person?
        - Do you think modern health facilities could offer anything for this person?
    - Do people with this condition face negative attitudes from other people?
    - Do people with this condition excluded from social gatherings?
    - Do people with this condition victims of violence or chained up?

1.2. Faith and Traditional Healing Practice (quantitative) [all FTHs in the district]

1. Demographic Information		
101	Age (How old are you?)	[ ][ ]
102	Sex (observed sex)	Male 1
		Female 2
103	Marital Status (What is your marital status?)	Single 1
		Married 2
		Divorced 3
		Widowed 4
		Married but not living together 5
104	Residence (State whether the Kebele of residence is urban or rural)	Urban 1
		Rural 2
105	Education (How many years have you spent in school)	[ ][ ]
106	Income (What is your monthly income?)	<500 birr/ month 1
		501-999 birr /month 2
		1000-1999 birr /month 3
		>2000 birr/ month 4
107	Annual income (What was your last year's earning?)	…….
108	Relative wealth (Compared to others in the Kebele, how do you see your economic standing?)	Poor 1
		Average 2
		Better off 3
109	Religion (What is your religion?)	Orthodox Christian 1
		Muslim 2
		Protestant 3
		Other 88
110	Ethnicity (What is your ethnicity?)	Gurage 1
		Oromo 2
		Amhara 3
		Other 88
111	Duration of Residence (How long have you been living in this kebele?)	[ ][ ] years
112	Household size (Including yourself and children, how many persons live in your household?)	[ ][ ]

113	Number of dependents (What is the total number of children under seven in your household?)	[ ][ ]
114	Occupation (What is your occupation?	Housewife 1
		Farmer 2
		Merchant/Trader 3
		Student 4
		Civil servant 5
		Daily laborer 6
		Other (please specify) 88
115	Partner's Occupation-if married (What is your husband/wife's occupation?)	Housewife 1
		Farmer 2
		Merchant/rader 3
		Student 4
		Civil servant 5
		Daily laborer 6
		Other (please specify) 88
116	Partner's education-if married (What is your husband/wife's education level)	Not literate 1
		No formal education but can read and write 2
		Primary education 3
		Secondary education 4
		College/University education 5

2. Traditional healing practice		
NO	QUESTIONS AND FILTERS	CODING CATEGORIES
101	How long have you been in this healing practice?	[_____] Years
102	What kind of healing service are you providing to your clients? Multiple answer possible	Prayer ……1 Holy water ……2 Recitation ……3 Scarification ……4 Magical ……5 Hypnotize ……6 Sorcery, enchantment……7 Herbalist (dispense herbal medicine) …….8 Mixed (Faith healer, diviner & herbalist) ……9 Bone settler ……10 Therapeutic cut/inoculation/cauterization ……11 Tooth extraction……..12 Other……..88
103	What are you treating?	Only Physical illness……1 Only mental illnesses……2 Both physical and mental illnesses……3 Other……..88
104	How did you enter to the healing practice?	Family kinship …….1 Ancestral spirit (contacted trough dreams)……2 I had illness treated by traditional healer…….3 Appreciation of the practice (conviction) …..4 Other……..88 DK…….99
105	What did you do when you start practicing?	Nothing……1 Instructed by supernatural power what to do……2 Training by other healer…….3 Participated in rituals/ceremonies……4 Other……..88
105.1	For those who received training, how long they received training?	[……..]
106	Are you practicing the healing alone or you have network with other healers?	Alone …..1 Have network with other FTHs……2
107	If you are treating patients with other healers, how are you doing it?	Call or invite other healers to help me…..1 I do to them and consult……2

		I simply send the patient to healers with message……3 Other……88
109	In your busy day, how many patients do you see per day?	[_____]
110	On average, how many patients do you see per day?	[_____]
112	On average, how many patients do you see per week?	[_____]
113	On average, how many patients do you see per month?	[_____]
114	What kinds of people are coming to you, in terms of sex	Predominantly male……1 Predominantly female……2 Equally both……3
115	What kinds of people are coming to you, in terms of age	Predominantly children/adolescents……1 Predominantly young……2 Predominantly old……3 Equally all……4
116	What kinds of people are coming to you, in terms of wealth	Predominantly poor……1 Predominantly rich……2 Equally both……3
117	From where do you get clients? (multiple answers possible)	Self referral (by word of mouth) ……1 Referred by family members/friend ……2 Referred by other traditional healer ……3 Referred from modern health facilities ……4 Other……88
118	Who do you think influence/advise patients to come to you?	Patients themselves…..1 Family members and friends …..2 Neighbors & villagers…….3 Community/opinion leaders…….4 Modern health professionals…….5 Others ……88 DK…….99
119	Are people come to you after they visit other treatment	Majority comes first to us……..1 Majority comes after they visited modern treatment…….2 Majority come while visiting modern treatment…..3
120	Why do you think people come to you?	We are easily available/ near/always open……1 They don't have other health care……3 They believe we are the best…….4 They trust us …..5 Our service is less costly……7 Our treatment style is simple……..8 Patients have right to talk/discuss……..9 We are their people/relatives/family …..10 We are from the same culture/tradition……11 We stayed for long time here……12 We solve both social & spiritual problem……..13 Healers are polite than health workers ……14 Other……..88 DK……99
121	From where do people come?	within this district……1 Around this district……2 All over the country……3 DK…….99
122	At what time do you practice healing?	Full time……1 Part-time……2
123	How often do you practice healing activities?	Every day ……1 Once per week……2 On holidays……4 Whenever client comes……..3
124	Which day of a week do you prefer to see patients	No preference……0 Specific day……
125	Which time (zone) of a day you prefer to see patients	No preference……0 Specific time (zone)……

126	Do you have place (accommodation) where patients can stay a night(s)?	Yes ……1 No ……0
127	What do you receive for healing service from your clients?	In kind…….1 In cash……..2
128	How much do you receive for healing service?	Fixed amount …… 1 Depends on the type of illness…….2 Determined by the client…….3 Depending on the wealth condition of the client…….4 Other……88
129	How do you see the cost of traditional healers compared to modern treatment?	Cheep……..1 Expensive……..2 Equal……..3
130	If you are treating mental illness, which kind of mental illness do you treat?	
131	How many people with mental illness you treat per month?	[_____]
132	What do you think influence the effectiveness of your treatment	Severity of illness……1 Duration of illness…….2 Willingness/compliance of client……3 Client status (nutrition, etc)…….4 Other……88 DK……99
133	Have you ever referred mentally ill patients to any other person?	Yes ……1 No ……0
	If you have ever referred patients, to whom you referred?	Fellow healer……..1 Modern health providers……2
134	What was your reason for referral to modern health sectors/professionals?	If I knew that the problem can't be treated by me……1 When I tried but failed to cure the patient ……..2 To temporarily calm down violent patients b/c they have injection...3 If the patient asked …….4 When I face acute medical problem……..5 if patient has additional medical problems…….6 Other……88
135	If yes, what was the reason?	As a permanent solution cure…..1 As a temporary measure…..2
136	Usually when you refer patients, when was the usual time	At the beginning of consultations…….1 As a last resort……2
137	What was your reason for not referring patients to modern health sectors/professionals?	I can treat by myself/no need of referral ……..1 I am better than they do…….2 They will not accept us/our patients……..3 I only have few patients……..4 They don't refer to us……..5 I don't trust them/believe in their capacity ……..6 I don't know whether I can refer or not…….7 Other……88
138	How you ever received patients referred form modern health sectors/professionals?	Yes ……1 No ……0
139	Why do you think that the modern health sectors/professionals referred patients to you?	They know that we are better than them…..1 They don't treat mental health problems……..2
140	Why do you think the modern health sectors/professionals are not referring patients to you?	They are taught not to refer to us…….1 They are better than us…….2 They think that they are better than us…….3 They think they can treat all problems…….4 They don't' trust us/believe in our capacity…….5 They dislike us…….6 They don't know us/accept our existence……..7 There is no such referral practice so far……..8 They fear that they lose patient's trust……9 Other……88
141	Were you having any kind of health problem before you become	Yes ……..1

	traditional healer?	No …….0
142	What was your problem?	Mental health problem……1 Other non-mental health problems……..2 Other ……..88

1.3. Topic Guide for EXPLANATORY MODEL in-depth interview with FTHs who currently treating SMDs (# 5)

- Worm up questions
  - Can we talk about the health problems in this area
  - Where do people go to seek health services for these problems
  - Depending on the response if they say modern healer, are there times when people seek health care from people like you?
- What kind of people prefer to use FTHs?
  - Probe for:
    - age, sex, status: marital, economic, educational
    - Availability: distance, working days & hours (full- or part-time;
    - Affordability: amount & type of payment by kind of services;
    - Provider factors: practitioners characteristics;
    - Problem factors: type of illness, etc)
- What kind of FTHs exists in your area:
    - Probe for
    - Faith, Diviners, Herbalist, other
- What kind of health conditions are treated by FTHs?
  - Probe for
    - Type of healers;
    - Type of health problems?
- When do you call a person 'FTHs user'
  - Probe, in terms of
    - Frequency of use
    - Duration of use
    - Exclusive or mixed use
    - predominantly use FTHs' and 'predominantly use BMP'

- Is mental health problem common in your area?
  - What kinds of mental illness do you think are common?
  - What local name you have for mental illnesses?
    - Does this differ by type
    - Can you give an example
  - What conditions or symptoms are commonly associated with mental illness?
    (ex: aggression, uttering incoherently, isolation, shouting, confusion and strange behavior, wandering away from home;
    eating or smearing feces; laughing at inappropriate times; impaired self-care such as not washing; and eating dirty food)
  - Which one is serious?
    - What kind of symptoms do people with severe mental disorder exhibit?
    - Can you tell me a story about a severe mental problem you have faced
    - Can you also tell me a simple one?
  - What do you think is the cause of mental illness?
    - Probe for family history,
    - Belief system
    - Curse
    - Ancestral heritage
  - What are the consequences of mental illness?
  - What is the treatment of mental illness?
  - What is the prognosis of mental illness?

Psychosis:

[READ OUT PSYCHOSIS VIGNETTE]

A previously normal person has changed over the past 1-2 weeks. He or she has become extremely restless, looking frightened, and trying to do unreasonable or dangerous things - starting a fire, smashing objects, undressing, tearing clothes, or even attempting to harm people for no reason. Sometimes such a person may behave as if hearing voices that no one else can hear, or seeing things which are not real. Such a person may be very difficult to stop or talk to, but may say that he/she is receiving orders from

God, or is communicating with spirits. Usually this sort of state lasts for days or a few weeks after which the person either returns to normal, or continues to say strange things and look about strangely but is no longer excited and difficult to manage.

- Have you experience of people who have this kind of condition?
  If yes,
  - Does this condition have a name? What do you call this kind of problem?
  - What do you think is the cause of such a condition?
    - How do you make the diagnosis
  - Why do you think it started when it did?
  - Without treatment, what would happen to the person? What does this sickness do to the patient? How does it work?
  - How severe is it? Will it have a short or long course?
  - What do you fear most about this sleekness?
  - What are the chief problems this sickness has caused for the patient?
  - What kind of treatment do you think such patients should receive?
  - What are the most important results patients hope to receive from the treatment?
  - Where do people with this kind of condition get help?

- Do they come to you for help?
  If yes,
  - How many do you see per day (or per week / per month)?
  - Do you offer treatment for this kind of condition?
  - What kind of treatment?
    - How do you practice the treatment?
    - How long it take to treat?
    - If you give remedies, how and where they obtain remedies?
  - Do you find your treatment to be effective for this kind of condition?
    - What is the purpose of the treatment?
      - Symptomatically: to cure or improve the condition?
      - Socially: family and other social responsibilities, relationship,
      - Economically: to bring back to work
  - Does this treatment interfere or complement with modern treatment?
  - Is referral to modern care useful?

- Are there some people with this condition who never receive help?
  - Why is that? Is it because they are poor? Are women less likely to get help?
  - Could the number getting help be increased? How? Could you help with this?

- Do you think modern health facilities could offer anything for this person?
  - Is it ok for people with this condition to have treatment from you at the same time as from a modern health facility? Why?
  - Do you have any contact with health extension workers, nurses or health officers?
  - Do you ever refer patients to modern health services?
    - If yes, for what reason?
    - If no, why not?
      - What have to change for you to consider referral?
  - Do modern health facilities ever refer patients to you?
- People with this condition can sometimes experience negative attitudes from other people. What do you think about this?
  - Could anything be done to help?
- People with this condition can sometimes be excluded from social gatherings, prevented from working with others, prevented from taking certain positions, even after they have recovered from their illness.
  - What do you think about this?
  - Could anything be done to help?
- People with this condition can sometimes be victims of violence or chained up.
  - What do you think about this?
  - Could anything be done to help?

2. Tools for Study II and Study III

2.1. OPCRIT

2.2. Patients (family member as care giver) interview

	1. Demographic Information	
101	Age (How old are you?)	[ ][ ]
102	Sex (observed sex)	Male……1 Female ….1
103	Marital Status (What is your marital status?)	Single……1 Married…….2 Divorced…….3 Widowed Married but not living together ……..4
104	Residence (State whether the Kebele of residence is urban or rural)	Urban ……1 Rural…….2
105	Education (How many years have you spent in school)	[ ][ ]
106	Annual income (What was your last year's earning?)	
107	What is your main source of income? (How do you make ends meet?)	Salary/Wage ……1 State benefits (incl. pension).….2 Family support …….3 Self-employment (e.g. farming, cash crops, khat).…..4 Other (e.g. undeclared earnings)……..88
108	Do you own property (such as a farm, cattle, a house) or have savings?	Yes …….1 No…….2
109	If yes, please can you describe your property or savings in the box below?	
110	Relative wealth (Compared to others in the Kebele, how do you see your economic standing?)	Poor……2 Average…….2 Better off……..3
111	Religion (What is your religion?)	Christian……1 Muslim…….2 Protestant……..3
112	Ethnicity (What is your ethnicity?)	Gurage ……..1 Other……88
113	Duration of Residence (How long have you been living in this kebele?)	[ ][ ] years
114	Occupation (What is your occupation?	Housewife ……1 Farmer ……..2 Merchant/Trader …….3 Student …….4 Civil servant ……..5 Daily laborer…..6 Other……88
115	Have you ever suffered a serious illness, organic mental disorders, psychoactive substance abuse disorders, injury or an assault?	Yes …….1 No…….2
116	Where did you often go for treatment?	No where…….1 Modern health care ……..2 Herbalist/Balemedhanit ……..3 Witch doctor/Awaki …….4 Holy water/ Church or Mosque prayer ……..5 Traditional healer with mixed practice…….6 Other (specify)……..88
117	Where you mixing treatment practitioner or you go only to one practitioner?	Often mix…….1 No use only one…….2
118	If you mix, did you take medication/treatment from both at the same time or you did after finishing one you go to the other	At the same time……..1 one after the other…….2
119	Age of onset, i.e. when was the onset of your problem (SMDs) [Onset was defined as the time when the patient's symptoms began to meet DSM-III-R criteria based on clinical interview with the patients and their family members].	……..years
120	Duration of Untreated Psychosis (DUP) i.e. duration of illness or the time between the onset of illness/symptom and treatment? or time required to go to the treatment facility (time required to go to the hospital) based on either medical records or interviews with subjects and their family members.	……..days/months/years
121	Type of onset (Acute onset was defined as onset of Schizophrenia within 1 month of onset of symptoms. Onset longer than 1 month was classified as insidious)	Acute onset (within 1 month)……..1 Insidious onset (longer than 1 month)……..2
122	Duration of illness (Illness of shorter duration is considered acute and that lasting more than 2 years is considered chronic).	Acute ……1 Chronic ……..2
123	Where are you receiving treatment/help for your mental illness?	Modern medical care……..1 Faith healer (prayer/holy water/recitation) ……2

		Diviner (scarification/magical/hypnotize/sorcery, enchantment)……3 Herbalist …….4 Mixed (Faith healer, diviner & herbalist) ……5
124	How did you come to the treatment service	Self……1 Accompanied by others (voluntarily)……2 Accompanied by others (involuntarily)……3
125	Family history of mental illness,	Yes….1 No……2
126	What type of mental illness	

