ADDIS ABABA UNIVERSITY
FACULTY OF MEDICINE
DEPARTMENT OF COMMUNITY HEALTH

ASSESSMENT OF HOME MANAGEMENT OF FEVER/ MALARIA IN UNDER-FIVE CHILDREN IN DEMBIA DISTRICT, NORTHWEST ETHIOPIA

By:

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Thesis Research Submitted to the Department of Community Health in Partial Fulfillment of the Requirements for the Degree of Masters in Public Health

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ADDIS ABABA
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ACRONYMS

ADA:	Community Drug Vendors
CFR:	Case Fatality Rate
CHA:	Community Health Agent
CHWs:	Community Health Workers
CDVs:	Community Drug Vendors
DHS:	Demographic and Health Survey
FGD:	Focus Group Discussion
IEC:	Information, Education, and Communication
ITN:	Insecticide Treated Net
KABP:	Knowledge, attitude, Belief, and Practice
KI:	Key Informant interview
MOH:	Ministry of Health
ORS:	Oral Re-hydration Solution
PA:	Peasant Association
PPAM:	Pre-packed Anti-malarial drugs
PPS:	Probability Proportional to Size
RBM:	Role Back Malaria
SSA:	Sub-Saharan Africa
WHO:	World Health Organization

Abstract

Background: Malaria kills more than 1 million people every year in the world, 90% of them in Sub-Saharan Africa; the majority of them are children under five years old. Early diagnosis and prompt access to treatment is the main strategy to reduce morbidity and mortality due to malaria. In Africa, evidences indicate that 70% of malaria cases in rural areas and about 50% of the cases in urban areas treat malaria first at home. Though prompt access to treatment within 24 hrs of onset of fever is appropriate, studies indicate that there is a poor, inadequate and inappropriate practice of treating fever/malaria in many developing countries.

Objective: The purpose of this study was to assess knowledge, attitudes, practices, and beliefs (KAPB) about a home management of malaria in under five children**.**

Methods: A cross-sectional study using qualitative and quantitative data collection methods were conducted in rural area of Dembia District, North Gondar, Amhara, Northwest Ethiopia. Multistage sampling technique was used to select randomly 517 households/ mothers (caregivers) of under-five children from 4 randomly selected Peasant Associations. Data were collected from 515 subjects using structured questionnaire. Focus Group Discussions and Key informants' interviews were conducted. The data were analyzed using EPI INFO version 6.04 and SPSS version 11 statistical packages.

Results: The study subjects had a better knowledge about symptoms of mild malaria, such as fever (99.4%), head ache (97.6%), chills and shivering (99.6%), poor appetite (95.1%), vomiting (98.2%) and joint and body pain (94.9%), but could association of the mosquitoes with malaria to lesser extent (69.9%), while majority of them attributed its cause to cold or changed weather (83.7%) and to stagnant water (77.1%). Most respondents believed malaria is preventable (85.8%). They practiced preventive methods such as Environmental management (74.4%), DDT spray of households (53.8%), and bed net use (3.4%) to prevent malaria. Home_Management of malaria/fever is practiced in the area in a high proportion of the under 5 children (45.2%) with modern anti-malarial drugs.

Reasons mentioned for delayed health care seeking of caregivers for fever or malaria were hoping the child will be well or taken to traditional healer (50.8%), far distance (27%), and shortage of money (7.7%).

Conclusion: The knowledge of caregivers about symptom of malaria and their practice to prevent the disease was very high. However, they could associate mosquitoes with malaria to a lesser extent, and most of them had also misconceptions about its causation. Home treatment of fever/ malaria was found to share a major part in the health service provision in under-five children in the area.

Recommendations: Thus, design of effective malaria communication strategy; training and motivation of community health agents and mothers to treat cases promptly and properly; and strengthening the link between private-public health sector partnerships with the community were recommended.

1. BACKGROUND

Malaria kills a child every 30 seconds anywhere in the world [1]. Over one million deaths occurring every year in the world, 90% of these deaths occur in Sub-Saharan Africa (SSA), majority of them are under-five children who live in areas of intense *Plasmodium falciparum* transmission. In Ethiopia [2], 11% of the outpatient visits, 18% of the admissions, 21% of the deaths occurred on infants by malaria (all types).

A national baseline survey [3] in selected health facilities documented that the proportion of deaths attributed to malaria among under five as 28.1%, case fatality rate of 5.2%, proportion of morbidity attributed to malaria in under 5 as 39.8%. The proportion of under five with fever/malaria receiving correct treatment within 24 hrs of onset of fever in communities surveyed in 2001 was 30.4% and that of children under 5 sleeping under mosquito nets was 28.9%, though that of sleeping under insecticide-treated bed nets (ITNs) not known.

As part of WHO's Roll Back Malaria (RBM) strategies [4], early diagnosis and prompt treatment is the main strategy set by Federal MOH, Malaria Control Program to reduce mortality and morbidity; especially among the most vulnerable groups - young children and pregnant women. It has been recognized that, in endemic countries, most malaria episodes are treated outside public health facilities, mainly at home [5]; health facility-based treatment does not reach the majority of the population. As a result, the provision of improved home-based treatment of uncomplicated malaria has become a key strategy for meeting RBM country targets. At RBM Summit in Abuja in April 2000,

Heads of most African countries made a commitment to ensure that, by the year 2005, 60% of malaria episodes are adequately treated with in 24 hrs onsets of symptoms [6, 7].

Although management of severe cases using the WHO Guideline [8] for management of severe and complicated malaria at referral heath care facilities can prevent mortality due to malaria, the outcome largely depends on the management of cases before admission.

Fever is a major manifestation of malaria and other infections in children. Malaria and fever contribute to high levels of malnutrition and mortality in children. Hence, presumptive treatment of fever with anti-malarial medication is advocated in many developing countries where malaria is endemic. In Africa, more than 70% of malaria episodes in rural areas and more than 50% in urban areas are self-treated [9, 10].

According to DHS-Ethiopia 2000 [11], the prevalence of fever (2 wks before the survey) among children varies with age. Those aged 6-11mth and 12-23mth are (40% and 35% respectively) more commonly sick with fever than other children. Very few of them are taken to a health facility or provider for treatment. Among those who had fever, 78% of them received no treatment. Overall, aspirin (8%) followed by antibiotics (6%) are mostly used medicines for treatment of fever; very few children with fever are treated with anti-malarial drugs (Fansidar, Chloroquine or Quinine).

2. LITERATURE REVIEW

In the absence of laboratory confirmation, the diagnosis of malaria is problematic. It has been difficult to develop clinical definition of malaria due to the wide variety of symptoms that may occur [12]. In Zimbabwe, no set of symptoms were better in predicting a positive blood slide than the unspecified criteria used by village health workers. In Liberia, a correlation between traditional perceptions of signs and symptoms and parasitological results was reported. However, in Sri Lanka, less than half of malaria patients in hospitals thought they had malaria.

In South Africa [13] 72% (n=299) of the interviewed female household heads reported that they knew what malaria disease was and of these, 92.1% mentioned mosquito bites as the cause of malaria. Their understanding of the causal role of mosquitoes in malaria was significantly related to their knowledge about disease symptoms. A survey in rural Zimbabwe of household heads [14] revealed that taking preventive measures was significantly related to knowledge of the causes of malaria

In Delhi, India [15] a survey undertaken to assess the awareness and practice of a population about malaria among patients attending malaria clinic reported that about 57% of the respondents were aware of the cause of malaria as parasite or mosquito and awareness increased with the literacy status (49.4% in illiterate to 85.4% in high

school and above literate), and more than half of the respondents attributed high fever with chills and rigor as the most important symptom of malaria, but some of the respondents also mentioned only high fever (18.9%) or high fever with diarrhea (21.2%) as main symptom of malaria.

In Ethiopia, knowledge of symptoms and causes of malaria also vary as else where from locality to locality. A community based cross-sectional survey conducted at Kishe settlement area, South western Ethiopia reported that 83% of the randomly selected study subjects (n=254) attributed the cause of malaria infection to dirt and rubbish, with 77% prioritizing cleaning dirt and rubbish, while 36% mentioned drainage of swampy areas [(10)]. The commonest reported symptoms of malaria were headache (86%), fever (85%), chills (74%), rigors (58%) and vomiting (48%).

The study showed among those who had history of malaria attack, the majority of the respondents (both indigenous and settlers) sought treatment for their illness. Treatment sites included health institutions (74%), community health workers (29%), malaria control laboratories (18%), local shops (6%), traditional healers (3%), and others (0.5%). Among the study subjects in Kishe, 43% had used traditional medicine for treatment of malaria; 34% of them reported relief for their illness. Reasons mentioned for using it were accessibility to traditional medicine, low cost of traditional medicine, lack of awareness about modern medicine, and belief that traditional medicine is better [(10)].

Another study conducted in Southern Ethiopia, Butajira District [5] reported that fever, headache, and chills and shivering were the most frequently mentioned symptoms of malaria by 89.7%, 87.5%, and 81.3% of the study subjects, respectively. And, about 66% of the study community related the mode of transmission to the bite of mosquitoes. Malaria is thought to be preventable by 85.7% of the respondents. Even though about 32% of the respondents believed that leaves to be used for the treatment of malaria, only 1.3% of the respondents reported that they used only traditional medicine for recent illness. But the majority of the respondents (91.9%) used only modern anti-malarial drugs, and 6.8% respond both modern and traditional medicines. Among those who used modern anti-malarial drugs, 73.5% and 60.6% of the respondents used Chloroquine followed by SP, respectively

A cross-sectional survey conducted in rural communities of Central Ethiopia by Hailu Yeneneh, et al. [16] reported that a total of 85% of the 300women were able to recognize one or more of the common symptoms of the disease; however, the modes of transmission were generally misunderstood and only 23% believed that transmission could be prevented.

In Ghana, among the Dangbe farming community, Agyepong [17] studied "asra", which translates best as fever and is believed to be cause by prolonged contact with heat. A self-diagnosis of "asra" was closely related to malaria. In one village, 71% of those who believed they had "asra" were positive for malaria (some had already taken anti-malarials). However, 47% of those who did not think they had "asra" were also positive.

Traditionally, as reported by community members, the only recognized variant of "asra" in the community is "asraku"- a more severe and complicated form of "asra", though currently an English name was also introduced through health personnel.

A few studies recorded multiple treatments in which individuals reported a combination of resorts including self-treatment, traditional medicines, or more than one clinic or health provider [13]. The proportion of multiple treatment rates of those who have had two or more treatments shows a considerable range (11-90%), but most are above 40%. A few studies reported the proportion with three or more treatments, and in most, this pattern represented less than 10% of the cases.

The majority of people with "asra" in Dangbe community are treated at home [17]. They only go to biomedical health facilities when they do not respond to home therapies or their disease is perceived as being exceptionally severe, or unusual in presentation. Home treatment can involve herbal preparations or biomedicines. However, the more common treatment is to use biomedicines, usually analgesics. Herbal treatments and biomedicines are sometimes combined. Chloroquine is very little used. Even, when it is used the dosage sub-therapeutic.

A prospective hospital based study of severe malaria in Under 5 children [18] revealed that most of the children (80%) presented to the hospital in more than 24 hrs after the onset of the illness. Forty-seven percent of children received drugs at home; almost in all (96%) of the cases it was anti-malarial drugs, which is adequate (dose/duration) in

71% of them. Children receiving appropriate anti-malaria treatment at home show a tendency towards a lower CFR.

A study conducted in rural Burkina Faso [19] to evaluate the impact of the use of pre-packed anti-malarial drugs (PPAM), by mothers in the home, on the progression of disease in children from uncomplicated fever to severe malaria. The results revealed that during the study period, 56% of 3202 fever episodes in children Under 6 years of age were treated promptly by mothers with the pre-packed drugs made available by the study. A total of 59% of the children receiving PPAM were reported to have received the drugs over the prescribed 3-day period, while 52%received the correct age-specific dose. PPAM use was found similar among literate (61%) and non-literate mothers (55%). The over all risk of developing severe malaria was 8%. This risk was lower in children treated with PPAM (5%) than in children not treated with PPAM (11%).

Nshakira, N. et al [20] in Eastern Uganda investigated whether there is appropriate treatment of malaria using anti-malarial drugs for children's fever in district medical units, drug shops and homes. The results of the study indicated that before attending the study sites (on which data was collected prior to attending the health facilities), 72%of the children had already been given some biomedical drugs, and 40% had received the recommended drug, Chloroquine. Only 28% of the children had received Chloroquine at the optimal dose of 20-30 mg/kg recommended by national policy.

An intervention study conducted in Cape Coast, Ghana to assess the impact of introducing pre-packed tablets for children on adherence to treatment and to compare the total cost of the tablets with that of syrup [21]. The study results showed that of the 155 caretakers given pre-packed tablets, 91% (n=141) adhered to the recommended dosage, while only 42% (n=61) of 144 who were provided syrup did. Only 20% of caregivers who received syrup used an accurate 5ml measure. The cost of treatment with tablets was about one-quarter that of syrup and 62% (n=96) of caregivers preferred tablets, indicating pre-packed tablets are a viable alternative to syrup.

In a rural coastal area of Kenya, Marsh, V.M. et al [22] conducted a formative research by training of shopkeepers thereby measured the likely impact of it on community drug use. According to the results, the percentage of drug sales for children with fever, which included an anti-malarial drug and the percentage of anti-malarial drug sales where an adequate amount of drug was purchased rose by more than a fold. The proportion of childhood fevers where an adequate dose of Chloroquine was given to the child increased the appropriate use of over-the-counter Chloroquine by at least 62%. The study findings dictate that the shopkeepers, if trained in areas where there is a considerable use of drug shops, can be key stakeholders in treating fever in rural areas.

3. RATIONALE OF THE STUDY

WHO through its RBM strategy, based on evidences found globally, identified home management of fever/ malaria as a main stay to combat malaria, especially in remote rural areas of the third world countries, where access to health service is limited; and hence, is focusing towards implementation to scale up home management [6]. African countries, including Ethiopia, also declared in Abuja, 2000 to implement and scale up home treatment of fever/ malaria to promptly access anti-malaria treatments and use of mosquito nets to about 60% coverage; especially among vulnerable groups- under-five children and pregnant women.

In Ethiopia, a community based malaria control program has been initiated in some parts of the country, since 1992 in Tigray [23]. A randomized community trial of teaching mothers to provide home treatment of malaria to ensure prompt access conducted in Tigray documented that under-five mortality of 29.8 per 1000 in intervention localities compared to 50.2 per 1000 in the control localities: a reduction in Under 5 mortality by 40% in the intervention localities [23].

In the review of literature, so far, there are some studies [5, 16, 24] conducted to assess KAP of caregivers at home in Ethiopia, but data on home management of fever/ malaria using both quantitative and qualitative methodology especially, in under-five children is scarce.

Hence, the knowledge and attitude of the caregivers at home as well as that of local health care providers is of paramount importance. This study envisages that it may strengthen the information so far for scaling up and to design effective communication strategy to combat malaria.

4. OBJECTIVES

4.1 General Objective

To assess knowledge, attitudes, practices, and beliefs about malaria home management in under five children

4.2 Specific Objectives

1. To examine myths and misconceptions about management of malaria in children under five
2. To describe knowledge, attitudes, beliefs, and practices (KABP) about home management of malaria in under-five children and its Prevention strategies
3. To assess factors affecting parents in seeking treatment of malaria for children under five

5. METHODOLOGY

5.1 Study Area

The study was conducted in Dembia District, North Gondar Administrative Zone, Amhara Regional State. North Gondar is situated on an area of 53176 Km^2, divided into 18 districts and 546 Kebeles. It has a population of more than 2.8 million. Seventy five percent of the area is exposed to malaria; 346 Kebeles are malarious; population at risk is 64%. The health service geographical coverage is around 35%; malaria was among the top diseases in the outpatient departments of the health institutions in the Zone in 2001-2002 [25]. The Dembia plain is known for its endemic malaria since 1550s.

The district had one training health center, one training clinic, 5 other clinics and 2 health posts functional during the study period and 8 newly constructed health posts. Malaria diagnostic laboratories were found only at the health center and a clinic. There were also 4 private rural drug vendors, one drug shop, and 6 private clinics in the district. There were trained Community Health Workers in the district serving the community. Most of the PAs have access road for transportation.

5.2 Study Design

The study design was a cross-sectional study with qualitative supplemented with quantitative methodological approaches.

5.3 Study Population

The study subjects included all under-five children in malarious Peasant Associations (PAs) of the district.

Inclusion Criteria: The study subjects must be permanent dwellers of the study area for at least one year

5.4 Sample Size Determination

5.4.1 Quantitative: To assess the knowledge, attitude and practice of the mothers/Caregivers about malaria and its prevention and control strategies, the sample size was determined using a single population proportion formula:

$$n = \frac{[(Z\alpha/2)^2 P(1-P)] D}{d^2}$$

Where, n = the number of households to be interviewed; i.e. sample size of the study

Z = standardized normal distribution curve value for the 95% Confidence Interval, which is 1.96

P = proportion of the community with knowledge about malaria and its prevention was taken as 80%, taken from previous studies (Ethiopia)

d = the margin of error was taken as 5%

D= design effect of 2 was taken

In addition, 5% contingency was considered for households who may refuse to participate, missed, change their residence, making the required sample size of 517 households.

5.4.2 Qualitative

a) Focus Group Discussions (FGDs): five FGDs were conducted in the study, 3 FGD groups for mothers and 2 FGD groups for fathers of under-five children. Six individuals were participated in each focus group discussion.

b) Key Informant (KI) interviewing: Key informants were interviewed as much as redundant information. The 'types' of key informants were:

1. Health workers from the formal sector that primarily treat childhood illnesses
2. Community Drug Vendors (CDVs) who work in drug stores, clinics or as shopkeepers
3. Traditional Herbalists/healers who are recognized and respected by the community, and
4. Community health agents (CHAs) (emerging design at field level)

5.5 Sampling procedures

Multistage sampling technique was used to select the study subjects. Dembia district has 44 kebeles; 4 urban kebeles and 40 rural PAs, of which almost all of them are malarious. The 40 PAs were divided into 12 highly malarious and 28 less malarious PAs based on the assurance of the district health office, depending on the number of reported cases and frequency of occurance of epidemic. Then, out of the 12 highly malarious PAs, 4 PAs having a total of 10 villages were selected randomly. Applying systematic random sampling of the households in all villages in the selected PAs, 517 households with Under 5 child/children were surveyed on the ground of probability proportional to size (PPS). An interval of 7 in each village was used and lottery method applied to select the first household in the first interval at the beginning of the village. A primary caregiver was selected for interview. Homogenous sampling strategy technique was used for FGDs. Criterion sampling strategy (picking all types that meet criterion of interest) was used for KIs.

5.5.1 Data Collection Procedures

Data were collected using structured questionnaire, semi-structured focus group discussion and key informant interviews.

5.5.1.1 Questionnaire Development

The structured questionnaire was developed specifically for this study purpose in English version. It was translated later into the local language of the study area, Amharic. Another translator who has knowledge of both languages again translated the Amharic version back into English version. Comparisons were made on the consistency of the two versions. The questionnaire was further modified after a pretest. Guiding questions for FGD and Key informant interview were adapted from a study conducted in Uganda [26].

5.5.1.2 Pretesting

A pretest was conducted in a rural village of the district not adjacent to the selected study PAs called Darna PA. Five percent of the total sample size was taken for pretest. The trained data collectors administered the pretest. Ambiguous questions and repetitive ideas were corrected. Additional response categories were also added based on the pretest findings.

5.6 Data Collection

5.6.1 Quantitative

Twelve data collectors, who completed high school, were recruited from Gorgora town and were trained by the principal investigator for two days on how to administer the questionnaire and the operational meaning of the questions in the questionnaire. Nine data collectors who showed better performance were selected out of those trained.

There were 2 supervisors to supervise the data collection. The supervisors closely followed the data collectors with a data check of 1 in 25 households. The principal investigator supervised the overall activities. Incomplete questionnaires were filled by callbacks while on the fieldwork. The data collection took ten days.

5.6.2 Qualitative

5.6.2.1 Focus Group Discussions

Focus group discussions were taken place by the principal investigator and an oriented notetaker; using tape recording and note taking techniques.

5.6.2.2 Key Informants Interviews

Key informant interviews were conducted using semi-structured interviews guides, by the principal investigator. This is a written list of questions or topics that need to be covered during the interview. The interview guide contains clear instructions concerning the main questions to be asked or topics to be probed, though the interviews do not followed it exactly.

5.7 Quality Control

The validity and reliability of the study methods and conclusions will be assured using a blend of qualitative and quantitative methods. Selectivity bias was avoided using appropriate sampling procedure. During data collection, the instrument was pre-tested, data collectors were trained and supervised, and consistency of the data was checked every day, incomplete question were filled by callbacks and interviewer-bias was minimized by using non-health professionals. Wiping data collection in a village at a

time minimized contamination of data. Representative ness of the qualitative data was ensured using homogenous groups. At the analysis of the collected data, using stratification and matching of confounding variables controlled the effect of confounding.

5.8 Operational Definitions

Home management of fever/malaria means diagnosis and treatment occurring outside the clinical setting in or near the home/village.

Home treatment means treatment given at home before or instead of going to a health facility.

Prompt access means having treatment available as near the home as possible either in the community or in the home itself within 1 or 2 days.

Primary caregiver means mothers, fathers, or other relatives of the under-five children who primarily take care of the child.

5.9 Variables of the Study

Variables include dependent and independent variables:

Dependent Variables

- Prompt access (within 48 hrs)
- Knowledge and attitude variables: sign and symptoms, causes, modes of transmission, usual biting time, common breading sites, common resting sites,
- Practice variables: sources of treatment, use of Impregnated bed nets

Independent Variables

- Socio-economic and demographic variables: age of primary caregiver, age of child, occupation of caregiver and spouse, Education of caregiver and spouse, distance from the nearby health facility, family size, and number of under five children

5.10 Data Analysis procedures

5.10.1 Quantitative

The data were entered into EPI Info version 6.04 and exported to SPSS statistical package. Descriptive statistics such as frequencies were calculated for dependent and independent variables; bivariate analyses were done to see the association between dependent and independent variables and multivariate analyses with stepwise Back Ward Likelihood Ratio (LR) method for significant bivariates. A confidence interval of 95% was calculated for the proportions.

5.10.2 Qualitative

The qualitative data were analyzed manually. Principal investigator analyzed FGDs and Key Informant interviews Data. Summaries were written first for each group discussion. Next, summaries were written for each 'type' of group. Finally, results from different groups were compared.

5.11 Ethical Consideration

This study was undertaken after the ethical committee of the Department of Community Health, Medical Faculty of Addis Ababa University. Before conducting the survey, a written consent, through a letter that was written from the Department of Community Health, was achieved from Amhara Regional Health Bureau, North Gondar Zone Health Desk and Dembia District Health Office, and discussion was held with the respective

health management team to brief the purpose of the study. Moreover, the local community leaders in the selected PA were informed about the aim of the study.

Each study subject was invited into the study after the purpose of the study was explained and an informed consent was achieved. The information that was gathered from study subjects is confidential and will not be used individually and other than this study. Those subjects who found febrile cases during the study time were treated empirically on site and those severely ill were referred to the nearest health facility by the supervisors (health professionals).

The health facilities were informed for early preparation prior to the commencement of data collection and free treatment of those cases was arranged in collaboration with the district health office and their families were also provided with the proper health education.

The results of the study will be disseminated in the form of presentation, hard copies of the report, and in the form of publication to the general public. The results will be presented to the community of Medical Faculty of A.A.U, and elsewhere where it is needed and feasible. The hard copies of the report will be documented in the Graduate Studies Office, Community Health Department of Medical Faculty of AAU, and Library of the department and that of Debub University, Health Sciences College. Results of the study will also be disseminated to the Zonal Health Desk and District Health Office of the study area. Study reports will also be available to the general public and the

scientific community through publication on any of the relevant scientific journals. In general, it will be made available to any Governmental or Non-Governmental organization, which is in need of the results for the benefit of public health.

6. RESULTS

6.1 Quantitative Survey

6.1.1 Socio-demographic characteristics

Out of the required sample size of 517 primary caregivers of under 5 children, 515 (99.6%) were completed the interview, but one respondent disagreed to participate and another one discontinued the interview. Of the total study participants, 441 (85.6%) were females and the rest were males. Most of the primary caregivers (93.4%) were mothers of Under 5 children and the rest being male and other female caregivers. The mean (SD) age of the respondents was 29.91 (8.45) years with a median age of 30 years. Majority of the respondents (84.9%) were housewives and most of their spouses (91.7%) were farmers.

Almost all (99.4%) respondents were from Amhara ethnic group, and followers of Orthodox Christian religion (99.6%). Marital status of the respondents showed that the majority (87.2%) were married; 33(6.4%) divorced; 22 (4.3%) widowed; 8 (1.6%) separated, and 3 (0.6%) single (Table 1).

The literacy statuses of the primary caregivers showed that 441 (85.6%) were illiterate (unable to read and write); and 46 (8.9%) were able only read and write. Only few of the respondents (5.4%) completed elementary and high school levels of formal education. Of the 441 female and 74 male primary caregivers, 39 (8.8%) and 7 (9.5%) of them are able only read and writes, 25 (5.7%) and 3 (4.1%) have got formal education of elementary and high school levels respectively. Out of the 457 spouses of the primary caregivers, 291 (63.7%) of them are illiterates; 120 (26.3%) able only read and writes; while only 10% of them have completed elementary and high school of formal education (Table 1). The mean (SD) family size was 5.56 (2.08). The mean (SD) number of under-five children in the household was 1.30(0.50).

Table 1.Socio-demographic Characteristics of study subjects, Dembia Woreda, Northwest Ethiopia (n=515)

Variables	Frequency	Percent
Sex of primary Caregiver		
Male	74	14.4
Female	441	85.6
Age of primary Caregiver		
15-24	123	38.9
25-34	249	48.3
35-44	119	23.1
45-54	17	3.4
55+	7	1.4
Role of primary Caregiver		
Mother	481	93.4
Non-mother female	11	2.1
Male Caregiver	23	4.5
Religion of primary Caregiver		
Orthodox Christian	513	99.6
Muslim	2	0.4
Ethnicity of primary Caregiver		
Amhara	512	99.4
Tigrie	3	0.6
Marital Status		
Single	3	0.6
Married	449	87.2

Divorced	33	6.4
Widowed	22	4.3
Separated	8	1.6
Occupation		
Primary Caregivers'		
Farmer	67	13
Merchant	4	0.8
Housewife	437	84.9
Others	7	1.4
Spouses'		
Farmer	419	91.7
Merchant	5	1.1
Housewife	18	3.9
Others	15	3.3

(Table 1- Continued)

Level of Education		
Primary Caregivers'		
Unable to read and write	441	85.6
Able to read and write only	46	8.9
1-4 (1st Cycle)	10	1.9
5-8 (2nd Cycle)	15	2.9
9-10/9-12 (high school)	3	0.6
Spouses'		
Unable to read and write	291	63.7
Able to read and write only	120	26.3
1-4 (1st Cycle)	23	5
5-8 (2nd Cycle)	12	2.6
9-10/9-12 (high school)	11	2.4

Malaria is the most common perceived disease of under-five children reported by the majority of the caregivers (93%), followed by diarrhea 16 (3.1%), common cold 8 (1.6%), and others 12 (2.4%). More than half of the households had access to health facility located within a walking distance of an hour, but 175 (34%) had access to it

within two hours walking distance, and the rest (9.9%) were more than two hours walking distance from health care facility.

6.1.2 Perception and Knowledge of Caregivers about Malaria

Almost all (98.4%) of the respondents replied 'yes' for the question forwarded 'Do you know what malaria is?' Of the 507 respondents who reported the knowledge of malaria, most recognized fever (99.4%), headache (97.6%), chills and shivering (99.6%), poor appetite (95.1%), joint and body pain (94.9%), and vomiting (98.2%) in a very high proportion as symptoms of mild malaria (Table2). Similarly, fever (99%), headache (97.2%), chills and shivering (98.4%), poor appetite (96.3%), joint and body pain (97.2%), and vomiting (97%) were also recognized by almost all of the respondents as symptoms of severe malaria. And, other symptoms like diarrhea, difficult breathing, cough and convulsion (loss of consciousness) were recognized as symptoms of severe malaria in a higher proportion than that of mild malaria ranging from 84.8% to 54.4% in that order (Table2).

Table2. Knowledge of Symptoms of mild and severe Malaria in under 5 children, Dembia Woreda, Dec 2004

Symptoms of malaria	**Mild malaria**		**Severe malaria**	
	freq	**(%)**	**freq**	**(%)**
Fever	504	(99.4)	502	(99.0)
Headache	495	(97.6)	493	(97.2)
Chills and shivering	505	(99.6)	499	(98.4)
Poor appetite	482	(95.1)	488	(96.3)
Joint and body pain	481	(94.9)	493	(97.2)
Vomiting	498	(98.2)	492	(97.0)
Diarrhea	309	(60.9)	389	(76.7)
Difficult breathing	395	(77.9)	430	(84.8)
Cough	373	(73.6)	405	(79.)

Convulsion	70	(13.8)	276	(54.4)
Others	9	(1.8)	399	(0.6)

From 515 respondents, 360 (69.9%) recognized mosquitoes' bite as a factor in the causation of malaria, and the majority (94.6%) didn't perceive evil spirit as a cause of the disease, while higher proportion of them misunderstanding that cold/ wet weather or change of it(83.7%) and stagnant water (77.1%) as a cause of malaria. Of the total respondents, only 297 (57.7%) knew that malaria could be transmitted from person to person. Of whom 297, only one fifth had the right knowledge about the mode of malaria transmission. A considerable number (64%) attributed the mode of transmission to close contact or sleeping with people got sick from malaria (Table3).

Table3. Knowledge about mosquito bite as a factor in malaria causation and preventability and mode of transmission of malaria, Dembia Woreda, Dec 2004

Causes of malaria (n=515)*			**Is Malaria preventable? (n=515)**	
	Yes(%)	No(%)		Freq (%)
Mosquitoes bite	360(69.9)	155(30.1)	Yes	442 (85.8)
Cold/wet/changed weather	431(83.7)	84(16.3)	No	66 (12.8)
Stagnant water	397(77.1)	118(22.9)	Don't know	7 (1.4)
Dirty personal and sanitary wastes	194(37.7)	321(62.3)		
Contaminated food and drinking water	202(39.2)	313(60.8)		
Evil spirit	28(5.4)	487(94.6)		
Others	9(1.7)			
Don't know	54(10.5)			

Two-third of the respondents (342) knew common breeding sites of mosquitoes, while 47 (9.1%) attributed it to running water, and 91 (17.7%) reported that they didn't know the mosquito breeding sites. Many respondents (70.9%) reported that the usual biting time of mosquitoes was at night, in the evening; 56 (10.9%) at night, after mid-night; 34 (6.6%) during the daytime; and the rest 92 (17.9%) reported 'didn't know'. Nearly half of

the respondents reported that the common resting places of mosquitoes was dirty areas, but only 112 (21.7%) knew that mosquitoes rest at dark places inside houses; whereas 92 (17.9%) replied 'didn't know' (Table4).

Table4. Knowledge about mode of transmission of malaria, Usual biting time, Common breeding sites, and Common resting places of mosquitoes, Dembia Woreda, Dec 2004

Mode of Transmission (n=257)*	Freq	(%)	**Usual Biting Time (n=515)**	Freq	(%)
Bite of infected mosquitoes	63	(21.2)	Day	34	(6.6)
Close contact/ sleeping	190	(64.0)	Night,in the evening	365	(70.9)
Unsafe drinking water	15	(5.1)	Night, after mid-night	56	(10.9)
Eating contaminated food	4	(1.3)	Any time	19	(3.7)
Through breathe	8	(3.1)	Don't know	41	(8.0)
Bad odor	5	(1.7)			
Others	10	(3.9)			

(Continued table4)

Common Breeding sites (n=515)	Freq	(%)	**Common Resting places (n=515)**	Freq	(%)
Stagnant water	342	(66.4)	Dark places inside house	112	(21.7)
Running water	47	(9.1)	At edge of streams	60	(11.7)
Animal wastes	21	(4.1)	Dirty areas	237	(46.0)
Others	14	(2.7)	Others	14	(2.7)
Don't know	91	(17.7)	Don't know	92	(17.9)

*percent will not add up to 100, due to multiple responses

Most of the respondents (316, 61.4%) believed that malaria affects (suffers) more under-five children; followed by pregnant women (79, 15.3%) and adult males (40, 7.8%). Priority to treatment of malaria should be sought first for under-five children (346, 67.2%), followed by pregnant women (110, 21.4%), as reported by the caregivers.

Regarding the transmission seasons of malaria, Majority of the respondents reported months from September (333, 64.7%), October (461, 89.5%), November (355, 68.9%),

and December (136, 26.4%) as the peak transmission seasons of the year; while February- April were months reported least by only 3, 8, and 9 respondents in that order.

6.1.3 Knowledge and Practice about Malaria Prevention and Treatment

Majority of the respondents (85.8%) believed/ perceived that malaria is preventable. Most of the study subjects had a good knowledge about preventive methods of malaria such as household DDT sprays (413, 93.4%), source reduction/ elimination of breeding sites (370, 83.7%); followed by chemo prophylaxis (63.1%); personal protection (54.1%); and bed net use (46.4%) (Table5).

Three hundred twenty nine (74.4%) of the respondents reported the practice of environmental management of the vector breeding sites; followed by households' DDT spray (53.8%); and the least being bed net use practiced only in 15 (3.4%) of the households.

Table5. Knowledge and practice of Caregivers about preventive methods of malaria, Dembia Woreda, Dec 2004

ntive methods (n=442)	Knowledge		Practice	
	Yes(%)	No(%)	Yes(%)	No(%)
Chemoprophylaxis	279(63.1)	163(36.9)	205(46.4)	237(53.6)
DDT spray	413(93.4)	29(6.6)	238(53.8)	204(46.2)
Source reduction/ elimination of breeding sites	370(83.7)	72(16.3)	329(74.4)	113(25.6)
Personal protection	239(54.1)	203(45.9)	198(44.8)	244(55.2)
Bed net use	205(46.4)	237(53.6)	15(3.4)	427(96.6)
Others	4(0.9)		2(0.5)	

Respondents were asked whether they know traditional remedies and modern drugs. Hence, 198 (38.4%) reported the knowledge of holy water, but only very few respondents (3.3%) knew leaves, roots, and herbs as traditional remedies for malaria. More than half of them (56.1%) do not knew any of the traditional remedies for malaria.

Almost all (98.8%) of the respondents knew Fansidar / Selphadoxine Pyremethamine (SP) as modern anti-malarial drug. Chloroquine was also known by most of the respondents (94.2%) identified as "white" and "bitter", which is followed by Quinine (74.2%). Premaquine was found to be the least (3.7%) known anti-malarial drug.

Fansidar/SP was the most effective anti-malarial drug by two-third of the respondents (336), followed by quinine 129 (25%), and Chloroquine 42 (8.2%); whereas Premaquine was the least (0.2%) 7 (1.4%) respondents replied ‘don’t know’. Majority of the respondents (88%) said 'yes' for the question asked whether Fansidar is currently an effective drug.

Anti-malarial drug administration preference of the primary caregivers for under-fives was assessed. Injection was found to be the most preferred way of administering by 356 (69.1%) of the respondents; 105 (20.4%) preferred oral medication, and the rest (10.5%) of them had no preference. Among those who preferred injection, 197 (55.3%) said that it is working faster, and 132 (37.1%) said that it is stronger than any other

medication. Other reasons (7.6%) included children refuse to take tablets, tablets vomits out, they hate the bitterness of tablets hence spit it out, etc.

Table6. Knowledge of Caregivers about Anti-malarial treatments, Dembia Woreda, Ethiopia, Dec 2004

Characterstics			**Characterstics**		
Traditional remedies (n=515)	**Knowledge**		**Modern medicine (n=515)**	**Knowledge**	
	Yes(%)	No(%)		Yes(%)	No(%)
Leaves	5(1.0)	510(99.0)	Chloroquine	485(94.2)	30(5.8)
Roots	2(0.4)	513(99.6)	SP/Fansidar	509(98.8)	6(1.2)
Herbs	10(1.9)	505(98.1)	Primaquine	19(3.7)	496(96.3)
Holy water	198(38.4)	317(61.6)	Quinin	382(74.2)	133(25.8)
Others	1(0.2)		Others	16(3.1)	
Don't know	289(56.1)				

Of all the respondents, 233 (45.2%) of them have heard of mosquito nets. Among those heard of mosquito nets, 78 (33.5%) of them have got the information from radio, followed by 61 (26.2%)from health professionals, 27 (11.7%) from town people and 23 (9.9%) from Community Health Agents, 13 (5.6%) from relatives, and 12 (5.2%) of them from neighbors. Other sources of information include television, school, teachers, peasant association leaders, etc.

Respondents were asked whether what the purpose of mosquito net is. Majority of them (177/233) reported that prevent mosquito bite/ nuisance, and only 51 (21.9%) answered to prevent malaria. Few of them responded to prevent coldness, spider/snake bite, etc.

Ownership of bed nets was found minimal (16/233). There were a total of 18 bed nets; only two of them had double bed nets. Nine owners reported that it was chemical

insecticide impregnated bed net. The night before the survey day, 9/16 said 'mother and father' slept under the bed net, 5/16 said 'mother and child' used it, a Caregiver said 'used by all family members' and another one said that it was not used that day. When asked whether the under-five children were slept under it the night before the survey, 14/16 said 'yes' and the rest 'no'.

Scores were computed for knowledge and practice of preventive methods and knowledge of mosquitoes as a factor in the causation of malaria each, providing values of one for those who reported "yes" and zero for those said "no" and then categorize the summation into higher for those who scored the median value and above and lower for those with scores less than the median value.

Association of knowledge score of preventive methods with selected socio-demographic variables (sex of primary Caregiver, family size, and literacy status of Caregivers and Spouses) showed a significant relation. While other variables like occupation, literacy level of caregivers and spouses, marital status, and walking distance from health care facility (in minutes) had no significant associations (Table7).

The finding revealed that male caregivers were more knowledgeable about preventive methods than females (OR=2.77, 95% CI (1.06, 7.22)). Those caregivers with small family size (up to 4) were more knowledgeable than those with larger family size (>4). Literate caregivers were about twice more knowledgeable than those who were not literate (unable to read and write) (Table7).

Table 7. Knowledge score of preventive methods of malaria with socio-demographic and other independent variables, Dembia Woreda, Ethiopia, Dec 2004

Socio-demographic Characterstics		Knowledge of preventive methods		OR (95% CI)	
		Higher (4-5)	Lower (0-3)	Crude	Adjusted
Sex of primary Caregiver	Male	16	6	2.77 (1.06, 7.22)	3.06 (1.13, 8.22) **
	Female	206	214	1.00*	
Family size	Large (>4)	133	156	0.61 (0.41, 0.91)	0.61 (0.40, 0.95) **
	Small(upto4)	89	64	1.00*	
Literacy status Primary Caregiver	Illiterate	178	196	0.495 (0.29, 0.85)	0.78(0.43, 1.41)
	Literate	44	24	1.00*	
Literacy status Spouse	Illiterate	112	140	0.54 (0.36, 0.81)	0.53(0.34, 0.82) **
	Literate	88	59	1.00*	

*The second category are the reference category (non-exposed) **statistically significant (p<0.05)

The data revealed that there is a significant association between practice of preventive methods with selected socio-demographic and other variables such as family size, literacy status of both primary caregivers and spouses, occupation of primary caregivers', and knowledge score of preventive methods. While variables like sex of primary Caregivers, literacy level (read and write versus 1st cycle or high school) for both primary Caregivers and spouses, marital status, spouses' occupation, and walking distance from health facility (in minutes) were not found statistically significant (Table8).

Primary caregivers who had small family size (up to 4) practiced preventive methods more than those with large family size (>4) (OR=1.75 95% CI (1.17, 2.58)). Literates practiced preventive methods more than those who were able to read and write in both caregivers and spouses. Those who completed grades 5-8 practiced preventive methods 5 times and more than those who were able only read and write. Likewise,

respondents who were housewives by occupation were about 3 times practiced more than other occupations. Caregivers with higher knowledge of preventive methods practiced preventive methods 13 times more than those with lesser knowledge about it (Table8).

Causation of malaria, mosquito as a factor was not significantly association with socio-demographic factors such as literacy and occupation of caregivers and spouses, sex of primary caregiver, and family size.

Multivariate analysis of practice and knowledge score of preventive methods showed that only knowledge score of preventive methods and spouses' level of education (5-8 grade) were significant predictors of practice of preventive methods; where as sex of caregivers, family size, and literacy status of spouse were significant predictors of knowledge of preventive methods (Tables 7 and 8).

Table8. Practice score of preventive methods of malaria with socio-demographic and other independent variables, Dembia Woreda, Ethiopia, Dec 2004

Socio-demographic Characterstics		**Practice Score of preventive methods**		**OR (95% CI)**	
		Higher (3-5)	Lower (0-2)	**Crude**	**Adjusted**
Sex	Male	13	9	1.75 (0.73, 4.18)	
	Female	190	230	1.00*	
Family size	small (up to 4)	84	69	1.74(1.17,2.58)**	0.00 (0.00,1.55E+48)
	large (>4)	119	170	1.00*	
Literacy caregiver	Illiterate	162	212	0.50 (0.297, 0.852)**	_***
	Literate	41	27	1.00*	
Spouse	Illiterate	104	148	0.656 (0.436, 0.989)**	_***
	Literate	76	71	1.00*	
Level of Education					
Primary	1st Cycle(1-4)	4	3	1.94 (0.38, 9.97)	

caregivers'	2nd Cycle(5-8)	5	10	5.17 (1.46, 18.28)** 1.18(0.09, 14.85)
	High school	1	2	5.17 (0.43, 62.39)
	Read and write	31	12	1.00*
Spouses'	1st Cycle(1-4)	10	12	1.54 (0.61, 3.88)
	2nd Cycle(5-8)	2	9	5.77(1.19,28.02)** 28.84(1.43,580.28)**
	High school	5	5	1.28 (0.35, 4.7)
	Read and write	59	46	1.00*
Marital status	Married	176	215	0.73 (0.41,1.31)
	else	27	24	1.00*
Occupation Primary caregiver	Housewife	184	183	2.96(1.69,5.18)**0.00(0.00, 6.47E+68)
	else	19	56	1.00*
Spouses'	Farmer	161	202	0.70 (0.43, 1.14)
	else	42	37	1.00*

Table 8...Cont'd

Walking distance (in min.)	0-60	117	128	1.18 (0.81, 1.72)
	>60	86	111	1.00*
Knowledge preventive methods	Higher(4-5)	165	57	13.86(8.74,21.99)
	Lower (0-3)	38	182	11.73(1.04,132.29)** 1.00*
Knowledge of cause of malaria	Higher(4-6)	64	135	0.355 (0.24,0.53)** 5.99(0.41, 88.20)
	Lower (0-3)	139	104	1.00*

*The second/ last category are the reference category (non-exposed) **statistically significant ($p<0.05$)
N.B constant for adjusted regression model is 0.027 (Exp (B)) ***since it's constant for all cases, it is removed from the analysis

6.1.4 Home Management of Fever/Malaria in Under-five Children

Among a total of 667 under five children identified in 515 households, 293 (43.9%) developed a febrile illness within the past two weeks from the date of survey according to the reports of the caregivers. Among children who developed the illness, 104 (35.5%)

completed the history of fever at the time of interview. Majority of the Caregivers (83.7%) attributed the child's health problem to malaria, 9 (8.7%) of them to diarrhea, 3 (2.9%) to respiratory problems, 3 (2.9%) said they don't know the child's health problem. Regarding the number of episodes of fever during the last one year, including the current one, 35.6% of them had fever for less than 3 times. The first person to recognize the child's fever/malaria first was mother (86.5%), followed by father (12.5%).

Modern health service was the most frequently reported (91.3%) source of treatment that caregivers consult first when the child got malaria. Only few (2.9%) consulted traditional healers; and 2.9% of them did nothing. Others reported by Caregivers to be consulted include the mother, the father and Shopkeepers.

Out of the 104 children with completed fever, 47 (45.2%) were treated with modern anti-malarial drugs at home, only few were treated with traditional medicine (7.8%), wetted sponge/ cloth (3.8%) at home, but forty-seven of them did nothing at home for the sick child. Out of the 47 children who have got home treatment with modern anti-malarial drugs, 18 (38.3%) had prompt access within 24hrs, 36 (76.6%) within 48hrs, 42 (91.5%) within 72hrs after fever onset, which extended up to a week time duration.

Chloroquine and Fansidar were the most frequently used anti-malarial drugs at home by 33 (70.2%) of the children, followed by anti-pain for 21 (44.7%) of them, 9 (19.1%) Quinin, and others include primaquin (10.6%) and primaquin (4.3%).

The major source of anti-malarial drugs reported was pharmacy (28/47), followed by rural drug vendor (6/47), and left over drugs at home / from relatives / neighbors (5/47), and Community Health Agents, clinic (3/47), and from shops and retailer (1/47).

Average walking distance (in minutes) to get anti-malarial drugs was within 60 minutes for 19 (40.4%) respondents, while the majority (59.6%) of them had accesses more than 60 minutes, which ranges up to 180 minutes. One-third of them were at a distance of 90 minutes.

Treatment sought first at home and then to modern health facilities by 26 (47.3%) of them, while 24 (43%) of them sought treatment first at health facility and then at home, and 5 (9.1%) of them treated only at home.

Of the thirty-one under-fives who were treated only at home and at home first, 21(67.7%) of them recovered due to home treatment as reported by the Caregiver. Those who were not recovered from their disease sought treatment next to modern health facility (9/10), and to traditional healer (1/10).

Out of the total 104 children, 58 (55.8%) of them sought treatment first at clinic/health post, 21 (20.2%) at health center, 11 (10.6%) at pharmacy, 3 (2.9%) to holy water, 2 (1.9%) from village shops, 2 (1.9%) traditional medicine for their children, while 7 (6.7%) of them gone nowhere. Of the 44 children who sought treatment for a second place, 18 of them gone to pharmacy, 16 to clinic, 8 to holy water, one to health center and another

one to traditional healer. Third place treatment was sought by 12 of the Caregivers, of which 4 gone to holy water, 3 to pharmacy, 4 to clinic and one to traditional healer ('qalicha'). Ninety-five (97.9%) of the under-fives were seen at health facility, of which 76 (79.2%) were seen at public health facility, and 19 (19.8%) at private health care facilities.

Table9. Children (<5yrs) seen for fever/ malaria at health facility with those treated at home with modern anti-malarial drugs, Dembia Woreda, Dec 2004

Seen at health facility	**Anti-malarial drugs given at home** ($p>0.05$, $=0.649$)				
	Yes(%)	No(%)	Total(%)	x^2	P-value
Yes(%)	44(43.6)	53(52.4)	97(96.0) P>0.05		0.43
No(%)	3(3.0)	1(1.0)	4(4.0)		
Total(%)	47(46.6)	54(53.4)	101(100)		

Regarding the promptness of the treatment at health care facility level, 34 (35.1%) of the children have got prompt access to treatment of fever/ malaria within a day (24hrs), 66 (68%) within two days (48hrs), and 86 (88.7%) of them within 3 days (72hrs) after fever onset. The mean (SD) and median time duration spent before treatment were 2.30(1.82) and 2.00 respectively. The time duration ranges up to a couple of weeks (15 days).

Reasons given for treatment delay (more than one day) were ' hoping the child will be well/ taken to traditional healer' by 32 (50.8%) of them, followed by 17 (27%) 'it is far',

and 'shortage of money' by 8 (7.7%) of the Caregivers. Other reasons include that 'the mother was sick', 'can't get companioning person', 'child given leftover drug', 'thought it is uvulitis', and 'child was given boiled milk and butter to subside for fever'.

Among those seen at health facility, 95 (99%) were prescribed drugs. The form of medication prescribed included tablets (48 (50.5%)), syrup (24 (25.3%)), injection (58 (61.1%)) and ORS for a child. None of the sick children were admitted during the past two weeks' period.

Association between under-fives seen at health facility for fever/ malaria and those treated at home with modern anti-malarial drugs did not have a statistical association ($p > 0.05$). But, a significant association ($P<0.001$) was observed between under-fives seen at health care facility and those treated at home with anti-malarial drugs within 48hrs since the onset of fever (OR=79.33, 95% CI (7.16, 878.83)) (Table 9 and 10).

Table10. Cross tabulation of Children (<5yrs) seen for fever/malaria at health facility within 48hrs with those treated at home with modern anti-malarial drugs within 48hrs, Dembia Woreda, Ethiopia, Dec 2004

		Seen at health facility within 48hrs			
		Yes(%)	No(%)	Total(%)	**OR (95% CI)**
Anti-malarial drugs given at home within 48hrs	Yes(%)	34(75.6)	3(6.7)	37(82.3)	79.33(7.16, 878.83)
	No(%)	1(2.2)	7(15.6)	8(17.7)	1.00
	Total(%	35(77.8)	10(22.3)	45(100)	

6.2 Qualitative Results

6.2.1 Key Informants interview

The key informants interview included 3 facility-based health professionals, working in public clinics and health center; 2 community health agents (male and female); and 2 traditional healers working in the woreda. The key informants' experiences range from few years to about 18 years, most of which was in the woreda.

All of the key informants mentioned malaria as one of the three most common health problems of under-five children in the area, and the majority ranked malaria first. Other health problems of under-fives mentioned (by most informants) included pneumonia or respiratory health problems and diarrhea. An old man serving as traditional healer explained his perceived disease of under-fives as,

"It is called 'Tila' (literally meaning shadow in Amharic), and it is caused when a mother with her sick child roams around a pregnant women, the faetus in the womb will be affected"

Diseases believed to cause fever in under-five children other than malaria by most of the informants included measles, tonsillitis ('qimo' in local terms), uvulitis ('ankar' in local terms) and respiratory diseases such as Tuberculosis, pneumonia, and common cold.

Most of the informants perceived that the reasons for delay to promptly access proper treatment were hoping the child will be well within 2 or 3 days after onset of fever, since the parents were poor and lack money (for transportation and treatment expenses), and they don't take it serious because of adaptation with the disease. A community health agent who have been serving the community for a longer time attributed it to the tradition existing so far in the area by saying as,

'They say, 'let us first deal with the traditional medicine', because there is herbal medicine, that is leaf, for problems of 'gerefta' (herpes simplex)" he added, "they don't suspect malaria first, rather it is 'gerefta'. Some of them goes to 'Debtera' (a type of traditional healer) and also to 'Tebel' (holy water)"

A young health professional working in a public health facility emphasized that most of the patients with malaria came late after taking drugs, and they said,

'Why we go there as the drug is available here (around their locality)' indicating the ease of getting anti-malarial drugs in retail shops.

A rural drug vendor keeper underlined the role of illegal 'local' medical practitioners, which he explained that they are 'junior' health professionals from the old army who

used to administer injections illegally in the rural areas contributed to delaying of malaria cases to prompt and proper treatment.

Mothers promptly respond to snake bites of their children, since they believe that it kills immediately, though malaria can kill, they adapt it and they think it may give time. A young health professional tried to put their perception as,

> *"People in the community perceive that those who bleed would die soon. They have got accustomed with malaria, and they don't suspect that malaria may kill"*

Most informants claimed that malaria was rampant in the area during seasons from May to December, in general, and from May to June, and from September to December, in particular. Though few of them told their observation that malaria was rampant during summer season, most underlined the fall of the number of cases of malaria during the same season, as the flooding washed out of mosquito larvae during rainy season.

The mode of transmission of malaria, and the relationships between mosquito, rainy season and malaria were well understood by all types of key informants. The health professionals associated the harvest season with the condition that the farmer work hard, and do not get enough diet at that time, hence lack of energy may cause relapse of malaria, or re-infection and complication of anemia. Other informants associated the increase in incidence of malaria to farming season than the harvest season.

However, all of the informants noted that people have the perception that eating maize stalk can cause malaria relapses, and some of them informed people think that it causes new infection. Other misconceptions perceived by community members as a cause of malaria included eating raw meat, drinking unfermented 'tela' (local beer), raw milk ('menkeria' in local term), even if they knew also mosquito bite causes malaria. The perceived mode of transmission of malaria included due to direct contact or being around the patient through breathe.

A CHA explained the case as,

> *"They call it (malaria) 'yezemenu' (literally meaning 'disease of the time') or 'worershign' (literally- epidemic disease) or 'Dembia's worershign'...they think that the cause (mode of transmission) is (via) direct transmission from person to person, rather than through the bite of mosquitoes,"*

He extended his explanation saying,

> *"For instance, if malaria occurred in a village, they say 'we do not go there to ask the patient (malaria)', because they think that they also may acquire the disease when they do that",*

People do not use bed nets, because of lack of awareness and capacity to buy it; mainly due to the fact that misuse of bed nets and inconsistent use of it may expose bed net owners to malaria, hence this experience discourages others and led individuals to a wrong conclusion that bed net won't protect them from malaria.

Health professionals were well aware of sign and symptoms of malaria such as high-grade fever (38.5^0C or more), chills, anorexia, and vomiting.

The main sources of health information claimed by most were health care facilities, like health center and clinics or health posts, and radio transmission (mass media). The most trusted source of information was facility based health professionals, followed by community health agents and radio transmission.

Regarding resources available in the area in order to control and prevent malaria, the resources available were health professionals, public and private health care facilities, CHAs, and local administrations, community labor, and hand tools to conduct environmental management activities, burned oil, bed nets, DDT spray, etc. No NGO was acting by the time on malaria prevention and control activity, except for Amhara Development Association (ADA), which provided few days training to CHAs and provided them hand tools to environmental activities, though most discussants said firstly *"we don't know"*, when asked about the resources available.

People bought anti-malarial drugs from retail shops to treat children and also give fluids at home. Some of the caregivers brought the children late to health facilities carrying the patient on stretcher after they have got "wagimit" (a traditional treatment by which blood is drawn from the body using horns), and some of them might die after they reached at health facility. A CHA said,

"When a child is febrile, as I visit the households or else when they came to me looking for Fansidar, I advise them to bring the child to health facility immediately, and they also do that (take the child to health facility)"

The best treatment believed by all informants for malaria was modern medicine. And, Fansidar was the most effective drug in the area, agreed by most informants, though it was said that it has got resistance. A CHA said,

> *"Previously they were using Chloroquine to treat malaria cases, but nowadays the body adopted it and it did not respond well"*

Most of the informants couldn't explain when to say a treatment is successful or unsuccessful or to switch to 2nd line drug treatment regimen, but a young health professional working in a health center could mention loss of consciousness, convulsion, and poor appetite.