2. Health service utilization			
201	Have you ever used FTHs care?	Yes….1 No……2	Go to 301
202	Have you ever visited Herbalist/Balemedhanit?	Yes….1 No……2	
203	Have you ever visited Witch doctor/Awaki?	Yes….1 No……2	
204	Have you ever visited Holy water/ Church-Mosque prayer?	Yes….1 No……2	
205	Have you ever visited FTHs who use mixed practices?	Yes….1 No……2	
206	What was the purpose you went to these FTHs?	Mental health problems…..1 Physical illness……..2 Others……88	
207	Did you visit FTHs for the treatment of SMDs in the past 6 months?	Yes….1 No……2	
208	If, yes, did you visit Herbalist/Balemedhanit in the past 6 months?	Yes….1 No……2	
209	If, yes, did you visit Witch doctor/Awaki in the past 6 months?	Yes….1 No……2	
210	If, yes, did you visit Holy water/ Church-Mosque prayer in the past 6 months?	Yes….1 No……2	
211	If, yes, did you visit FTHs who use mixed practices in the past 6 months?	Yes….1 No……2	
212	For how long did you use FTHs for SMDs (maximum) in the past 6 months [Duration of use]	….. days	
213	When was the last time you used FTHs for SMDs in the past 6 months [Recent use]	…….date	
214	How often did you use FTHs practice for SMDs in the past 6 months? [Frequency of use] (i.e. how many times the patient had been brought to the traditional healer centre)	……..#	
215	How did you receive treatment for your SMDs?	Only outpatient …….1 Only inpatient……..2 Both out and in-patient…..3	
216	If you received in-patient treatment, how many days you spent in your last visit with in the past 6 months?	…….days	
217	If you need to visit the FTHs as soon as possible, about how long do you usually have to wait to get the treatment (when you do not have an appointment scheduled)?	……. time	
218	About how long does it usually take you to get to the FTHs?	……. Time or ……distance	
219	About how long do you usually have to wait from the time you arrive to the time you actually get care, at FTHs?	……. time	
220	In the last 6 months, did you visit any other health care provider for SMDs care from the usual FTHs?	Yes….1 No……2	Go to 225
221	If yes visit other health care, what was that another health care provider?	Modern medical care…..1 Another FTHs……..2	
222	If you visited other health care, what was the reason?	Referred by first FTHs……1 To complement the FTHs care….2 Family/friend advise ……3 Others……88	
223	When you use that another health care, how was your visit	Use both simultaneously……1 Only the other one until I finish with it 2	
224	How did you find the FTHs practice for the SMDs problems? [Perceived benefit]	No change ….1 Improved ...2 Cured …..3 Get worse …..4	
225	Have you ever faced any problem while using FTHs practice [harm practices]	Yes….1 No……2	

226	If yes, what kind of problem did you face? [types of harm practices]	Biting…..1 Chained ……2 Hunger…..3 Thirst ….4 Isolation…….5 Others……88	

3. SHORT EXPLANATORY MODEL INTERVIEW (SEMI)			
301	HEALTH & ILLNESS; CURRENT HEALTH STEM:		
What are / were your problems?			
2.1.1	Problem 1:	Code [ ] [ ]	PROB1
2.1.2	Problem 2:	Code [ ] [ ]	PROB2
2.1.3	Problem 3:	Code [ ] [ ]	PROB3
2.1.4	Problem 4:	Code [ ] [ ]	PROB4
2.1.5	Problem 5:	Code [ ] [ ]	PROB5
2.1.6	Problem 6:	Code [ ] [ ]	PROB6
2.1.7	Problem 7:	Code [ ] [ ]	PROB7
2.1.8	Problem 8	Code [ ] [ ]	PROB8
2.1.9	Problem 9:	Code [ ] [ ]	PROB9
2.1.10	Problem 10:	Code [ ] [ ]	PROB10
	Are / were there any other problems?		
2.1.11	Problem 11	Code [ ] [ ]	PROB11
2.1.12	Problem 12	Code [ ] [ ]	PROB12
2.1.13	Problem 13:	Code [ ] [ ]	PROB13
2.1.14	Problem 14:	Code [ ] [ ]	PROB14
2.1.15	Problem 15	Code [ ] [ ]	PROB15
2.2	What do you call this / these problem(s)? Probe: If you had to give them names what would they be?		
2.2.1	Name 1:	Code [ ] [ ]	NAME1
2.2.2	Name 2:	Code [ ] [ ]	NAME2
2.2.3	Name 3:	Code [ ] [ ]	NAME3
2.3	When did you first notice < specify identified problem>? Probe: how long ago was it, when did it start?		
2.3.1	Onset 1:	Code [ ] [ ]	ONSET1
2.3.2	Onset 2:	Code [ ] [ ]	ONSET2
2.3.3	Onset 3:	Code [ ] [ ]	ONSET3
2.3.4	Onset 4:	Code [ ] [ ]	ONSET4
2.3.5	Onset 5:	Code [ ] [ ]	ONSET5
2.4	Why do you think these problems started when they did?		
2.4.1	Reason 1:	Code [ ] [ ]	WHY1
2.4.2	Reason 2:	Code [ ] [ ]	WHY2
2.4.3	Reason 3:	Code [ ] [ ]	WHY3
2.5	Is there anything you have or haven't done that has caused this?	Yes….1 No….2 Unable to say…..3	PERSONAL
2.5.1	If 'yes' what, probe for examples and note down verbatim.		
2.5.2	Example 1:		INTERN1
2.5.3	Example 2:		INTERN2
2.5.4	Example 3:		INTERN3
2.6	Is there anything anyone else has done or not done that has caused this?	Yes….1 No….2 Unable to say…..3	EXTERNAL
2.6.1	If 'yes', probe for example and note down verbatim.		
2.6.2	Example 1:		EXTERN1
2.6.3	Example 2:		EXTERN2
2.6.4	Example 3		EXTERN3
2.7	So who or what is the cause of you getting this?	Mainly me ….1 Someone else ….2 Something happened to me…….3 Unable to say…….4	INTEX
2.8	Do you believe that someone has done something?	Yes….1 No….2 Unable to say…..3	SUPERN
2.8.1	If 'yes', probe for example and note down verbatim.		
2.8.2	Example 1:		SUPERN1
2.8.3	Example 2:		SUPERN2

2.8.4	Example 3:		SUPERN3
3	PERCEIVED SEVERITY		
3.1.	How SERIOUS are your problems? < If there are several complaints probe separately for each of them >		
3.1.1	Severity of problem 1:	Code [ ] [ ]	SEVERE1
3.1.2	Severity of problem 2:	Code [ ] [ ]	SEVERE2
3.1.3	Severity of problem 3:	Code [ ] [ ]	SEVERE3
3.2	Out of the above which one do you think is most serious?		
3.2.1	Most serious problem:	Code [ ] [ ]	WORST
3.3.	What do you most FEAR about these problems? < Are you frightened and if so >		
3.3.1	Most fear about problem:	Code [ ] [ ]	FEAR1
3.4	Do you have any other fear?		
3.4.1	Other fear 1:	Code [ ] [ ]	FEAROT1
3.4.2	Other fear 2:	Code [ ] [ ]	FEAROT2
3.4.3	Other fear 3:	Code [ ] [ ]	FEAROT3
3.5	Why did you come looking for help at this particular time? Probe: Had it got worse? Were you afraid? Did others advise you?		
3.5.1	Reason wanted help now:	Code [ ] [ ]	WHYNOW1
3.6	How and when do these problems get WORSE? < What would make them worse? Probe for example and note down verbatim >		
3.6.1	Makes problem worse 1:	Code [ ] [ ]	WORSE1
3.6.2	Makes problem worse 2:	Code [ ] [ ]	WORSE2
3.6.3	Makes problem worse 3:	Code [ ] [ ]	WORSE3
3.7	How and when do these problems get BETTER? <What would make them better? Probe for example and note down verbatim. >		
3.7.1	Makes problem better 1:	Code [ ] [ ]	BETTER1
3.7.2	Makes problem better 2:	Code [ ] [ ]	BETTER2
3.7.3	Makes problem better 3:	Code [ ] [ ]	BETTER3
5	EXPECTATIONS OF / SATISFACTION WITH CARE		
4.1	What do/did you HOPE to gain from seeing the healer / health worker / coming to holy water today? What did you expect/want the healer / health worker to do		
4.1.1	Expectation 1:	Code [ ] [ ]	EXPECT1
4.1.2	Expectation 2:	Code [ ] [ ]	EXPECT2
4.1.3	Expectation 3:	Code [ ] [ ]	EXPECT3
4.2	Have you ASKED the healer / health worker about these problems?	All of them …..1 Some of them….2 Not asked any…..3 Unable to say….4	DISCLOSE
4.2.1	If yes, what did the healer / health worker tell you?		
4.2.2	What told about problem (1):	Code [ ] [ ]	TOLD1
4.2.3	What told about problem (2)	Code [ ] [ ]	TOLD2
4.2.4	What told about problem (3)	Code [ ] [ ]	TOLD3
4.2.5	What told about problem (4)	Code [ ] [ ]	TOLD4
4.2.6	What told about problem (5)	Code [ ] [ ]	TOLD5
4.3	What did the healer / health worker DO about your problems?		
4.3.1	What healer / health worker did (1):	Code [ ] [ ]	HEAL1
4.3.1	What healer / health worker did (2):	Code [ ] [ ]	HEAL2
4.3.3	What healer / health worker did (3):	Code [ ] [ ]	HEAL3
4.3.4	What healer / health worker did (4):	Code [ ] [ ]	HEAL4
4.3.5	What healer / health worker did (5):	Code [ ] [ ]	HEAL5
4.4	How USEFUL did you find it talking to the healer / health worker about your problems?		
4.4.1	Talking to healer / health worker:	Code [ ] [ ]	TALK
4.5	Up to now, was there anything about your treatment you were unhappy about?	Yes….1 No….2 Unable to say…..3	UNHAPPY
4.5.1	If 'yes' clarify		
4.5.2	Unhappy with (1)	Code [ ] [ ]	UNHAP1
4.5.3	Unhappy with (2):	Code [ ] [ ]	UNHAP2
4.5.4	Unhappy with (3):	Code [ ] [ ]	UNHAP3
5	ACTIVITIES and FUNCTIONING		
5.1	What are the MAIN DIFFICULTIES your problems have caused you?		
5.1.1	Difficulty (1):	Code [ ] [ ]	DIFFIC1

5.1.2	Difficulty (2):	Code [ ] [ ]	DIFFIC2
5.1.3	Difficulty (3)	Code [ ] [ ]	DIFFIC3
5.2	What PART of YOUR BODY are most affected by your problems?		
5.2.1	Part of body (1):	Code [ ] [ ]	BODY1
5.2.2	Part of body (2):	Code [ ] [ ]	BODY2
5.2.3	Part of body (3):	Code [ ] [ ]	BODY3
5.3	How and to what extent have you been affected EMOTIONALLY by your problems? < For an example were you more upset, worried or unhappy etc. and to what extent?>		
5.3.1	Emotional impact (1):	Code [ ] [ ]	EMOT1
5.4	Have these problems STOPPED you getting about as well as you used to? < Probe: how and to what extent? >		
5.4.1	Impact on mobility (1):	Code [ ] [ ]	MOBIL1
5.5	Have these problems affected your SOCIAL LIFE? < Probe: how and to what extent? >		
5.5.1	Social impact (1):	Code [ ] [ ]	SOCIAL1
5.6	Have these problems affected your FAMILY LIFE? < Probe: how and to what extent? >		
5.6.1	Family impact (1):	Code [ ] [ ]	FAMILY1
5.7	Have these problems affected how you get on with people in general? < Probe: for example getting more irritable/angry/ less friendly etc. and to what extent?>		
5.7.1	Impact on getting on with people (1):	Code [ ] [ ]	RELATE1
5.8	Has your work (including house work) / job been affected? < Probe: how and to what extent? >		
5.8.1	Impact on work (1):	Code [ ] [ ]	WORK1
6	OTHER HEALTH BEHAVIOUR		
6.1	Have you asked for ADVICE from anyone else about your problems? < Probe: friends, family, alternative forms of therapists including traditional healers, religious healers		
6.1.1	Asked for advice (1):	Code [ ] [ ]	ADVICE1
6.1.2	Asked for advice (2):	Code [ ] [ ]	ADVICE2
6.1.3	Asked for advice (3):	Code [ ] [ ]	ADVICE3
6.1.4	Asked for advice (4):	Code [ ] [ ]	ADVICE4
6.1	What different kinds of healer / specialist health worker have you obtained treatment or advice about these problems?		
6.2.1	Healer (1):	Code [ ] [ ]	HEALER1
6.2.2	Healer (2):	Code [ ] [ ]	HEALER2
6.2.3	Healer (3):	Code [ ] [ ]	HEALER3
6.3	HOW MANY healers / health workers have treated you for your problems? < during the total duration of illness >		
6.3.1	[ ] [ ] healers		HEALNUM
6.3.2	[ ] [ ] health workers		HWNUM
6.4	HOW MUCH approximately have you spent for treatment? < Probe: estimated direct cost for the illness >	Expense _____ BIRR	HEALEXP
6.5	Do you treat yourself for the problems?	Yes….1 No….2 Unable to say…..3	SELFTX
6.6	If so how?		
6.6.1	Self-help (1):	Code [ ] [ ]	SELFHEL1
6.6.2	Self-help (2):	Code [ ] [ ]	SELFHEL2
6.6.3	Self-help (3):	Code [ ] [ ]	SELFHEL3
6.7	Are you taking any medication now?		
6.7.1	Medicine (1):	Code [ ] [ ]	MEDS1
6.7.2	Medicine (2):	Code [ ] [ ]	MEDS2
6.7.3	Medicine (3):	Code [ ] [ ]	MEDS3
6.8	Are you taking any other cures or remedies? <Probe: herbal medicine/homeopathy etc>		
6.8.1	Traditional treatment (1):	Code [ ] [ ]	TRADTX1
6.8.2	Traditional treatment (2):	Code [ ] [ ]	TRADTX2
6.8.3	Traditional treatment (3):	Code [ ] [ ]	TRADTX3

Thank you for telling me details of your illness/problems. Finally I would like to ask your opinion about some other peoples' problems and their visits to doctors. I would like you to listen/read a short account of their problems and then ask you a few questions about them

7. VIGNETTE I

A 34 year old bus conductor goes to the GP. He has been unable to get on a bus since a friend of him was assaulted at work. He has been off work

for four months now. As a result, the family now has financial problems and they are in arrears on the rent. He used to go shopping with his wife but now feels very uncomfortable in supermarkets. Crowds make him out in sweat and feel tense and panicky. When this happens he feels like something terrible is about to happen. Consequently he is spending more and more time indoors.
7.1. What is his problem? [WHAT]
7.2. Does he have< suffering from> an illness. If yes, what is it? [ILLNESS]
7.3. What are the causes of his problems? [COUSE]
7.4. What should he do about it? [ACTION]
7.5 What should the doctor do about it? [DOCDO]
8. VIGNETTE II A 45 years old machine operator married with two children has been feeling tired, irritable, lacking in energy for about three months. There has been a lot of uncertainty about the future of the company she works for. She has trouble getting to sleep and has chronic backache, stomach pain and aching legs. This has affected her ability to care foe her children and enjoy their company. She prefers to sit around the house aching television
8.1. What is his problem?
8.2. Does she have< suffering from> an illness. If yes, what is it?
8.3. What are the causes of his problems?
8.4. What should she do about it?
8.5 What should the doctor do about it?
9.VIGNETT III She is a 29 year old mother of two children. They live a difficult life on a fairly run down estate. She feels low in energy, has lost weight, is not sleeping properly, feels terrible in the mornings. She feels she has no self confidence and that the future hold nothing for her. At times, if it wasn't for children she wonders if it would be worth living. Her husband pop in from time to time but does not contribute for child care or their expenses.
9.1. What is his problem?
9.2. Does she have< suffering from> an illness. If yes, what is it?
9.3. What are the causes of his problems?
9.4. What should she do about it?
9.5 What should the doctor do about it?
10.VIGNETT III He is a 25 years old man. He goes to a doctor and complaint that he had been suffering from chest pain from time to time during last 8 months. He has been to more than 3 doctors already. They have done blood tests, X ray, ECG and told that there is nothing wrong with him. He had been admitted twice and ruled out any possibility of heart attacks/disease. His wife reports him having difficulty in sleeping, loss of appetite, lack of interest, and not being happy. His 55 year old father has died one year ago after a heart attack. His wife feels that all his problems and change started a few months after the death of the father. A man who equally loved his parents now blames his mother for not looking after/neglecting the father properly. .
10.1. What is his problem?
10.2. Does she have< suffering from> an illness. If yes, what is it?
10.3. What are the causes of his problems?
10.4. What should she do about it?
10.5 What should the doctor do about it?