Drug vendor keepers reported as they were not selling anti-malarial drugs with out prescription and under doses even if mothers ask them to do so, for the drugs were available at cheaper doses, but some of them also mentioned that they used to do it in cases when health care facilities were closed, so as to save the life of the patient. However, in an instantaneous observation during the time of interview, a mother came and asked the drug shopkeeper to sell her a drug (self-prescribed). But he told her to go the health center. He also tried to direct the attention of the interviewer saying that nowadays drugs are available in retail shops.

Regarding the new anti-malarial treatment policy, even though some professionals have got trained, others didn't, and the gap in communication between public and private health care partners (drug vendors) was reported to be wider. They didn't get any current information from MOH.

6.2.2 Results of Focus Group Discussion

A total of 18 mothers and 12 fathers of under-five children were participated in a series of 5 focused group discussions in five different villages of the woreda. The participants were those who were not literate and their age ranges from 18 to 60, of whom the majority were between the age range of 25 and 35 inclusive.

Most male and female focus group discussants mentioned and agreed that malaria is among the top listed health problems of under-five children. Other diseases of under-five s mentioned by most of the discussants were 'qimo' (tonsillitis), 'ankar' (uvulitis), vomiting and diarrhea, measles ('alemoche'), common cold, etc. Some group discussants didn't mentioned malaria, but responded 'yes' when asked whether it is a problem in young children.

Diseases having fever, other than malaria were mentioned as 'nifas' (pneumonia), 'ankar', 'qimo', 'mekechet' (back pain), teeth problem, common cold, injuries, diarrhea, etc. Fever, diarrhea and vomiting were the most frequently mentioned symptoms of malaria in under-five children. Other symptoms included poor appetite, thirsty, change in color of eye and urine, and abdominal distention. But, none of them could mention convulsion and loss of consciousness.

Malaria and 'qimo' (tonsillitis) were perceived as the most dangerous diseases to the life of under-five children agreed by most of the discussants both male and female FGDs.

Some of the discussants in both categories perceived 'ankar' (uvulitis), unless it is cut traditionally; teeth problem (extracted traditionally); and diarrhea and vomiting as dangers to life of children under the age of 5 years. A 60 year old man, as he explained the seriousness of malaria, said,

> *"...When a person have got severe malaria, he would say, 'it is Mr. X's evil eye ('buda') that caused my illness', unconsciously and madly",*

Reasons mentioned by almost all discussants for delaying under-fives from going to health facilities were hoping the sick child will be better (well), when treated at home with modern anti-malarial drugs sold from retail shops or pharmacies, with one or two ETB, and some of the discussants agreed that they went to traditional healers thinking the cause of their illness were tonsillitis or uvulitis, since such problems were believed to be treated traditionally. Other reasons mentioned included time of onset of illness (at night), lack of money (especially during summer seasons), due to the delay in service delivery of public health facilities. A young man said,

> *"When a child's fever comes and goes now and then, and he doesn't get well, they (parents) take him to 'wofegna' (a traditional healer called 'balezar', believed to have some kind of spirit up on him), and if the child doesn't become well even after such actions were taken, she (mother) will go to health facility at last",*

Warning signs of danger to a mother that her sick child's health is getting worse and should seek for medical attention mentioned and agreed by most of the discussants were high grade fever, poor appetite, unable to open his eyes or sunken eyes, vomiting and diarrhea. Symptoms like loss of consciousness, body weakening, and becoming

disturbed, low breathe, acuteness of the diseases was also mentioned by some of them. However, few discussants attributed lowered temperature to sign of danger. A mother explained the seriousness of the disease as,

> *"It is when the child vomits a yellowish fluid, and have diarrhea, in that case we say that it is 'bicha woba' (literally meaning yellow malaria)"*

Most discussants knew that malaria ia caused by mosquito bite, but it is only few of them that really understood the right mode of transmission of the disease, where as the majority do believed that it is transmitted through multiple ways such as eating of contaminated food or water, direct contact via the vomitus material or breathe of the patient, and also they believed to cause when there is excessive sun light or cold weather, or when eaten maize stalk ('rifa'), honey or drinking unfermented local beer ('gush tela'), raw milk ('menkeria'), etc.

Malaria was believed to be rampant during the rainy season, especially on October and November, while it falls during summer season. Some of them related the rise of malaria to decrease of the productivity.

Mostly, as it was agreed by most discussants, it is the mother who identifies that the child has malaria, and consult to her husband, but the decision to seek for health facility for treatment was mainly on the hand of the husband, provided that the mother do not have money, and males (husbands} are the source of household income in rural areas. In some cases, grand parents, if they are available, and also other

relatives and neighbors may suggest, and borrow money to the parents of the child when there is shortage of money.

Most discussants said that it is the grand parents, if any, and the husband or else neighbors who convince mothers to seek for effective anti-malarial treatment for her child's fever or malaria.

Fansidar and Chloroquine were believed by most discussants as effective anti-malarial drugs to treat under-five children's fever. Some said holy water and injection, and others said injection and tablets. Most knew combined treatments of Chloroquine and Fansidar, but few did not accept it for children, rather only to adults.
Obstacles to effectiveness of the treatment were mainly due to delay for economic reasons, and dealing at home with traditional treatments, and self-purchased, cheap anti-malarial drugs from retail shops. Traditional treatment included putting raw butter on child's head, in intent to decrease fever and making coffee ceremonies.

The main reason mentioned by most discussants for mothers' fear of anti-malarial drugs was due to their perception that Fansidar is contraindicated to pregnant women causing miscarriages, and for children thinking that they cannot resist the drug side effect, and few attributed it to bitterness of Chloroquine tablet.

Mothers, husbands, health professionals and CHAs were mentioned by different groups of FGDs as to who could convince mothers to prioritize the modern treatment to fever of under-five children.

There was no compliance of anti-malarial drugs, as it was agreed up on all groups of FGDs, among mothers when administering Chloroquine tablets. A mother explained it as,

> *"If the child becomes well (while administering prescribed drugs), she (the mother) will interrupt it, and may give it to somebody else (a child at home or in the neighbors) with similar illness for the time being...or save it to other times (episodes of fever)",*

The reasons given for opting other sources of anti-malarial drugs like retail shops of private drug vendors were mainly shortage of money, long journey, ease of access to and availability of such sources, and cheap prices of their drugs (one or two ETB per adult dose) and relatively higher cost of health facility treatments (10 to 15 ETB).

Most discussants mentioned that the source of health information were health professionals, CHAs, and radio. The most trusted source of information agreed up on most discussants was facility-based health professionals, followed by CHAs.

Most discussants knew the preventive methods such as DDT spray of households, environmental control and bed net use. While almost all of the discussants have heard of mosquito nets, and believed that it prevents from mosquito bites, only some of them believed that it prevents from malaria. A mother said,

"Since we have already infected with malaria, it doesn't protect us from the illness that is what we think",

Most of the discussants in the group agree with her idea. A father said,

"Since a person owning bed net in the neighbor got malaria, while using it, we don't think it prevents malaria,"

However, some discussants opposed his idea saying that guy have already had the disease before he start to use the bed net. All discussants believed that DDT spray of households would prevent malaria, and stressed on it. Environmental control was known and being practiced, but some of them doubted its effectiveness as a mother said emphatically as,

"Previously, it was said, 'keep your personal and environmental hygiene to prevent malaria', but nowadays, there is no difference between those who practiced and those who do not..."

Local vernacular terms to name malaria were 'woba', 'nidad', 'bishaw', 'bicha woba' (cerebral malaria), and 'zemenegnaw'. Resources that mentioned to prevent and control malaria were health professionals, labor, CHAs, PA leaders, but no health committee, nor NGOs.

7. DISCUSSION

This study assessed the knowledge, attitudes, and practices of caregivers of under-five children about malaria, the mosquitoes, and anti-malarial treatments. It also looked into the practices of home management of fever/ malaria in under-fives in the study area.

The knowledge of caregivers about the symptoms of mild and severe malaria was very high that almost all of them (98.4%) knew at least one of the classic symptoms of malaria. Previous studies in Ethiopia at Butajira [(5)], on household heads, in central Ethiopia [(16)] on women, and in Kishe settlement area [(10)] on male or female representatives of the households showed that there was a relatively good knowledge of symptoms of malaria among the study subjects. However, the current study revealed that there is much better level of recognition of symptoms of malaria among caregivers of under-fives in the study area, which coincides with the study in Sidama [(27)].

This might be due to the fact that the former study areas were characterized by unstable malaria, and the endemicity and frequent occurrence of malaria epidemics in the current study area for a longer period of time since 1950s might have enabled them to experience the symptoms of the disease more. Further more, the public health training centers in the area and frequent exposure to health education by public health and medical students of Gondar University, the then College of Public Health, might have had an impact on improving the knowledge of caregivers about malaria symptoms. On

the other hand, this result could be a bit inflated due to 'yes' or 'no' multiple responses rather than the open ended ones as compared to the previous studies [16, 27].

The caregivers associate the possible cause of malaria with the bite of infective mosquitoes (69.9%), although they attributed it to other perceived causes of malaria such as dirty personal and sanitary condition (62.3%) and contaminated food and water (39.2%) along with others. This shows that there is a progressively increasing trend of the knowledge of the people about modes of transmission of malaria as compared to the Butajira study (59.5%), and that of the central Ethiopia (17.3%) studies [5, 16] mentioned before, though it is lower than that of the study in Kishe [10] discussed above (80%) (Among settlers (83%) and indigenous (74%)), which could be due to the diffusion of new knowledge from settlers to indigenous people. In Tanzania and Ghana, it is associated with excessive heat exposure and overwork; in Guatemala, it is thought that malaria is caused by bathing too frequently or by drinking unboiled water, and also exposure to cold or wet condition, or related hygiene or eating habits, and the like; while the Guatemalans participated in the studies were 'quite' knowledgeable about the role of mosquito in the transmission of malaria [28]. Nevertheless, the misconceptions along with this belief could have masked the effort to combat malaria in the study area.

The findings of this study imply that caregivers might believe that malaria could be caused by different factors other than *Plasmodium* parasite or mosquito bite, though they had the correct knowledge about it. In fact, this kind of thought was also demonstrated by most discussants of FGDs. This might have hindered the efforts made to prevent and control malaria with community participation [28]. In The Gambian and in

Kenya, malaria especially in children, is often perceived as the result of the child being possessed by an evil spirit or devil; and also in Tanzania, convulsions are not associated with malaria (which, of course, they usually are) [28]. The presence of such perceptions in the community was reflected by some of the FGD discussants.

Knowledge of caregivers included this study about the transmission of malaria from person to person was lower than the study result of central Ethiopia [16], and higher than that of Butajira [5]. The majority of the participants in this study didn't have the scientific public health knowledge as to how malaria is transmitted. Rather, majority of them associated the transmission of malaria through close contact or sleeping together with malaria patient. This is also demonstrated in central Ethiopia with the same proportion. While the study result in Butajira [5] differs in that majority of the respondents had the correct knowledge of how malaria is transmitted and only few (10%) of them associated it to close body contact with malaria patient. This may be explained by the fact that the study subjects were more literate than the subjects in Central Ethiopia [16] and also this study, which both have similar proportion of illiterates.

The misconception that body contact or sleeping together with malaria patient transmit malaria might have affected the control activity of vectors through the main strategies, environmental management, household insecticide spray, personal protection using bed nets, outdoor and indoor mosquitoes bites, etc [28].

Majority of the caregivers knew the common breeding sites of mosquitoes, which is somewhat similar with the study result of Butajira [5]. The usual biting time of mosquitoes was believed to be at night by the majority of the study participants (81.8%), which would have reinforced them to control the vector, provided that they have had the correct knowledge of mode of transmission of the disease. However, the majority misunderstood the common resting places of mosquitoes, which would have a direct implication on the effectiveness of the household spray of residual insecticides.

The participants were well aware of the peak transmission seasons of malaria, immediately after the rainy season and lowest during the dry season. This is also evidenced by the number of cases seen at health facilities in the woreda at each month of the years during the last five years (from 1992-1996 E.C), during which most cases were seen, and the focused discussants also agreed with similar seasons. This can be explained by a number of malaria attacks happened in the area for many years.

Regarding the preventability of malaria, most of the subjects believed that malaria is a preventable disease. The condition in Butajira's study was similar to this one, while the majority of the women interviewees at central Ethiopia believed that it was not possible to avoid malaria. Of courses, almost the entire subject in the study at Sidama [27] believed that it was preventable. This may partly be explained by their difference in literacy status of the subjects and their exposure to information, education and communication (EIC) about preventability of malaria in the last few years. In addition, in general, the literacy status of women is lesser than that of men in rural areas, in

which the majority of the primary caregivers interviewed were females in this study.

The knowledge about preventive methods was higher than the studies in Butajira and at central Ethiopia [5, 16]. This may implies that the long standing P.H. training in the area and the government's current effort in malaria prevention and control have had impacted on their knowledge about preventive methods. The condition in Sidama's study [27] was lower than the current, except an equivalent proportion of knowledge about DDT spray was observed, and it is also higher than the two aforementioned studies.

Environmental management or manipulation was the most practiced preventive method, followed by DDT spray, which of course was higher than previous similar studies, [5, 27]. Through, there was a good practice of environmental manipulation to prevent and control malaria, the higher knowledge of household insecticide spray seems to make people depend more on it, than any other means of preventive methods, as it was implicated in the study at Sidama. This kind of attitude might have a negative effect on the effort to prevent and control malaria in a sustainable manner.

Even though, the knowledge of existence of bed net use seemed relatively higher, the practice of bed net use was still very low, as compared to the study in Gambia [29], which implies that there is still a long way to go in malaria prevention and control program of the area. A study in Philippines found that there was a general disbelief in

the mosquito as a vector of malaria, and therefore, doubts about the efficacy of bed nets [28]. Insecticide treated mosquito net is a key strategy in the effort to reduce malaria morbidity and mortality among the vulnerable groups like under-five children and pregnant women. The sources of information about mosquito nets were mainly radio and health professionals. The role of community health workers in disseminating health related information was minimal, despite their closeness to the community at grass root level, which in turn may imply the lack of frequent training and motivation of these front-line health workers.

Only few participants perhaps due to its un-affordability and their poor willingness to pay for and use of bed nets understood the purpose of bed net. Though the majority perceived that mosquito net only prevents mosquito bite or nuisances, which may undermine the purpose of bed nets, and decrease their willingness to spent money on it, even if it is sold at a fair social market price.

The knowledge and hence the practice of traditional treatment among the participants of this study was very low (negligible), except that more than one-third of them knew holy water for treatment of malaria, in most case to subside malaria. This was also confirmed in the KI interview of traditional healers. This result differs from previous studies that showed the more utilization of leaves in the study at Butajira, and about 34% of the study subject in Kishe settlement reported the use of traditional medicines like onion (38%), pepper (29%), bitter fruits (20%) and old butter (18%).

This may be attributed to the fact that malaria was a problem for decades and malaria prevention and control program was there since the early times. Hence, modern drugs for malaria treatment were known by most of them. Fansidar (SP), Chloroquine and Quinine were well known by most of the study participants. Fansidar was found to be the most effective anti-malarial drug by most of the caregivers, while only few mentioned Chloroquine as effective drug at the time of the study. This finding was inline with the Chloroquine drug resistance faced in different parts of Ethiopia [30]. The clinical failurity of Chloroquine for *P. falciparum* in different parts of the country shifted the treatment regimen of 1st line drugs of malaria to SP.

What is noticed also in this study was that there is much better knowledge of anti-malarial drugs as compared to the previous studies mentioned in Ethiopia in that Quinine was known by the same proportion of the respondents in Butajira those who knew Chloroquine, which even was not mentioned by any of the respondents in Butajira and perceived as the most effective drug by a quarter of the caregivers. This was also quite different from the central Ethiopia in which none of them could mention any of the anti-malarial drugs by name.

In this study, most caregivers preferred injection as a mode of anti-malarial drug administration, and of whom, the majority gave the reason that it is working faster and thought it is stronger than any other form of medication. Tablets have a problem of bitterness (Chloroquine tablet) and hence difficult and often disliked to be taken by children, whereas syrups were a main stay of malaria treatment in children in many

countries [21], though it has also a problem of compliance. The qualitative result also revealed that there was no compliance with Chloroquine tablets and adherence by caregivers, as they interrupt the medication when fever stops, and save it for future use, as it was found elsewhere [28]. The study in Ghana [21] showed that there was no significant difference in the outcomes of Chloroquine tablets (pre-packed) and syrup among children who had malaria, and Chloroquine tablet (pre-packed, which dissolved into homogenous mixture) was more adhered by caregivers than those who prescribed syrups. In this study, the more preference of caregivers to injection might be due to less compliance and recovery experiences of per oral medications. On the other hand, this kind of preference may encourage illegal drug vendors to administer injections irrationally, due to low cost preference of caregivers in rural areas to such private firms, and may also predispose the community to unsafe injection practice and hence HIV/AIDS and other blood contact transmission diseases like Hepatitis (B).

The prevalence of fever in under-fives in two weeks time was 41.6%. In Bungoma district, Kenya 64% had experienced fever and 46% completed fever. In the Kenyan study, 94% of the carers thought their children had had malaria. This shows that primary caregivers were able to recognize the symptoms of malaria very well.

According to WHO's case definition of malaria, those who live in malarious area or have been there in recent times, having fever can be classified as possible cases in the absence of laboratory confirmation. But, cases with fevers and some more classic symptoms of malaria shall be classified as probable cases. In this study, accordingly,

out of 104 children with completed fever, 103 were probable cases, and one possible case. Caregivers identified the child's problem as malaria, which is consistent with the number of cases classified as probable cases. It was found that caregivers consulted more modern health services when the child got malaria than the traditional healers, which were few in proportion. This shows that there is much more believe and dependability on anti-malarial drugs than the traditional ones. This was not true in Kishe settlement [10], where most depended on traditional treatment.

Fifty two (53.6%) were seen at health facility, whereas 45 (46.4%) of the recently febrile children were treated at home with modern anti-malarial drugs. This is a similar finding with the study at Butajira and Kenya that caregivers were major partners of the health care providers in the treatment of malaria.

Majority of the caregivers self-treated their children at home with Chloroquine and Fansidar, and an equivalent proportion of the children got recovered from their illnesses. Though the dose of anti-malarial drug administered and compliance with it was not studied quantitatively, it seems that there was a correct dosage administration of the drugs by most of the caregivers [30]; in fact there is no way to prove this hypothesis. Under-dosage is the most prevalent problem of self-treatment in many countries [12].

The proportion of cases received any type of treatment (treatment rates) varies in different places. It ranges from 40 to 95%, but the majority of them were over 90% [12]. A few studies recoded multiple treatments in which individuals reported a combination

of resorts including self-treatment with traditional medicines, or more than one clinic or health provider. In this study, the treatment rate was found 97 (93.3%). The rates of multiple treatments that have had two or more treatments in African, Asian and American countries range from 11-90%, but most were above 40%. And, few studies reported the proportion with three or more treatments, and in most, it was less than 10% [12]. In this study, the proportion of two or more treatments was 42.3% and that of three or more treatments was 11.5%.

The use of traditional healers or medicines to treat malaria varies in Africa where 53% in Somalia; 45% in Gambia; and Kenya 3% [12]. The current study documented 2.9%. At Butajira, 1.1% used only traditional treatments. This may be due to the activities done for many years in the area by Malaria Prevention and Control Program. Traditional medicine has been used in Ethiopia for many years, since before the introduction of 'western' medicine, to treat a wide range of diseases including malaria [32].

The promptness of treatment with anti-malarial drugs in different studies showed that most cases took anti-malarias at home first, and then they visited health facilities later [12, 24, 33]. In Kenya, 91% of who treated at home with anti-malarial drug were received it during the first 2 days of illness, and among those visited health facilities, only 51% did it. In Butajira, more than half of those malaria cases treated at home started it within 2 days of onset of illness. In this study, 76.6% of the children with malaria symptoms were treated at home within 2 days of onset fever, whereas 68% of those who were seen at health facilities in the first two days of onset of fever. These evidences suggest

that home treatment may enhance the promptness of treatments with anti-malarial drugs, which might in turn delay the progression of *P. falciparum* in to severe malaria, by then would be able to reduce morbidity and mortality, as far as it is given in proper therapeutic doses. This was proved in a study in Northern Ethiopia that 40% reduction of mortality rate was achieved by involving mothers to treat malaria [(23)].

Reasons given for delay were mainly hoping that the child will be well or given traditional treatment, and it is far to get anti-malarial drugs. And, only few attributed it to shortage of money, though most discussants in FGDs indicated shortage of money as a main factor. The study in central Ethiopia documented that the principal reason of women to opted Government health institutions was effectiveness of treatment, while cost, waiting time, and distance from health facility were of less importance. However, the focus group discussants indicated that mothers seek first traditional treatment or healers for their child's illness; confusing fever of malaria origin with that of others' such as tonsillitis, and make modern medicine the last.

Among those children treated at home, 59.6% & 12.8% brought anti-malarial drugs at pharmacies and rural drug vendors respectively and about 10% got the drug at home left over or from relatives or neighbors. This finding was consistent with studies in Butajira and Guatemala, in which 55% bought the drugs from pharmacy drug shop, market or any shop. Lack of access to and inadequate health care services (the long waiting time and shortage of drugs at health facilities) and ease of access to illegal and legal private drug shops with low cost and sub-therapeutic doses might have

encouraged people to use such sources of anti-malarial drugs in the area [16, 24]. The relatively higher cost of health care services and the incapacity to pay for it also urged parents to opt such sources, as explained by focused group discussants. The role of community health workers and Malaria Control Centers as sources of anti-malarial drugs was found minimal or null. This may be mainly due to lack of Malaria Control Centers in the area and the CHAs got free anti -malaria drugs to treat cases during the time of epidemics.

Perception of caregivers about severity of malaria was appreciable that most of them identified under-five children. Priority to treatment of malaria cases was also agreeable with their opinion of who suffers most by the diseases. It was also observed in central Ethiopia [16] and Kenya [33] where about 43% of the respondents identified under-five as the most affected group, which is justified on the immunological basis.

In Bungoma district, Kenya [31] there was no significant difference in the distributions of treatment-seeking delays between the two groups, where anti-malaria treated children at home within 1 or 2 days of onset of fever were more likely to visit health service facility within 48hrs. A similar finding was observed in this study showing a strong significant association between those who promptly treated at home with anti-malarial drugs and those seen at health facility within 48hrs after fever onset. This evidence might show that home treatment enhances promptness of treatment at health facility.

In a multivariate analysis of central Ethiopian study, literacy and village of residence were found significant predictors of knowing whether malaria is preventable or not. In this study also literacy of spouses was found a predictor of both knowledge and practice of preventive methods, besides to that of being male caregiver and small family size as a predictor of knowledge of preventive methods. This might be explained by the fact that males were more literate than females in the areas.

8. Strength and Limitation of the Study

8.1 Strength

- **Employed both quantitative and qualitative methods**
- **Focused on home management of under-five children**
- **It was done entirely on rural areas**
- **Caregivers (most of them were females) were the study participants**

8.2 Limitation

- **Treatment doses, drug compliance and adherence were not included in quantitative part of the study**

- **There were no urban comparison groups**
- **The qualitative data analysis was limited to descriptive analysis**
- **Previous history of exposure of caregivers to malaria was not assessed**
- **One year history of fever could be subjected to recall bias**

9. Conclusion

The study population had a good level of knowledge about symptoms of malaria. Nevertheless, they could associate mosquito with malaria to a lesser extent; rather, they had prevailing myths and misconceptions with regard to causation and modes of transmission of malaria.

Despite the good knowledge level of the community about the preventive methods of malaria, there was a minimal use of and willingness to pay for mosquito nets, even though it was available in the area with low social market cost (ETB18). This emanated from their misunderstanding about the protective effect of mosquito nets from new malaria attacks.

The proportion of home treated under-five children with anti-malarial drugs for recent episodes of fever were high, of whom majority took drugs first at home. The private health care providers were the major sources of anti-malarial drugs for home treatment of fever/malaria. The role of CHWs and Malaria Control Centers in the treatment of malaria was limited to the response for epidemic calls.

The community opted modern medicine more than the traditional one. Factors that affect prompt access to proper treatment of malaria in under-five children were lack of money; poor access (transportation) to poor health service delivery (long waiting time, cost, etc) at public health care facilities; and misdiagnosis of malaria cases by caregivers of under-fives, as they confused it with diseases like tonsillitis and uvulitis, and cerebral malaria with evil spirit, which they thought was solved by traditional healers.

10. Recommendations

Based on the conclusion, in order to improve the prevention and control of malaria in the area, and hence, reduce the high morbidity and mortality burden posed by malaria on the community, especially, the vulnerable groups- under-five children and pregnant women, the following is recommended as,

1. Effective information, education and communication (IEC) strategies should be designed and strengthened to raise their awareness and modify or change their behavior, focusing on the prompt and proper treatment of malaria; and the causation

and mode of transmission of the disease; and practice of preventive methods, especially on the use of bed nets.

2. Training and motivation of CHWs and mothers in proper home treatment of malaria patients, especially vulnerable groups, and teaching the community to eliminate myths and misconceptions that delay prompt treatment, is very important. Hence, it should be given emphasis in order to scale up home management of malaria.

3. Enhancing the role of private partners in malaria treatment such as private clinics, pharmacies, and drug vendors or shops in proper management and referral of cases is mandatory. Therefore, the link between the health care provision facilities (both private and public) with the community and also between the private and public health care partners should be strengthened.

4. Effectiveness of pre-packed tablets, anti-malarial drugs compliance and adherence, especially with regard to Coartem, the future 1st line drug of choice, is recommended for future studies.

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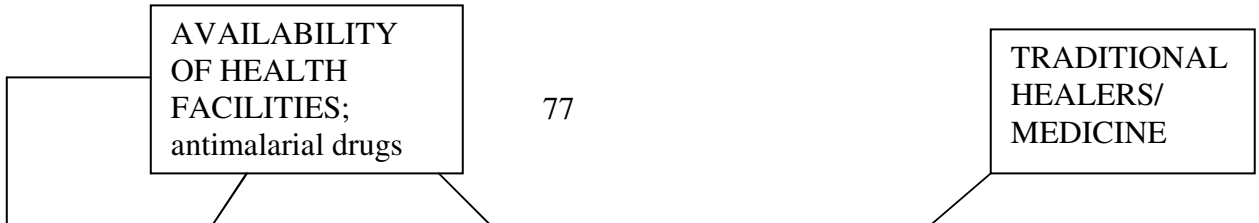
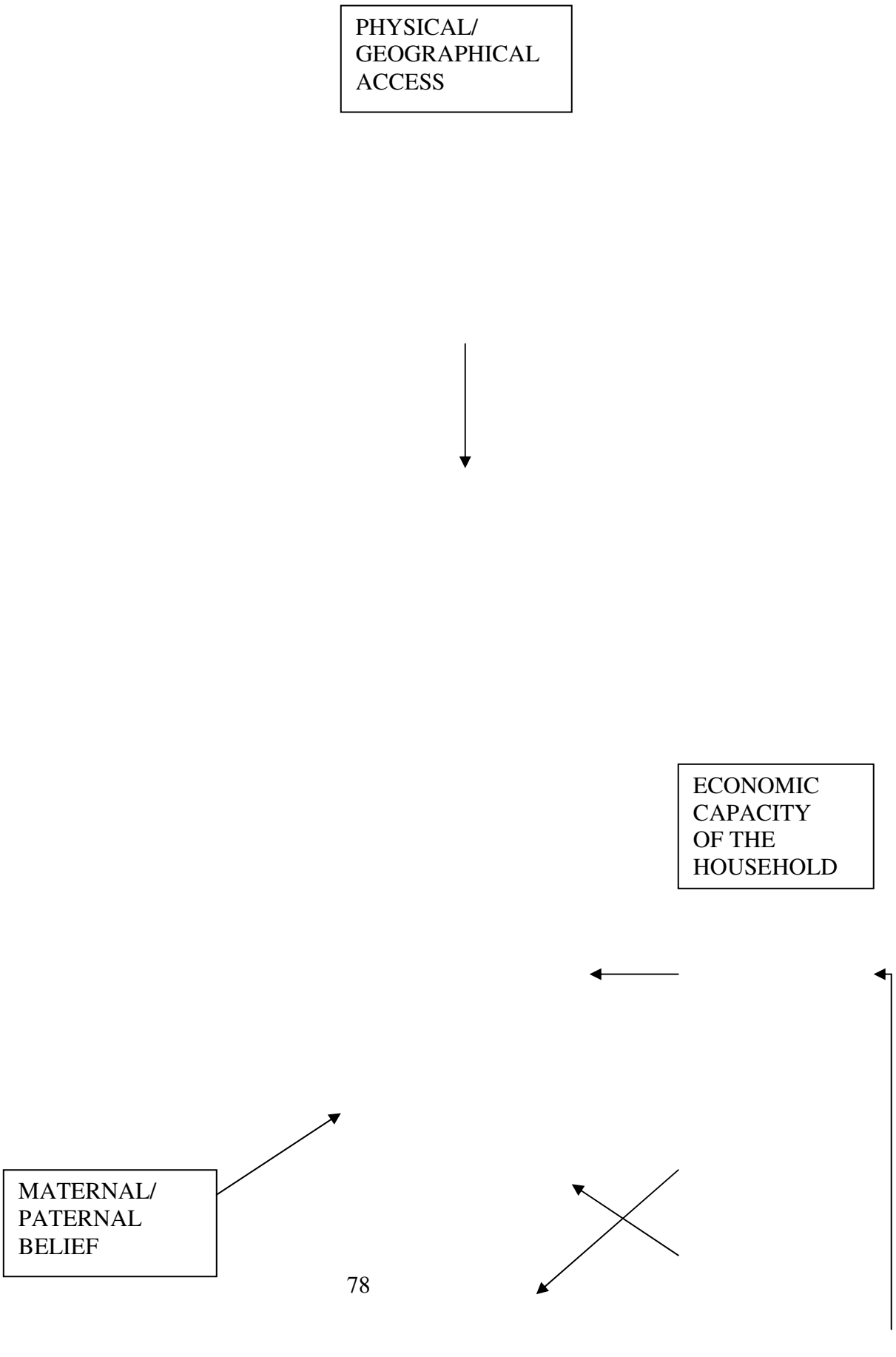
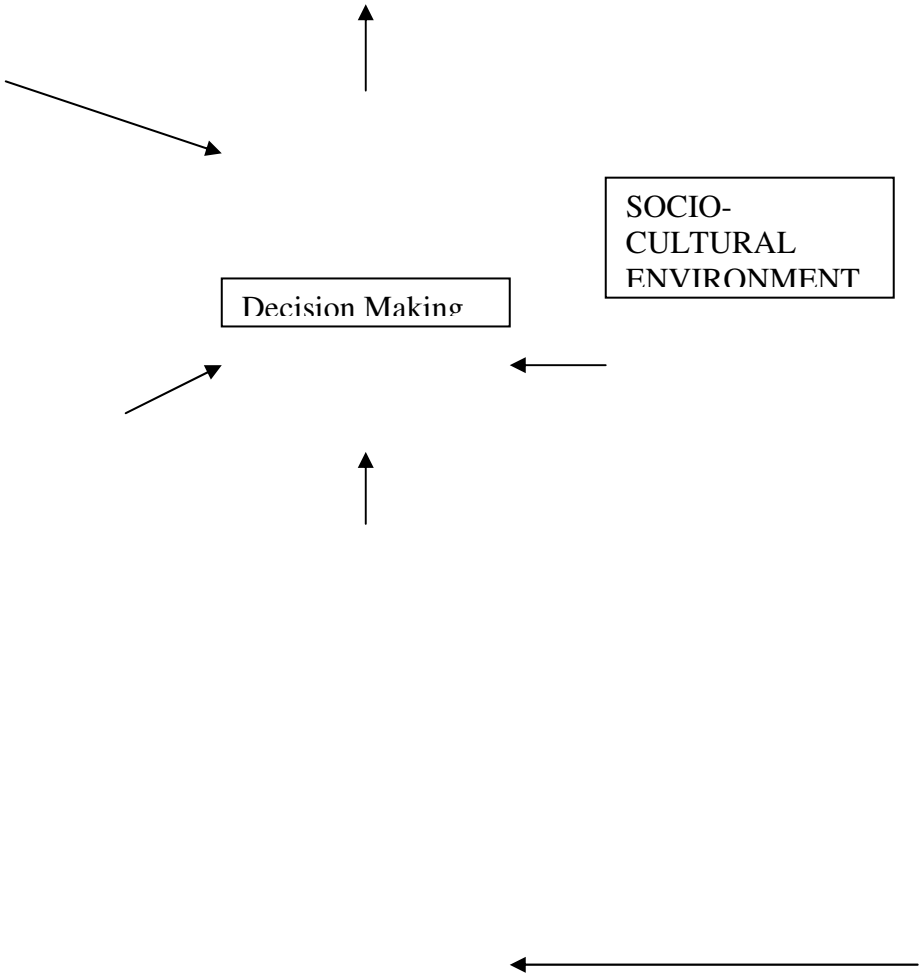
ANNEXES

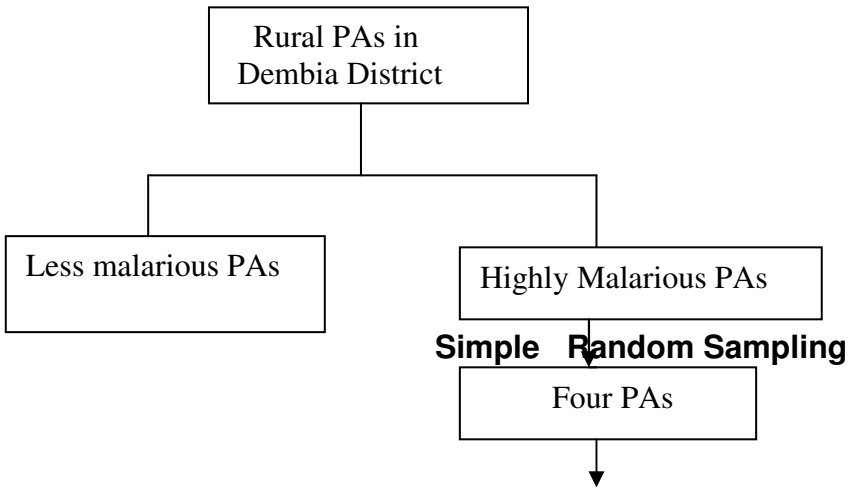
ANNEX-I: CONCEPTUAL FRAMEWORK OF HOME MANAGEMENT OF FEVER/MALARIA

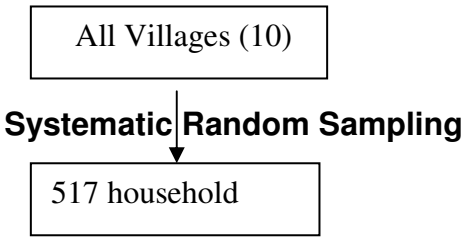



PHYSICAL/
GEOGRAPHICAL
ACCESS
ECONOMIC
CAPACITY
OF THE
HOUSEHOLD
MATERNAL/
PATERNAL
BELIEF


SOCIO-
CULTURAL
ENVIRONMENT
Decision Making

ANNEX II: SCHEMATIC PRESENTATION OF SAMPLING PROCEDURE





ANNEX III: DIFFERENT OPTIONS OF DETERMINING THE SAMPLE SIZE

Proportion	α	Design-effect	Absolute Precision	Contingency	Sample Size(n)
80%	0.05	1	5%	5%	
	0.05	2	5%	5%	
					517
	0.10	2	5%	5%	
	0.05	2	10%	5%	

ANNEX IV: SURVEY QUESTIONNAIRE

This questionnaire is prepared to assess home management of fever/ malaria in Dembia district, North Gondar Zone, Amhara Regional State.

Consent form for participation:

001. Questionnaire I.D._____
002. Kebele/ Peasant Association Code_____
003. House No./ Code_____

Good Morning/ Afternoon

My name is _____. This study is conducted by Addis Ababa University, Medical Faculty, Department of Community Health. The aim of the study is to assess the practice of home management of under-five children with fever during the last two weeks, and the knowledge, attitude, belief, and practice/ behavior of caregivers of under-fives. Therefore, all responses for the interview are kept confidential. However, your genuine responses will help to see the truth and find solutions for the treatment seeking and develop preventive behaviors. It is your right to refuse to participate in the study or interrupt the participation at any time in between the interview. We thank you in participation in the study.

004. Are you willing to participate in the study?
1. Yes
2. No

005. Responses of the interviewee:
1. Complete
2. Interviewee not available
3. Not willing to participate
4. Partially completed
88. Others (specify)

006. Interviewer I.D. No._____ Name _____
007. Date of interview _____
008. Supervisor's Name_____ Sign. _____
Date _____

QUESTIONNAIRE PART ONE

This questionnaire is intended to assess the knowledge, attitude, beliefs and practice of under-5 children mothers/caregivers with respect to symptoms, causation, severity, treatment and prevention of malaria.

I. SOCIO-DEMOGRAPHY:

101. Role of the primary caregiver in giving care:
1. Mother
2. Not mother/ female Gardner
3. Male caregiver
88. Others (specify) _____

102. Respondent's: Age_____

103. Respondent's: Sex 1.male 2.Female

104. Respondent's Address: 1. P/A code_____
2.Village code _____
3. House No. /code _____

105. Literacy status (caregiver)
1. Illiterate/ unable to write and read
2. Literate

106. (if literate, Q # 105) To what level does the caregiver is learned?
1. Read and writes only
2. Grade 1-4 completed
3. Grade 5-8 completed
4. Grade 9-10 /9-12/ completed
5. Preparatory class and above

107.Religion of the caregiver:
1. Orthodox Christian
2. Protestant, Catholic
3. Muslim
88. Others (specify)_____

108.Occupation of the caregiver:
1. Farmer
2. Merchant/trader
3. Housewife
88. Others (specify)_____

109. Marital status:
1.Single
2.Married/living together
3.Divorced
4.Widowed
5.Separated

110. (If married, Q109) Spouse's literacy status:
1.Illiterate/unable to read and write/
2.Literate

111. (If literate, Q110) To what level do the spouse educated?
1. Read and writes only
2.Grade 1-4 completed
3.Grade 5-8 completed
4.Grade 9-10 /9-12/ completed
5.Preparatory class and above

112. Spouse's occupation:
1. Farmer
2. Merchant/trader
3. Housewife
88. Others (specify)_____

113. Family size (#): _____
114. Number of under-5 children in the household: _____
115.Ethnicity of the caregiver:
1. Amhara
2. Tigrian
3. Gurage
4. Oromo
88. Others (specify)_____
116. Walking distance (hr) from the nearest health facility (public or private; clinic, health station, health post, health center or hospital; drug dispensary/shop) to their home:_____ hrs
117. What do you think are the most common diseases among children in this community?
1. Malaria
2. Diarrhea
3. Cough
4. Abdominal cramp
5. Vomiting
6. Fever
88. Others (specify)_____

KAP Survey Questions

201. Do you know what malaria is?
1. Yes
2. Don't know (skip to Q 204)

202. (If yes, Q 201) would you please specify the signs and symptoms of malaria (uncomplicated) in children or adults?

	Yes	No
1. Fever	1	2
2. Headache		1 2
3. Chills/shivering	1	2
4. Poor appetite	1	2
5. Joint and body pain	1	2
6. Vomiting	1	2
7. Diarrhea	1	2
8. Difficult breathing	1	2
9. Cough	1	2
10. Convulsions	1	2
88. Others (specify)_____		
99. Don't know		

203. Do you know the danger signs and symptoms of malaria (complicated)?

	Yes	No
1. Fever	1	2
2. Headache	1	2
3. Chills/shivering	1	2

4. Poor appetite 1 2
5. Body and joint pain 1 2
6. Vomiting 1 2
7. Diarrhea 1 2
8. Difficult breathing 1 2
9. Cough 1 2
10. Convulsions 1 2
88. Others (specify)_____
99. Don't know

204. Who is most vulnerable to malaria in the family?(choose only one)
1. Children under-5 years old
2. Children above 5 years old
3. Pregnant women
4. Breast feeding mothers
5. Adult male
6. Old aged people
88. Others (specify)_____

205. Whom do you think should get priority for treatment? (choose only one)
1. Children under-5 years old
2. Children above 5 years old
3. Pregnant women
4. Breast feeding mothers
5. Adult male
6. Old aged people
88. Others (specify)_____

206.What causes malaria?

	Yes	No
1. Mosquito bite		1 2
2. Cold, wet weather or change in weather	1	2
3. Dirty stagnant water	1	2
4. Dirty personal and sanitary condition		1 2
5. Contaminated food and drinking water	1	2
6. Evil spirit	1	2

88. Others (specify)_____
99. Don't know

207. Can malaria be transmitted from one person to another?
1.Yes
2.No
99.Don't know

208. (If yes, Q207) how is malaria transmitted?
1. Bite of infective mosquitoes
2. Close contact/sleeping together with malaria patient
3. Unsafe drinking water
4. Bad odor

6. Eating contaminated food
88. Others (specify)_____
99. Don't know

209. When do you think the usual biting time of mosquitoes?

1. Day
2. Night (in the evening)
3. Night (after midnight)
4. Any time
99. Don't know

210. Where do you think is common breeding sites of mosquitoes?

1.Stagnant water
2.Running water
88. Others (specify) _____
99. Don't know

211. Where do you think is the common resting sites of mosquitoes during day or night?

1.Dark places inside houses
2.At edges of streams
3.Dirty areas
88. Others (specify)_____
99. Don't know

212. Do you think malaria is a preventable disease?

1.Yes
2.No (skip to Q215)
99.Don't know (skip to Q215)

213. (If yes, Q 212) what preventive methods of malaria do you know?

	Yes	No	
1. Chemoprophylaxis		1	2
2. DDT spraying	1	2	
3. Source reduction/ elimination of breeding sites		1	2
4. Personal protection	1	2	
5. Bed net use		1	2

88. Others (specify)_____

214. (If yes, Q 213) What do you do currently at your household level to prevent malaria?

	Yes	No	
1. Chemoprophylaxis		1	2
2. DDT spraying	1	2	
3. Source reduction/ elimination of breeding sites		1	2
4. Personal protection	1	2	
5. Bed net use		1	2

215. If a child is sick from malaria, what are the best ways to cure the child?

1.Treating the child at home with modern drugs
2. Treating the child at home with herbal medicine
3.Taking the child to traditional healers
4.Taking him/her to holy water
5.Taking him/her to modern health service organization
88. Others (specify)_____

216. Which modern drugs do you know to treat malaria?

	Yes	No	
1. Chloroquine	1	2	
2. SP/Fansidar	1	2	
3. Primaquine		1	2
4. Quinine	1	2	

88. Others (specify)_____
99. Don't know

217. Which of the drugs is/are more effective? (Circle only one)

1. Chloroquine
2. SP/Fansidar
3. Primaquine
4. Quinine
88. Others (specify)_____
99. Don't know

218. Is Fansidar currently effective in the treatment of malaria? (Show sample)

1.Yes
2.No
99.Don't know

219. Which of the anti-malarial drug administration do you prefer when your child is ill at health facility level?

1. Injections
2. Oral medications
3. No preference

220. (if inject able, Q219) Why do you preferred inject able ones? Because,

1. Working faster
2. Stronger than any medication
88. Others (specify)_____

221. Which traditional remedies do you know to treat malaria?

	Yes	No	
1. Leaves		1	2
2. Roots	1	2	
3. Herbs	1	2	
4. Holy water	1	2	

88. Others (specify)_____
99. Don't know

222. In which months (season) of the year is malaria a big problem in this area?

1.September 2. October 3. November 4. December
5. January 6.February 7.March 8.April
9. May 10.June 11.July 12.Augest
99. Don't know

223. Have you ever heard the name 'mosquito net'?
1. Yes
2. No (skip to Q231)

224. (if yes, Q223) What were the sources of information?
1. Radio
2. Community health workers
3. Health professionals
88. Others (specify) _____

225. What is the purpose of mosquito net?
1. To protect from mosquito bite/nuisance
2. To prevent the transmission of malaria
88. Others (specify) _____

226. Do you currently own mosquito net for your family?
1. Yes 2. No (skip to Q231)

227. (if yes, Q226) How many? _____Observe if there is a bed net around the bed/ sleeping area hanged over the bed? (Observation by interviewer)

228. (if yes, Q226) Was the bed net impregnated with insecticide?
1. Yes 2. No

229. (if yes, Q226) Who slept under the net the night before the survey?
1. Mother/father
2. Children
3. Others (specify) _____

230. (if yes, Q226) Was the under-5 child slept under the bed net the night before the survey day?
1. Yes 2. No

231. Do any of the under-5 children in the family have fever during the last two weeks period (before the survey day)?
1. Yes 2. No (don't continue to the next QUESTIONNAIRE part II)

232. (if yes, Q 231) Please fill the table below.

Name of the under 5 Child	Sex 1=Male 2=Female	Age (mths)	Episodes of fever during the last two weeks(#)	Does the child have Fever now?	
				1.Yes 2.No	(if 'no') Duration of fever (days)

QUESTIONNAIRE PART TWO: HOME MANAGEMENT OF FEVER

301. Name of the under 5 child (fever completed, Q 232) _____

House No./ code _____

302. What signs and symptoms did the child had other than fever?

	Yes	No
1. Cough	1	2
2.Chills/shivering		1 2
3.Poor appetite	1	2
4.Headache	1	2
5.Vomiting	1	2
6.Difficult breathing	1	2
7.Joint pain	1	2
8.Diarrhea		1 2
9.Convulsions	1	2

88.Others (specify)_____

303. What do you think that made the child ill?

1. Malaria
2. Diarrhea
3. Cough/Respiratory problem

88. Others (specify)_____

99. Don't know

304. Including this episode, how many times did the child become ill due to malaria over the last one year? _____

305. Who first recognized from the household that your child had malaria?

1.mother
2.father
88.Others (specify) _____

306. Whom did you first consult that the child had malaria?

1. Modern health facility
2. Traditional healers

88. Others (specify) _____

307. How did you manage your child's fever at home?

	Yes	No
1. Modern drugs	1	2
2. Traditional remedies	1	2
3. Tepid sponge/ wet cloth	1	2

4. Did nothing (skip to Q315)

88. Others (specify)_____

308. (if treated with modern drug at home, Q307) After how many days since the onset of fever did you start treatment with modern drugs?_____(days)

309. (if treated with modern drug at home, Q307) What kind of drug did she/he received?

	Yes	No
1. Chloroquine	1	2
2. Fansidar/ SP	1	2
3. Premaquine	1	2
4. Cotrimoxizol	1	2
5. Antipyretics	1	2

88.Others (specify)_____

99.Don't know

310. Where did you get the anti-malarial drugs for treatment at home?

1. At home (from previously leftover/relatives/neighbors) (skip to Q312)
2. Pharmacies
3. Small drug shops
4. CHWs
88. Others (specify)_____

311. (if the source of drug is out of home, Q310)Average walking distance (hrs) to get anti-malarial drugs from home?_____(hrs)

312. Where did you seek for help?

1. Only at home
2. At home first and then at health facility
3. At health facility first before home (skip to Q315)
4. Did nothing (skip to Q315)
88. Others (specify)_____

313. Did your child recover due to home treatment?

1. Yes 2.No

314. (If No Q313) where did you seek treatment next?

1. Modern health facility
2. Traditional healers
88. Others (specify) _____

315. How many different places did you seek treatment for the child?

First _____ Next _____ Third _____

316.Was the diagnosis made at a health facility?

1.Yes
2.No

317. (if yes, Q316) Type of the health facilities at which the child was seen?

1. Public
2. Private
3.Others (specify) _____

318. If the child was not taken to a health facility, what was the reason? (Q312)

1. Hopping it will subside by itself/ taking home remedies

2. The health facility is located farther
3. Lack of money
88. Others (specify) _____

319.If "nothing" was done for the child, what was the reason? (Q312)
1. Hopping it will subside by itself/ taking home remedies
2.The health facility is located farther
3. Lack of money
88. Others (specify) _____

320. (If treated with modern drug at health facility level, Q312) After how many days did you arrive at the first health facility since the onset of fever? _____(Days)

321. If the treatment at health facility was sought after one day (Q312), what was the reason for the delay?
1.The health facility is located farther
2.Lack of money
3.Hopping it will subside by itself/ taking home remedies
88. Others (specify) _____

322. (If treated with modern drug at health facility level, Q316) Did the child given or prescribed
medication?
1. Yes 2. No

323. (if yes,Q322) What kind of medicine was prescribed or given?

	Yes	No
1. Tablets	1	2
2. Syrup	1	2
3. Injections	1	2

99. Don't know

324.Was the child admitted?
1. Yes 2. No

ANNEX V

Selection and Training of group moderators:

Three types of people will be available to conduct FGDs:-

- Recruiters, to locate and invite participants (i.e researcher/s);
- Moderators, to conduct the group discussions; and
- Note takers who list topics that will be discussed, reactions of the group participants, and ensure that the entire discussion is tape-recorded. They will also assist with the transcription of taped discussions.

If possible, FGDs will be moderated by people who already have experience with the technique, and who are familiar with the target population and culture. If skilled professionals are not available, several practice sessions will be conducted in which moderators will be trained on:

- Introduce the topics to be discussed
- Gain the confidence and trust of the participants
- Ensure the participation of everyone in the group
- Facilitate discussion among group members
- Control the timing and rhythm of the discussion
- Be sensitive to nonverbal communication

Note takers will be trained to:

- Observe and record the group dynamics and other subtle reactions and interactions that might be of interest for the analysis
- Assist the moderator by recording background information on the participants
- Develop a system for identifying all the participants and attributing their remarks

Selection and Training of Interviewers: interviewers (two male and two female) who are able to read and write the language fluently and frequently have knowledge of the culture of the study population will be selected and preferably will having previous experience in such type of study or will be trained for a few days (3-4) with theoretically and practical sessions before the actual use.

Selection of Key Informants: key informants are defined as individuals who possess special knowledge and who are willing to share their knowledge with the researcher.

The selection will be made based on two major criterions: Theory and/or data driven characteristics and personal characteristics.

ANNEX VI: GUIDE TOPICS AND QUESTIONS FOR FGD AND KI INTERVIEW (26)

FOCUS GROUP DISCUSSION GUIDE

Home Treatment of Malaria in Under Fives

Fathers of Children Under-Five Years

The moderator should make the effort to interact with the participants briefly outside of the discussion room before the focus group discussion takes place.

I. INTRODUCTION

Good morning/afternoon and thank you all for coming. My name is _____ and this is my colleague _____. We are working with A.A.U, MF, DCH, ------- We are conducting several meetings with people like you to find out how you feel about several health issues. We will be talking to groups of men and women. Your opinions are very important, and they will help us improve the kind of services

that are provided. Please tell us your feelings and ideas about the topics that come up in today's talk.

There are no right or wrong answers, and you do not have to agree with what someone else says. Everyone's contribution is valuable. We want this to be a group discussion; so don't wait for me to call on you. Just speak up. Speak up one at a time so we all can hear.

Your answers will remain confidential and anonymous. Your answers will help us plan programs for your area.

So that we do not lose any important information, we would like to tape-record the discussion. Is that all right with everyone? You may listen to the discussion at the end if you wish.

Note to the moderator: Moderators should pay attention to the mood of the group, and ask
questions about respondents' personal opinions and practices as much as possible with phrases like
"How about you?"

ICE-BREAKER EXERCISE

Conduct round-table introductions. Request each participant to take a few minutes to talk with the person on his left. He should find out all they can about that person--where he lives, how he spends his time in the village and what his interests are. Give participants 2 or 3 minutes to talk with their neighbours. Then ask each participant to introduce his neighbour to the group

WARM-UP

Make small talk, such as:

How do you find life here these days?

Pick up on what they talk about and expand into section IV

FOCUSSED DISCUSSION

- Symptom recognition and Seriousness

What are the three most common health problems among children in this community? List them in order of importance.

1. *Is malaria a serious health problem among children in this community? (If not already mentioned in #1)*
2. *What are the common signs and symptoms of malaria in children?*
3. What other fevers do you know of in this community? What are the causes of these fevers?
4. Among those mentioned, which are most dangerous fevers in this community? *(Probe: To children under five?)*
5. *We have learned that when a child gets malaria, mothers give herbs, sponging with cold water or give a panadol and only buy Chloroquine/Fansidar or take the child to a health facility as a last resort. Why do you think this is happening?*
6. *How do you define successful or unsuccessful treatment? (*Probe: What are the warning signs that tells the mothers to switch to another treatment? How do you interpret success or failure)?

Causality

7. In your view, how does a mosquito cause (malaria?)? (*Please use name given)* (Probe: When a mosquito bites, what happens?)
   What is the relationship between (malaria) and mosquito bites?
8. When is (malaria) most rampant in this area? (Probe: what is the relationship between malaria, mosquitoes and seasons of the year, especially the rainy season or the harvest season? maize and mangoes

Decision Making

9. How are decisions made, whether to treat at home or elsewhere? Who influences mothers to seek effective treatment for malaria (Chloroquine Fansidar) for their sick children?
10. What are some of the signs that indicate to the family that a child needs attention of a health worker? ***(Probe for perceived danger signs, severity)***
11. What makes mothers rush their sick child to a health facility for some conditions (e.g. snake bite) and not malaria? (If response is "Snake bite kills" then ask "What about malaria?"

Treatment Practices

12. What is the best treatment today, for malaria in children? *(Probe:*
    i. *Have you heard about chloroquine- Fansidar combination?*
    ii. *What are the barriers to effective treatment of malaria in children?*
13. We have learned that some mothers fear drugs like Fansidar? *(.Probe:*
    i. *What have you heard? What have you experienced?*
    ii. *How can we convince those mothers that it is an effective treatment for malaria?*
    iii. *Who is a credible person to convince them?*
    iv. *How can we convince mothers to obtain and these drugs before any other type of treatment for malaria in children?*

Compliance to Treatment

14. Do mothers always give all drugs as prescribed by the health worker or drug vendor to their sick children? *(Probe: Always, sometimes, never) Why or why not?)*
15. How can we convince mothers to complete the prescribed treatment of malaria for their sick children?