4. Beliefs about FTHs						
401	FTHs give good information on maintaining a healthy lifestyle	Str. disagree 1	Disagree 2	Haven't decided 3	Agree 4	Str. Agree 5
402	There are less side effects when using FTHs practice	1	2	3	4	5
403	FTHs involves practice which are more healthy than taking drugs given by the modern biomedical practitioners	1	2	3	4	5
404	People are more empowered when using FTHs because providers involve them in decisions about their health care treatments [autonomy]	1	2	3	4	5
405	FTHs treatment practice works	1	2	3	4	5
406	FTHs are usually available	1	2	3	4	5
407	FTHs service is more affordable	1	2	3	4	5
408	FTHs service is near the people					
409	FTHs understand people well because they share similar culture/tradition	1	2	3	4	5
410	FTHs are well known to the people	1	2	3	4	5
411	FTHs have lived with the people for long time	1	2	3	4	5
412	FTHs respect patients	1	2	3	4	5
413	FTHs predominantly used by poor people?	1	2	3	4	5
414	FTHs predominantly used by men people?	1	2	3	4	5

415	FTHs predominantly used by iterate people?	1	2	3	4	5
416	FTHs predominantly used by people with SMDs?	1	2	3	4	5
417	Parent(s) and family influence people to use FTHs [social influence]	1	2	3	4	5
418	People who believe in the physical, mental and spiritual aspects of SMDs are more likely to use FTHs [EM]	1	2	3	4	5
419	People believe that FTHs for SMDs is not harmful [Perceived risk]	1	2	3	4	5

	5. Oslow Social Support (OSS) for FAMILY as CARER	
501	How many people are so close to you that you can count on them if you have serious personal problems	None .....1 1 to 2 .....2 3 to 5 .....3 >5 4
502	How much concern do people show in what you are doing	No concern and interest .....1 Little concern and interest.....2 Uncertain .....3 Some concern and interest .....4 A lot of concern and interest 5
503	How easy is it to get practical help from neighbors if you should need it	Very difficult.....1 Difficult.....2 Possible.....3 Easy.....4 Very easy.....5

	6. FAST Alcohol screening test			
601a	For MEN: How often do you have eight or more drinks on one occasion?	Never……0 Weekly……3	Less than monthly……1 Daily or almost daily……4	Monthly……2
602	How often during the last year have you been unable to remember what happened the night before because you have been drinking?	Never……0 Weekly……3	Less than monthly……1 Daily or almost daily……4	Monthly……2
603	How often during the last year have you failed to do what was normally expected of you because of drinking?	Never……0 Weekly……3	Less than monthly……1 Daily or almost daily……4	Monthly……2
604	In the last year has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	Never……0 Weekly……3	Less than monthly……1 Daily or almost daily……4	Monthly……2

	7. WHODAS (Functional status & quality of life)				
701	How do you rate your overall health in the past 30 days?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
In the last 30 days, how much difficulty did you have in					
702	Starting for long periods such as 30 minutes?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
703	Taking care of your household responsibilities?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
704	Learning a new task, for example, learning how to get to a new place?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
705	How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
706	How much have you been emotionally affected by your health problems?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
707	Concentrating on doing something for 10 minutes?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
708	Walking a long distance such as a kilometer (or equivalent)?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
709	Washing your whole body?	Very good……1 Bad……4	Good……2 Very bad……5	Moderate……3	
710	Getting dressed?	Very good……1	Good……2	Moderate……3	

		Bad……..4 Very bad……..5	
711	Dealing with people you do not know?	Very good……1 Good……..2 Moderate……..3 Bad……..4 Very bad……..5	
712	Maintaining a friendship?	Very good……1 Good……..2 Moderate……..3 Bad……..4 Very bad……..5	
713	Your day to day work?	Very good……1 Good……..2 Moderate……..3 Bad……..4 Very bad……..5	

8. CMHEI - Brief Psychiatric Rating Scale - F2								
FILL THE APPROPRIATE CIRCLE to represent level of severity for each symptom in the PAST WEEK.		Not present	Very mild	Mild	Moderate	Moderately sever	Sever	Extremely sever
801	SOMATIC CONCERNS							
802	ANXIETY							
803	DEPRESSION							
804	SUICIDALITY							
805	GUILTY							
806	HOSTILITY							
807	ELEVATED MOOD							
808	GRANDIOSITY							
809	SUSPICIOUSNESS							
810	HALLUCINATIONS							
811	UNUSUAL THOUGHT CONTENT							
812	BIZARRE BEHAVIOUR							
813	SELF NEGLECT							
814	DISORIENTATION							
815	CONCEPTUAL DISORGANIZATION.							
816	BLUNTED AFFECT							
817	EMOTIONAL WITHDRAWAL							
818	MOTOR RETARDATION							
819	TENSION							
820	UNCOOPERATIVENESS							
821	EXCITEMENT							
822	DISTRACTIBILITY							
823	MOTOR HYPERACTIVITY							
824	MANNERISMS/ POSTURING							

Study IV: formative research

Operationally 'Behavior'is defined in terms of its target, action, context, and time elements, and is the "Collaboration of FTHs & BMPs bi-directionally refer patients with SMDs i.e. FTHs refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months; and BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling) in the coming six months"

Attitude: Instrumental and experiential aspect
FTHs: my practice of referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months would be
Bad: ___1__:___2__:___3__:___4__:___5__:___6__:___7___: good
Pleasant: ___1__:___2__:___3__:___4__:___5__:___6__:___7___: unpleasant

BMPs: my practice of referring patients with SMDs to FTHs for reintegration/ rehabilitation /social support and counseling in the coming six months would be
Bad: ___1__:___2__:___3__:___4__:___5__:___6__:___7___: good
Pleasant: ___1__:___2__:___3__:___4__:___5__:___6__:___7___: unpleasant

Perceived norm: Injunctive and descriptive aspects
Most people who are important to me (patients, community/opinion leaser, BMPs) approve of my referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months
agree :___1__:___2__:___3__:___4__:___5__:___6__:___7___: disagree

Most people like me (FTHs) referred patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months
unlikely :___1__:___2__:___3__:___4__:___5__:___6__:___7___: likely

Most people who are important to me (patients, supervisors, medical directors, FTHs) approve of my referring patients with SMDs to FTHs for reintegration/ rehabilitation /social support and counseling) in the coming six months
agree :___1__:___2__:___3__:___4__:___5__:___6__:___7___: disagree

Most people like me (BMPs) referred patients with SMDs to FTHs for reintegration / rehabilitation / social support and counseling in the coming six months
unlikely :___1__:___2__:___3__:___4__:___5__:___6__:___7___: likely

Perceived behavioral control: Capacity and autonomy aspects

I am confident that I can refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months
true :___1__:___2__:___3__:___4__:___5__:___6__:___7___: false

My practice of referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months is up to me
disagree:___1__:___2__:___3__:___4__:___5__:___6__:___7___: agree

I am confident that I can refer patients with SMDs to FTHs for reintegration /rehabilitation/ social support and counseling in the coming six months
true :___1__:___2__:___3__:___4__:___5__:___6__:___7___: false

My practice of referring patients with SMDs to FTHs for reintegration / rehabilitation / social support and counseling in the coming six months is up to me
disagree:___1__:___2__:___3__:___4__:___5__:___6__:___7___: agree

Intention
I intend to refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months
likely :___1__:___2__:___3__:___4__:___5__:___6__:___7___: unlikely

I intend to refer patients with SMDs to FTHs for reintegration /rehabilitation/ social support and counseling in the coming six months
likely :___1__:___2__:___3__:___4__:___5__:___6__:___7___: unlikely

Past behavior
In the past three months, I have referred patients with SMDs to BMPs for diagnosis and drug/medication
false :___1__:___2__:___3__:___4__:___5__:___6__:___7___: true

In the past three months, I have referred patients with SMDs to FTHs for reintegration /rehabilitation/ social support and counseling
false :___1__:___2__:___3__:___4__:___5__:___6__:___7___: true

Formative research to eliciting salient or accessible beliefs

A brief one to one discussion will be held with five FTH & five BMPs representative of the two research population to elicit readily accessible behavioral outcomes, normative referents, and control factors.

They will be asked to share their belief about the possibility of collaboration (FTHs refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months; and BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling) in the coming six months.

Instructions:
- Please take few minutes to tell us what you think about collaboration (FTHs refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months; and BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling) in the coming six months. Furthermore, they will be informed that there are no right or wrong responses, what we are interested is on their personal opinions.
- We will ask you questions and please tell us the thoughts that come immediately to your mind. You may have multiple thought, it is ok, just tell us what you think.

Behavioral outcomes (perhaps clinical, social & economic outcomes of collaboration)

- What do you see as the advantages of your referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling exercising) in the coming six months?
- What do you see as the disadvantages of your referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling exercising) in the coming six months?
- What else comes to mind when you think about referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling exercising) in the coming six months?

Normative referents

- When it comes to your referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration /rehabilitation / social support and counseling exercising), there might be individuals or groups who would think you should or should not refer patients.
- Please list the individuals or groups who would approve or think you should refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling exercising) in the coming six months
- Please list the individuals or groups who would disapprove or think you should not refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/rehabilitation/social support and counseling exercising) in the coming six months
- Sometimes, when we are not sure what to do, we look to see what others are doing. Please list the individuals or groups, who refer patients with SMDs to BMPs for diagnosis and drug/medication (BMPs refer patients with SMDs to FTHs for reintegration/ rehabilitation/social support and counseling exercising) in the coming six months
- Please list the individuals or groups, who are least likely to refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/ rehabilitation/social support and counseling exercising) in the coming six months

Control factors

(1) Please list any factors or circumstances that would make it easy or enable you to refer patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs refer patients with SMDs to FTHs for reintegration/ rehabilitation/social support and counseling exercising) in the coming six months

(2) Please list any factors or circumstances that would make it difficult or prevent you from referring patients with SMDs to BMPs for diagnosis and drug/medication in the coming six months (BMPs referring patients with SMDs to FTHs for reintegration/ rehabilitation/social support and counseling exercising) in the coming six months

Constructing Sets of Modal Salient Beliefs as 'pilot questionnaire'.

After analyzing the responses using 'content analysis' a list of modal salient outcomes, referents, and control factors will be developed, that further be used for the construction of valid and reliable items or questions in the final questionnaire.

The pilot questionnaire will also include measures of background factors or other variables that are believed to influence the behavior under investigation; demographic characteristics (age, sex, ethnicity, level of education, income, residence), EMs of SMDs, perceived self and counterpart's competency in the treatment of SMDs (better treatment outcomes), perceived acknowledgement and respect of own EMs by their counterpart; suggested components of care for collaboration; expected basic skills and competence required for collaboration by each other; assumed basic provisions of legal framework required for implementation of collaboration; assumed elements and framework of monitoring and regulatory mechanisms, etc.

የጥናቱ መጠይቅ

ጥናት 1.1፡

1.1፡ ለባህል ሀኪም የተዘጋጀ መጠይቅ

ተ.ቁ	ጥያቄ	ምርጫ	መልስ	ኮድ
101	ዕድሜ	. . . .		ዕድሜ
102	ጸተ	ወንድ 1 ሴት 2		ጸተ
103	የጋብቻ ሁኔት	ያላገባ 1 ያገባ 2. የተፋታ 3 የትዳር ጓደኛው የሞተበት 4 ያገባ ግን አብረው የማይኖሩ 5		
104	የመኖሪያ ስፍራ	ከተማ 1 ገጠር 2		
105	የትምህርት ደራጃ	_____		
106	ወርሃዊ የገቢ መጠን	_____		
107	አመተዊ የገቢ መጠን (ያለፈው ዓመት)	_____		እ
108	ከአከባቢው ሰው ጋረ ሲወዳደር የሀብት ሁኔተ	ደሃ 1 መሀከለኛ 2 ሃብተም 3		
109	ሀይማኖት	ኦርቶዶክስ ክርስቲያን 1 ሙስሊም 2 ሌላ _____		
110	ብሄረሰብ	ጉራጌ 1 ኦሮሞ 2 አማራ 3		
111	እዚህ አከባቢ ለስንት ግዜ ኖረዋል?	_____		
112	እዚህ ቤት ዕርሶን ጨምሮ ስንት ይኖራል?	_____		
113	እዚህ ቤት ከ7 ዓመት በተች ዕድሜ ያላቸው ልጆች ስንት ናቸው?	_____		
114	ስራ	የቤት ዕመቤት 1 ግብርና 2 ነጋዴ 3 ተማሪ 4 የመንግስት ሰራተኛ 5 ወዛደር 6 ሌላ _____		
115	የትዳር ጓደኛ ስራ	የቤት ዕመቤት 1 ግብርና 2 ነጋዴ 3 ተማሪ 4 የመንግስት ሰራተኛ 5 ወዛደር 6 ሌላ _____		
116	የትዳር ጓደኛ የትምህርት ደራጃ	_____		

ስለባህል ህክምና አልግሎት				
ተ.ቁ	ጥያቄ	ምርጫ	መልስ	ኮድ
201	በዚህ የህክምና አገልግሎት ስራ ምን ያህል ሆኖት?	_____		
202	ምን አይነት የህክምና አገልግሎት ነው የሚሰጡት?	የቤተ ዕምነት ጸሎት 1 ጸበል 2 ማባረር 3 መሰዋት 4 ማጂክ 5 ማደንዘዝ 6 ጥንቆላ 7 መድሐኒት 8 ቅልቅል 9 አጥንት ጥገና 10 መብጣት 11 ጥርስ መንቀል 12 ሌላ_____		
203	ምን አይነት ህመም ነው የሚያክሙት?	አከላዊ ብቻ 1 መንፈሳዊ ብቻ 2 ሁለቱንም 3 ሌላ_____		
204	ይህን የህክምና አገልግሎት አንዴት ጀመሩት?	ከቤተሰብ የተላለፈ 1 በዘርማንዘር መንፈስ (በህልም ተጠርቼ) 2 በዚህ የህክምና ዘዴ ተክሜ በነበረ ግዜ 3 የዚህ የህክምና ዘዴ አድናቂ ስለሆንኩ 4 ሌላ_____ አላውቅም 99		
205	ሲጀምሩት ምን አደረጉ? አንዴት ነበር?	ምንም 1 ከመንፈስ መመሪያ ተቀበልኩ 2 ሌላ የባህል ሀኪም አስተማረኝ 3 የተለየ ስርአት አደረኩ 4 ሌላ_____		
205.1	በሌላ የባህል ሀኪም ከተማሩ፤ ለስንት ግዜ ተማሩ	.....		
207	ይህንን የባህል ህክምና የሚሰጡት ለብቻዎ ነው ወይስ ከሌላ የባህል ሀኪም ጋር በመቀናጀት ነው?	ለብቻይ ነው 1 በመቀናጀት ነው 2		

208	ከሌላ የባህል ሀኪም ጋር በመቀናጀት የሚሰሩ ከሆነ፤ አንዱት ነው በቅንጅት የምትሰሩት	ያኛውን የባህል ሀኪም ወደኔ በመጥራት 1 አዛው ባሉበት ምክር በመጠየቅ 2 መልዕክት አስይዤ ህመምተኛውን በመላክ 3 ሌላ_____		
209	በጣም ስራ በበዛብዎት ግዜ፤ በቀን ስንት በሽተኛ ያክማሉ?	_____		
210	ባማከኝ በቀን ስንት በሽተኛ ያክማሉ?	_____		
211	ባማከኝ በሳምንት ስንት በሽተኛ ያክማሉ?	_____		
212	ባማከኝ በወር ስንት በሽተኛ ያክማሉ?	_____		
213	በጾተ አንጻር፤ ምን አይነት ሰዎች ናቸው ዕርሶ ጋ የሚመጡት?	ባብዛኛው ወንዶች 1 ባብዛኛው ሴቶች 2 ዕኩል ናቸው 3		
214	በዕድሜ አንጻር፤ ምን አይነት ሰዎች ናቸው ዕርሶ ጋ የሚመጡት?	ባብዛኛው ልጆች 1 ባብዛኛው ወጣቶች 2 ባብዛኛው ትልልቅ ሰዎች 3 ዕኩል ናቸው 4		
215	በሀብት አንጻር፤ ምን አይነት ሰዎች ናቸው ዕርሶ ጋ የሚመጡት?	ባብዛኛው ደሆች 1 ባብዛኛው ሀብተሞች 2 ዕኩል ናቸው 3		
216	ዕርሶዎ ጋ ለመተከም በሽተኞች ከየት ነው የሚመጡት?	ህመምተኞቹ በራሳቸው 1 የራሳቸው ጓደኞች/ቤተሰቦች መክረዋቸው 2 ሌላ የባህል ሀኪም መክረዋቸው 3 ዘመናዊ ሀኪም መክረዋቸው 4 ሌላ_____		
217	ህመምተኞች ወደርሶ ህክምና አንዲመጡ ተጽዕኖ ያደረገባቸው ማን ይመ ስሎተል?	ህመምተኞቹ ራሳቸው 1 የራሳቸው ጓደኞች/ቤተሰቦች መክረዋቸው 2 ጎረቤቶች 3 ያገር ሽማግሌ 4 ዘመናዊ ሀኪም 5 ሌላ_____88		
218	ወደርሶ የሚመጡት ህመምተኞች ዕርሶ ጋ ከመምጣተቸው በፊት ሌላ ይሄዳሉ?	ብዙዎች አስቀድመው ዕኔ ጋ ነው የሚመጡት 1 ብዙዎች አስቀድመው ዘመናዊ ሀኪም ጋ ሄደው ነው ዕኔ ጋ የሚመጡት 2 ብዙዎች ዘመናዊ ሀኪም ጋ አየሄዱ ዕኔም ጋ ይመጣሉ 3		
219	ህመምተኞች ዕርሶ ጋ የሚመጡት ለምን ይመስሎተል?	ሁልግዜ ስለሚያገኙን/ቀለል ስለምንላቸው 1 ሌላ ህክምና የሚሰጥ ባከባቢው ስለሌለ 2 ዕኛ የተሻልን ስለሆንን 3 ስለሚያምኑን 4 ዋጋችን ረከስ ስለሚል 5 ህክምናችን ቀለል ስለሚል 6 ህመምተኞችን በደንብ ስለምናወያያቸው 7 ዕኛ ከነዋሪው ጋ አንድ/ዘመድ ስለሆንን 8 ዕኛ ከነዋሪው ጋ አንድባህል ስላለን 9 ለረጅም ግዜ ነዋሪ አዚሁ ስለሆንን 10 ማህበራውንም መንፈሳዊውንም ችግራቸውን ስለምንፈተላቸው 11 ዕኛ ከዘመናው ሀኪሞች ይልቅ ትሁት ስለሆንን 12 ሌላ_____88		
220	ህመምተኞች ዕርሶ ጋ ከየት አከባቢ ነው የሚመጡት?	ከዚሁ ወረዳ 1 ከአከባቢው ወረዳ 2 ከአገሪቱ በጠቅላላ 3 አላውቅም 4		
221	መቼ መቼ ሰአት ነው ህክምና የሚሰጡት?	ሁልግዜ 1 በትርፍ ግዜ 2		
223	ምን ምን ቀን ነው ህክምና የሚሰጡት?	ሁልቀን 1 በሳምንተ አንድ ቀን 2 በየዓመት በዐሉ 3ቨ በሽተኛ በመጣ ቁጥር 4		
224	ከሳምንቱ ቀናት በየትኛው ቀን ነው ህክምና ለመስጠት የማመርጡት?	የቀን ምርጫ የለኝም 1 የተለየ ቀን _____		
225	ከሰዓተት በየትኛው ሰአት ነው ህክምና ለመስጠት የማመርጡት?	የሰዐት ምርጫ የለኝም 1 የተለየ ሰዐት _____		
226	ለበሽተኛ ማደሪያ ቦተ አለዎት?	አለ 1 የለም 2		
227	ከበሽተኛ ለህክምና ምን በምንድነው ነው የሚያስከፍሉት?	በገንዘብ 1 በተለያየ ነገር 2		
228	ከበሽተኛ ለህክምና ምን ያህል ነው የሚያስከፍሉት?	አንድ ለሁሉም ቁርጥ ዋጋ አለ 1 አንደበሽተው አይነት ይለያያል 2 ህመምተኛው አንደሰጠ 3 ህመምተኛው አንደሚች፤አንደአቅሙ 4 ሌላ_____88		
229	ከዘመናው ህክምና ጋር ሲወዳደር የባህል ህክምና ዕንዱት ነው ይላሉ፤ መክፍያ ኣጻር?	ርከሽ ነው 1 ውድ ነው 2 ዕኩል ነው 3		
230	የአዕምሮ ህመም የሚያክሙ ከሆነ፤ ምን አይነት የአዕምሮ	_____		