Sources of Treatment

16. Why do you think that some families prefer ordinary shops /drug stores to health facilities for obtaining effective anti-malarials?

Sources of Information

17. What are the sources of information about malaria for people in the community? (Probe: on prevention, on treatment)
    Which sources of information do they trust most *(Probe and rank – most to least trusted)*

Preventive Measures

18. *What can be done to prevent malaria? (Probe: do you do it? Why/Why not?) What can be done to prevent mosquito bite? (Probe: Do you do it? Why/Why not?)*
19. Have you heard that children should sleep under a mosquito net? Who told you? Do you know of any family in this community that uses them? What have they said about them?

    Do you think that they are useful? Would you be willing to pay for them?)

20. How can a community make it easy for families to buy mosquito nets?

Confirmation of Terminology and Illness Concepts

21. What should we call malaria in this community? How should we describe the relationship between mosquitoes and malaria? How can you help others to know this information?)
22. What resources do you have in this community that will enable you to effectively manage malaria? *(If the following structures are not mentioned, Probe if they are available and if they can be used: local councils, 'Edir', Revolving Funds for prevention of Malaria, Religious organisations, CBO's*)

WRAP-UP

Wrap up the discussion:

This has been a very interesting discussion....

End by saying:

Is there anything else you'd like to mention to me or to the group?

Ask more than one respondent in different ways. Then be sure to correct any blatant, dangerous misconceptions and ask the group if they have any questions about the facts.

FOCUS GROUP DISCUSSION GUIDE

Home Treatment of Malaria in Under Five

Mothers of Children Under-Five

The moderator should make the effort to interact with the participants briefly outside of the discussion room before the focus group discussion takes place.

INTRODUCTION

Good morning/afternoon, and thank you all for coming. My name is _____ and this is my colleague _____. We are working with A.A.U, MF, DCH, ------- We are conducting several meetings with people like you to find out how you feel about several health issues. We will be talking to groups of men and women. Your opinions are very important, and they will help us improve the kind of services that are provided. Please tell us your feelings and ideas about the topics that come up in today's talk.

There are no right or wrong answers, and you do not have to agree with what someone else says. Everyone's contribution is valuable. We want this to be a group discussion; so don't wait for me to call on you. Just speak up. Speak up one at a time so we all can hear.

Your answers will remain confidential and anonymous. Your answers will help us plan programs for your area.

So that we do not lose any important information, we would like to tape-record the discussion. Is that all right with everyone? You may listen to the discussion at the end if you wish.

Note to the moderator: Moderators should pay attention to the mood of the group, and ask questions about respondents' personal opinions and practices as much as possible with phrases like "How about you?"

ICE-BREAKER EXERCISE

Conduct round-table introductions. Request each participant to take a few minutes to talk with the person on her left. She should find out all they can about that person--where she lives, how she spends her time in the village and what her interests are. Give participants 2 or 3 minutes to talk with their neighbours. Then ask each participant to introduce her neighbour to the group

WARM-UP

Make small talk, such as:

How do you find life here these days?

Pick up on what they talk about and expand into section IV

FOCUSSED DISCUSSION

- Symptom recognition and Seriousness

1) *What are the three most common health problems among children in this community? List them in order of importance.*

2) *Is malaria a serious health problem among children in this community? (If not already mentioned in #1)*

3) *What are the common signs and symptoms of malaria in children?*

4) What other fevers do you know of in this community? What are the causes of these fevers?

5) Among those mentioned, which are most dangerous fevers in this community? *(Probe: To children under five?)*

6) We have learned that when a child gets malaria, mothers give herbs, sponging with cold water or give a panadol and only buy Chloroquine/Fansidar or take the child to a health facility as a last resort. Why do you think this is happening?

*7) How do you define successful or unsuccessful treatment? (*Probe: What are the warning signs that tells the mothers to switch to another treatment? How do you interpret success or failure)?

- **Causality**

8) In your view, how does a mosquito cause (malaria?)? (*Please use name given)* (Probe: When a mosquito bites, what happens?)
What is the relationship between (malaria) and mosquito bites?

9) When is (malaria) most rampant in this area? (Probe: what is the relationship between malaria, mosquitoes and seasons of the year, especially the rainy season or the harvest season? maize and mangoes

- **Decision Making**

10) How are decisions made, whether to treat at home or elsewhere? Who influences mothers to seek effective treatment for malaria (Chloroquine Fansidar) for their sick children?

11) What are some of the signs that indicate to the family that a child needs attention of a health worker? *(Probe for perceived danger signs, severity)*

12) What makes mothers rush their sick child to a health facility for some conditions (e.g. snake bite) and not malaria? (If response is "Snake bite kills" then ask "What about malaria?"

- **Treatment Practices**

13) What is the best treatment today, for malaria in children? *(Probe:*

i. *Have you heard about chloroquine- Fansidar combination?*
ii. *What are the barriers to effective treatment of malaria in children?*

14) We have learned that some mothers fear drugs like Fansidar? *(.Probe:*

iii. *What have you heard? What have you experienced?*
iv. *How can we convince those mothers that it is an effective treatment for malaria?*
v. *Who is a credible person to convince them?*
vi. *How can we convince mothers to obtain and these drugs before any other type of treatment for malaria in children?*

- **Compliance to Treatment**

15) Do mothers always give all drugs as prescribed by the health worker or drug vendor to their sick children? *(Probe: Always, sometimes, never) Why or why not?)*

16) How can we convince mothers to complete the prescribed treatment of malaria for their sick children?

- **Sources of Treatment**

17) Why do you think that some families prefer ordinary shops /drug stores to health facilities for obtaining effective anti-malarials?

- **Sources of Information**

18) What are the sources of information about malaria for people in this community? (Probe: on prevention, on treatment)

Which sources of information do they trust most *(Probe and rank – most to least trusted)*

- **Preventive Measures**

19) What can be done to prevent malaria? (Probe: Do you do it? Why/Why not?) What can be done to prevent mosquito bite? (Probe: Do you do it? Why/Why not?)

20) Have you heard that children should sleep under a mosquito net? Who told you?

Do you know of any family in this community that uses them? What have they said about them?

Do you think that they are useful? Would you be willing to pay for them?)

21) How can a community make it easy for families to buy mosquito nets?

- **Confirmation of Terminology and Illness Concepts**

22) What should we call malaria in this community? How should we describe the relationship between mosquitoes and malaria? How can you help others to know this information?)

23) What resources do you have in this community that will enable you to effectively manage malaria? *(If the following structures are not mentioned, Probe if they are available and if they can be used: local councils, 'Edir', Revolving Funds for prevention of Malaria, Religious organisations, CBO's*)

WRAP-UP

Wrap up the discussion:

This has been a very interesting discussion....

End by saying:

Is there anything else you would like to mention to me or to the group?

Ask more than one respondent in different ways. Then be sure to correct any blatant, dangerous misconceptions and ask the group if they have any questions about the facts.

MALARIA in Children Under Five

KEY INFORMANT INTERVIEW GUIDE 3

To be conducted among Traditional Healers

The purpose of the interview is to elicit a comprehensive story from each interviewee about their knowledge and attitudes and practices with regard to Malaria in children under five years of age. As much as possible, let the interviewee talk. Only interject occasionally to be sure that the topic areas in the question guide are covered.

I. INTRODUCTION

Good morning/afternoon, and thank you for coming. My name is _____ I am working with A.A.U, MF, DCH to improve delivery of services in this community. I am conducting several meetings with people like you to find out how you feel about certain health issues. Your opinions are very important, and they will help us improve the kind of service we provide.

Your answers will remain confidential and anonymous. Your answers will help us plan programs for your area. Therefore, please be as detailed as possible. We have plenty of time.

So that we do not lose any important information, I would like to tape-record the discussion. Is this all right with you? You may listen to the discussion at the end if you wish.

II. WARM-UP

Ask the respondent his/her name, occupation, how long he/she has lived there and things she/he likes to do, etc. SHARE SOMETHING PERSONAL ABOUT YOURSELF TOO.

III. INTERVIEW

I am going to ask a few questions about some health problems in this community.

- Symptom recognition and Seriousness

1. *What are the three most common health problems among children in this community? List them in order of importance.*
2. *Is malaria a serious health problem among children in this community? (If not already mentioned in #1)*
3. *What are the common signs and symptoms of malaria in children?*
4. What other fevers do you know of in this community? What are the causes of these fevers?
5. Among those mentioned, which are the most dangerous fevers in this community? *(Probe: To children under five?)*
6. *How do you define successful or unsuccessful treatment? (*Probe: What are the warning signs that tell the mother to use another type of treatment? How do you interpret success or failure)?

▪ Causality

7. In your view, how does a mosquito cause malaria? *(Please use name given and Probe:* When a mosquito bites, what happens?)
8. When is (malaria) most rampant in this area?

▪ Probe: what is the relationship between:
▪ Malaria and mosquitoes
▪ Malaria, mosquitoes and the rainy season?
▪ Malaria, mosquitoes, the rainy season, the harvest season - maize and mangoes?)

9. In your view, what do people of this area think is the cause of malaria?

▪ Decision Making

10. How are decisions made, whether to treat at home or elsewhere? Who influences mothers to seek effective treatment for malaria (Chloroquine & Fansidar) for their sick children? Are you sometimes consulted?
11. What makes mothers rush their sick child to a health facility for some conditions (e.g. snake bite) and not malaria? (If response is "Snake bite kills," then ask, "What about malaria?")

▪ Treatment Practices

12. If a child is brought to you and you suspect the child is suffering from malaria, what do you do? (*Probe for advice given, medication, referral)*
13. What is the best treatment today, for malaria in children? *(Probe:*
- *Have you heard about chloroquine- Fansidar combination?*
- *What are the barriers to effective treatment of malaria in children?*

14. We have learned that some mothers fear drugs like Fansidar? (.Probe:
- What have you heard? What have you experienced?
- How can we convince those mothers that it is an effective treatment for malaria?
- Who is a credible person to convince them?
- How can we convince mothers to obtain and use *these drugs before any* other type of treatment for malaria in children?

- **Compliance to Treatment**

15. Do mothers always give all drugs as prescribed by the health worker or drug vendor to their sick children? *(Probe: Always, sometimes, never) Why or why not?)*
16. How can we convince mothers to complete the prescribed treatment for malaria for their sick children?

- **Sources of Information**

17. What are the sources of information about malaria to people in the community? *(Probe: on prevention, on treatment, etc.)?*

18. Which of these sources of information do they trust most? *(Probe and rank – most to least trusted)*

19. What resources do you have in this community that will enable you to effectively manage malaria? *(If the following structures are not mentioned, Probe if they are available and if they can be used: local councils, 'Edir', Revolving Funds for prevention of Malaria, Religious organisations, CBO's*)

- **Preventive Measures**

20. What can people in this community do to prevent malaria?

Have you heard that children should sleep under a mosquito net? Who told you?

Do you know of any family in this community that uses them? What have they said about them?

Do you think that they are useful? Would you be willing to pay for them?)

21. How can a community make it easy for families to buy mosquito nets?

- **Confirmation of Terminology and Illness Concepts**

22. What local name should we call malaria in this community? How should we describe the relationship between mosquitoes and malaria? How can you help others to know this information?)

IV. WRAP-UP

Wrap up the discussion: "This has been a very interesting discussion"

Clarify unclear points made by the interviewee by stating: “You said….. Did I understand you correctly?"

Be sure to correct any incorrect information that the interviewee may have told you during the interview.

V. CLOSURE

Thank the interviewee

MALARIA in Children Under Five

KEY INFORMANT INTERVIEW GUIDE 4

To be conducted among Facility-Based Health Workers

The purpose of the interview is to elicit a comprehensive story from each interviewee about their knowledge and attitudes and practices concerning Malaria in uner-five children. As much as possible, let the interviewee talk. Only interject occasionally to be sure that the topic areas in the question guide are covered.

I. INTRODUCTION

Good morning/afternoon, and thank you for coming. My name is _____ I am working with A.A.U, MF, DCH to improve delivery of services in this community. I am conducting several meetings with people like you to find out how you feel about certain health issues. Your opinions are very important, and they will help us improve the kind of service we provide.

Your answers will remain confidential and anonymous. Your answers will help us plan programs for your area. Therefore, please be as detailed as possible. We have plenty of time.

So that we do not lose any important information, I would like to tape-record the discussion. Is this all right with you? You may listen to the discussion at the end if you wish.

II. WARM-UP

Ask the respondent his/her name, occupation, how long he/she has lived there and things she/he likes to do, etc. SHARE SOMETHING PERSONAL ABOUT YOURSELF TOO.

III. INTERVIEW

• Symptom Recognition and Seriousness

I am going to ask a few questions about some health problems in this community.

1. What are the 3 most common health problems among children under five years old in this community? (List them in order of importance).
2. Is malaria a serious or common health problem among children under five years old in this community? (If not already mentioned in #1)
3. What other fevers do you know of in this community? What are the causes of these fevers?
4. Among those mentioned, which are the most dangerous? *(Probe: To children under five, to pregnant women?)*
5. What is <u>the fever</u> that is recognized as malaria in this community? (Probe: In children under five. In pregnant mothers? What do people in this area call this type of fever? (local name)
6. *We have learned that when a child gets malaria, mothers give herbs, sponge with cold water or give a panadol and only buy Chloroquine/Fansidar or take the child to a health facility as a last resort. In you opinion, why do you think this is happening?*
7. What makes mothers rush their sick child to a health facility for some conditions (e.g. snake bite) and not malaria? (If response is "Snake bite kills" then ask "What about malaria?"

- **Causality**

8. When is malaria most rampant in this area?
   Probe: what is the relationship between
   a. *Malaria and mosquitoes*
   b. *Malaria, mosquitoes and the rainy season?*

c. *Malaria, mosquitoes, the rainy season and the harvest season (maize and mangoes)?*

9. In your view, what do people of this area believe is the cause of malaria?

- **Sources of Information and community Resources**

10. What are the sources of information about malaria to people in the community? *(Probe: on prevention, on treatment, etc.)?*
11. Which sources of information do they trust most? *(Probe and rank – most to least trusted)*
12. What resources do you have in this community that will enable you to effectively manage malaria? *(If the following structures are not mentioned, Probe, if they are available and if they can be used: local councils, 'Edir', Revolving Funds for prevention of Malaria, Religious organizations, CBO's*).

- **Treatment Practices**

Now, I am going to ask a few questions about how malaria is treated in this community you are serving.

13. What type of things do people in this community use or do to treat malaria in children under five years old? Of these, which are the most effective? Which of these are negative, which are positive?
14. How do you define successful or unsuccessful treatment? (*Probe: How do you decide that this treatment is not working to be able to switch to another line of treatment? How do you interpret success or failure of treatment?)*
15. What types of drugs do you prescribe for children under five suffering from malaria? What dose do you prescribe?

- **Prevention**

16. What can people in this community do to prevent malaria (Probe: Do they do it? Why/Why not?) what can people in this community do to prevent mosquito bites (Probe : Do they do it? Why/Why not?)

- **Anti Malarial Drug Policy.**

17. Have you heard of a Malaria Drug Policy for treating children? What have you heard?
18. How can the Ministry help you to implement the guidelines?
19. What do you health workers believe about the effectiveness of the recommended and alternative drugs mentioned in the policy guidelines?

- **Confirmation of Terminology and Illness Concepts**

20. What local name should we call malaria in this community?

IV. WRAP-UP

Wrap up the discussion: "This has been a very interesting discussion"

Clarify unclear points made by the interviewee by stating: “You said….. Did I understand you correctly?"

Be sure to correct any incorrect information that the respondent may have told you during the interview.

V. CLOSURE

Thank the interviewee

MALARIA IN Children Under Five

KEY INFORMANT INTERVIEW GUIDE 5

To be conducted among Drug Vendors/Shop Owners at Community Level

The purpose of the interview is to elicit a comprehensive story from each interviewee about their knowledge and attitudes and practices with regard to Malaria in children under five years of age. As much as possible, let the interviewee talk. Only interject occasionally to be sure that the topic areas in the question guide are covered.

I. INTRODUCTION

Good morning/afternoon, and thank you for am working with A.A.U, MF, DCH to improve delivery of services in this community. I am conducting several meetings with people like you to find out how you feel about certain health issues. Your opinions are very important, and they will help us improve the kind of service we provide.

Your answers will remain confidential and anonymous. Your answers will help us plan programs for your area. Therefore, please be as detailed as possible. We have plenty of time.

So that we do not lose any important information, I would like to tape-record the discussion. Is this all right with you? You may listen to the discussion at the end if you wish.

II. WARM-UP

Ask the respondent his/her name, occupation, how long he/she has lived there and things she/he likes to do, etc. SHARE SOMETHING PERSONAL ABOUT YOURSELF TOO.

III. INTERVIEW

• Symptom Recognition and Seriousness

I am going to ask a few questions about some health problems in this community.

1. What are the 3 most common health problems among children under five years old in this community? (List them in order of importance).
2. Is malaria a serious or common health problem among children under five years old in this community? **(If not already mentioned in #1**)
3. What other fevers do you know of in this community? What are the causes of these fevers?
4. Among those mentioned, which are most dangerous? *(Probe: To children under five)*
5. What is the fever that is recognised as malaria in this community? (Probe: In children under five. What do people in this area call this type of fever? (local name)
6. *We have learned that when a child gets malaria, mothers give herbs, sponging with cold water or give a panadol and only buy Chloroquine/Fansidar or take the child to a health facility as a last resort. Why do you think this is happening?*
7. What makes mothers rush their sick child to a health facility for some conditions (e.g. snake bite) and not malaria? (If response is "Snake bite kills" then ask "What about malaria?")

▪ Causality

8. When is (malaria) most rampant in this area? *Probe:*
   - *what is the relationship between, Malaria and mosquitoes*
   - *Malaria, mosquitoes and the rainy season?*
   - *Malaria, mosquitoes, the rainy season and the harvest season (maize and mangoes)?*
9. In your view, what do people of this area think is the cause of malaria?

- **Sources of Information and Community Resources**

10. *What are the sources of information about malaria to people in this community?(Probe: on prevention, on treatment)*
11. Which sources of information do they trust most *(Probe and rank – most to least important)?*
12. What resources do you have in this community that will enable you to effectively manage malaria? *(If the following structures are not mentioned, Probe if they are available and if they can be used: local councils, 'Edir', Revolving Funds for prevention of Malaria, Religious organisations, CBO's*)

- **Treatment Practices**

Now, I am going to ask a few questions about how malaria is treated in this community you are serving.

13. What type of things do people in this community use or do to treat malaria in children under five years old? Of these, which are most effective? Which ones are negative? Which ones are positive?
14. How do you define successful or unsuccessful treatment? (*Probe: How do you decide that this treatment is not working to be able to switch to another type? How do you interpret success or failure of treatment?*
15. What types of drugs do you prescribe for children under five suffering from malaria?
16. If a mother comes to you to buy medicine for malaria, which you know, is under-dose, what do you do?

- **Anti Malarial Drug Policy.**

17. Have you heard of a Malaria Drug Policy guidelines for treating malaria in children? What have you heard? (if response is "no" go to # 21)
18. How can the Ministry help you to implement the guidelines?
19. What do you as drug vendors/ shop owners believe about the effectiveness of the recommended and alternative drugs mentioned in the policy?

- **Confirmation of Terminology and Illness Concepts**

20. What local name should we call malaria in this community? How should we describe the relationship between mosquitoes and malaria? How can you help others to know this information?

IV. WRAP-UP

Wrap up the discussion: "This has been a very interesting discussion"

Clarify unclear points made by the interviewee by stating: “You said….. Did I understand you correctly?"

Be sure to correct any incorrect information that the interviewee may have told you during the interview.

V. CLOSURE

Thank the interviewee

ANNEX VII. AMHARIC VERSION OF SURVEY QUESTIONNAIRE

ቃለ መጠይቅ

መግቢያ
የየህ ቃለ መጠይቅ የተዘጋጀው በቤተሰብ ፡ ደረጃ አንድ ሰው ህመም ሲያጋጥመው የሚወስደውን እረምጃዎች ለማወቅ ሲሆን ምርምሩ የሚካሄደው በደንቢያ ወረዳ ነው፡፡

በምርምሩ ለመሳተፍ ፈቃደኝነትረ ፎርም

001. የቃለ መጠይቁ መለያ ቁጥር /----------/----------/
002. ቀበሌ /ገበሬ ማህበር----------
003. የቤት ቁጥር----------
እነደምን ዋሉ----------

እኔ ስሜ ----------እባላለሁ፡፡ በአዲስ አበባ ዩኒቨርስቲ እና በምዲካል ፋኩልቲ በህብረተሰብ ጤና የትምህርት ክፍል አማካኝነት ለሚካሄደው ምርምር እነዲሳተፉ በቅድሚያ ትብብሮን እንጠይቃለን፡፡ የዚህ መጠይቅ አላማ በቤት ውስጥ ህመም ያለበት ሕፃን ሕክምና በሚያስፈልግበት ወቅት የሚወስዳቸውን እርምጃዎችን ለማወቅ ነው፡፡ በዚሁ መሠረት በቤትዎ ውስጥ የሚገኙ የቤተሰብ አባል የሆኑ እድሜአቸው ከ5 ዓመት በታች የሆኑ ሕፃናት ባለፉት ሁለት ሣምንታት ውስጥ የታመሙትን ህመም ዓይነት

የጎበኙትን የህክምና ድርጅት ለሕክምና ለመሄድ የሚወስደውን ውሳኔ አሰጣጥ እና የመንደር ህክምና መስጫ ግለሰቦችን ያለቸውን ተፅዕኖ እነዲሁም የሞግዚቶችን እዉቀትና አመለካከት ለማወቅ ነው። ስለዚህ እርስዎም በዚህ የጥናት ምርምር እንዲሳተፍ በአክብሮት ይጠይቃሉ። በመጠይቁ ወቅት የሚሰጡት መልሶች እና አስተያየቶች በሙሉ በሚስጥር የተጠበቁ ይሆናሉ። ይሁን እንጂ የሚሰጡት መልሶች ሁሉ እውነትነት ያላቸው ቢሆኑም የሰዎችን አስተሳሰብ በህክምና ፍለጋ ዙሪያ ለማወቅ ከፍተኛ ጥቅም ይኖረዋል። በዚህ የጥናት ምርምር ላለመካፈልና በመሀል በማንኛውም ጊዜ ለማቆም መብትዎ ነው። በጥናትና ምርምር በመሳተፍዎ በጣም እናመሰግንዎታለን።

004 በዚሁ የጥናት ምርምር ለመሳተፍ ፍቃደኛ ኖት?
1. አዎን
2. አልከፈልም

005 የተጠያቂዉ ምላሽ ዉጤት
1. የተሟላ ነዉ
2. መረጃ ሰጭዉ አልተገኙም
3. አልተስማሙም
4. በከፊል ተሞልቶል
88. ሌላ----------

006. የጠያቂዉ መለያ ቁጥር----------ስም ----------
007. ቃለ መጠይቁ የቀረበበት ቀን ----------
008. የተቆጣጣሪዉ ስም----------ፈርማ----------ቀን ----------

መጠይቅ

ክፍል 1:ማኅበራዊና ሥነ-ሕዝባዊ መረጃዎች				
ተ. ቁ	መጠይቅ	የተሰጠ ምላሽ		
101	የመጀመሪያ ሞግዚትዋ በህጻኑ/ኗላይ ያላት ሚና ምንድን ነዉ?	1. እናት 2. እናት ያልሆነች 3. የወንድ ሞግዚት 88. ሌላ.....		
102	መጠይቁን የሚመልሰዉ ሰዉ ዕድሜ	(በዓመት).....		
103	መጠይቁን የሚመልሰዉ ሰዉ ፆታ	1. ወንድ 2. ሴት		
104	መጠይቁን የሚመልሰዉ ሰዉ አድራሻ	1. ቀበሌ/ገበሬ ማኅበር መለያ ቁጥር..... 2. የመንደር መለያ ቁጥር..... 3. የቤት መለያ ቁጥር.....		
105	የተጠያቂዉ/ዋ (ሞግዚትዋ) የትምህርት ደረጃ	1. ያልተማረ/ች (ማንበብና መጻፍ የማትችል)		

		2. የተማረ/ች		
106	(በተ.ቁ 105 መሠረት፡ምላሹ የተማረ ከሆነ) የትምህርቱ/ቷ ደረጃ	1. ማንበብና መጻፍ የምትችል 2. ከክፍል 1-4 ያጠናቀቀች 3. ከክፍል 5-8 ያጠናቀቀች 4. ከክፍል 9-10/9-12 ያጠናቀቀች 5. የመዘጋጃ ክፍል (11-12) የጨረሰችና ከዚያ በላይ		
107	የተጠያቂዉ (ሞግዚት) ሃይማኖት	1. ኦርቶዶክስ 2. ፕሮትስታንት/ካቶሊክ 3. ሙስሊም 88. ሌላ.....		
108	የተጠያቂዉ(ሞግዚት) ሥራ	1. ገበሬ 2. ነጋዴ 3. የቤት እመቤት 88. ሌላ.....		
109	የጋብቻ ሁኔታ(የህጻኑ/ኗ ወላጆች)	1. ያላገባ/ች 2. ያገባ/ች (አብረዉ የሚኖሩ) 3. የተፋታ/ች 4. ባል/ሚስት የሞተባት/የሞተችበት 5. የተለያዩ ባልና ሚስት (ሣይፋቱ)		
110	(በተ.ቁ 109 መሠረት፡ ያገባ/ች ከሆነ) የተጉዋዳኙ/ኟ የትምህርት ደረጃ	1. ያልተማረ/ች (ማንበብና መጻፍ የማትችል) 2. የተማረ/ች		
111	(በተ.ቁ 110 መሠረት፡ የተማለ/ች ከሆነ) የትምህርት ደረጃዉ/ዋ ስንት ነዉ?	1. ማንበብና መጻፍ የሚችል 2. ከክፍል 1-4 ያጠናቀቀች 3. ከክፍል 5-8 ያጠናቀቀች 4. ከክፍል 9-10/9-12 ያጠናቀቀች 5. የመዘጋጃ ክፍል (11-12) የጨረሰችና ከዚያ በላይ		
112	የተጓዳኟ/ኙ ስራ	1. ገበሬ 2. ነጋዴ 3. የቤት እመቤት 88. ሌላ.....		
113	የቤተሰብ ብዛት (መጠን)	(በቁጥር).....		
114	በቤት ዉስጥ ያሉ ዕድሜያቸዉ ከ 5 ዓመት በታች የሆኑ ህጻናት ብዛት	(በቁጥር).....		
115	የተጠያቂዋ/ዉ (ሞግዚት) ብሄረሰብ	1. አማራ 2. ትግሬ 3. ጉራጌ 4. ኦሮሞ 88. ሌላ.....		
116	የቤቱ ርቀት በአቅራቢያ ከሚገኝ የጤና ድርጅት በአግር መንገድ ምን ያህል ጊዜ (ሰዓት) ያስኬዳል	.....ሰዓት		
117	በዚህ አካባቢ ህጻናትን ከሚያጠቁ በሽታዎች ዋና	1ኛ.....		