	ህመም ነው የሚያክሙት?	_____		
231	ባማከኝ ምን ያህል የአዕምሮ ህመምተኞች በወር ያክማሉ?	_____		
232	የርሶን ህክምና ውጤተማነት የሚወስነው ምንድነው ይላሉ?	የበሽተው ክብደት 1 ምሽተው የቆየበት ግዜ 2 የህመምተኛው ለተሰጠው ህክምና ተባባሪነት 3 የህመምተኛው ጉዳት/በምግብ ወዘተ 4 ሌላ_____88 አላውቅም 99		
233	የአዕምሮ ህመምተኞችን ወደ ሌላ ስፍራ ለህክምና ልከው ያውቃሉ?	አዎ 1 አልላኩም 2		
234	ልከው ከነበር፤ የት ነበር የላኩት?	ለሌላ ባህል ሀኪም 1 ለዘመናዊ ሀኪም 2		
235	ለዘመናዊ ሀኪም ከነበረ የላኩት፤ የላኩበት ምክንያት ምን ነበር?	ዕኔ ለማከም የማልችለው ህመም ስለነበር 1 ሞክሬ ከአቅሜ በላይ ስለነበር 2 በሽተኛውን ለግዜው አንዲያረጋጉል 3 በሽተኛው አልድልከው ስለጠየቀኝ 4		
236	ለዘመናዊ ሀኪም በሽተኛን ሲልኩ፤ በዋናነት የሚልኩት ለምንድነው?	ለግዜያዊ መፍትሄ 1 ለዘላቂ መፍትሄ 2		
237	በሽተኛን ሲልኩ፤ ባብዛኛው መቼ ነው የሚልኩት?	በሽተኛውን መጀመሪያ አንዳየሁት 1 በስተመጨረሻ 2		
238	የአዕምሮ ህመምተኞችን ወደዘመናዊ ህክምና የማይልኩበት ምክንያት ምንድነው?	ዕኔ ራሴ ማከም ስለምችል 1 ዕኔ የተሸለ ማከም ስለምችል 2 ዕኛ የምልከውን ስለማይቀበሉ 3 ትንሽ ቁጥር በሽተኛ ስላለኝ 4 አነሱ ለኛ ስለማየልኩ 5 አነሱን/የነሱን ህክምና ስለማላምንበት 6 መላክ አንዳለብኝና አንደሌለብኝ ስለማላውቅ 7 ሌላ_____88		
239	ከዘመናዊ ህክምና ተቋማት ወይም ባለሙያዎች ህመምተኛ ተልኮሎት ያውቃል?	አዎ 1 የለም 2		
240	ዘመናዊ ህክምና ተቋማት ወይም ባለሙያዎች ህመምተኛ የላኩሎት ለምን ይመስሎተል?	አኛ የተሸልን አንደሆንን ስለሚያውቁ 1 የአዕምሮ ህመምን ስለማያክሙ 2		
233	ዘመናዊ ህክምና ተቋማት ወይም ባለሙያዎች ህመምተኛ የማይልኩሎት ለምን ይመስሎተል?	ለኛ በሽተኛ አንዳይልኩ ተደርገው ስለሚማሩ 1 ከኛ የተሸለ ማከም ስለሚችል 2 ከኛ የተሸሉ ስለሚመስላቸው 3 ሁሉንም ህመም ማከም የሚችሉ ስለሚመስላቸው 4 ስለማያምኑን 5 ሰለማይወዱን 6 ስለማያውቁን/ህክምናችንን ስለማይቀበሉት 7 መላላክ ስላልተለመደ 8 ህመምተኞች ይርቁናል/ይሄዱብናል/ዕምነት ያጣሉ ብለው ስለሚፈሩ 9 ሌላ_____88		
241	የባህል ሀኪም ከመሆንዎ በፊት ህመም ያውቆት ነበር?	አዎ 1 የለም 2		
	ተማሚ ከነበሩ፤ ህመምዎ ምን ነበር?	የአዕምሮ ህመም 1 ሌል ህመም 2 ሌላ_____88		

ጥናት 1.2፡

1.3፡ ከባህል ህክምና ባለሙያ ጋር ለሚደረግ ጠለቅ ላለ የአንድ ለአንድ ውይይት መነሻ ነጥቦች

መጀመሪያ

- አናንተ አከባቢ ስላለው የጤና ችግር ሊነግሩኝ ይችልሉ?
- ለነዚህ የጤና ችግሮች ሰዎች ህክምና ለማግኘት የት ነው የሚሄዱት?
- ለነዚህ የጤና ችግሮች ሰዎች ዕርሶ ጋ ይመጣሉ?

ምን አይነት ሰዎች ናቸው የባህል ህክምና ባለሙያ ጋ ለመሄድ የሚመርጡት?

- በዕድሜ? በጾተ? በጋብቻ ሁኔተ? በሀብት ሁኔተ?፤ በትምህርት ደረጃ?
- <u>አገልግሎቱን ከማግኘት አንጻር</u>፡- በቅርበት፤ በስራ ቀንና ሰዓት? ማለትም ሙሉ ቀን ክፍት ስለሚሆን
- <u>ለአገልግሎቱ ከሚከፈለው ክፍያ አንጻር</u>፡- በመጠን፤ በአየነት?
- <u>አገልግሎት ከሚሰጠው የባህል ህክምና ባለሙያው ባህሪ አንጻር</u>፡-
- <u>ጤና ችግር አንጻር</u>፡- ጤና ችግር አይነት?

ምን አይነት የባህል ህክምና ባለሙያዎች አሉ?

- የቤተ ዕምነት ጸሎት፡ ጸበል?
- ባለመድሐኒት (የባህል መድሀኒተኛ) ከቅጠልና ስራስር ምድሃኒት የሚሰጡ?
- አዋቂ (ጠንቋይ፤ ኮኮብ ቆጣሪ፤ ሞራ ገላጭ፤ ቃልቻ)
- ቅልቅል (ባለመድሐኒትም አዋቂም የሆነ ሰው)

ምን አይነት የጤና ችግሮችን ነው አነዚህ የባህል ህክምና ባለሞያዎች የሚያክሙት?
- በባህል ህክምና ባለሙያዎችአይነት አንጻር፡-
- ጤና ችግሮች አይነት አንጻር፡-

አንድን ሰው ምን ሲያደርግ ወይም ምን ሲሆን ነው የባህል ህክምና ተጠቃሚ የሚባለው? ማለትም የአጠቃቀም ሁኔተው
- ምን ያህል ግዜ ደጋግም በመጠቀም?
- ለምን ያህል ግዜ ሲጠቀም?
- የባህል ህክምናን ብቻ ዚጠቀም፡ ማለትም ሌላ አይነት የህክምና ዘዴ አለመጠቀም?

በአናንተ አከባቢ የአዕምሮ ጤና ችግር ምን ያህል አለ?
- ምን <u>አይነት</u> የአዕምሮ ጤና ችግሮች ያሉ ይመስሎተል?
- የአዕምሮ ጤና ችግር በአናንተ አከባቢ ምን ተብሎ ያጠራል? ምን በመባል ይተወቃል?
    - አነዚህ መጠሪያ ስሞች ለተለያዩ የአዕምሮ ጤና ችግሮች የተለያዩ ናቸው?
    - ምሳሌ ሊሰጡኝ ይችላሉ?

ምን ምን አይነት ምልክቶች ናቸው የአዕምሮ ህመም ያለበት ሰው የሚያሳየው?
የትኞቹ ምልክቶች ናቸው በጣም አደገኞቹ?

ከባድ የአዕምሮ ህመም ያለበት ሰው ምን አይነት ምልክቶች ያሳያል?

ዕርሰዎ ሰስከዛሬ ከዩአቸው **<u>ከባድ</u>** የአዕምሮ ህመም ያለባቸው ሰዎች ምሳሌ አርገው ሰለሁኔተቸው ቢያጫውቱኝ?

ዕርሰዎ ሰስከዛሬ ከዩአቸው **<u>ቀለል ያለ</u>** የአዕምሮ ህመም ያለባቸው ሰዎች ምሳሌ አርገው ሰለሁኔተቸው ቢያጫውቱኝ?

የአዕምሮ ህመም *መንስኤው* ምንድነው ብለው ያምናሉ?
- ከቤተሰብ *ጋር* በተያያዘ? ከአመለከከት *ጋር* በተተያያዘ? ከዕርግማን *ጋር* በተተያያዘ?
- ከዘርማንዘር *ጋር* በተተያያዘ?
- የአዕምሮ ህመም *መንስኤው* ምንድነው ብለው ያምናሉ?

የአዕምሮ ህመም አስከፉ ውጤቱ ምንድነው ብለው ያምናሉ?
የአዕምሮ ህመም ህክምና ምንድነው ብለው ያምናሉ?
የአዕምሮ ህመም የመዳን ሁኔተው ምን ያህል ነው ብለው ያምናሉ?

አንድ ምሳሌ አንመልከት

ቀድሞ ጤነኛ የነበረ አንድ ሰው ባለፉት አንድ ሁለት ሳምንት ውስጥ የባህሪ ለውጥ አመጣ። ማለትም በጣም መቅብጠብጥ፤ ፍርሀት ፍርሀት ማለት፤ ምክንያተዊ ያልሆኑ ወይም አደገኛ የሆኑ ነገሮችን ማድረግ ለምሳሌ ያላግባብ አሳት ማቀጣጠል፤ ንብረት መሰባበር፤ ራቁት መሆን፤ ልብስ መቅደድ፤ አልፎ ተርፎ ሰዎችን መተናኩልና መጣላት የመሳሰሉ ነገሮችን ማድረግ ጀምሯል። አንዳንዱም ሌላ ሰው የማይሰማውን ድምጽ ይሰማኛል፤ አንዲሁም ሌላ ሰው የማያየው ነገር ይተየኛል ይላል። አንደዚህ አይነት ሰዎች የሚያደርጉትን ነገር ለማስቆም አንዲሁም ለማነጋገርና ለመግባባት አስቸጋሪ ይሆናል፤ ምክንያቱም ከአግዛብሄር ወይም ከሌላ መንፈስ መመሪያ አየተቀበልኩ ወይም አየሰማሁ ነው ይላሉ። አብዛኛውን ግዜ አንዲህ አይነቶቹ ምልክቶች ከተሰወሰነ ግዜ በኋላ ማለትም ከቀናት ወይ ከሳምንተት በኋላ ይጠፋሉ፤ አለያም የሚያደናግርና አንግዳ የሆኑ ነገሮችን መናገራቸውን ይቀጥላሉ ሆኖም ግን ሁኔተቸው አንደቀደመው ግዜ አይነት አስቸጋሪ አይሆንም።

አንዲህ አይነት ሰው አጋጥሞት ያውቃል?
አዎ ከሉ፡-
- አንዲህ አይነቱ ችግር ወይመ ህመም ስም አለው? ምን ተብሎ ይጠራል?

የዚህ ችግር ወይም ህመም መንስዔው ምን ይመስሎተል?
- አንዴት ነው የህመሙን አይነት ለመለየት የሚችሉት?
- ምን ይመስሎተል ይህ ችግር በተከሰተበት ሰዓት አንዲቀሰቀስ ያደረገው?
- ችግሩ ያለበት ሰው ህክምና ከላገኘ ምን ይሆናል ብለው ያስባሉ? ምን ይከሰተል?
    - ማለትም በግለሰቡ ላይ?
    - ይህ ክስተት አንዴት ይመጣል? ወይም ይፈጸማል?
    - ምን ያህል አደገኛ ወይም አስቸጋሪ ነው ይለሉ?
    - ይህ ውጤት ወይም ክስተት ለምን ያህል ግዜ ይቆያል ይላሉ? ማለትም ለአጭር ወስ ለረጅም ግዜ?
- ስለአንዲህ አይነቱ ችግር ወይም ህመም በጣም የሚፈሩት ወይም የሚያሳስቦት ነገር ምንድነው?
- አንዲህ አይነቱ ህመም ለተማሚው በዋናነት የሚያዩት ችግር፤ ማለትም ዋናው ችግር ምንድነው ይላሉ?
- ምን አይነት ህክምና ነው የሚያስፈልገው ብለው ያስባሉ?

- ተማሚው ከህክምናው የሚያገኘው ወይም የሚጠብቀው ውጤት ምንድነው ይላሉ? ማለትም በዋናነት ከህክምናው ምን አይነት ውጤት ይጠበቃል?
- የዚህ ህመም ተጠቂዎች የህክምና ዕርዳታ ለማግኘት የት ነው የሚሄዱት?
    - የባህል ሀኪሞች ለዚህ ህመም መፍትሄ አላቸው ብለው ያምናሉ?
    - የዘመናዊ ህክምና ባለሙያዎችስ ለዚህ ህመም መፍትሄ አላቸው ብለው ያምናሉ?
- የዚህ ህመም ተጠቂዎች በህብረተቡ የመገለል ወይም የተለየ አመለከከት ይገጥማቸዋል ብለው ያስባሉ?
- የዚህ ህመም ተጠቂዎች ከህብረተብ ስብሰባዎች ማለትም ማህበራዊ ጉባኤዎች ይገለላሉ ብለው ያስባሉ?
- የዚህ ህመም ተጠቂዎች ለተለያ አይነት ጥቃቶች ማለትም አንደ አባት ውስጥ መተሰር አይነት ያጋጥማቸዋል ብለው ያስባሉ?

የዚህ አይነት ህመም ተጠቂዎች ዕርስዎ ጋ ይመጣሉ?
አዎ ከሉ፡-

- የዚህ አይነት ህመም ያላቸውን ምን ያህል ሰዎች ያያሉ? በቀን/በሳምንት/በወር?
- ለዚህ አይነት ህመም ህክምና ይሰጣሉ?
- ምን አይነት ህክምና ነው የሚሰጡት?
    - ህክምናውን አንዴት ነው የሚሰጡት? ወይም የሚከናውኑት?
    - በሽተኛውን ለማከም ምን ያህል ግዜ ይፈጃል?
    - መድሀኒት የሚሰጡ ከሆነ፤ በሽተኞቹ መድሀኒቱን ከየት ነው የሚያገኙት?
- ዕርስዎ የሚሰጡት ህክምና ውጤተማ ሆኖ አገኙት?
- ዕርስዎ የሚሰጡት ህክምና ዋናው ዓላማ ምንድነው?
    - ከህመሙ ምልክት አንጻር፡- ለማዳን ወይስ ለማስተገስ?
    - ከማህባዊ ግንኙነት አንጻር፡- ቤተሰባዊ ወይም ማህበራዊ ሀላፊነቶችን አንዲወጡ ለማድረግ?
    - ከኢኮኖሚ አንጻር፡- ወደቀድሞ ስራቸው አንዲመለሱ?

ዕርስዎ የሚሰጡት ህክምና ዘመናዊው የህክምና ዘዴ ከሚሰጠው ጋር ይደጋገፋል ወይስ አይስማሙም?
ለዚህ አይነት ህመም ወደ ዘመናዊው የህክምና ማስተላለፍ ይጠቅማል ይላሉ?
አንዲህ አይነት ህመም ያለባቸው ሰዎች ምንም አይነት ህክምና ሳያገኙ የቀሩ ያውቃሉ?
አዎ ከሉ፡-

- ለምን ይመስሎተል? ደሃ ስለሆኑ ይመስሎተል? ሴቶች ህክምና የማግኘት ዕድላቸው ትንሽ ነው ብለው ያስባሉ?
- ህክምና ማግኘት የሚገባቸው በሽተኞችን ቁጥር ማሳደግ ይቻላል ብለው ያስባሉ?
- አንዴት ነው የሚቻለው? አርሶ ምን በማድረግ ሊተባበሩ ይችላሉ?

ዘመናዊው የህክምና ዘዴ ለአንዲህ አይነት ህመም መፍትሄ አለው ብለው ያምናሉ?

አንዲህ አይነት ህመም ያባቸው ሰዎች ባህላዊውምንም ዘመናዊውንም ህክምና አቀላቅለው ቢጠቀሙ ጥሩ ነው ብለው ያስባሉ?

አዎ ጥሩ ነው ከሉ ለምን፡-

የለም ጥሩ አይደለም ከሉ ለምን፡-

ዕርሶ ከጤና ኤክስተንሽን ሰራተኛ፤ ከነርሶች ወይም ከኤና መኮንን ጋር ግንኙነት አለዎት?

- አስከዛሬ ድረስ ወደዘመናዊ ህክምና ህመምተኛ ልከው ያውቃሉ?
- አዎ ከሉ፡- ለምን ምክንያት?
- አልላኩም ከሉ፤ ለምን አልላኩም?
    - ለወደፊቱ መላክ አንዲችሉ ምን መለወጥ አለበት ይላሉ?
- ከዘመናዊ ህክምናስ ህመምተኛ ተልኮልዎት ያውቃል?

የዚህ አይነት ህመም ተጠቂዎች በህብረተቡ የመገለል ወይም የተለየ አመለከከት ይገጥማቸዋል።

- ስለዚህ ጉዳይ ምን ያስባሉ?
- ምን ሊደረገግ ይችላል ብለው ያስባሉ?

የዚህ አይነት ህመም ተጠቂዎች ከህብረተብ ስብሰባዎች ማለትም ማህበራዊ ጉባኤዎች ይገለላሽላቸውም ።። በተጨማሪም በሌሎች ሰዎች ጋር ስራ አንዳይሰሩ ሁሉ ይደረጋሉ፤ ከተሸብለውም በኋላም ቢሆን።

- ስለዚህ ጉዳይ ምን ያስባሉ?
- ምን ሊደረገግ ይችላል ብለው ያስባሉ?

የዚህ ህመም ተጠቂዎች ለተለያ አይነት ጥቃቶች ማለትም አንደ አባት ውስጥ መተሰር አይነት ያጋጥማቸዋል

- ስለዚህ ጉዳይ ምን ያስባሉ?
- ምን ሊደረገግ ይችላል ብለው ያስባሉ?

ጥናት 2 እና 3: ከባድ የአዕምሮ ህመማን ወይም ለቤተሰቦቻቸው የሚቀርብ መጠይቅ

1. አጠቃላይ ሁኔታ		
ተ.ቁ	**ጥያቄ**	**ምርጫ**
101	ዕድሜ	. . . .
102	ጾተ	ወንድ 1 ሴት 2
103	የጋብቻ ሁኔት	ያላገባ 1 ያገባ 2. የተፋታ 3 የትዳር ጓደኛው የሞተበት 4 ያገባ ግን አብረው የማይኖሩ 5
104	የመኖሪያ ስፍራ	ከተማ 1 ገጠር 2
105	የትምህርት ደራጃ	_____
106	አመተዊ የገቢ መጠን (ያለፈው ዓመት)	_____
107	ዋና የገቢ ምንጭ	ደሞዝ 1 ጡረተ 2 የቤተሰብ ዕርዳተ 3 በግል 4 ሌላ _____
108	ንብረት አለዎት?	አዎ 1 የለኝም 2
109	አዎ ከሉ፤ ንብረትዎን ቢገልጹልን	
110	ከአከባቢው ሰው ጋረ ሲወዳደር የሀብት ሁኔተ	ደሃ 1 መሀከለኛ 2 ሃብተም 3
111	ሀይማኖት	ኦርቶዶክስ ክርስቲያን 1 ሙስሊም 2 ሌላ _____
112	ብሄረሰብ	ጉራጌ 1 ኦሮሞ 2 አማራ 3
113	አዚህ አከባቢ ለምን ያህል ግዜ ሮረዋል?	.....
114	ስራ	የቤት ዕመቤት 1 ግብርና 2 ነጋዴ 3 ተማሪ 4 የመንግስት ሰራተኛ 5 ወዛደር 6 ሌላ _____
115	ከዚህ ቀደም ከበድ ያለ ህመም፡ ለምሳሌ አንደ የአዕምሮ በሽተ፤ በዕጽ ሱስ፤ አደጋ፤ የአከል ጥቃት የመሳሰሉት	አዎ 1 የለኝም 2
116	አዎ ከሉ፤- ለህክምና የት ነበር የሄዱት?	የትም አልሄድኩም 1 ዘመናዊ ጤና ተቋም 2 ባለመድሐኒት 3 አዋቂ/ጥንቆላ 4 የቤተ ዕምነት ጸሎት/ጸበል 5 ሁሉንም የሚያደርግ ባለሞየ ጋር 6
117	ዘመናዊና ባህላዊ ህክምና አጠቃቀምዎ ምን ይመስላል?	በአንድ ግዜ በመቀላቀል 1 በአንድ ግዜ አንዱ ጋ ብቻ 2
118	ዘመናዊና ባህላዊው ጋር ባንድ ግዜ ሄደው ነበር?	አዎ 1 የለም አንዱን አስጨርሼ ነው ወደ ሌላው የሄድኩት 2
119	የአዕምሮ ህመምዎ መቼ ነበር የጀመሮት?	_____አመት
120	ይህ የአዕምሮ ህመም ከጀመርዎት መድሀኒት አስከ ጀመሩበት ግዜ ድረስ ምን ያህል ግዜ ወስዷል?	_____ቀን/ወር/አመት/
121	የበሽተው አነሳስ አንዱት ነበር?	ድንገተኛ (አንድ ወር ብች የቆየ) 1 ቀስ-በቀስ የመጣ (ከአንድ ወር በላይ) 2
122	ህመሙ የቆየበት ግዜ	ትኩስ 1 የቆየ 2
123	ለአዕምሮ ህመምዎን የት ነው የሚ ከሙት?	ዘመናዊ ጤና ተቋም 1 የቤተ ዕምነት ጸሎት/ጸበል 2 አዋቂ/ጥንቆላ 3 ባለመድሐኒት 4 ሁሉንም የሚያደርግ ባለሞየ ጋር 5
124	ወደህክምና ስፍራው ከማን ግ ሄዱ?	ለብቻዬ 1 በፍላጎት ከሰው ጋር 2 ያለፍላጎት ከሰው ጋር 3
125	በቤተስብዎ ውስጥ አዕምሮ ህመም ያለበት ሰው አለ?	አዎ 1 የለኝም 2
126	ምን አይነት የአዕምሮ ህመም ነው?	_____

2. ህክምና			
201	የባህል ህክምና ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
202	ባለመድሐኒት ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
203	አዋቂ/ጥንቆላ ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
204	የቤተ ዕምነት ጸሎት/ጸበል ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
205	ሁሉንም የሚያደርግ ባለሞያ ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
206	ወደህክምና የሄዱት ለምን ነበር?	ለአዕምሮ ህመም 1 ለአከላዊ ህመም 2 ሌላ 3	
207	ለአዕምሮ ህመም የባህል ህክምና ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
208	አዎ ከሉ፡- ባለመድሐኒት ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
209	አዎ ከሉ፡-አዋቂ/ጥንቆላ ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
210	አዎ ከሉ፡-የቤተ ዕምነት ጸሎት/ጸበል ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
211	አዎ ከሉ፡- ሁሉንም የሚያደርግ ባለሞያ ተጠቅመው ያውቃሉ?	አዎ 1	የለኝም 2
212	ባለፉት 6 ወራት ውስጥ፤ ለምን ያህል ቆይተ ነበር ለአዕምሮ ህመምዎ የባህል ህክምና የሄዱት?	_____ቀን	
213	ባለፉት 6 ወራት ውስጥ፤ ለመጨረሻ ግዜ ለአዕምሮ ህመምዎ የባህል ህክምና የሄዱት መቼ ነበር?	_____ ቀን	
214	ባለፉት 6 ወራት ውስጥ፤ ለስንት ግዜ ነበር ለአዕምሮ ህመምዎ የባህል ህክምና የሄዱት?	_____ ግዜ	

215	ህክምናውን የት ነበር የሚወስዱት?	በተመላላሽ 1 ተኝቼ 2 በተመላላሽና ተኝቼ 3
216	ተኝተው ከሆን፤ ባለፉት 6 ወራት ለመጨረሻ በተከሙ ግዜ፤ ለስንት ቀን ነበር የተኙት?	_____ ቀን
217	ቀጠሮ ሳይኖሮት፤ የባህል ህክምና ለማግኘት ቢፈልጉ በስንት ግዜ/ቀን ውስጥ መ ከም ይችላሉ?	_____ ግዜ/ ቀን
218	የባህል ህክምና ለማግኘት ምን የህል ይጓዛሉ?	_____ ግዜ/ቀን ወይም _____ ኪ.ሜ
219	የባህል ህክምና ስፍራ ደርሰው ህክምናውን ለማግኘት ምን የህል ግዜ ያቆዬ ላ?	_____ ግዘ/ ሰዐት
220	ባለፉት 6 ወራት ውስጥ፤ሁሌ የሄዱበት ከነበረው ባህል ህክምና ውጪ ሌላ ህክምና አድርገዋል?	አዎ 1 የለኝም 2
221	አዎ ከሉ፡-የት ነበር የሄዱት?	ዘመናዊ ህክምና 1 ሌላ የብህል ህክምና 2
222	የሄዱት ለምን ነበር?	ሁሌ የምሄድበት የነበረው የባህል ህክምና ልኮኝ 1 የጀመርኩት የባህል ህክምናን ለማጠናከር/ለሚሚላት 2 የቤተሰብ/የጓደኛ ምክር 3 ሌላ _____
223	አዚህኛው የህክምና ስፍራ አከሄድዎ አንዱት ነበር?	የቀድሞውንም አዲሱንም አንድላይ አጠቀም ነበር 1 አንዱን ጨርሼ ወደ ሌላው ሄድኩ 2
224	ባህል ህክምናውን አንዱት አዩት?	ለውጥ አላመጣም 1 ተሸሎኛል 2 አድሮኛል 3 ብሶብኛል 4
225	የባህል ህክምናውን ሲጠቀሙ ችግር አጋጥሞት ያውቃል?	አዎ 1 የለኝም 2
226	አዎ ከሉ፡- ችግሩ ምን ነበር?	ድብደባ 1 አስራት 2 ረሀብ 3 መገለል 4 ሌላ_____

3. ቮርት ኤክስፐላናቶሪ ሞዴል ኢንተርቪው; (ኤስ.ኢ.ኤም.ስዩ)-ህትም 3.1

ሲንስሲስ ህትም፣1997

ኬት ሊዮድ[1] ስቱላ ሱማቲፓላ[2]

ፊቨን ስንዌላ 3፣ኤስ ጄኮቭ 2፣ ቪክሬም ፓቴል4፣ሲን ሴንት ሲዊስ2፣ ዲኒሽ ቡግሬ2፣ ስዘ ማን2

[1]ኤክሲተር ዩኒቨርስቲ፣ የስእምሮ ጤና ት/ክፍል፣ ኤክሲተር፣ ዩኬ; [2]የሥነ- ስእምሮ ተቋም፣ኪንግስ ኮሌጅ፣ዩኒቨርስቲ ሶፍ ለንደን
[3]ሳይኮሎጂካል ህክምና ት/ክፍል፣ የህክምና ፋክሊቲ፣ ዩኒቨርስቲ ሶፍ ኮሎምቦ፣ ስሪላንካ; [4]ሳንጋታ የህፃናት ሴድገት ማዕከል፣ ጎአ፣ ህንድ

1. መግቢያ: ስለ ጤናዎ ከኔ ጋር ስመነጋገር ስለፈቀዱ ስመሰግናለሁ። ስለ ጤናዎትና ስላ ስከተሰቦት ችግር ስንዳንድ ጥያቄዎች ስጠይቆታለሁ። እምጠይቋት ጥያቄ የተዛፈ ጥያቄ ስለሆነ ስንዳንዱ ጥያቄዎች እርሶን ሳይመለከቶት ይችላሉ። የሚመልሱልኝ መልስ ስሌላ ሰው ሳላጋራ ስፉሌ በሚስጥር እይዘዋለው።

የመዝገብ (ካርድ) ቁጥር ☐☐☐☐☐ 1 - 1.3
ቃለ- መጠይቁ የተደረገበት ቀን ☐☐ ☐☐ ☐☐ 1.4 - 9
ቃለ- መጠይቁ የተጀመረበት ሰዓት ☐☐ ☐☐ 1.10 - 13
ፃታ 1.14
ሴድሚ ☐ 1.15 - 6

2. ጤናና ህምም

ወቅታዊ የጤና ሁኔታ

a) ስላልዎት ወቅታዊ ሁኔታ ሲነግሪኝ ይችላሉ ምን ዓይነት የጤና ችግሮች/ የህምም ምልክቶች ነበርት በስሁኑ ሰዓት ስልዎት

I. ☐☐ 2.1 - 2.2 የጤና ችግር 1
.....
II. ☐☐ 2.3 - 2.4 የጤና ችግር 2
.....
III. ☐☐ 2.5 - 2.6 የጤና ችግር 3
.....
IV. ☐☐ 2.7 - 2.8 የጤና ችግር 4
.....
V. ☐☐ 2.9 - 2.10 የጤና ችግር 5
.....
VI. ☐☐ 2.11 -2.12 የጤና ችግር 6
.....

VII. ☐ ☐ 2.13-2.14 የጤና ችግር 7

VIII. ☐ ☐ 2.15-2.16 የጤና ችግር 8

IX. ☐ ☐ 2.17 -2.18 የጤና ችግር 9

X. ☐ ☐ 2.19-2.20 የጤና ችግር 10

b) ሌላ የጤና ችግሮች ወደም የህመም ምልክቶች ነበረ/አለዎት?

I. ☐ ☐ 2.21 - 2.22 የጤና ችግር 1

II. ☐ ☐ 2.23 - 2.24 የጤና ችግር 2

III. ☐ ☐ 2.25 - 2.26 የጤና ችግር 3

IV. ☐ ☐ 2.27 - 2.28 የጤና ችግር 4

V. ☐ ☐ 2.29 - 2.30 የጤና ችግር 5

c) ይሄን ችግር ምን ብለው ይጠሩታል? ስም ቢሰጡዋቸው ምን ብለው ይጠሩታል?

I. ☐ ☐ 2.21 - 2.22 ስም 1

II. ☐ ☐ 2.23 - 2.24 ስም 2

III. ☐ ☐ 2.25 - 2.26 ስም 3

d) ለመጀመሪያ ጊዜ ችግሩን (የተሰየሙን ችግር ጠርተህ) ያስተዋሉት መቼ ነው? ስንት ጊዜ ሆኖታል? መቼ ነው የጀመረው?

I. ☐ ☐ 2.27 - 2.28 ችግሩ የተከሰተበት ጊዜ 1

II. ☐ ☐ 2.29 - 2.30 ችግሩ የተከሰተበት ጊዜ 2

III. ☐ ☐ 2.31 - 2.32 ችግሩ የተከሰተበት ጊዜ 3

IV. ☐ ☐ 2.33 - 2.34 ችግሩ የተከሰተበት ጊዜ 4

V. ☐ ☐ 2.35 - 2.36 ችግሩ የተከሰተበት ጊዜ 5

e) እነዚህ ችግሮች ሲጀምሩ ለምን የጀመሩ ይመስሎታል?

I. ☐ ☐ 2.37 - 2.38 ለምን1

II. ☐ ☐ 2.39 - 2.40 ለምን2

III. ☐ ☐ 2.41 - 2.42 ለምን3

f) ለችግሩ መንስኤ የሚሆን ያደረጉት ወይንም ያላደረጉት ነገር አለ?
አዎ/አይ/ለመናገር ይከብደኛል
አዎ ከሆነ መልሱ፤ምሳሌ እንዲሰጡ ጠይቀው የተናገሩትን ንግግር እንዳለ ያስቆረ?

I. ☐ ☐ 2.45 - 2.46 ውስጣዊ1

II. ☐ ☐ 2.45 - 2.46 ውስጣዊ2

III. ☐ ☐ 2.47 - 2.48 ሙስጣዊ3

.....

☐ ☐ 2.49 - 2.50 ሙስጣዊ4

IV. .....

g. ለችግረ መንስኤ የሚሆኑ ሴሎች ያደረጉት ጀነም ያላደረጉት ነገር ስለ?

ለምሳሌ አዎ/አዳ/ለመናገር ደከብደኛል

አዎ ከሆነ መልሱ፤ምሳሌ እንዲሰሙ ጠይቀው የተናገረትን ንግግር ያስፍረ?