	ዋናዎቹን ቢጠቅሱልን (እንደችግሩ መጠን በቅደም ተከተል ያስቀምጧቸዉ)	2ኛ..... 3ኛ.....		
ክፍል 2፡ የጥናቱ ዋና ዋና መረጃዎች				
201	የወባ በሽታ ምን እንደሆነ ያዉቃሉ?	1. አዎን 2. የለም (ወደ ጥያቄ ቁጥር 21 ይዝለሉ)		
202	(ለጥያቄ ቁጥር 201 መልስዎ አዎን ከሆነ) ቀለል ያለ (ያለተወሳሰበ)የወባ በሽታ ምልክቶችና ስሜቶች በህጻናት/ በአዋቂዎች ላይ ምን ችንደሚመስል ቢገልጹልን?	አዎን የለም 1.ትኩሳት 1 2 2.ራስ ምታት 1 2 3 ማንቀጥቀጥናብርድ ብርድ ማለት 1 2 4.የምግብ ፍላጎት ማጣት 1 2 5.የሰዉነት መገጣጠሚያ ሕመም 1 2 6.ማስታዎክ/ ማስመለስ 1 2 7.ተቅማጥ 1 2 8.የመተንፈስ ችግር 1 2 9. ሣል 1 2 10. ራስን ስቶ መንቀጥቀጥ 1 2 88.ሊላ ካለ ይጠቀስ---------- 99.አላዉቅም		
203	ኃይለኛ 3ቀ6(የተወሳሰበ) የወባ በሽታ ምልክቶችና ስሜቶች ምን እንደሚመስል ቢገልጹልን?	አዎን የለም 1.ትኩሳት 1 2 2.ራስ ምታት 1 2 3 ማንቀጥቀጥናብርድ ብርድ ማለት 1 2 4.የምግብ ፍላጎት ማጣት 1 2 5.የሰዉነት መገጣጠሚያ ሕመም 1 2 6.ማስታዎክ/ ማስመለስ 1 2 7.ተቅማጥ 1 2 8.የመተንፈስ ችግር 1 2 9. ሣል 1 2 10. ራስን ስቶ መንቀጥቀጥ 1 2 88.ሊላ ካለ ይጠቀስ---------- 99.አላዉቅም		
204.	ቢተሰቡ ዉስጥ በወባ በይበልጥ የሚጎዳዉ ማን ነዉ?(አንድ ምላሽ ብቻ ይስጡ)	1. ዕድሜያቸዉ ከ5 ዓመት በታች የሆኑ ህጻናት 2. ዕድሜያቸዉ ከ 5 ዓመትና ከዚያ በላይ 3. ነፍሰ-ጡር ሴቶች 4. ጡት የሚያጠቡ እናቶች/እመጫቶች 5. ጎልማሳ ወንዶች 6. አዛዉንቶችና ቸሮጊቶች 88.ሌላ.....		
205.	ለወባ ህመም ህክምና ቤተሰቡ ዉስጥ ቅድሚያ መሠጠት የሚገባዉ ብለዉ የሚያስቡት ማን ነዉ? (አንድ ምላሽ ብቻ ይስጡ)	1. ዕድሜያቸዉ ከ5 ዓመት በታች የሆኑ ህጻናት 2. ዕድሜያቸዉ ከ 5 ዓመትና ከዚያ በላይ 3. ነፍሰ-ጡር ሴቶች 4. ጡት የሚያጠቡ እናቶች/እመቾቶች 5. ጎልማሳ ወንዶች 6. አዛዉንቶችና ቸሮጊቶች 88. ሌላ.....		
206.	የወባ በሽታ መንስዔ ምንድን	አዎን		

	ነዉ?	<u>የለም</u> 1. በወባ ትንኝ መነደፍ 1 2 2.ቅዝቃዜ/ርጥበታማ የአየር ጠባይ/ የአየር ጠባይ ለዉጥ 1 2 3. ቆሻሻ ዕቋሪ ዉሃ 1 2 4. የሰዉ፡ የቤት እጣቢ ዉሃ 1 2 5. የተበከለ ዉሃ፡ የተመረዘ ምግብ 1 2 6. ርኩስ መንፈስ 1 2 88. ሌላ..... 99. አላዉቅም		
207.	የወባ በሽታ ከአንድ ሰዉ ወደ ሌላ ሰዉ የሚተላለፍ በሽታ ነዉ?	1. አዎን 2. አይደለም 99. አላዉቅም		
208.	(ለጥያቄ ቁጥር 206 ምላሽዎ አዎን ከሆነ) የወባ በሽታ የሚተላለፈዉ እንዴት ነዉ?	1. በሽታዉን በተሸከመች የወባ ትን አማካይነት 2. ከበሽተኛዉ ጋር በቅርበት በመነካካት/ አብሮ በመተ ት 3. ንጹህ ያልሆነ ዉሃ በመጠጣት 4. የተመረዘ ምግብ በመመገብ 5. በመጥፎ ሽታ 88. ለ ላ ካለ ይጠቀስ---------- 99. አላዉቅም		
209.	***በአብዛኛዉ የወባ ትንኝ ሰዎችን የምትነድፈዉ በየትኛዉ የቀኑ ሰዓት ይመስልዎታል?***	1. ቀን ቀን 2. ማታ በምሽት እስከ እኩለ ለሊተ 3. ማታ ከእኩለ ለሊት በኋላ 4. በማንኛዉም ሰዓት 99. አላዉቅም		
210.	የወባ ትንኞች የሚራቡበት ቦታ የት ይመስልዎታል?	1. የታቆረ ቆሻሻ ዉሃ 2. በወራጅ ዉሃ ላይ 88. ሌላ ካለ ይጠቀስ---------- 99. አላዉቅም		
211.	የወባ ትንኞች በቀን ወይም በማታ የሚያርፉት የት ይመስልዎታል?	1. በቤት ዉስጥ ባለ ጨለማ ስፍራ 2. በወራጅ ዉሃ ዳር አካባቢ 3. በቆሻሻ ስፍራ አካባቢ 88. ሌላ ካለ ይጠቀስ---------- 99. አላዉቅም		
212.	የወባ በሽታ ለመከላከል የሚቻል በሽታ ነዉ ብለዉ ያስባሉ?	1. አዎን 2. አይደለም 99. አላዉቅም		
213.	(ለጥያቄ ቁጥር 211 መልስዎ አዎን ከሆነ) የትኞቹን የወባ መከላከያ ዘዴዎች ያዉቃሉ?	<u>አዎን</u> <u>የለም</u> 1. መከላከያ መድሃኒት በመዉሰድ 1 2 2. ዲዲቲ በመርጨት 1 2 3. የወባ ትን መራቢያ ቦታዎችን ማጥፋት 1 2 4. ራስን ከትን ንክሻ በመከላከል 1 2 5. የአልጋ አጎበር በመተቀም 1 2		
214.	(ለጥያቄ ቁጥር 211 መልስዎ አዎን ከሆነ) በአሁኑ ጊዘ በቤትዎ	<u>አዎን</u> <u>የለም</u> 1. መከላከያ መድሃኒት በመዉሰድ 1 2		

	የሚጠቀሙት የወባ መከላከያ ዘዴ የትኛዉ ነዉ?	2. ዲዲቲ በመርጨት 1 2 3. የወባ ትንኝ መራቢያ ቦታዎችን ማጥፋት 1 2 4. ራስን ከትንኝ ንክሻ በመከላከል 1 2 5. የአልጋ አጎበር በመተቀም 1 2		
215.	እድሚዉ ከ 5 ዓመት በታች የሆነ ህጻን ልጅ በወባ በሽታ ቢያዝ የተሻለዉ የህክምና ዘዴ ምንድነዉ ይላሉ?	1. ህጻኑን በቤት ዉስጥ በዘመናዊ መድሃኒት ማከም 2. ህጻኑን በቤት ዉስጥ በባህላዊ መድሃኒት ማከም 3. ህጻኑን ወደ ባህላዊ መድሃኒት አዋቂ መዉሰድ 4. ህጻኑን ወደ ጠበል መዉሰድ 5. ህጻኑን ወደ ዘመናዊ የህክምና ድርጅት መዉሰድ 88. ሊላ ካለ ይጠቀስ.....		
216.	የትኞቹን ዘመናዊ የወባ መድሃኒቶች ያዉቃሉ?	<u>አዎን</u> <u>የለም</u> 1. ክሎሮክዊን 1 2 2. ፋንሲደር 1 2 3. ፕሪማክዊን 1 2 4. ኪዉኒን 1 2 88. ሊላ ካለ ይጠቀስ..... 99.አላዉቅም		
217.	የትኛዉ መድሃኒት ወባን በማዳን የበለጠ ዉጤት ያለዉ ይመስልዎታል? (አንድ ምላሽ ብቻ ይስጡ)	1. ክሎሮክዊን 2.ፋንሲደር 3. ፕሪማክዊን 4. ኪዉኒን 99.አላዉቅም		
218.	በአሁኑ ጊዚ ፋንሲደር ለወባ ህክምና ዉጤታማ የሆነ መድሃኒት ይመስለዎታል? (ናሙናዉን ያሳዩአቸዉ)	1. አዎን 2. አይደለም 99. አላዉቅም		
219	ልጅዎ በወባ በሽታ በሚታመም ጊዚ በጤና ድርጅት ሲታከም የትኛዉን ዓይነት የመድሃኒት አወሳሰድ መንገድ ይመርጣሉ?	1.በመርፌ የሚሰጥ 2.በአፍ የሚወሰድ 3.ምንም ምርጫ የለንም		
220	(ለጥያቄ ቁጥር 218 መልስዎ በመርፌ የሚሰጠዉን ከሆነ) በመርፌ የሚሰጠዉን መድሃኒት የመረጡበት ምክንያት ምንድን ነዉ?	1. በፍጥነት ስለሚሰራ 2. ከሊላዉ መድሃኒት የተሻለ ፍቱንነት ስላለዉ 88. ሊላ ካለ ይጠቀስ----------		
221	ወባን ለማከም የሚረዱ የባህል ህክምና መስጫ መንገዶች ዉስጥ ከሚከተሉት የትኞቹን ያዉቃሉ?	<u>አዎን</u> <u>የለም</u> 1. ቅጠሎች 1 2 2. ሥራሥሮች 1 2		

		3. ለመድሃኒትነት የሚጠቅም ተክል 1 2 4. ጠበል 1 2 88. ሊላ ካለ ይጠቀስ---------- --- 99. አላዉቅም		
222.	በዚህ አካባቢ የወባ በሽታ ትልቅ የህብረተሰብ ችግር የሚሆነዉ በየትኞቹ ወራት (ወቅቶች) ነዉ?	1. መስከረም 2. ጥቅምት 3. ህዳር 4.ታህሣሥ 5. ጥር 6. የካቲት 7. መጋቢት 8. ሚያዝያ 9. ግንቦት 10. ሰኔ 11. ሐምሌ 12. ነሐሴ 99. አላዉቅም		
223.	ስለ የአልጋ አጎበር ሰምተዉ ያዉቃሉ?	1. አዎን 2. የለም (ወደ ጥያቄ ቁጥር 231 ይዝለሉ)		
224.	(ለጥያቄ ቁጥር 222 መልስዎ አዎን ከሆነ) ስለ የአልጋ አጎበር የሰሙት ከየት ነበር?	1. ከራዲዮ 2. ከጤና ተጠሪዎች 3. ከጤና ባለሙያዎች 88. ሊላ ካለ ይጠቀስ---------- ----		
225.	የወባ መከላከያ የአልጋ አጎበር ጥቅም ምንድን ነዉ?	1. ከወባ ትንን ንክሻ/ረብሻ ይከላከላል 2. ከወባ በሽታ ይከላከላል 88. ሊላ ካለ ይጠቀስ---------- ---		
226.	በአሁኑ ሰዓት በቢታችሁ ዉስጥ የወባ መከላከያ የአልጋ አጎበር አላችሁ?	1. አዎን 2. የለም (ወደ ጥያቂ ቁጥር 231 ይዝለሉ)		
227.	(ለጥያቄ ቁጥር 225 መልስዎ አዎን ከሆነ) ምን ያህል የአልጋ አጎበር እንዳለ ቢነግሩን? (ጠያቂዉ መኖሩን በማየት ያረጋግጥ)	(በቁጥር)----------		
228.	(ለጥያቄ ቁጥር 225 መልስዎ አዎን ከሆነ) የአልጋ አጎበሩ በኪሚካል የተነከረ ነዉን?	1. አዎን 2. አይደለም		
229.	(ለጥያቄ ቁጥር 225 መልስዎ አዎን ከሆነ) ትላንት ለዛሬ ሌሊት በአጎበሩ ተጠቅሞ ያደረ ማን ነበር?	1. እናትና አባት 2. አባት ብቻዉን 3. ትልቅ ልጆች 88. ሊላ ካለ ይጠቀስ----------		
230.	(ለጥያቄ ቁጥር 225 መልስዎ አዎን ከሆነ) ትላንት ለዛሬ ሌሊት ዕድሚያቸዉ ከ 5 ዓመት በታች ያሉ ህጻናት በአጎበሩ ተጠቅመዉበታል?	1. አዎን 2. የለም		

231.	**በቢተሰባችሁ ዉስጥ ካሉት ዕድሚያቸዉ ከ 5 ዓመት በታች የሆኑ ህጻናት መካከል ከባለፉት 2 ሣምንታት ወዲህ (ከጥናቱ መጀመር በፊት) ትኩሳት የታየባቸዉ አሉን?**	**1. አዎን** **2. የለም (መልስዎ የለም ከሆነ ወደ ቀጣዩ የመጠይቅ ክፍል እንዳያመሩ)**		

232. **(ለጥያቄ ቁጥር 230 መልስዎ አዎን ከሆነ) እባክዎን ቀጣዩን ከዚህ በታች ያለዉን ሠንጠረዥ መረጃ ይሙሉ፡**

የህጻኑ ሥም **(ዕድሚዉ ከ 5 ዓመት በታች የሆነ)**	**ጾታ** **1.ወንድ** **2. ሲት**	**ዕድሚ** **(በወራት)**	**በሁለት ወራት ዉስጥ የታየ የትኩሳት ብዛት (በቁጥር)**	**ያለፈ ትኩሳት**	
				1.አዎን **2.የለም**	**(መልስዎ አዎን ከሆነ) ትኩሳቱ የቆየበት ጊዚ(በቀናት)**

መጠይቅ 2

301. **(በጥያቂ ቁጥር 231 መሠረት፡ ትኩሳቱ የተጠናቀቀለት ህጻን)**
ስም.....
የቢት ቁጥር/ ኮድ.....

<u>መጠይቅ ክፍል 3፡ በቤት ዉስጥ የሚደረግ የትኩሳት ሕክምና</u>				
ተ.ቁ	**መጠይቅ**	**ምላሽ**		
302	**ከትኩሳት በተጨማሪ በህጻኑ ላይ የታዩ የበሽታ ምልክቶችና ስሚቶች የትኞቹ ናቸዉ?**	**<u>አዎን</u> <u>የለም** **1. ሣል 1 2** **2. ማንቀጥቀጥና**		

		ብርድ ብርድ ማለት 1 2 3. የምግብ ፍላጎት ማጣት 1 2 4. ራስ ምታት 1 2 5. ማስታዎክ/ ማስመለስ 1 2 6. የመተንፈስ ችግር 1 2 7. የሰዉነት መገጣጠሚያ ሕመም 1 2 8. ማስመለስ 1 2 9. ተቅማጥ 1 2 10. ራስን ስቶ መንቀጥቀጥ1 2 88. ሊላ ካለ ይጠቀስ.....		
303	የህጻኑ የጤና ችግር ምንድን ነዉ ብለዉ ያስባሉ?	1. የወባ በሽታ 2. ተቅማጥ 3. ሣል (የመተንፈሻ አካል ችግር) 88. ሊላ ካለ ይጠቀስ..... 99. አላዉቅም		
304	የመጨረሻዉን ትኩሳት ጨምሮ ባለፈዉ አንድ ዓመት ዉስጥ ህጻኑ በወባ በሽታ ለምን ያህል ጊዚ ታሚል/ታማለች	(በቁጥር).....		
305	ህጻኑ በወባ መያዙን ለመጀመሪያ ጊዚ በቢት ዉስጥ ያወቀዉ ማን ነዉ?	1. እናት 2. አባት 88. ሊላ ካለ ይጠቀስ.....		
306	ህጻኑ በወባ አንደታመመ ለመጀመሪያ ጊዚ ያማከራችሁት ለማን ነበረ?	1. ወደ ዘመናዊ የጤና ድርጅት ተወሰደ/ች 2. ወደ ባህላዊ ፈዋሽ ተወሰደ/ች 88. ሊላ ካለ ይጠቀስ.....		
307	የህጻኑን ህመም ለማስታገስ መጀመሪያ በቢት ዉስጥ ምን ተደረገለት?	<u>አዎን</u> <u>የለም</u> 1. ዘመናዊ መድሃኒት 1 2 2. ባህላዊ መድሃኒት 1 2 3. የረጠበ ስፖንጅ/ጨርቅ 1 2 4. ምንም አልተደረገም(ወደ ጥያቂ ቁጥር 319 ይለፉ) 88. ሊላ ካለ ይጠቀስ.....		
308	(በጥያቄ ቁጥር 306 መሠረት፡ ህጻኑ በቢት ዉስጥ በዘመናዊ መድሃኒት ከታከመ) ትኩሳቱ ከጀመረ ከስንት ሰዓት በኋላ ነዉ ዘመናዊ መድሃኒቱን መዉሰድ የጀመረዉ/ቸዉ?	(በሰዓት)----------		
309	(ህጻኑ በቤት ዉስጥ በዘመናዊ መድሃኒት ከታከመ፡ በጥያቄ ቁጥር 306 መሠረት) የተሰጠዉ/ጣት መድሃኒት አይነት ምንድን ነዉ?	<u>አዎን</u> <u>የለም</u> 1. ክሎሮክዊን 1 2 2. ፋንሲደር 1 2 3. ፕሪማክዊን 1 2 4. ኮትሪሞክሳዞል 1 2 5. የህመም/ትኩሳትማስታገሻ 1 2 88. ሊላ ካለ ይጠቀስ..... 99. አላዉቅም		
310	በቤት ዉስጥ ያከሙበትን ዘመናዊ	1.በቤት ዉስጥ የቆየ/ የተረፈ/ ከዘመድ/		

	መድሃኒት ከየት አገኙት?	ከጎረቤት 2.ከፋርማሲ 3.ከትናንሽ የመድሃኒት መደብሮች 4.ከቀበሌ የጤና ተጠሪዎች 88.ሌላ ካለ ይጠቀስ----------		
311	(መድሃኒቱ የተገኘዉ ከቤት ዉጪ ከሆነ፡ በጥያቄ ቁጥር 310 መሠረት) የፀረ-ወባ መድሃኒቱን ለማግኘት በአማካይ ለምን ያህል ሰዓት በእግር ያስጉዛል?	(ሰዓት).....		
312	የሕክምና እርዳታ የፈለጋችሁት ወዴት ነበር?	1.በቤት ዉስጥ ብቻ 2.በመጀመሪያ ቤት ዉስጥ ከዚያም ወደ ዘመናዊ የጤና ድርጅት 3.በመጀመሪያ ወደ ዘመናዊ የጤና ድርጅት ከዚያም በቤት ዉስጥ 4.ምንም አላደረግሁም 88.ሌላ ካለ ይጠቀስ.....		
313	(መጀመሪያ ሕክምናዉ በቤት ዉስጥ ከተሰጠ፡ በጥያቄ ቁጥር 312 መሰረት) በቤት ዉስጥ በተሰጠ ሕክምና ህጻኑ ከህመሙ ዳነ?	1.አዎን 2.የለም		
314	(ለጥያቄ ቁጥር 313 መልስዎ የለም ከሆነ) ከቤት ዉስጥ ህክምናዉ በመቀጠል የህክምና አርዳታ የፈለጉት ወዴት ነዉ?	1.ወደ ዘመናዊ የጤና ድረጅት 2.ወደ ባህላዊ ሕክምና አዋቂ 88.ሌላ ካለ ይጠቀስ----------		
315	ለህጻኑ ሕክምና በመፈለግ ምን ያህል ቦታዎች ሄደዋል?	መጀመሪያ---------- ሁለተኛ---------- ሦስተኛ----------		
316	ሕክምናዉ የተካሄደዉ በዘመናዊ ሕክምና ድርጅት ነዉ?	1.አዎን 2.የለም		
317	(ለጥያቄ ቁጥር 316 መልስዎ አዎን ከሆነ) ህጻኑ የታየበት የጤና ድርጅት አይነት ምንድን ነዉ?	1.የህዝብ 2.የግል 88.ሌላ ካለ ይጠቀስ.....		
318	(በጥያቄ ቁጥር 312 መሰረት) ህጻኑን ወደ ዘመናዊ ሕክምና ካልዎሰዱት ምክንያትዎ ምን ነበር?	1.ይሻለዋል በማለት 2.ሕክምና ድርጅቱ ስለሚርቀን 3.ገንዘብ ስላጠረን 88. ሌላ ካለ ይጠቀስ---------- 99.አላዉቅም		
319	(ለጥያቄ ቁጥር 312 መልስዎ ምንም አላደረግሁም ከሆነ) ለህጻኑ ምንም ያላደረጉበት ምክንያትዎን ቢገልጹልን?	1. ይሻለዋል በማለት 2. ሕክምና ድርጅቱ ስለሚርቀን 3. ገንዘብ ስላጠረን 88. ሌላ ካለ ይጠቀስ---------- 99. አላዉቅም		
320	(በጥያቄ ቁጥር 312 መሰረት) ህጻኑ የታከመዉ በዘመናዊ ሕክምና ድርጅት ከሆነ በጤና ድርጅቱ ለመጀመሪያ ጊዜ የደረሱት ትኩሳቱ	(በቁጥር)----------		

	ከጀመረ ከስንት ቀን በኋላ ነዉ?			
321	(በጥያቄ ቁጥር 321 መሰረት) ህጻኑ በዘመናዊ ሕክምና ድርጅት የታየዉ ከአንድ ቀን በኋላ ከሆነ ለመዘግየት ምክንያቱ ምንድን ነበር?	1. ሕክምና ድርጅቱ ስለሚርቀን 2. ገንዘብ ስላጠረን 3. ይሻለዋል በማለት/ባህላዊ መድሃኒትስለወሰደ 88. ሊላ ካለ ይጠቀስ----------		
322	(ለጥያቄ ቁጥር 316 መልስዎ አዎን ከሆነ) ለህጻኑ መድሃኒት ተሰጥቶት ወይም ታዘለት ነበር?	1. አዎን 2. የለም		
323	(ለጥያቄ ቁጥር 322 መልስዎ አዎን ከሆነ) ለህጻኑ የታዘዘለት መድሃኒት ወይም የተሰጠዉ ምን አይነት ነበር?	<u>አዎን</u> <u>የለም</u> 1. ክኒን 1 2 2. ሹሮፕ 1 2 3.መርፊ 1 2 99. አላዉቅም		
324	(ለጥያቄ ቁጥር 316 መልስዎ አዎን ከሆነ) ሕጻኑ በጤና ድርጅቱ ተኝቶ እንዲታከም ተደርጎ ነበር?	1.አዎን 2.የለም		

ANNEX VIII-FGD AND KI GUIDES (AMHARIC VERSION)

Male FGD

ሀ. መግቢያ

እንደምን አደራችሁ/ዋላችሁ? ጥሪያችንን አክብራችሁ በመምጣታችሁ በመምጣታችሁ ላመሰግናችሁ እወዳለሁ። እኔ .....እባላለሁ፡ ከእኔ ጋር የሚሰራዉ ይህ ባልደረባየ ደግሞ.....ይባላል። እኛ በኢ.ኢ.ዩ. ሜዲከል ፋከልቲ የሕብረተሰብ ጤና አጠባበቅ ት/ክፍል ለሚከሄደዉ ጥናት በመስራት ላይ እንገኛለን። እንደናንተ ከመሳሰሉ ሰች ጋርበጤና ነክ ጉዳዩች ያላቸዉን ዕዉቀት እንዲያከፍሉን ተከታታይ ዉይይቶችን በማከሄድ ላይ እንገኛለን። ከሴቶችና ከወንዶች ምድብ ጋር እንወያያለን። በዉይይቱ የምትሰጡት ሀሳብ በዚሂ አንባቢ ለሚንሄደዉ የጤና አገልግሎት አሰጣጥ መሻሻል እጅግ ጠቃሚ ነዉ። ስለሆነም በሚነሱት ርእሶች ዙሪያ የሚሰማችሁንና የምታስቡትን ሁሉ እንድታከፍሉን ትለመናላችሁ። በዉይይታችን ትክክል ወይንም ስህተት የሚባል ምላሽ አይኖርም። በተጨማሪም ሌላዉ በተናገረዉ ሃሳብ የግድ ሌላዉ መስማማት አይኖርበትም።ዐያንዳንዱ ሰዉ የሚሰጠዉ አስተያየትና ሃሳብ ዋጋ ያለዉ ነዉ። ይህ ዉይይትም የወል /የጋራ ዉይት እንዲሆን እንፈልጋለን። ስለሆነም እኔ እንድትናገሩ እድሉን ስስክሰጣችሁ ብቻ መፎበቅ አይኖርባችሁም።ይቂቁንም በመደማመጥ የተሰማንን ሃሳብ መሰንዘር ይቻላል። በዉይይታችን የምትሰጡት ምቁሽ ሚስጢራዊነት የተጠበቀ ይሆናል። የተናጋሪዉ ስምም አይገለጽም። የእናንተ የዉይይት ዉጤት ለአከባቢያችሁ ጠቃሚ እቅዶችን ለማዉጣት ያግዙናል። ስለሆነም ማንኛዉም ጠቃሚ መረጃ እንዲያመልጠን አልፈልግም። እናም ዉይይቱን መቅዳት እንፈልጋለን። ይህ በእናንተ በኩል ችግር ይኖረዋል? ከስፈለገ በመጨረሻም ልታዳምጡት ትችላላችሁ።

ለ. የዉይይት መክፈቻ

በተሳታፊች መከከል ትዉዉቅ ማከሄድ፡ እያንዳንዱ ተሳታፊ ጥቂት ደቂቃች ወስዶ በአጠፉቡ ከለ ሰዉ ጋር እንዲነጋገር ይፍቀዱ። ስለ ሰዉየዉ የት እንደሚኖር፡ ጊዜዉን በሰፈር ዉስጥ እንዴት አንደሚያሳልፍ፡እና ፍላጎቱ ምን እንደሆነ ይጠያየቁ፡ ለዚህም ከ 2-3 ደቂቃ ይፈቀዱላቸዉ። በመቀጠልም እያንዳንዱ ተሳታፊ በአጠገቡ ያለዉን ሰዉ ለሌሎች ተሳታፊች ያስተዋዉቅ።

ሐ. ዉይይቱን ማስጀመር

መጠነኛ ንግግር በማድረግ ዉይይቱን ያስጀምሩ። እንዲህ በማለት ይጠይቁ፡-
በአከባቢያችሁ ህይወት ምን ትመስላለች?
በዉይይቱ መከከል ከሚያነሱት ሃሳብ በመነሳት ዉይይቱን ወደ ዋናዉ የዉይይት ክፍል (መ) ይምሩት።

መ. የቡድን ተኮር ዉይይት

- ስለ የበሽታ ምልክቶችና አደገኛነት ያላቸዉ ዕዉቀት

1. በዚህ አከባቢ በህጻናት ላይ በብዛት የሚታዩ ዋና ዋና በሽታች የትኞች ናቸዉ? (እንደችግሩ መጠን በተርታ ያስቀምጧቸዉ)
2. የወባ በሽታ በአንባቢያችሁ በህጻናት ላይ የሚከሰት በሽታ ነዉን? (በተራ ቁጥር 1 ምላሽ ዉስጥ ከልተጠቀሰ)
3. በህጻናት ላይ የሚታዩ የበሽታዉ ዋና ዋና ሚልክቶችና ስሜቶች ምንድን ናቸዉ?
4. በዚህ አከባቢ ሌሎች ትኩሳትን የሚያስከትሉ የሚታዩ በሽታች ምን ምን ናቸዉ? የትኩሳቱ መንስዔ ምንድን ነዉ ትላላችሁ?
5. ከላይ ከተጠቀሱት ትኩሳትን የሚያመጡ በሽታች መከከል በዚህ አከባቢ ለህጻናት ህይወት አደገኛ የሆኑት የትኞቹ ናቸዉ ? (ያስታዉሱ ፡ ዕድሜያቸዉ ከ 5 ዓመት በታች ላሉ ህጻናት ?)
6. ከዚህ ቀደም እንደተመለከትነዉ አንድ ህጻን ልጅ በወባ ሲያዝ/ሲታመም እናቶች ባህላዊ መድሃኒትን ለታማሚዉ ይሰጣሉ ፡ በቀዝቃዛ ዉሃ በእስፖንጅ/በጨርቅ ህጻኑን ማርጠብ ወይንም የህመም ማስታገሻ መድሃኒት(ፓናዶል) ይሰጣሉ ፡ እንዲሁም ክሎሮክዊን/ፋንሲደር የተባሉ የወባ መድሃኒት በመግዛት ብቻ ለሽጻናት መስጠት ወይም ደግሞ እንደ መጨረሻ

መፍትሄ ወደ ህክምና ተቋም መውሰድ የመሳሰሉትን የመፍትሄ እርምጃችን ይወስዳሉ ፡ ይህ የሚሆነዉ ለምን ይቋስለታል ?