I. ☐ ☐ 2.51 - 2.52 ሙጫዊ1

.....

II. ☐ ☐ 2.53 - 2.54 ሙጫዊ2

.....

III. ☐ ☐ 2.55 - 2.56 ሙጫዊ3

.....

☐ ☐ 2.57 - 2.58 ሙጫዊ4

IV. .....

h. ስለዚህ ለችግርዎ መንስኤ ማን ጀነም ምንድን ነው?

በዋነኝነት እኔ /ሴላ ሰው/ የሆነ የተፈጠረ ነገር ነበር/ ለመናገር አልችልም

I. ☐ ☐ 2.59 - 2.60 ሙስጣዊ/ሙጫዊ1

.....

II. ☐ ☐ 2.61 - 2.62 ሙስጣዊ/ሙጫዊ2

.....

i.የሆነ ሰው የሆነ ነገር ያደረገብዎት ይመስልዎታል? (ስለማታዊ፤ የተደገመበት ምግብ፤ ድግምት፣ መተት፣የሰው እጅ) ሴላ ስጀነት ተጽዕኖ (እድል፤ የ80 ቀን ሰድል ፤የለምልኮት ተፅኖ)

አዎ/አዳ/ለመናገር አልችልም

አዎ ከሆነ መልሱ፤ ምሳሌ እንዲሰሙ ጠይቀው የተናገረን ንግግር ያስፍረ

I. ☐ ☐ 2.63 - 2.64 ጥፊ1

.....

II. ☐ ☐ 2.61 - 2.62 ጥረ2

.....

3. የችግረን ክብደት እንደተረዱት

a) ችግርት ምን ያህል ከባድ ነው?

(ብዙ ችግሮች ካሉ ሁሉንም ለየብቻቸው እንዲያብራረ ይጠይቁ)

I. ☐ ☐ 3.1 - 3.2 ከባድ ችግር 1

.....

II. ☐ ☐ 3.3 - 3.4 ከባድ ችግር 2

.....

III. ☐ ☐ 3.5 - 3.6 ከባድ ችግር 3

.....

b. ከላይ ከተጠቀሱት ሁሉ የትኛው ነው በጣም ከባዱ ችግር?

I. ☐ ☐ 3.7 - 3.8 በጣም ከባድ ችግር1

.....

c. ከነዚህ ችግሮች በጣም የሚያስፈራዎት ጉዳይ ምንድን ነው? ሴላ ተጨማሪ ፍርሃት አለዎት?

I. ☐ ☐ 3.9 - 3.10 በጣም የሚያስፈራ 1

.....

d. ሴላ ፍራቻዎች አለዎት?

I. ☐ ☐ 3.11 - 3.12 ሴላ የሚያስፈራ 1

.....

II. 3.13 - 3.14 ሴላ የሚያስፈራ 2

.....☐.....☐.....

III. ☐ ☐ 3.15 - 3.16 ሴላ የሚያስፈራ 3

.....

e.አሁን ባሉበት ጊዜ ስችግሮች መፍትሄ ከፈለጉ፤ ለምን በዚህ ጊዜ መፍትሄ ፈለጉ፤ችግርት ተባባሰ? ፍርሃት ኖሮት? በሴሎች ሰዎች ምክር ተሰግሶት ነበር?

I. ☐ ☐ 3.17 - 3.18 አሁን ለምን መጡ 1

.....

f. እንዴትና መቼ ችግሮቹ ተባባሱ?

ምን አደነት ነገሮች ያባብሱታል፤ምሳሌዎችና የተናገሩትን እንዳስ አስፍር?

I. ☐ ☐ 3.19 - 3.20 የተባባሠ 1

.....

II. 3.21 - 3.22 የተባባሠ 2

..... ☐ ..... ☐ .....

III. ☐ ☐ 3.23 - 3.24 የተባባሠ 3

.....

g, እንዴትና መቼ እነዚህ ችግሮች ተሻሻሉ?

ምን አደነት ነገሮች አሻሻሉት?

I. ☐ ☐ 3.25 - 3.26 የተሻሻለ 1

.....

II. 3.27 - 3.28 የተሻሻለ 2

..... ☐ ..... ☐ .....

III. ☐ ☐ 3.29 - 3.30 የተሻሻለ 3

....

4. በተሰጠው እንክብካቤ የጠበቁት ልርካታ ማግኘት

a. የጤና ባለሙያን፣ የዘጼማኖት አባት፣ ባህላዊ ሐኪም በማየት የጠበቁት/ወደንም ተስፋ ያደረጉት ነገር ምንድን ነው? የጤና ባለሙያን፣ የዘጼማኖት አባት፣ ባህላዊ ሐኪም ምን እንዲያደርጉ ነበር የፈለጉት?

I. ☐ ☐ 4.1 - 4.2 የጠበቁት/ግምት 1

.....

II. ☐ ☐ 4.3 - 4.4 የጠበቁት/ግምት 2

.....

III. ☐ ☐ 4.5 - 4.6 የጠበቁት/ግምት 3

.....

IV. ☐ ☐ 4.7 - 4.8 የጠበቁት/ግምት 4

.....

V. ☐ ☐ 4.9 - 4.10 የጠበቁት/ግምት 5

.....

b. እነዚህን የጤና ባለሙያ፣ የዘጼማኖት አባት፣ ባህላዊ ሐኪም ስለችግሮት ጠይቀዋቸዋል? ሁሉንም/እንዳንዱን/ማንንም/ስመናገር አልችልም

I. ☐ ☐ 4.11 - 4.12 ግምት 1

.....

የጤና ባለሙያ፣ የዘጼማኖት አባት፣ ባህላዊ ሐኪሙ ምን ነገሮት?

I. ☐ ☐ 4.13 - 4.14 ግምት 1

.....

II. ☐ ☐ 4.15 - 4.16 ግምት 2

.....

III. ☐ ☐ 4.17 - 4.18 ግምት 3

.....

IV. ☐ ☐ 4.19 - 4.20 ግምት 4

.....

V. ☐ ☐ 4.21 - 4.22 ግምት 5

.....

c. ስለችግሮ የጤና ባለሙያ፣ የዘጼማኖት አባት፣ ባህላዊ ሐኪሞቹ ምን አደረጉ?

I. ☐ ☐ 4.23 - 4.24 ድርጊት 1

.....

II. ☐ ☐ 4.25 - 4.26 ድርጊት 2

.....

III. ☐ ☐ 4.27 - 4.28 ድርጊት 3

.....

IV. ☐ ☐ 4.29 - 4.30 ድርጊት 4

V. ☐ ☐ 4.31 - 4.32 ድርጊት 5

d. ስጤና ባለሙያ፣ ለሀኪማኖት አባት፣ ለባህላዊ ሀኪሞቹ ስለችግር ማሙራት ጠቃሚ ሆኖ አገኙት?

I. ☐ ☐ 4.33 - 4.34 ዕርካታ 1

II. ☐ ☐ 4.35 - 4.36 ዕርካታ 2

III. ☐ ☐ 4.37 - 4.38 ዕርካታ 3

e. እስካሁን ድረስ በተሰጥዎ ህክምና ያልተደስቱበት ነገር ስለ? ስዎ/ስደ/ስመናገር ስልችልም ስዎ ከሆነ መልሱ፣ያብራሩ

I. ☐ ☐ 4.39 - 4.40 ደስተኛ ያልሆኑበት 1

II. ☐ ☐ 4.41 - 4.42 ደስተኛ ያልሆኑበት 2

III. ☐ ☐ 4.43 - 4.44 ደስተኛ ያልሆኑበት 3

5. እንቅስቃሴዎችና ተግባራችች

a. የጤና ችግርዎ ካስከተሉት እክሎች ዋነኞቹ ምን ምን ናቸው?

I. ☐ ☐ 5.1 - 5.2 ችግር 1

II. ☐ ☐ 5.3 - 5.4 ችግር 2

III. ☐ ☐ 5.5 - 5.6 ችግር 3

b. በጤና ችግርዎ በጣም የተጠቃው የሰውነትዎ ስካል የትኛው ነው?

I. ☐ ☐ 5.7 - 5.8 ስካል 1

II. ☐ ☐ 5.8 - 5.9 ስካል 2

III. ☐ ☐ 5.10 - 5.11 ስካል 3

c. የጤና ችግርዎ በስሜትዎ ላይ እንዴትና በምን ያህል ክብደት ጎድቶታል? ለምሳሌ በጣም ደክፋ ነበር፣ ደጨነቁ ነበር፣ ምን ያህል

I. ☐ ☐ 5.12 - 5.13 ስሜት 1

d. እነዚህ የጤና ችግሮች ሰላማዊ ኑሮዎን ስለናከስዋል? እንዴትና ምን ያህል?

I. ☐ ☐ 5.14 - 5.15 መስናክል 1

e. እነዚህ የጤና ችግሮች ማህበራዊ ኑሮዎን ስለናከስዋል? እንዴትና ምን ያህል?

I. ☐ ☐ 5.16 - 5.17 ማህበራዊ1

f. እነዚህ ችግሮች የቤተሰብ ኑሮዎን ስለናከስዋል? እንዴትና ምን ያህል?

I. ☐ ☐ 5.18 - 5.19 ቤተሰብ1

g. እነዚህ ችግሮች በስጠቃላይ ከሰዎች ጋር ያለዎትን ግንኙነት ስለናከስዋል? ለምሳሌ በቀላሉ የመነጫነጭ/የመቆጣት፣ንዴት/ስለመግባባት/ወዘተ ምን ያህል?

I. ☐ ☐ 5.19 - 5.20 ግንኙነት1

h. በችግርት ምክኒያት ስራዎት (የቤት ስራ) ተበድሎ ነበር? እንዴትና ምን ያህል?

I. ☐ ☐ 5.21 - 5.22 ሥራ1

6. ሌሎች የጤና ባህሪያት

a. ስለችግርዎ ከሌሎች ሰዎች ምክር ጠይቀው ያውቃሉ? (ከጓደኞች፣ ቤተሰብ፣ ስማራጭ የህክምና ባለሙያዎች ፣የባህላዊ ሃኪም፣ ቀሳውስት፣ ካህናት)

I. ☐ ☐ 5.23 - 5.24 ምክር 1

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II. ☐ ☐ 5.25 - 5.26 ምክር 2

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III. ☐ ☐ 5.27 - 5.28 ምክር 3

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IV. ☐ ☐ 5.29 - 5.30 ምክር 4

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V. ☐ ☐ 5.31 - 5.32 ምክር 5

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b.ከተስመደው የህክምና ዶክተርዎ ውጪ ሌላ ህክምና ጠይንም ምክር ስለ ችግርዎ የሰጠዎ አካል ነበር? ስላዩዋቸው የተለያዩ ባለሙያዎችና ዶክተሮች

I. ☐ ☐ 5.33 - 5.34 ምክር 1

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II. ☐ ☐ 5.35 - 5.36 ምክር 2

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III. ☐ ☐ 5.37 - 5.38 ምክር 3

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IV. ☐ ☐ 5.39 - 5.40 ምክር 4

.....

V. ☐ ☐ 5.41 - 5.42 ምክር 5

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c. ስንት የህክምና ባለሙያዎች ችግሮን ሲያክሙ ሞክረዋል? /በሙሉ የህመሙ ጊዜያት/

I. ☐ ☐ 5.43 - 5.44 ሰነድ 1

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II. ☐ ☐ 5.45 - 5.46 ሰነድ 2

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III. ☐ ☐ 5.47 - 5.48 ሰነድ 3

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IV. ☐ ☐ 5.49 - 5.50 ሰነድ 4

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V. ☐ ☐ 5.51 - 5.52 ሰነድ 5

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d. ስህክምናው በስጠቃላይ በግምት ምን ያህል ገንዘብ አውጥተዋል? ቀጥታ ስህክምና ያወጡትን ገንዘብ ይገምቱ

I. ☐ ☐ 5.53 - 5.54 ወጪ 1

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e. ችግርዎን በቀጥታ ራስዎ ሲያክሙ ሞክረዋል? ስዎ /ስደ/ ስመናገር ስልችልም

I. ☐ ☐ 5.55 - 5.56 ራስን ማከም 1

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f. ከሆነም እንዴት?

I. ☐ ☐ 5.57 - 5.58 እንዴት 1

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g. በዚህ ጊዜ የሚወስዱት መድሃኒት ስለ?

I. ☐ ☐ 5.43 - 5.44 መድሀኒት 1

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II. ☐ ☐ 5.45 - 5.46 መድሀኒት 2

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h. ከዚህ ሌላ ችግሩ ስመቀረፍ የሚወስዱት መድሃኒት?/የባህል፣የሰልዋት፣ፀበል/ስቡ

I. ☐ ☐ 5.47 - 5.48 መድሀኒት 1

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II. ☐ ☐ 5.49 - 5.50 መድሀኒት 2

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i. በቀን ውስጥ ምን ያህል ሲጋራ ያጨሳሉ?

I. ☐ ☐ 5.47 - 5.48 ሲጋራ 1

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j. ስልኮል ደጠጣሱ? ስዎ/ስደ/ስመናገር ስልችልም

I. ☐ ☐ 5.48 - 5.49 ስልኮል 1

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k. የሚጠሙ ከሆነ ምን ያህል? በየቀኑ/በየሳምንቱ/በየወረ ወዘተ

I. ☐ ☐ 5.50 - 5.51 ስልኮል 2

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l. የስልኮል መጠን በሳምንት የሚወስዱት?

I. ☐ ☐ 5.51 - 5.52 ስልኮል 3

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m. ሴላ የሚጠቀሙት ስደገኛ ሰፃችና መዳህኒችች ስምሳሌ ጫት ስኩ?

I. ☐ ☐ 5.53 - 5.54 ስደገኛ ሰፃችና መዳህኒችች 1

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ስለ ህመምዎ ዝርዝር መረጃ ስለሰጡኝ ስመሰግናለሁ። በመጨረሻም ስለሌሎች ሰዎች ችግሮችና ስለሚያደርጉት የደክተር ጉብኝት የርሶን ስስተያየት ልጠይቅ እፈልጋለሁ። ስለሰዎቹ ችግሮች ስጠር ያስ መረጃ ሰምተው/ስንብበው ከዛም ጥያቄዎች ልጠይቅዎ እሻለሁ።

4. ስለባህል ህክምናና ባለሞያዎች አስተሳሰብ/አመለካከት፤ Beliefs about FTHs							
	በማነሳው ሀሳብ ላይ መስማማት አለመስማማቶን ይነገሩኝ	በጣሙን አልስማማም 1	አልስማማም 2	አልወሰንኩም 3	በጣም አስማማለሁ 4	አስማማለሁ 5	
401	የባህል ህክምና ባለሞያዎች ስለጤናማ የአኗኗር ዘዬ ጥሩ መረጃ ይሰጣሉ						
402	የባህል ህክምና የሚያስከትለው ተጓዳኝ ጉዳት በጣም ጥቂት ነው						
403	በዘመናዊው የህክምና ዘዬ ከሚሰጠው መድሀኒት ጋር ሲወዳደር በባህል ህክምና የሚሰጠው ህክምና ለክፉ የማይሰጡና ጤናማ ናቸው						
404	የባህል ህክምና ህመምተኛውን አሳተፊ ስለሆነ ለተማሚው ብዙ ክፍተትና ጉልበት ያሰጣል						
405	የባህል ህክምና ይሰራል						
406	የባህል ህክምና ሁሉ ስፍራ ያገኛል						
407	የባህል ህክምና ዋጋው ረከስ ይላል						
408	የባህል ህክምና ለህዝቡ ቅርብ ነው						
409	የባህል ህክምና ባለሞያዎች ከህዝቡ ውስጥ የወጡ ስለሆኑ ህዝቡን የተሸለ ይረዱተል						
410	የባህል ህክምና በህዝቡ ዘንድ በደንብ ይተወቃል						
411	የባህል ህክምና ባለሞያዎች ከህዝቡ ጋር አብረው ለረጅም ዘመን የኖሩ ናቸው						
412	የባህል ህክምና ባለሞያዎች ለሰው አክብሮት አላቸው						
413	የባህል ህክምናን የሚጠቀሙት ባብዛኛው ደሆች ናቸው						
414	የባህል ህክምናን የሚጠቀሙት ባብዛኛው ወንዶች ናቸው						
415	የባህል ህክምናን የሚጠቀሙት ባብዛኛው ያልተማሩ ሰዎች ናቸው						
416	የባህል ህክምናን የሚጠቀሙት ባብዛኛው ከባድ አዕምሮ ህመምተኞች						
417	አንድ ሰው የባህል ህክምናን ዕንዲጠቀም ጫና የሚፈሩት ወላጅና ቤተሰብ ናቸው						
418	ከባድ አዕምሮ ህመም መንስዔ አከላዊ፤ ሰነልቦናዊና መንፈሳዊ ቸግሮች ናቸው ብለው የሚያምኑ ሰዎች የባህል ህክምናን የመጠቀም ዕድላቸው ብዙ ነው						
419	ሰዎች የባህል ህክምና ለከባድ አዕምሮ ህመም ምንም ችግር አይፈጥርም						

5. ማህበረሰባዊ ዕርዳታ Orientation of Social Support (OSS) for FAMILY as CARER		
501	ከበድ ያለ የግል ችግር ቢገጥሞት ከዕኔ ጋ ሊቆሙ ይችላሉ ብለው የሚመኩባቸው ሰዎች ስንት ይሆናሉ?	....
502	ዕርሶ ዕየሰሩ ባሉት ስራ ሰዎች ምን ያህል ትኩረት ያሳያሉ ወይም ፍላጎት አላቸው	ምንም ትኩረት የላቸውም 1 ትንሀ ትኩረት/ፍላጎት ያሳያሉ 2 ርግጠኛ አይደለሁም 3 መጠነኛ ትኩረት/ፍላጎት ያሳያሉ 4 ከፍተኛ ትኩረት/ፍላጎት ያሳያሉ 5
503	ዕድራተ ማግኘት ቢፈልጉ ከጎረቤትዎ ዕርዳ ለማግኘት ምን ያህል ቀላል ነው	ዕጅግ አስቸጋሪ ነው 1 አስቸጋሪ ነው 2 ይቻላል 3 ቀላል ነው 4 በጣም ቀላል ነው 5

6. ስለአልኮል አጠቃቀም FAST Alcohol screening test							
ተ.ቁ.	ጥያቄ	ነጥብ					ነጥብ
		0	1	2	3	4	
601	በየስንት ጊዜው ከ6 መለኪያ በላይ (ለሴት)/ከ8 መለኪያ በላይ (ለወንድ) ይጠጣሉ?	ጠጥቸ አላውቅም	</= 1 ጊዜ በወር	በየወሩ	በየሳምንቱ	በየቀኑ	
ቀጣይ ጥያቄዎችን ለመጀመሪያው ጥያቄ ምላሽ በወር ወይም ከወር ባነሰ ጊዜ ውስጥ ከሆነ ብቻ ይመልሱ							
602	ባለፈው ዓመት ውስጥ በየስንት ጊዜው በጠጡበት ጊዜ የሆነውን ለማስታወስ ተቸግረዋል?	ተቸግሬ አላውቅም	</= 1 ጊዜ በወር	በየወሩ	በየሳምንቱ	በየቀኑ	
603	ባለፈው ዓመት ውስጥ በየስንት ጊዜው በመጠጣትዎ ምክንያት መስራት ያለብዎትን ሳይሰሩ ቀርተዋል?	ሳልሰራ አልቀረሁም	</= 1 ጊዜ በወር	በየወሩ	በየሳምንቱ	በየቀኑ	
604	ዘመድ/ወዳጅ/ የጤና ባለሙያ መጠጥ እንዲያቆሙ መክሮዎት ያውቃል?	አያውቅም		አዎ፣ ዓመት አልፎታል		አዎ፣ ባለፈው ዓመት ውስጥ	

7. የአከላዊ አንቅቃሴን የኑሮ ምቾት ሁኔተ WHODAS (Functional status & quality of life)			
701	ባለፉት 30 ቀናት ውስጥ የነበረዎትን አጠቃላይ የጤንነት ሁኔተ እንዴት ይገልጹተል?	ምጣም ጥሩነበር	1
		ጥሩ ነበር	2
		መልከም ነበር/ምንም አይል	3
		መጥፎ ነበር	4
		አጅግ መጥፎ ነበር	5
ባለፉት 30 ቀናት ውስጥ በሚከተሉት ሁኔተዎች ምን ያህል አንደተቸገሩ ቢነግሩኝ			
702	ለረጅም ግዜ ለምሳሌ ለ30 ደቂቃ ያህል መቆም	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
703	የተለመደውን (መደበኛውን፤ የየዕት) ተግባርን በሚያከናውኑበት ግዜ	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
704	አዳዲስ ነገሮችን ለምሳሌ ድሮ ወደ ማያውቁት ወደ አዲስ መንደር ለመሄድ	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
705	ከህብረተሰቡ ጋር ተቀላቅሎ አንዳንድ ስራዎችን ለመስራት፡ ለምሳሌ ምአል ለማክበር፤ ቤተስኪያን ወይም መስጊድ ለመሄድ?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
706	በስነልቦናዎ ስለጤንነትዎ ሁኔተ ተጨንቁው ነበር?	ምንም አልተጨነርኩም	1
		በትንሹ ተጨንቁ ነበር	2
		በመጠኑ ተጨንቁ ነበር	3
		በደንብ ተጨንቁ ነበር	4
		በጣም በጣም ተጨንቁ ነበር	5
707	ስለሚሰሩት ስራ (አየሰሩ ስላሉት ስራ) ለ10 ደቂቃ ያህል ሀሳብዎን መሰብሰብ ተቸግረው ነበር?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
708	ትንሽ ራቅ ወዳለ ቦተ ማለትም አንድ ግማሽ ሰዓት የሚያስከድ መንገድ ለመሄድ ተቸግረው ነበር?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
709	ሰውነቶዎን ለመተጠብ ተቸግረው ነበር?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
710	ልብስዎን ለመልበስ ተቸግረው ነበር?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
711	ከማያውቁት ሰው ጋ ለመነጋገር ወይም ለመስማማት?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3

		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
712	ከሰው ጋር የቆየ ጓደንነትዎን ለመቀጠል ተቸግረው ነበር?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5
713	ማንኛውንም የየዕለት ተዕለት ስራዎን ወይም ዕንቅስቃሴዎን ለማከናወን ተቸግረው ነበር?	ምንም አልተቸገርኩም	1
		በትንሹ ተቸግሬ ነበር	2
		በመጠኑ ተቸግሬ ነበር	3
		በደንብ ተቸግሬ ነበር	4
		በጣም በጣም ተቸግሬ ነበር/ መስራት አልቻልኩም	5

8. አጭር የአዕምሮ ጤንነት ሁኔተ መለኪያ CMHEI - Brief Psychiatric Rating Scale - F2								
	ስለሚነሱት ምልክቶች የክብደት ደረጃ ምን ያህል ነበር	አልነበረም 1	በጣም ትንሽ ነበር 2	ትንሽ ነበር 3	መከከለኛ ነበር 4	መከከለኛ ከባድ ነበር 5	ከባድ ነበር 6	ዕጅግ ከባድ ነበር 7
801	አከላዊ ጤንነት							
802	ጭንቀት							
803	ድብርት							
804	ራስን የማጥፋት ስማትና ፍላጎት							
805	ራስና የመውቀስ ስሜት							
806	ቅንነት ወይም ግልጥነት							
807	ከፍተኛና የተሟሟቀ የጤንነት ስሜት							
808	ከመጠን በላይ ራስን ከፍ አድርጎ ማየት							
809	ሌላ ሰውን በከፍተኛ ጥርጣሬ መመልከት							
810	ዕውነት ያልሆነና ነገር አንደሆነ አድርጎ መገመት ወይም ማሰብ							
811	ከዕውነት የራቀ ወይም ያልተለመደ ይዘት ያለው ሐሳብ ማሰብ							
812	ያልተለመደ ወይም ግራ የሆነ ባህሪ							
813	በሁሉ ነገር ራስን የመርሳት ወይም መዘንጋት ሁኔተ							
814	ስለሁሉ ነገር ግራ መጋባት ወይም ሁኔተን በቅጡ መረዳት አለመመቻል							
815	ግራ የሚያጋባ አስተሳሰብ፤ አመለከከት፤ ንግግር ግልጽ አለመሆን							
816	የራስን ስሜትና ፍላጎት በገጽተ ወይም በንግግር ወይም በሰውነት ሁኔ ማሳየት አለመቻል/አለመግለጽ							
817	ከሰው ጋ ባለ ግንኙነት ስሜተዊ አለመሆን ወይም መቀዝቀዝ							
818	በንግግርም ሆነ በድርጊት ምጣም ዝግተኛ መሆን							
819	መወጣጠር፤ በሰውነትና በዕንቅስቃሴ							
820	አለመተባበር፤ዕንቅፋት መሆን							
821	ከፍተኛ ተነሳሽነት፤ መነቃቃት							
822	በንግግርም ሆነ በድርጊት በትንሹ መተወክ ወይም ከሚያደርጉት ነገር መተጓጎል							
823	መቅበጥበጥ፤ መጣደፍ							
824	ትክክለኛ ያልሆነ የሰውነት ሁኔተ ወይም አገላለጽ/አቀማመጥ፤ አቋቋም							

ጥናት 4፡ ሶስት ክፍል ሲኖረው፡ 1ኛ) ተፈላጊ ባህሪን መለየት፤ ይህ ባህሪ አሁን ያለበትን ደረጃ ማወቅና ባህሪው አሁን ከለበት ደረጃ ወደሚፈለገው ደረጃ ለማድረስ መከናወን ያለባቸውን ስራዎች፤ የዕውቀት፤ የመረጃ፤ የክህሎት፤ የትምህርት ነጥቦችን ማውጣት 2ኛ) ባህሪው አሁን ከለበት ደረጃ ወደሚፈለገው ደረጃ ለማድረስ መከናወን ያለባቸውን ስራዎች፤ የዕውቀት፤ የመረጃ፤ የክህሎት፤ የትምህርት ነጥቦችን ለስድስት ማከናወን 3ኛ) ከስድስት ወር ስራ በኋላ የሚፈለገው ደረጃ መደረስ አለመደረሱን መገምገም ናቸው፡፡

<u>ጥናት 4.1</u>: ቅድመ-ጥናት መረጃ «የተፈላጊ ባህሪ» ትርጉም ጽንሰ-ሀሳቦችን መለየትና ማጠናቀርና አንዲሁም ለሁለተኛው ክፍል መጠይቅ ለማዘጋጀት፡፡

- **ተፈላጊ ባህሪ**፡- በባህላዊና በዘመናዊ ህክምና ስርዓት መሀከል የሚደረግ መቀናጀት/ቅንጅት መገለጫ «በባህላዊና በዘመናዊ ህክምና ስርዓቶች መሀከል የሚደረግ የበሽተኞች መላላክ» ሲሆን ይህም አንደተፈላጊ ባህሪ ይወሰዳል፡፡ ይህ የበሽተኞች መላላክ የሁለትዬሽ ሲሆን፤ ማለትም ባህላዊ ባለሞያዎች ህመምተኞችን «የከባድ የአዕምሮ ህመምተኞችን የበሽተውን ምንነት ለማወቅና መድሀኒት ለመጀመር» ወደ ዘመናዊ የህክምና ባለሞያዎች መላክ ሲሆን ዘመናዊ የህክምና ባለሞያዎች ደግሞ «ተማሚዎችን ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ማድረግ» ናቸው፡፡

- ***ዝንባሌ***፡ ድርጊተዊና ተግባራዊ መግለጫ

  - **ባህላዊ ሀኪሞች**፡ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት ለማስጀመር ወደ ዘመናዊ የህክምና ባለሞያዎች የመላክ ተግባራ በሚቀተሉት 6 ወራት፤ የሚከተለውን ይመስላል፡-

    መጥፎ 1 2 3 4 5 6 7 ጥሩ
    አስደሳች 1 2 3 4 5 6 7 አሰከፊ

  - **ዘመናዊ የህክምና ባለሞያዎች**፡ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ» አንዲረዷቸው ማድረግ ወደባህላዊ የህክምና ባለሞያዎች የመላክ ተግባራ በሚቀተሉት 6 ወራት፤ የሚከተለውን ይመስላል፡-

    መጥፎ 1 2 3 4 5 6 7 ጥሩ
    አስደሳች 1 2 3 4 5 6 7 አሰከፊ

- ***ስለማህበረሰባዊ የአኗኗር፡- ሀግጋት፤ ስርዓትና ይሉኝታ***

  - **ባህላዊ ሀኪሞች፡**
    - ለኔ በጣም አስፈላጊ ወይም ወሳኝ የሆኑ ሰዎች (በሽተኞች፤ በህብረሰቡ የተከበሩ አዋቂ ሰዎች፤የዘመናዊ ህክምና ባለሞያዎች) የበሽተውን ምንነት አንዲተወቅና መድሀኒት ለማስጀመር ወደ ዘመናዊ የህክምና ባለሞያዎች የመላክ ተግባሬን የደግፉተል፡፡

      አስማማከሁ 1 2 3 4 5 6 7 አልስማማም

    - በሚቀተሉት 6 ወራት አረደ አኔ ያሉ ብዙ ባህላዊ ሀኪሞች የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት ለማስጀመር ወደ ዘመናዊ የህክምና ባለሞያዎች ይልከሉ፡፡

      ሌሆን አይችልም 1 2 3 4 5 6 7 ሊሆን ይችላል

  - **ዘመናዊ የህክምና ባለሞያዎች**፡
    - ለኔ በጣም አስፈላጊ ወይም ወሳኝ የሆኑ ሰዎች (በሽተኞች፤ በህብረሰቡ የተከበሩ አዋቂ ሰዎች፤የባህላዊና ዘመናዊ ህክምና ባለሞያዎች) «ተማሚዎችን ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች የመላክ ተግባሬን የደግፉተል፡፡

      አስማማከሁ 1 2 3 4 5 6 7 አልስማማም

    - በሚቀተሉት 6 ወራት አረደ አኔ ያሉ ብዙ ዘመናዊ ሀኪሞች«ተማሚዎችን ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» የከባድ የአዕምሮ ህመምተኞችን ወደ ባህላዊ የህክምና ባለሞያዎች ይልከሉ፡፡

      ሊሆን አይችልም 1 2 3 4 5 6 7 ሊሆን ይችላል

ተፈላጊውን ባህሪ ለማምጣት ወሳኝ ጫና አምጪ ጉዳዮች፡-የማከናወን ብቃትና በራስ ወሳኝነት መተማመን

- **ባህላዊ ሀኪሞች፡**
  - በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች አንደምልክ አርግጠኛ ነኝ

    ውነት 1 2 3 4 5 6 7 ውሸት

  - በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች የመኬን ጉዳይ ወሳኙ ዕኔ ራሴ ነኝ

    አስማማከሁ 1 2 3 4 5 6 7 አልስማማም

- **ዘመናዊ የህክምና ባለሞያዎች**፡
  - በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች አንደምልክ አርግጠኛ ነኝ

    ውነት 1 2 3 4 5 6 7 ውሸት
  - በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች የመኬን ጉዳይ ወሳኙ ዕኔ ራሴ ነኝ

    አስማማከሁ 1 2 3 4 5 6 7 አልስማማም

- **ተፈላጊውን ባህሪ ለማምጣት ያለ ተነሳሽነት/ ፍላጎት**
  - **ባህላዊ ሀኪሞች፡**
    - በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች ለመላክ አላማና ፍላጎት አለኝ

      ሊሆን አይችልም 1 2 3 4 5 6 7 ሊሆን ይችላል
  - **ዘመናዊ ሀኪሞች፡**
    - በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች ለመላክ አላማና ፍላጎት አለኝ

      ሊሆን አይችልም 1 2 3 4 5 6 7 ሊሆን ይችላል

- **ተፈላጊውን ባህሪ አስመልክቶ የነበረ የቀድሞ ባህሪ**
  - **ባህላዊ ሀኪሞች፡**
    - ባለፉት 3 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች ልኬአለሁ፡፡

      ውነት 1 2 3 4 5 6 7 ውሸት
  - **ዘመናዊ ሀኪሞች፡**
    - ባለፉት 3 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች ልኬአለሁ፡፡

      ውነት 1 2 3 4 5 6 7 ውሸት

<u>ጥናት 4.2: ቅድመ-ጥናት መረጃ ፊትለፊት ያለ ዕምነትንና ግንዛን ለማወቅ:</u> ለ5 የብህልና 5 ዘመናዊ ህክምና ባለሞያዎች ጋር «ስለመቀናጀት ያላቸውን አመለከከት፤ ዕምነትና ግንዛቤ» ለመረዳት የሚደረግ የአንድ ለአንድ ውይይት፡፡ ለተወያዮቹ አስቀድሞ ሊገለጹልቸው የሚገቡ ሀሳቦች፡- ሀ) ጥያቄውን ሲጠየቁ የተለያየ ወይም በርከተ መልስ ሊኖራቸው ቢችልም፤ አሁን ግን ወዲያው ወደ አዕምሮአቸው የሚመጣውን መልስ አንዲመልሱ ለ) የሚመልሱት የግል አመለከከጣቸውን መሆን አንዳለበት ሐ) የትኛውም መልስ ትክክል ወይም ትክክል ያልሆነ ነው ሊባል አንደማይችል አንዲያውቁት ይደርግ፡፡

<u>1.</u> **<u>መሰረተዊ አመለከከት</u>፡-** ስለ መቀነጀት፤ ማለትም «የከባድ የአዕምሮ ህመምተኞችን ስለመላላክ» ምን ያስባሉ?

<u>2.</u> **<u>ስለ ተፈላጊው ባህሪ ሚያመጣው ውጤት (ጥቅምና ጉዳት)</u>**፡- የከባድ የአዕምሮ ህመምተኞችን መላላክ ምን አይነት ውጤት ያመጣል? በተለይ በህመሙ ምልክት አንጻር፤ በማህበራ ግንኙነቶች አንጻር፤ በኢኮኖሚ አንጻር፤ ህመምተኞችን በመላላክ መቀናጀት ምን አይነት ውጤት ያመጣል?