7. አንድን ህጻን ለወባ ህክምና ከተሰጠዉ በኋላ ህክምናዉ ዉጤት አምጥቷል ወይንም አላመጣም የሚባለዉ እንዴት ነዉ ? (ያስታዉሱ ፡ እናቶች የታመመን ልጅ ህመሙ አደገኛ ደረጃ መድረሱን የሚጠቁሚቸዉና ወደ ተሸለ ህክምና እንዲደርሱ የሚያስጠነቅቁ ምልክቶች ምንድን ናቸዉ ? በህክምናዉ የተገኘዉን መሻሻል ወይም የበሽታዉን መባባስ እንዴት ይታያል ?)

- **ስለ የበሽታ መንስዔ**

8. በእናንተ አመለከከት/እይታ (የወባ ትንኝ) (ወባ)ን የምታመጣዉ እንዴት ነዉ ? (እባክን በአከባቢዉ መጠሪያ ይጠቀሙ) (ያስታዉሱ ፡ የ (ወባ ትንኝ) ሰችን ስትነድፍ ምን ይፈጠራል ?) በወባ ትንኝና በወባ በሽታመከከል ለ ዝምድና/ግንኙነት ምን ይመስልታል ?)
9. በዚህ አከባቢ የወባ በሽታ አስቸጋሪ የሚሆንበት/በስፋት የሚዛመትበት ወቅት/ጊዜ የትኛዉ ነዉ ? (ያስታዉሱ ፡ ለወባ በሽታ ፡ በወባ ትንኝና በተለያዩ የአመቱ ወቅቶች በተለይም በዝናብ/ምርት ወቅት መከከል ያለዉ ግንኙነት/ተዛምዶ ምንድን ነዉ ? የማሽላ አገጻስ ? ማንሳና ሌሎች ፍራፍሬችስ ?)

- **ስለ ዉሳኔ አሰጣጥ**

10. ህጻኑ በቤት ዉስጥ ወይንስ ሌላ ቦታ ይታከም የሚለዉን ዉሳኔ የሚሰጠዉ ማን ነዉ? እናቶች ለልጆቻቸዉ ዉጤታማ የወባ ህክምና (ክለሮሮክዊን፡ፋንሲደር) እንዲፈልጉ የሚያበረታታቸዉ ማን ነዉ ?
11. ህጻኑ ወደ ጤና ድርጅት ሄዶ እንዲታከም ፡ ጠ ,ና ባለሙያ እገዛ እንደሚያሻዉ ቤተሰቡን የሚጠቁሙ ምልክቶች ምን ምን ናቸዉ ? (ያስታዉሱ ፡ ቤተሰቡስለ አደገኛ የበሽታ ምልክቶችና አደገኛነት ያላቸዉ ዕዉቀት)
12. እናቶች አንዳንድ የጤና ችግሮች በህጻናት ላይ ሲያጋጥማቸዉ ወደ ጤና ድርጅት ህጻኑን ዘዉ ፈጥነዉ የሚሄዱበት ሁኔታ ይታያል (ለምሳሌ ፡ እባብ ሲነደፉ) እንደዚሁ ሁሉ በወባ ሲታመሙ ይህ የማይሆነዉ ለምን ይመስላችኋል ? (ምላሻቸዉ ፡ እባብ ገዳይ ስለሆነ ፡ ከሆነ ፡ የወባ በሽታስ ? ብለዉ ይጠይቋቸዉ)

- **የህክምና አሰጣጥ ዘዴች**

13. በህጻናት ላይ ከሚደረጉ የወባ ህክምና ዘዴች የበለጠ ዉጠ ,ታማዉ የትኛዉ ነዉ ? (ያስታዉሱ ፡ ሀ. ስለ ክሎሮክዊን-ፋንሲደር ጥምር ህክምና ሰምተዋልን ?
ለ. ለህጻናት የሚደረግ የወባ ህክምና ዉጤታማ እንዳይሆን መሰናክሎች/እክሎቹ ምንድን ናቸዉ ?)

14. እንደተመለከትነዉ አንዳንድ እናቶች የወባ መድሃኒት (ፋንሲደር/ክሎሮክዊን) የመሳሰሉትን ሲፈሩ ይታያል ፡ ይህ የሚሆነዉ ለምን የመስላችኋል ? (ያስታዉሱ ፡
ሀ. በዚህ ዙሪያ ምን ሰምታችኋል ምንስ አጋጥሟችኋል (ተሞክሮአችሁ ምንድን ነዉ)?
ለ. እናቶች ዉጤታማ የሆነዉን የወባ ህክምና እንዲቀበሉ ለማድረግ እንዴት ማሳመን ይቻላል ?
ሐ. እናቶችን ለማሳመን ተቀባይነት ያለዉ ግለሰብ ማን ይመስላችኋል?
መ. እናቶች በወባ የታመመ ልጃቸዉን ይዘዉ ወደ ሌላ ህክምና ከመሄዳቸዉ በፊት እነዚህን
መድሃኒቶች ማግኘት እንዲችሉና እንዲጠቀሙባቸዉ ለማስቻል እንዴት ማሳመን ይቻላል ?

- **ስለ መድሃኒት ክትትል ሁኔታ**

15. እናቶች በወባ ለታመመ ልጃቸዉ በጤና ባለሙያ ወይም በመድሃኒት በ ,ት የታዘዘዉን መድሃኒት በትእዛዙ መሰረት በትክክል መድሃኒቱ እስከሚያልቅ ይሰጧቸዋል ? (ያስታዉሱ ፡ ሁልጊዜ፡ አንዳንዴ ፡ የለም በፍጹም ፡ ለምን ሆነ/አልሆነም ?)

16. እናቶች በወባ ለታመሙ ልጆቻቸዉ በጤና ባለሙያ ወይም በመድሃኒት በ ጎት የታዘዘላቸዉን መድሃኒት ለልጆቻቸዉ በትክክል እንዲሰጧቸዉ እንዴት ማሳመን/መስረዳት ይቻላል ?

- **የመድሃኒት መገኛች**

17. አንዳንድ ቤተሰቦች ወደ ህክምና ተቋም ከመሄድ ይልቅ ወደ መድሃኒት በ ጎት ወይንም መድሃኒትን ጨበሮ ሌላ ሽቀጥ ወደሚሸጡ ሱቆች ሄዶ መድሃኒት መግዛትን ይመርጣሉ ፡ ይህ የሚሆነዉ ለምን ይቋስላችኋል ?

- **የመረጃ ምንጮች**

18. በአከባቢያችሁ ሰች ስለወባ በሽታ መረጃ የሚያገኙት ከየት ነዉ ? (ያስታዉሱ ፡ ስለ መከላከያ ዘዴች ፡ ስለ ህክምናዉ) የትኞቹን የመረጃ ምንጮች በይበልጥ ያምኗቸዋል ? (ያስታዉሱ ፡ በጣም ከሚያምኗቸዉ እስከ ዝቅተኛዉ በደረጃ ያስቀምጧቸዉ)

- **የመከላከያ እርምጃች**

19. የወባ በሽታን ለመከላከል ምን ማድረግ ይቻላል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?) የወባ ትንኝ ንክሻን ለመከላከል ምን ማድረግ ይበጃል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?)
20. ህጻናትን የአልጋ አጎበር ስር መተኛት እንዳለባቸዉ ሰምተዋል ? ማን ነገረት ? በዚህ አከባቢ በአልጋ አጎበር የሚጠቀም በ ጎተሰብ ታዉቃላችሁ ? እነዚህ ሰች ስለ አጎበሩ ምን ይላሉ ? የአልጋ አጎበር ጠቃሚ ነዉ ብላችሁ ታስባላችሁ ? ለመግዛትስ ፈቃደኛ ናችሁ ?
21. ቤተሰቦች የወባ መከላከያ አጎበር መግዛት እንዲችሉ ለማድረግ ሕበረተሰቡ ምን ማድረግ ይችላል ?

- **የቃላትና የህመም ጽንሰ-ሃሳቦች ማረጋገጫ**

22. የወባ በሽታን በዚህ አከባቢ ምን ብለን መጥራት ይኖርብናል ? በወባ ትንኝና በወባ በወባ በሽታ መከከል ያለዉን ተዛምዶ እንዴት ይገለጻል ? ለ ጎች ሰች ይህንን መረጃ እንዲያዉቁት እንዴት እንረዳቸዋለን ?
23. በዚህ አከባቢ ወባን በሚገባ ለመከላከልና ለመቆጣጠር የሚያስችሉ በተግባር ሊዉል የሚችል ምን ሃብት አላችሁ ? (የሚከተሉት ከልተጠቀሱ ያስታዉሱ ፡ መኖሩንና መጠቀም መቻላቸዉን ፡ የወባ መከላከል/የጤና ኮሚቲ ፡ የተዘዋዋሪ ፈንድ/የገንዘብ ምንጭ/ ለወባ መከላከል ፡ ሃይማኖታዊ ድርጅቶች ፡ ሕብረተሰብ አቀፍ ድርጅቶች ፡ መንግስታዊ ያልሆኑ ድርጅቶች ፡ ወዘተ)

መዝጊያ :-

ዉይይቱን እንዲህ በማለት ይዝጉ ፡-

በእዉነቱ እጅግ አስደሳች ዉይይት ነበር ያደረግነዉ

ዉይይቱን እንዲህ በማለት ይጨርሱ ፡-

ሌላ ልትጠቅሱልኝ የምትፈልጉት ወይም ለተወያዩች ልታከፍሉት የምትፈልጉት ሃሳብ ከለ ?

(<u>ለአወያዩ</u> ፡- እባክን ከአንድ በላይ ተወያዩችን በተለያየ መንገድ ይጠይቁ ፡ ከዚያም የተሳሳተ አመለከከት/ግንዛቤ ከለ መስተከከሉን እርግጠኛ ይሁኑ ፡ እንዲሁም ተወያዩች ትክክለኛዉን የጤና መረጃ በተመለከተ ያልተረዱት ነገር ከለ ይጠይቁ)

Female FGD

ሀ. መግቢያ

እንደምን አደራችሁ/ዋላችሁ? ጥሪያችንን አክብራችሁ በመምጣታችሁ በመምጣታችሁ ላመሰግናችሁ እወዳለሁ፡፡ እኔ .....እባላለሁ፡ ከእኔ ጋር የሚሰራዉ ይህ ባልደረባየ ደግሞ.....ይባላል፡፡ እኛ በኢ.አ.ዩ. ሜዲከል ፋከልቲ የሕብረተሰብ ጤና አጠባበቅ ት/ክፍል ለሚከሄደዉ ጥናት በመስራት ላይ እንገኛለን፡፡ እንደናንተ ከመሳሰሉ ሰች ጋርበጤና ነክ ጉዳዩች ያላቸዉን ዕዉቀት እንዲያከፍሉን ተከታታይ ዉይይቶችን በማከሄድ ላይ እንገኛለን፡፡

ከሴቶችና ከወንዶች ምድብ ጋር እንወያያለን፡፡ በዉይይቱ የምትሰጡት ሀሳብ በዚሂ አንባቢ ለሚንሄደዉ የጤና አገልግሎት አሰጣጥ መሻሻል እጅግ ጠቃሚ ነዉ፡፡ ስለሆነም በሚነሱት ርእሶች ዙሪያ የሚሰማችሁንና የምታስቡትን ሁሉ እንድታከፍሉን ትለመናላችሁ፡፡ በዉይይታችን ትክክል ወይንም ስህተት የሚባል ምላሽ አይኖርም፡፡ በተጨማሪም ሌላዉ በተናገረዉ ሃሳብ የግድ ሌላዉ መስማማት አይኖርበትም፡፡ዐያንዳንዱ ሰዉ የሚሰጠዉ አስተያየትና ሃሳብ ዋጋ ያለዉ ነዉ፡፡ ይህ ዉይይትም የወል /የጋራ ዉይት እንዲሆን እንፈልጋለን፡፡ ስለሆነም እኔ እንድትናገሩ እድሉን ስስክሰጣችሁ ብቻ መፎበቅ አይኖርባችሁም፡፡ይቂቁንም በመደማመጥ የተሰማንን ሃሳብ መሰንዘር ይቻላል፡፡ በዉይይታችን የምትሰጡት ምቁሽ ሚስጢራዊነት የተጠበቀ ይሆናል፡፡ የተናጋሪዉ ስምም አይገለጽም፡፡ የእናንተ የዉይይት ዉጤት ለአከባቢያችሁ ጠቃሚ እቅዶችን ለማዉጣት ያግዙናል፡፡ ስለሆነም ማንኛዉም ጠቃሚ መረጃ እንዲያመልጠን አልፈልግም፡፡ እናም ዉይይቱን መቅዳት እንፈልጋለን፡፡ ይህ በእናንተ በኩል ችግር ይኖረዋል? ከስፈለገ በመጨረሻም ልታዳምጡት ትችላላችሁ፡፡

ለ. የዉይይት መክፈቻ

በተሳታፊች መከከል ትዉዉቅ ማከሄድ፡ እያንዳንዱ ተሳታፊ ጥቂት ደቂቃች ወስዶ በአጠፉቡ ከለ ሰዉ ጋር እንዲነጋገር ይፍቀዱ፡፡ ስለ ሰዉየዉ የት እንደሚኖር፡ ጊዜዉን በሰፊር ዉስጥ እንዴት አንደሚያሳልፍ፡እና ፍላጎቱ ምን እንደሆነ ይጠያየቁ፡ ለዚህም ከ 2-3 ደቂቃ ይፈቀዱላቸዉ፡፡ በመቀጠልም እያንዳንዱ ተሳታፊ በአጠገቡ ያለዉን ሰዉ ለሌሎች ተሳታፊች ያስተዋዉቅ፡፡

ሐ. ዉይይቱን ማስጀመር

መጠነኛ ንግግር በማድረግ ዉይይቱን ያስጀምሩ፡፡ እንዲህ በማለት ይጠይቁ፡-
በአከባቢያችሁ ህይወት ምን ትመስላለች?
በዉይይቱ መከከል ከሚያነሱት ሃሳብ በመነሳት ዉይይቱን ወደ ዋናዉ የዉይይት ክፍል (መ) ይምሩት፡፡

መ. የቡድን ተኮር ዉይይት

- ስለ የበሽታ ምልክቶችና አደገኛነት ያላቸዉ ዕዉቀት

1. በዚህ አከባቢ በህጻናት ላይ በብዛት የሚታዩ ዋና ዋና በሽታች የትኞች ናቸዉ? (እንደችግሩ መጠን በተርታ ያስቀምጧቸዉ)
2. የወባ በሽታ በአንባቢያችሁ በህጻናት ላይ የሚከሰት በሽታ ነዉን? (በተራ ቁጥር 1 ምላሽ ዉስጥ ከልተጠቀሰ)
3. በህጻናት ላይ የሚታዩ የበሽታዉ ዋና ዋና ሚልክቶችና ስሜቶች ምንድን ናቸዉ?
4. በዚህ አከባቢ ሌሎች ትኩሳትን የሚያስከትሉ የሚታዩ በሽታች ምን ምን ናቸዉ? የትኩሳቱ መንስዔ ምንድን ነዉ ትላላችሁ?
5. ከላይ ከተጠቀሱት ትኩሳትን የሚያመጡ በሽታች መከከል በዚህ አከባቢ ለህጻናት ህይወት አደገኛ የሆኑት የትኞቹ ናቸዉ ? (ያስታዉሱ ፡ ዕድሜያቸዉ ከ 5 ዓመት በታች ላሉ ህጻናት ?)
6. ከዚህ ቀደም እንደተመለከትነዉ አንድ ህጻን ልጅ በወባ ሲያዝ/ሲታመም እናቶች ባህላዊ መድሃኒትን ለታማሚዉ ይሰጣሉ ፡ በቀዝቃዛ ዉሃ በእስፖንጅ/በጨርቅ ህጻኑን ማርጠብ ወይንም የህመም ማስታገሻ መድሃኒት(ፓናዶል) ይሰጣሉ ፡ እንዲሁም ክሎሮክዊን/ፋንሲደር የተባሉ የወባ መድሃኒት በመግዛት ብቻ ለሽጻናት መስጠት ወይም ደግሞ እንደ መጨረሻ መፍትሄ ወደ ህክምና ተቋም መዉሰድ የመሳሰሉትን የመፍትሄ እርምጃችን ይወስዳሉ ፡ ይህ የሚሆነዉ ለምን ይቋስለታል ?
7. አንድን ህጻን ለወባ ህክምና ከተሰጠዉ በኋላ ህክምናዉ ዉጤት አምጥቷል ወይንም አላመጣም የሚባለዉ እንዴት ነዉ ? (ያስታዉሱ ፡ እናቶች የታመመን ልጅ ህመሙ አደገኛ ደረጃ መድረሱን የሚጠቁሟቸዉና ወደ ተሸለ ህክምና እንዲደርሱ የሚያስጠነቅቁ ምልክቶች ምንድን ናቸዉ ? በህክምናዉ የተገኘዉን መሻሻል ወይም የበሽታዉን መባባስ እንዴት ይታያል ?)

- **ስለ የበሽታ መንስዔ**

8. በእናንተ አመለከከት/እይታ (የወባ ትንኝ) (ወባ)ን የምታመጣዉ እንዴት ነዉ ? (እባክን በአከባቢዉ መጠሪያ ይጠቀሙ) (ያስታዉሱ ፡ የ (ወባ ትንኝ) ሰችን ስትነድፍ ምን ይፈጠራል ?) በወባ ትንኝና በወባ በሽታመከከል ለ ዝምድና/ግንኙነት ምን ይመስልታል ?)
9. በዚህ አከባቢ የወባ በሽታ አስቸጋሪ የሚሆንበት/በስፋት የሚዛመትበት ወቅት/ጊዜ የትኛዉ ነዉ ? (ያስታዉሱ ፡ ለወባ በሽታ ፡ በወባ ትንኝና በተለያዩ የአመቱ ወቅቶች በተለይም በዝናብ/ምርት ወቅት መከከል ያለዉ ግንኙነት/ተዛምዶ ምንድን ነዉ ? የማሸላ አገጸስ ? ማንሳና ሌሎች ፍራፍሬችስ ?)

- **ስለ ዉሳኔ አሰጣጥ**

10. ህጻኑ በቤት ዉስጥ ወይንስ ሌላ ቦታ ይታከም የሚለዉን ዉሳኔ የሚሰጠዉ ማን ነዉ? እናቶች ለልጆቻቸዉ ዉጤታማ የወባ ህክምና (ክለሮሮክዊን፡ፋንሲደር) እንዲፈልጉ የሚያበረታታቸዉ ማን ነዉ ?
11. ህጻኑ ወደ ጤና ድርጅት ሄዶ እንዲታከም ፡ ጠ ና ባለሙያ እገዛ እንደሚያሻዉ ቤተሰቡን የሚጠቁሙ ምልክቶች ምን ምን ናቸዉ ? (ያስታዉሱ ፡ ቤተሰቡስለ አደገኛ የበሽታ ምልክቶችና አደገኛነት ያላቸዉ ዕዉቀት)
12. እናቶች አንዳንድ የጤና ችግሮች በህጻናት ላይ ሲያጋጥማቸዉ ወደ ጤና ድርጅት ህጻኑን ይዘዉ ፈጥነዉ የሚሄዱበት ሁኔታ ይታያል (ለምሳሌ ፡ እባብ ሲነደፉ) እንደዚሁ ሁሉ በወባ ሲታመሙ ይህ የማይሆነዉ ለምን ይመስላችኋል ? (ምላሻቸዉ ፡ እባብ ገዳይ ስለሆነ ፡ ከሆነ ፡ የወባ በሽታስ ? ብለዉ ይጠይቋቸዉ)

- **የህክምና አሰጣጥ ዘዴች**

13. በህጻናት ላይ ከሚደረጉ የወባ ህክምና ዘዴች የበለጠ ዉጠ ታማዉ የትኛዉ ነዉ ? (ያስታዉሱ ፡ ሀ. ስለ ክሎሮክዊን-ፋንሲደር ጥምር ህክምና ሰምተዋልን ? ለ. ለህጻናት የሚደረግ የወባ ህክምና ዉጤታማ እንዳይሆን መሰናክሎች/እክሎቹ ምንድን ናቸዉ?)
14. እንደተመለከትነዉ አንዳንድ እናቶች የወባ መድሃኒት (ፋንሲደር/ክሎሮክዊን) የመሳሰሉትን ሲፈሩ ይታያል ፡ ይህ የሚሆነዉ ለምን የመስላችኋል ? (ያስታዉሱ ፡

ሀ. በዚህ ዙሪያ ምን ሰምታችኋል ምንስ አጋጥሟችኋል (ተሞክሮአችሁ ምንድን ነዉ)?

ለ. እናቶች ዉጤታማ የሆነዉን የወባ ህክምና እንዲቀበሉ ለማድረግ እንዴት ማሳመን ይቻላል ?

ሐ. እናቶችን ለማሳመን ተቀባይነት ያለዉ ግለሰብ ማን ይመስላችኋል?

መ. እናቶች በወባ የታመመ ልጃቸዉን ይዘዉ ወደ ሌላ ህክምና ከመሄዳቸዉ በፊት እነዚህን

መድሃኒቶች ማግኘት እንዲችሉና እንዲጠቀሙባቸዉ ለማስቻል እንዴት ማሳመን ይቻላል ?

- **ስለ መድሃኒት ክትትል ሁኔታ**

15. እናቶች በወባ ለታመመ ልጃቸዉ በጤና ባለሙያ ወይም በመድሃኒት ቤት የታዘዘዉን መድሃኒት በትእዛዙ መሰረት በትክክል መድሃኒቱ እስከሚያልቅ ይሰጧቸዋል ? (ያስታዉሱ ፡ ሁልጊዜ፡ አንዳንዴ ፡ የለም በፍጹም ፡ ለምን ሆነ/አልሆነም ?)
16. እናቶች በወባ ለታመሙ ልጆቻቸዉ በጤና ባለሙያ ወይም በመድሃኒት በ ት የታዘዘላቸዉን መድሃኒት ለልጆቻቸዉ በትክክል እንዲሰጧቸዉ እንዴት ማሳመን/መስረዳት ይቻላል ?

የመድሃኒት መገኛች

17. አንዳንድ ቤተሰቦች ወደ ህክምና ተቋም ከመሄድ ይልቅ ወደ መድሃኒት በ ት ወይንም መድሃኒትን ጨበሮ ሌላ ሸቀጥ ወደሚሸጡ ሱቆች ሄዶ መድሃኒት መግዛትን ይመርጣሉ ፡ ይህ የሚሆነዉ ለምን ይቋስላችኋል ?

- **የመረጃ ምንጮች**

18. በአከባቢያችሁ ሰች ስለወባ በሽታ መረጃ የሚያገኙት ከየት ነዉ ? (ያስታዉሱ ፡ ስለ መከላከያ ዘዴች ፡ ስለ ህክምናዉ) የትኞቹን የመረጃ ምንጮች በይበልጥ ያምኗቸዋል ? (ያስታዉሱ ፡ በጣም ከሚያምኗቸዉ እስከ ዝቅተኛዉ በደረጃ ያስቀምጧቸዉ)

- **የመከላከያ እርምጃች**

19. የወባ በሽታን ለመከላከል ምን ማድረግ ይቻላል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?) የወባ ትንኝ ንክሻን ለመከላከል ምን ማድረግ ይበጃል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?)
20. ህጻናትን የአልጋ አጎበር ስር መተኛት እንዳለባቸዉ ሰምተዋል ? ማን ነገረት ? በዚህ አከባቢ በአልጋ አጎበር የሚጠቀም በ ፡ተሰብ ታዉቃላችሁ ? እነዚህ ሰች ስለ አጎበሩ ምን ይላሉ ? የአልጋ አጎበር ጠቃሚ ነዉ ብላችሁ ታስባላችሁ ? ለመግዛትስ ፈቃደኛ ናችሁ ?
21. ቤተሰቦች የወባ መከላከያ አጎበር መግዛት እንዲችሉ ለማድረግ ሕበረተሰቡ ምን ማድረግ ይችላል ?

- **የቃላትና የህመም ጽንሰ-ሃሳቦች ማረጋገጫ**

22. የወባ በሽታን በዚህ አከባቢ ምን ብለን መጥራት ይኖርብናል ? በወባ ትንኝና በወባ በወባ በሽታ መከከል ያለዉን ተዛምዶ እንዴት ይገለጻል ? ለ ፡ሎች ሰች ይህንን መረጃ እንዲያዉቁት እንዴት እንረዳቸዋለን ?
23. በዚህ አከባቢ ወባን በሚገባ ለመከላከልና ለመቆጣጠር የሚያስችሉ በተግባር ሊዉል የሚችል ምን ሃብት አላችሁ ? (የሚከተሉት ከልተጠቀሱ ያስታዉሱ ፡ መኖሩንና መጠቀም መቻላቸዉን ፡ የወባ መከላከል/የጤና ኮሚቲ ፡ የተዘዋዋሪ ፈንድ/የገንዘብ ምንጭ/ ለወባ መከላከል ፡ ሃይማኖታዊ ድርጅቶች ፡ ሕብረተሰብ አቀፍ ድርጅቶች ፡ መንግስታዊ ያልሆኑ ድርጅቶች ፡ ወዘተ)

መዝጊያ ፡

ዉይይቱን እንዲህ በማለት ይዝጉ ፡-

በእዉነቱ እጅግ አስደሳች ዉይይት ነበር ያደረግነዉ

ዉይይቱን እንዲህ በማለት ይጨርሱ ፡-

ሌላ ልትጠቅሱልኝ የምትፈልጉት ወይም ለተወያዩች ልታከፍሉት የምትፈልጉት ሃሳብ ከለ ?