<u>ሀ) ከጥቅም አናጻር</u>

- **ባህላዊ ሀኪሞች፡-**በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች መላክዎ ምን <u>ጥቅም</u> አለው ይላሉ?

- **ዘመናዊ ሀኪሞች፡-**በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች መላክዎ ምን <u>**ጥቅም**</u> አለው ይላሉ?

<u>ለ) ከጉዳት አንጻር</u>

- **ባህላዊ ሀኪሞች፡-**በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች መላክዎ ምን <u>**ጉዳት**</u> አለው ይላሉ?

- **ዘመናዊ ሀኪሞች፡-** በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች መላክዎ ምን <u>**ጉዳት**</u> አለው ይላሉ?

<u>ሐ) ከሌላ ጉዳይ አንጻር</u>

- **ባህላዊ ሀኪሞች፡-** በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች መላክዎ ምን <u>**ሌላ ጉዳይ**</u> ያሳስቦተል ወይም አለው ይላሉ?

- **ዘመናዊ ሀኪሞች፡-** በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች መላክዎ ምን <u>**ሌላ ጉዳይ**</u> ያሳስቦተል ወይም አለው ይላሉ?

<u>3. አየተለመዱና የሚከበሩ ህግጋትና ደንቦች</u>

- **ባህላዊ ሀኪሞች፡-** በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን የበሽተው ምንነት አንዲተወቅና መድሀኒት አንዲጀመርላቸው ወደ ዘመናዊ የህክምና ባለሞያዎች ሰለመላክዎ ወይም ስላለመላከዎ <u>**ጉዳይ**</u> ሌሎች የሚመለከተቸው/የሚያሳስባቸው ስለዚህም አንዲልኩ ወይም አንዳይልክ የሚፈልጉ/የሚያደርጉ ሰዎች/ቡድን ሊኖሩ ይችላሉ

- **ዘመናዊ ሀኪሞች፡-** በሚቀጥሉት 6 ወራት ውስጥ የከባድ የአዕምሮ ህመምተኞችን «ከማህበረሰቡ ጋር አንዲቀላቀሉና አስፈላጊው የማቋቋም ስራ አንዲሁም ወደቀድሞው ቤተሰባዊና ኢኮኖሚያዊ የሐላፊነት ስፍራቸው አንዲመለሱ ማድረግ፤ በተጨማሪም ዘመናዊ የህክምና ባለሞያዎች የተጀመረላቸውን መድሀኒት ያለማቋረጥ መውሰድ አንዲችሉ ለማድረግ» ወደ ባህላዊ ህክምና ባለሞያዎች ሰለመላክዎ ወይም ስላለመላከዎ <u>**ጉዳይ**</u> ሌሎች የሚመለከተቸው/የሚያሳስባቸው ስለዚህም አንዲልኩ ወይም አንዳይልክ የሚፈልጉ/የሚያደርጉ ሰዎች/ቡድን ሊኖሩ ይችላሉ

መላክዎን ከሚፈልጉ/ከሚያበረተቱ

- **ባህላዊ ሀኪሞች፡-** አስቲ ከነዚህ ህመምተኛን መላክዎን ከሚፈልጉ/ከሚያበረተቱ ሰዎች/ቡድን ዋናዎቹን ቢጠቅሱልኝ
- **ዘመናዊ ሀኪሞች፡-**አስቲ ከነዚህ ህመምተኛን መላክዎን ከሚፈልጉ/ከሚያበረተቱ ሰዎች/ቡድን ዋናዎቹን ቢጠቅሱልኝ

መላክዎን ከማይፈልጉ/ከማያበረተቱ

- **ባህላዊ ሀኪሞች፡-** አስቲ ከነዚህ ህመምተኛን መላክዎን ከማይፈልጉ/ከማያበረተቱ ሰዎች/ቡድን ዋናዎቹን ቢጠቅሱልኝ
- **ዘመናዊ ሀኪሞች፡-**አስቲ ከነዚህ ህመምተኛን መላክዎን ከማይፈልጉ/ከማያበረተቱ ሰዎች/ቡድን ዋናዎቹን ቢጠቅሱልኝ

ስለሌሎች ባለሞያዎች፡ ተጠያቂዎቹ ባለሞያዎች አንደምሳሌ የሚመለከቷቸው

<u>ይልከሉ የሚሏቸውን፡-</u>

- አሁን ደግሞ፤ አስቲ አርሶ የሚያውቋቸው ሌሎች **የባህላዊ ሀኪሞች** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ **ዘመናዊ ሀኪሞች** ይልከሉ የሚሏቸውን ይንገሩኝ

- አሁን ደግሞ፤ አስቲ አርሶ የሚያውቋቸው ሌሎች **ዘመናዊ ሀኪሞች** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ **ባህላዊ ሀኪሞች** ይልከሉ የሚሏቸውን ይንገሩኝ

<u>አይልኩም የሚሏቸውን፡-</u>

- አሁን ደግሞ፤ አስቲ አርሶ የሚያውቋቸው ሌሎች **የባህላዊ ሀኪሞች** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ**ዘመናዊ ሀኪሞች** አይልኩም የሚሏቸውን ይንገሩኝ

- አሁን ደግሞ፤ አስቲ አርሶ የሚያውቋቸው ሌሎች **ዘመናዊ ሀኪሞች** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ**ባህላዊ ሀኪሞች** አይልኩም የሚሏቸውን ይንገሩኝ

<u>ወሳኝና ጫና አምጪ ጉዳዮች</u>

- **ለባህላዊ ሀኪሞች፡** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ **ዘመናዊ ሀኪሞች** ለመላክ የሚያስችሉ ሁኔታዎች ወይም አጋዥ የሚሆኑ ወይም ነገር የሚያቀሉ ሁኔታዎችን ከሉ ይንገሩኝ
- **ለዘመናዊ ሀኪሞች፡** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ **ባህላዊ ሀኪሞች** ለመላክ የሚያስችሉ ሁኔታዎች ወይም አጋዥ የሚሆኑ ወይም ነገር የሚያቀሉ ሁኔታዎችን ከሉ ይንገሩኝ

- **ለባህላዊ ሀኪሞች፡** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ **ዘመናዊ ሀኪሞች** ለመላክ የማያስችሉ ሁኔታዎች ወይም አዳጋች የሚሆኑ ወይም ነገር የሚያከብዱ ሁኔታዎችን ከሉ ይንገሩኝ
- **ለዘመናዊ ሀኪሞች፡** በሚቀጥሉት 6 ወራት ውስጥ ከባድ የአዕምሮ ህመምተኞችን ወደ **ባህላዊ ሀኪሞች** ለመላክ የማያስችሉ ሁኔታዎች ወይም አዳጋች የሚሆኑ ወይም ነገር የሚያከብዱ ሁኔታዎችን ከሉ ይንገሩኝ

<u>ተጨማሪ ጥያቄዎች</u>

- አጠቃላይ ሁኔተ፡ ዕድሜ፤ ጾተ፤ የትምህርት ደረጃ፤ የገቢ ሁኔተ፤ መኖሪያ ስፍራ
- ስለ ከባድ የአዕምሮ ህመም መንስኤ፤ ምልክቶች፤ ህክምና፤ ህክምና ከልተደረገላቸው የሚያስከትለው ውጤት አስመልክቶ ያላቸው ዕውቀት፤አመለከከትና ግንዛቤ
- ስለራሳቸው «ከባድ የአዕምሮ ህመምና ለማከምና *(ለማዳን ወይም ምልክቶቹን ለመቀነስ)* የሚያስፈልገውን ዕውቀትና ክህሎት» አለኝ ብለው ያስባሉ? ሌላውስ የህክምና ስርዓት?
- የሌላው የህክምና ስርዓት ወይም ባለሞያዎች ስለአኛ የህክምና ስርዓት ወይም ባለሞያዎች ዕውቅና ይሰጣሉ ወይም አክብሮት አላቸው ብለው ያስባሉ?
- ተቀናጅቶ ለመስራት የሚያስፈልጉ መሰረተዊና ወሳኝ «የህክምና አገልግሎት ስራዎች» ምንድናቸው ይላሉ?
- ከሁለቱም የህክምና ስርዓት ባለሞያዎች ተቀናጅቶ ለመስራት ሊኖሯቸው ይገባሉ የሚሏቸው መሰረተዊና ወሳኝ ክህሎቶች ምንና ምን ናቸው ይላሉ?
- ተቀናጅቶ ለመስራት የሚያስፈልጉ መሰረተዊ የህግ ማዕቀፎች ምን መሆን አለባቸው ይላሉ?
- ተቀናጅቶ ለመስራት የሚያስፈልጉ መሰረተዊና የክትትልና የግምገማና ማዕቀፎችና ዝርዝር ተግባራት ምን መሆን አለባቸው ይላሉ?

ANNEX 2: Information sheet and consent form

A. Information sheet

Title of the research project: - Role of faith and traditional healing practices in the care of Severe Mental Disorders and impact on patient level outcomes: A population based study in Sodo District, Southern Ethiopia.

Name of principal investigators: - Dr Ayele Belachew

Introduction: This information sheet and consent form is prepared for study subjects (community members, faith and traditional healers, patients with severe mental disorder and their close family members and bio-medical care providers) who are going to participate in the research at different stages of the project.
It is prepared with the aim of clearing issues around the research project that you are asked to join by the group of research investigators.

Purpose of the research project: The main aim of this research project is to assess the Faith and traditional healing practices for severe mental disorders, distribution of faith and traditional practitioners and pattern of utilization by patients, patient level outcomes of these practices, as well as intention of faith and traditional healers and biomedical practitioners towards collaboration in the management of severe mental disorders. The findings would allow development of possible models of broader collaboration and interventions to improve access to quality mental health care and hence improve the mental health status of people with severe mental disorders.

Procedure: In order to accomplish the project, you are invited to take part in our studies. Participation in this study is voluntary. If you decide to participate, you are free to withdraw at any time without penalty. You will not be treated differently if you decide to stop taking part in the study. You are also free to skip any questions that you would prefer not to answer.

If you understand and agree to participate, you will be asked to respond to a series of questions about your life styles and experiences, health status and use of traditional practices. You may participate in one-on-one interviews and/or in group discussions with some of your peers. You can skip any question you would prefer not to answer.

Risk and /or discomfort: By participating in this research project you may feel some discomfort especially on sacrificing your time (to the maximum 30-40 minutes) otherwise, no risk in participating in this research project.

Benefits: If you are participating in this research project, the output of the study will have both direct and indirect benefit to you, as you and your families will use the services in the future.

Incentives/payments for participating: You will not be provided any incentives or payment to take part in this project.

Confidentiality: The information collected from this research project will kept confidential and information about you that will be collected by this study will be stored in a file, without your name, but a code number assigned to it. And it will not be revealed to anyone except the principal investigator and will be kept locked with key. Audio recordings will not be publicly connected to you. We may use your photograph in presentations and publications of the research findings, but we will not connect your photograph to any details about you.

Right to refusal or withdraw: You have a full right to refuse from participating in this research. You can choose not to respond to some or all the questions and this will not affect you from getting any kind of health related service within the community or health facilities.

Person to contact: This research project was reviewed and approved by the ethical committee of the Addis Ababa University, college of health sciences. If you want to know more information you can contact Dr Ayele Belachew at 0903306792

B. Informed consent form

Do you understand all that has been said so far?

Are you willing to participate in the study?

Yes ☐

Signature/finger print of the participant

Signature/finger print _____ date _____

(Proceed with the interview)

No ☐ (Terminate the interview)

Signature of the interviewer

Name _____ Signature _____ date _____

Supervisors/Researcher remark and signature

_____

Name _____ Signature _____ date _____

የመረጃና የስምምነት ውል ቅፅ

የምርምሩ/ጥናቱ ርዕስ፤ በሶዶ ወረዳ ከባድ የአዕምሮ ህመምን አስመልክቶ የባህል ህክምና አጠቃቀምና ውጤተማነትን ለማወቅና ባህላዊውን ህክምና ከዘመናዊው ጋር በማጣመር ከባድ የአዕምሮ ህመምን በተሻለ ሁኔተ ለህብረተሰቡ ለማዳረስ የሚያስችል መረጃ ለመሰብሰብ የሚደረግ ጥናት፡፡

የዋና ተመራማሪው ስም፤ ዶ/ር አየለ በላቸው

መግቢያ: ’ይህ የመረጃና የስምምነት ውል ቅፅ የተዘጋጀው እርስዎ ተሳታፊ እንዲሆኑ ስለተጋበዙበት በምርምር ቡድኑ የእርስዎን ፈቃደኛነት ለማወቅ ነው፡፡

የጥናት ፕሮጀክቱ የሚካሄድበት ምክንያት: የምርምር ፕሮጀክቱ ዋና ዓላማ ከባድ የአዕምሮ ህመምን ለማከም የባህል ህክምና አጠቃቀምና ውጤተማነትን በማወቅና ባህላዊውን ህክምና ከዘመናዊው ጋር በማጣመር ከባድ የአዕምሮ ህመምን በተሻለ ሁኔተ ለህብረተሰቡ ለማዳረስ፡፡

አተገባበር: ይህንን ጥናት ለመተግበር መጀመሪያ የእርስዎን ፈቃደኝነት እናረጋግጣለን፡፡ በዚህ መሰረትም በመረጃ ሰብሳቢዎቹ የሚሰጠዎትን ጥያቄዎች እንድመልሱ እንጠይቃለን፡፡

ተጓዳኝ ጉዳቶች: በዚህ ጥናት በመሳተፈዎ በሚያባክኑት ሰዓት ምክንያት ምቾት ላይሰማዎት ይችላል፡፡ በተረፈ ግን በጥናቱ መሳተፍ ምንም ዓይነት ጉዳት አያስከትልም ፡፡ ስለዚህ የሚሰጡት መረጃ ከባድ የአዕምሮ ህመምን ህክምናን ለማሻሻል ጠቃሚ ግብዓት ይሆናል፡፡

ጥቅሞች: እርስዎ በዚህ ጥናት ተሳታፊ በመሆንም በቀጥታ ወይም በሌላ መንገድ የውጤቱ ተጠቃሚ ነዎት፡፡ ወደፊትም የርሶ ቤተሰብ እና ማህበረሰብ ተጠቃሚ የሚሆኑበት ጥናት ነው፡፡

ሌሎች ጥቅማጥቅሞች: በዚህ ጥናት ተሳታፊ በመሆኖዎ ምንም ዓይነት ማበረታቻ ወይም ክፍያ አይሰጥዎትም፡፡

ምስጢራዊነት: ለዚህ የጥናት ፕሮጀክት የሚሰበሰበው መረጃ የግል ጉዳያችሁን ያካተተ በመሆኑ ማን ምን መልስ እንደሰጠ/ች ምስጥር እንዲሆን ጥንቃቄ ይደርግበታል። በቁልፍ ተቆልፎ እንድቀመጥም ይደረጋል፡፡

ከጥናቱ ያለመሳተፍ ወይም የማቋረጥ መብት: በዚህ ጥናት ያለመሳተፍ መብትዎ ሙሉ በሙሉ የተጠበቀ ነዉ፡፡ ለጥያቄዎቹ በሙሉም ሆነ በከፊል መልስ አለመስጠት ይችላሉ፡፡ እንድሁም በማንኛውም ሰዓት ማንኛውንም መብትዎን ሳያጡ የማቋረጥ ሙሉ መብት አለዎት፡፡

ማግኘት የሚችሏቸው ሰዎች: ይህ የምርምር ፕሮጀክት በአድስ አበባ ዩኒቨርሲቲ የጤና ሳይንስ ኮሌጅ የምርምር ስነ ምግባር ኮሚቴ ተከልሶ የጸደቀ ነው፡፡ የበለጠ መረጃ ማግኘት የሚፈልጉ ከሆነ ከዶ/ር አየለ በላቸውን በስልክ ቁጥር +251-930-306792 ማግኘት ይችላሉ፡፡

<u>የጥናት ተሳፍፎ ፍቃድ የመጠየቂያ ቅጽ</u>

ከላይ የተሰጡትን መረጀዎች በማገናዘብና በመረዳት በጥናቱ ለመሳተፍ ፈቃደኛ ኖት?

አዎን ☐

የተሳታፊ ፊርማ/የጣት አሻራ
ፊርማ/የጣት አሻራ _____ ቀን _____
(ወደ ቃለ-መጠይቁ ይለፉ)

የለም ☐ (ቃለ-መጠይቁን ያቁሙ)

የመረጃ ሰብሳቢዉ ፊርማ
ስም _____ ፊርማ _____ ቀን _____ ሰዓት _____

የተቆጣጣሪዉ ፊርማ
ስም _____ ፊርማ _____ ቀን _____

15. Assurance of Investigator

The undersigned agrees to accept responsibility for the scientific ethical and technical conduct of the research project and for provision of the required progress reports as per terms and conditions of the Institutional Review Board as the result of this research.

Name of the student as primary investigators

Dr. Ayele Belachew, Date ---------- Signature ----------

Approval of the advisors:

Dr. Abebaw Fikadu, Date ---------- Signature ----------

Dr. Mitike Molla, Date ---------- Signature ----------

Prof. Damen Hailemariam, Date ---------- Signature ----------

ANNEX 3: Cariculum Vitae (Investigator and supervisors)