(<u>ለአወያዩ</u> ፡- እባክን ከአንድ በላይ ተወያዩችን በተለያየ መንገድ ይጠይቁ ፡ ከዚያም የተሳሳተ አመለከከት/ግንዛቤ ከለ መስተከከሉን እርግጠኛ ይሁኑ ፡ እንዲሁም ተወያዩች ትክክለኛዉን የጤና መረጃ በተመለከተ ያልተረዱት ነገር ከለ ይጠይቁ)

Key informant interview Guide

የቁልፍ ጠቋሚ ግለሰብ መጠይቅ መመሪያ 3

በአከባቢዉ ለሚሰሩ የባህል መድ·ኒት አዋቂች የሚያገለግል ቁልፍ ጠቋሚ ግለሰብ መጠይቅ

ሀ. መግቢያ

እንደምን ዋሉ·? ጥሪዉን አክብረዉ በመምጣት ላቋሰግን እወዳለሁ·፡፡ እኔ .....እባላለሁ· እኔ በኢ.ኦ.ዴ. ሜዲከል ፋከልቲ የሕብረተሰብ ጤና አጠባበቅ ት/ክፍል

ለሚከሄደዉ ጥናት በመስራት ላይ እገኛለሁ። እንደርስ ከመሳሰሉ ሰች ጋር በጤና ነክ ጉዳዩች ያላቸዉን ዕዉቀት እንዲያከፍሉኝ ተከታታይ ዉይይቶችን በማከሄድ ላይ እገኛለሁ። በዉይይቱ የሚሰጡት ሀሳብ በዚሂ አከባቢ ለሚከሄደዉ የጤና አገልግሎት አሰጣጥ መሻሻል እጅግ ጠቃሚ ነዉ። ስለሆነም በሚነሱት ርእሶች ዙሪያ የሚሰማትኑንና የሚያስቡትን ሁሉ እንዲያከፍሉን እጠጹቃለሁ።
በዉይይታችን የሚሰጡት ምላሽ ሚስጢራዊነት የተጠበቀ ይሆናል። የእርስ ስምም አይገለጽም። የእርስ ሃሳብ ለአከባቢያችሁ ጠቃሚ እቅዶችን ለማዉጣት ያግዘናል። ስለዚህ በተቻለ መጠን በጥልቀትና በዝርዝር ያለትን ሃሳብ እንዲገልጹልን እጠጹቃለሁ።
ስለሆነም ማንኛዉም ጠቃሚ መረጃ እንዲያመልጠኝ አልፈልግም። እናም ዉይይቱን መቅዳት እፈልጋለሁ። ይህ በእርስ በኩል ችግር ይኖረዋል? ከስፈለገ በመጨረሻም ሊያዳምጡት ይችላሉ።

ለ. የዉይይት መክፈቻ
ከተጠያቂዉ ጋር ትዉዉቅ ማከሄድ፡ የሰዉየዉን ስም፡ ስራ፡ ሰዉየዉ ለምን ያህል ጊዜ በአከባቢዉ እንደኖረ፡ ጊዜዉን በሰፈር ዉስጥ ምን ነገሮችን በመስራት አንደሚያሳልፍ፡ እና ፍላጎቱ ምን እንደሆነ ይጠይቁ፡ በመቀጠልም እርስ ስለግል ሁኔታ ያጋሩዋቸዉ።

ሐ. ቃለ መጠይቅ
በዚህ አከባቢ ስላለዉ አንዳንድ የጤና ችግሮች ጥቂት ጥያቄችን ልጠይቅት እፈልጋለሁ

- **ስለ የበሽታ ምልክቶችና አደገኛነት ያላቸዉ ዕዉቀት**

1. በዚህ አከባቢ ዕድሜያቸዉ ከ 5 ዓመት በታች የሆኑ ህጻናትን የሚያፎቁ 3 ዋና ዋና የጠ ,ና ችግሮችን ቢገልጹልኝ? (እንደችግሩ መጠን በቅደም ተከተል ያስቀምጧቸዉ)
2. የወባ በሽታ በአንባቢያችሁ በህጻናት ላይ የሚከሰት ዋነኛ የጤና ችግር ነዉን? (በተራ ቁጥር 1 ምላሽ ዉስጥ ከልተጠቀሰ)
3. በህጻናት ላይ የሚታዩ የበሽታዉ ዋና ዋና ምልክቶችና ስሜቶች ምንድን ናቸዉ?
4. በዚህ አከባቢ ሌሎች ትኩሳትን የሚያስከትሉ የሚታዩ በሽታች ምን ምን ናቸዉ? የትኩሳቱ መንስዔ ምንድን ነዉ?
5. ከላይ ከተጠቀሱት ትኩሳትን የሚያመጡ በሽታች መከከል በዚህ አከባቢ ለህይወት አደገኛ የሆኑት የትኞቹ ናቸዉ ? (ያስታዉሱ ፡ ዕድሜያቸዉ ከ 5 ዓመት በታች ላሉ ህጻናት ?)
6. አንድን ህጻን ለወባ ህክምና ከተሰጠዉ በኋላ ህክምናዉ ዉጤት አምጥቷል ወይንም አላመጣም የሚባለዉ እንዴት ነዉ ? (ያስታዉሱ ፡ እናቶች የታመመን ልጅ ህመሙ አደገኛ ደረጃ መድረሱን የሚጠቁሟቸዉና ወደ ተሸለ ህክምና እንዲደርሱ የሚያስጠነቅቁ ምልክቶች ምንድን ናቸዉ ? በህክምናዉ የተገኘዉን መሻሻል ወይም የበሽታዉን መባባስ እንዴት ይታያል ?)

- **ስለ የበሽታ መንስዔ**

7. በእናንተ አመለከከት/እይታ (የወባ ትንኝ) (ወባ)ን የምታመጣዉ እንዴት ነዉ ? (እባክን በአከባቢዉ መጠሪያ ይጠቀሙ) (ያስታዉሱ ፡ የ (ወባ ትንኝ) ሰችን ስትነድፍ ምን ይፈጠራል ?) በወባ ትንኝና በወባ በሽታመከከል ለ ዝምድና/ግንኙነት ምን ይመስልታል ?)
8. በዚህ አከባቢ የወባ በሽታ አስቸጋሪ የሚሆንበት/በስፋት የሚዛመትበት ወቅት/ጊዜ የትኛዉ ነዉ ? (ያስታዉሱ ፡ በወባ በሽታ እና በወባ ትንኝ መከከል:
   በወባ በሽታ ፡ በወባ ትንኝና በዝናብ ወቅት መከከል ፡
   በወባ በሽታ ፡ በወባ ትንኝ ፡ በዝናብ ወቅት እና የምርት ወቅት መከከል ያለዉ ግንኙነት/ተዛምዶ ምንድን ነዉ ? የማሽላ አገጸስ ? ማንጎና ሌሎች ፍራፍሬችስ ?)

9. በእናንተ እይታ የአከባቢዉ ህብረተሰብ ወባ የሚመጣዉ እንዴት ነዉ ብለዉ ያስባሉ ?

- **ስለ ዉሳኔ አሰጣጥ**

10. ህጻኑ በቤት ዉስጥ ወይንስ ሌላ ቦታ ይታከም የሚለዉን ዉሳኔ የሚሰጠዉ ማን ነዉ? እናቶች ለልጆቻቸዉ ዉጤታማ የወባ ህክምና (ክለሮሮክዊን፡ፋንሲደር) እንዲፈልጉ የሚያበረታታቸዉ ማን ነዉ ? በዚህ ረገድስ ወላጆች እርስን አንዳንዱ ያማክራሉ ?
11. እናቶች አንዳንድ የጤና ችግሮች በህጻናት ላይ ሲያጋጥማቸዉ ወደ ጤና ድርጅት ህጻኑን ዘዉ ፈጥነዉ የሚሄዱበት ሁኔታ ይታያል (ለምሳሌ ፡ እባብ ሲነደፉ) እንደዚሁ ሁሉ በወባ ሲታመሙ ይህ የማይሆነዉ ለምን ይመስላችኋል ? (ምላሻቸዉ ፡ እባብ ገዳይ ስለሆነ ፡ ከሆነ ፡ የወባ በሽታስ ? ብለዉ ይጠይቋቸዉ)

- **የህክምና አሰጣጥ ዘዴች**

ከዚህ በመቀጠል ጥቂት ጥያቄችን እናንተ በምትሰሩበት ህረተረሰብ ስላለዉ የወባ ህክምና አሰጣጥ ለመጠየቅ እፈልጋለሁ

12. አንድን የታመመ ህጻን ወደ እርስ ቢያመጡልትና ህጻኑ በወባ ተይዞ ዕየተቸገረ እንደሆነ ቢጠረጥሩ ፡ ለህጻኑ ምን ያደርጉለታል ? (ያስታዉሱ ፡- መከርን ፡ መድሃኒትን ፡ ሪፈራልን በተመለከተ ይጠይቁ)
13. በህጻናት ላይ ከሚደረጉ የወባ ህክምና ዘዴች የበለጠ ዉጠ ,ታማዉ የትኛዉ ነዉ ? (ያስታዉሱ ፡ ሀ. ስለ ክሎሮክዊን-ፋንሲደር ጥምር ህክምና ሰምተዋልን ?
ለ. ለህጻናት የሚደረግ የወባ ህክምና ዉጤታማ እንዳይሆን መሰናክሎች/እክሎቹ ምንድን ናቸዉ ?)
14. እንደተመለከትነዉ አንዳንድ እናቶች የወባ መድሃኒት (ፋንሲደር/ክሎሮክዊን) የመሳሰሉትን ሲፈሩ ይታያል ፡ ይህ
የሚሆነዉ ለምን የመስላችኋል ? (ያስታዉሱ ፡
ሀ. በዚህ ዙሪያ ምን ሰምታችኋል ምንስ አጋጥሟችኋል (ተሞክሮአችሁ ምንድን ነዉ)?
ለ. እናቶች ዉጤታማ የሆነዉን የወባ ህክምና እንዲቀበሉ ለማድረግ እንዴት ማሳመን ይቻላል ?
ሐ. እናቶችን ለማሳመን ተቀባይነት ያለዉ ግለሰብ ማን ይመስላችኋል?
መ. እናቶች በወባ የታመመ ልጃቸዉን ይዘዉ ወደ ሌላ ህክምና ከመሄዳቸዉ በፊት እነዚህን
መድሃኒቶች ማግኘት እንዲችሉና እንዲጠቀሙባቸዉ ለማስቻል እንዴት ማሳመን ይቻላል ?

- **ስለ መድሃኒት ክትትል ሁኔታ**

15. እናቶች በወባ ለታመመ ልጃቸዉ በጤና ባለሙያ ወይም በመድሃኒት ቤት የታዘዘዉን መድሃኒት በትእዛዙ መሰረት
በትክክል መድሃኒቱ እስከሚያልቅ ይሰጧቸዋል ? (ያስታዉሱ ፡ ሁልጊዜ፡ አንዳንዴ ፡ የለም በፍጹም ፡ ለምን
ሆነ/አልሆነም ?)
16. እናቶች በወባ ለታመሙ ልጆቻቸዉ በጤና ባለሙያ ወይም በመድሃኒት ቤት የታዘዘላቸዉን መድሃኒት ለልጆቻቸዉ በትክክል እንዲሰጧቸዉ እንዴት ማሳመን/ማስረዳት ይቻላል ?

- **የመረጃ ምንጮች**

17. በአከባቢያችሁ ሰች ስለወባ በሽታ መረጃ የሚያገኙት ከየት ነዉ ? (ያስታዉሱ ፡ ስለ መከላከያ ዘዴች ፡ ስለ ህክምናዉ)
18. የትኞቹን የመረጃ ምንጮች በይበልጥ ያምኗቸዋል ? (ያስታዉሱ ፡ በጣም ከሚያምኗቸዉ እስከ ዝቅተኛዉ በደረጃ ያስቀምጧቸዉ)

19. በዚህ አከባቢ ወባን በሚገባ ለመከላከልና ለመቆጣጠር የሚያስችሉ በተግባር ሊዉል የሚችል ምን ሃብት አላችሁ ? (የሚከተሉት ከልተጠቀሱ ያስታዉሱ ፡ መኖሩንና መጠቀም መቻላቸዉን ፡ የወባ መከላከል/የጤና ኮሚቲ ፡ የተዘዋዋሪ ፈንድ/የገንዘብ ምንጭ/ ለወባ መከላከል ፡ ሃይማኖታዊ ድርጅቶች ፡ ሕብረተሰብ አቀፍ ድርጅቶች ፡ መንግስታዊ ያልሆኑ ድርጅቶች ፡ ወዘተ)

- **የመከላከያ እርምጃች**

20. የወባ በሽታን ለመከላከል ምን ማድረግ ይቻላል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?) የወባ ትንኝ ንክሻን ለመከላከል ምን ማድረግ ይበጃል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?)
ህጻናትን የአልጋ አጎበር ስር መተኛት እንዳለባቸዉ ሰምተዋል ? ማን ነገረት ? በዚህ አከባቢ በአልጋ አጎበር የሚጠቀም ቤተሰብ ታዉቃላችሁ ? እነዚህ ሰች ስለ አጎበሩ ምን ይላሉ ? የአልጋ አጎበር ጠቃሚ ነዉ ብላችሁ ታስባላችሁ ? ለመግዛትስ ፈቃደኛ ናችሁ ?
21. ቤተሰቦች የወባ መከላከያ አጎበር መግዛት እንዲችሉ ለማድረግ ሕበረተሰቡ ምን ማድረግ ይችላል ?

- **የቃላትና የህመም ጽንሰ-ሃሳቦች ማረጋገጫ**

22. የወባ በሽታን በዚህ አከባቢ ምን ብለን መጥራት ይኖርብናል ? በወባ ትንኝና በወባ በሽታ መከከል ያለዉን ተዛምዶ/ግንኙነት እንዴት ይገለጻል ? ሌሎች ሰች ስለዚህ መረጃ እንዲያገኙ እንዴት መርዳት ይቻላል ?

መዝጊያ ፡-

ዉይይቱን እንዲህ በማለት ይዝጉ ፡-
በእዉነቱ እጅግ አስደሳች ዉይይት ነበር ያደረግነዉ
ዉይይቱን እንዲህ በማለት ይጨርሱ ፡-
ሌላ ልትጠቅሱልኝ የምትፈልጉት ወይም ለተወያዩች ልታከፍሉት የምትፈልጉት ሃሳብ ከለ ?

(<u>ለአወያዩ</u> ፡- እባክን ከአንድ በላይ ተወያዩችን በተለያየ መንገድ ይጠይቁ ፡ ከዚያም የተሳሳተ አመለከከት/ግንዛቤ ከለ መስተከከሉን እርግጠኛ ይሁኑ ፡ እንዲሁም ተወያዩች ትክክለኛዉን የጤና መረጃ በተመለከተ ያልተረዱት ነገር ከለ ይጠይቁ)

Key informant interview Guide

የቁልፍ ጠቋሚ ግለሰብ መጠይቅ መመሪያ 4

በጤና ተቋማት ለሚሰሩ የጤና ባለሙያች የሚያገለግል ቁልፍ ጠቋሚ ግለሰብ መጠይቅ

ሀ. መግቢያ

እንደምን ዋሉ? ጥሪዉን አክብረዉ በመምጣት ላቋሰግን እወዳለሁ፡፡ እኔ .....እባላለሁ፡ እኔ በኢ.አ.ዩ. ሜዲከል ፋከልቲ የሕብረተሰብ ጤና አጠባበቅ ት/ክፍል ለሚከሄደዉ ጥናት በመስራት ላይ እገኛለሁ፡፡ እንደርስ ከመሳሰሉ ሰች ጋር በጤና ነክ ጉዳዩች ያላቸዉን ዕዉቀት እንዲያከፍሉኝ ተከታታይ ዉይይቶችን በማከሄድ ላይ እገኛለሁ፡፡ በዉይይቱ የሚሰጡት ሀሳብ በዚሂ አከባቢ ለሚከሄደዉ የጤና አገልግሎት አሰጣጥ መሻሻል እጅግ ጠቃሚ ነዉ፡፡ ስለሆነም በሚነሱት ርእሶች ዙሪያ የሚሰማችሁንና የሚያስቡትን ሁሉ እንዲያከፍሉን እጠጾቃለሁ፡፡

በዉይይታችን የሚሰጡት ምላሽ ሚስጢራዊነት የተጠበቀ ይሆናል፡፡ የእርስ ስምም አይገለጽም፡፡ የእርስ ሃሳብ ለአከባቢያችሁ ጠቃሚ እቅዶችን ለማዉጣት ያግዘናል፡፡ ስለዚህ በተቻለ መጠን በጥልቀትና በዝርዝር ያለትን ሃሳብ እንዲገልጹልን እጠጾቃለሁ፡፡

ስለሆነም ማንኛዉም ጠቃሚ መረጃ እንዲያመልጠኝ አልፈልግም፡፡ እናም ዉይይቱን መቅዳት እፈልጋለሁ፡፡ ይህ በእርስ በኩል ችግር ይኖረዋል? ከስፈለገ በመጨረሻም ሊያዳምጡት ይችላሉ፡፡

ለ. የዉይይት መክፈቻ

ከተጠያቂዉ ጋር ትዉዉቅ ማከሄድ፡ የሰዉየዉን ስም፡ ስራ፡ ሰዉየዉ ለምን ያህል ጊዜ በአከባቢዉ እንደኖረ፡ ጊዜዉን በሰፈር ዉስጥ ምን ነገሮችን በመስራት አንደሚያሳልፍ፡ እና ፍላጎቱ ምን እንደሆነ ይጠይቁ፡ በመቀጠልም እርስ ስለግል ሁኔታ ያጋሩዋቸዉ፡፡

ሐ. ቃለ መጠይቅ

በዚህ አከባቢ ስላለዉ አንዳንድ የጤና ችግሮች ጥቂት ጥያቄችን ልጠይቅት እፈልጋለሁ

- **ስለ የበሽታ ምልክቶችና አደገኝነት ያላቸዉ ዕዉቀት**

1. በዚህ አከባቢ ዕድሜያቸዉ ከ 5 ዓመት በታች የሆኑ ህጻናትን የሚያጠቁ 3 ዋና ዋና የጠ ,ና ችግሮችን ቢገልጹልኝ? (እንደችግሩ መጠን በቅደም ተከተል ያስቀምጧቸዉ)

2. የወባ በሽታ በአንባቢያችሁ በህጻናት ላይ የሚከሰት ዋነኛ የጤና ችግር ነዉን? (በተራ ቁጥር 1 ምላሽ ዉስጥ ከልተጠቀሰ)

3.በዚህ አከባቢ ሌሎች ትኩሳትን የሚያስከትሉ የሚታዩ በሽታች ምን ምን ናቸዉ? የትኩሳቱ መንስዔ ምንድን ነዉ?

4.ከላይ ከተጠቀሱት ትኩሳትን የሚያመጡ በሽታች መከከል በዚህ አከባቢ ለህይወት አደገኛ የሆኑት የትኞቹ ናቸዉ ? (ያስታዉሱ : ዕድሜያቸዉ ከ 5 ዓመት በታች ላሉ ህጻናት ?)

5.ከዚህ ቀደም እንደተመለከትነዉ አንድ ህጻን ልጅ በወባ ሲያዝ/ሲታመም እናቶች ባህላዊ መድሃኒትን ለታማሚዉ ይሰጣሉ : በቀዝቃዛ ዉሃ በእስፖንጅ/በጨርቅ ህጻኑን ማርጠብ ወይንም የህመም ማስታገሻ መድሃኒት(ፓናዶል) ይሰጣሉ : እንዲሁም ክሎሮክዊን/ፋንሲደር የተባሉ የወባ መድሃኒት በመግዛት ብቻ ለሽጻናት መስጠት ወይም ደግሞ እንደ መጨረሻ መፍትሄ ወደ ህክምና ተቋም መዉሰድ የመሳሰሉትን የመፍትሄ እርምጃችን ይወስዳሉ : ይህ የሚሆነዉ ለምን ይቋስለታል ?

6.ከዚህ ቀደም እንደተመለከትነዉ አንድ ህጻን ልጅ በወባ ሲያዝ/ሲታመም እናቶች ባህላዊ መድሃኒትን ለታማሚዉ ይሰጣሉ : በቀዝቃዛ ዉሃ በእስፖንጅ/በጨርቅ ህጻኑን ማርጠብ ወይንም የህመም ማስታገሻ መድሃኒት(ፓናዶል) ይሰጣሉ : እንዲሁም ክሎሮክዊን/ፋንሲደር የተባሉ የወባ መድሃኒት በመግዛት ብቻ ለሽጻናት መስጠት ወይም ደግሞ እንደ መጨረሻ መፍትሄ ወደ ህክምና ተቋም መዉሰድ የመሳሰሉትን የመፍትሄ እርምጃችን ይወስዳሉ : ይህ የሚሆነዉ ለምን ይቋስለታል ?

7.እናቶች አንዳንድ የጤና ችግሮች በህጻናት ላይ ሲያጋጥማቸዉ ወደ ጤና ድርጅት ህጻኑን ይዘዉ ፈጥነዉ የሚሄዱበት ሁኔታ ይታያል (ለምሳሌ : እባብ ሲነደፉ) እንደዚሁ ሁሉ በወባ

ሲታመሙ ይህ የማይሆነዉ ለምን ይመስላችኋል ? (ምላሻቸዉ ፡ እባብ ገዳይ ስለሆነ ፡ ከሆነ ፡ የወባ በሽታስ ? ብለዉ ይጠይቋቸዉ)

- **ስለ የበሽታ መንስዔ**

8.በዚህ አከባቢ የወባ በሽታ አስቸጋሪ የሚሆንበት/በስፋት የሚዛመትበት ወቅት/ጊዜ የትኛዉ ነዉ ? (ያስታዉሱ ፡

በወባ በሽታ እና በወባ ትንኝ መከከል፡

በወባ በሽታ ፡ በወባ ትንኝና በዝናብ ወቅት መከከል ፡

በወባ በሽታ ፡ በወባ ትንኝ ፡ በዝናብ ወቅት እና የምርት ወቅት መከከል

ያለዉ ግንኙነት/ተዛምዶ ምንድን ነዉ ? የማሽላ አገጸስ ? ማንሳና ሌሎች ፍራፍሬችስ ?)

9.በእርስ አመለከከት/እይታ ፡ የአከባቢዉ ሕብረተሰብ የወባ በሽታ መንስዔዉ ምንድን ነዉ ብሎ ያምናል?

- **የመረጃ ምንጮችና በተግባር ሊዉል የሚችል የአከባቢዉ ሃብቶችመገኛ**

10.በአከባቢያችሁ ሰች ስለወባ በሽታ መረጃ የሚያገኙት ከየት ነዉ ? (ያስታዉሱ ፡ ስለ መከላከያ ዘዴች ፡ ስለ ህክምናዉ)

11.የትኞቹን የመረጃ ምንጮች በይበልጥ ያምኗቸዋል ? (ያስታዉሱ ፡ በጣም ከሚያምኗቸዉ እስከ ዝቅተኛዉ በደረጃ ያስቀምጧቸዉ)

12.በዚህ አከባቢ ወባን በሚገባ ለመከላከልና ለመቆጣጠር የሚያስችሉ በተግባር ሊዉል የሚችል ምን ሃብት አላችሁ ? (የሚከተሉት ከልተጠቀሱ ያስታዉሱ ፡ መኖሩንና መጠቀም መቻላቸዉን ፡ የወባ መከላከል/የጤና ኮሚቲ ፡ የተዘዋዋሪ ፈንድ/የገንዘብ ምንጭ/ ለወባ መከላከል ፡ ሃይማኖታዊ ድርጅቶች ፡ ሕብረተሰብ አቀፍ ድርጅቶች ፡ መንግስታዊ ያልሆኑ ድርጅቶች ፡ ወዘተ)

- **የህክምና አሰጣጥ ዘዴች**

ከዚህ በመቀጠል ጥቂት ጥያቄችን እናንተ በምትሰሩበት ህረተረሰብ ስላለዉ የወባ ህክምና አሰጣጥ ለመጠየቅ እፈልጋለሁ

13.በዚህ አከባቢ ሰች ዕድሜያቸዉ ከ 5 ዓመት በታች ያሉ ህጻናትን ወባ ሲይዛቸዉ ህብረተሰቡ ለማከም ምን ይጠቀማሉ ? ከነዚህስ የበለጠ ዉጤታማዉ የትኛዉ ነዉ ? የትኞቹ አሉታዊ /አንታዊ ተጽዕኖ ያመጣሉ ?

14.ለህጻናት የተሰጠዉ ህክምና ዉጤታማ ነዉ ወይም አይደለም ለማለት የሚቻለዉ እንዴት ነዉ ? (ያስታዉሱ፡

አንድ መድሃኒት ያለመስራቱን/ያለማዳኑን አዉቀዉ ወደ ሌላ የመድሃኒት ደረጃ ለመሄድ የሚወስኑት እንዴት ነዉ? ህክምናዉ ዉጤታማ ነዉ/አይደለም የሚሉትን እንዴት ነዉ የሚተረጉሙት?)

15.በወባ ለተጠቃ ከ 5 ዓመት በታች የሆነ ሕጻን ምን ዓይነት መድሃኒት ያዙለታል ? የመድሃኒቱ አወሳሰድ መጠንስ

እንዴት ነዉ?

- **የመከላከያ እርምጃች**

16.የወባ በሽታን ለመከላከል ህብረተሰቡ ምን ማድረግ ይችላል ? (ያስታዉሱ ፡ ሰች ይህንን ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?) የወባ ትንኝ ንክሻን ለመከላከል ህብረተሰቡ ምን ማድረግ ይችላል ? (ያስታዉሱ ፡ ተግባራዊ ያደርጉታል ? ከደረጉ/ከላደረጉስ ለምን ?)

- **የፀረ-ወባ መድሃኒት ፖሊሲ**

17.ህጻናትን ለማከም ስለሚያገለግለዉ የፀረ-ወባ ፖሊሲ መመሪያ ሰምተዉ ያዉቃሉን ? ምን ሰምተዋል ?

18.የፀረ-ወባ ፖሊሲ መመሪያን ለመተግበር የጤና ጥበቃ ሚኒስቴር ምን አይነት እገዛ ያደርግላችኋል ?

19.አንደ የጤና ባለሙያነታችሁ በፖሊሲና መመሪያዉ መሰረት የታዘዙትና አማራጪ ተብለዉ የቀረቡት መድሃኒቶች
ዉጤታማ ናቸዉ ብለዉ ያምናሉ?

- **የቃላትና የህመም ጽንሰ-ሃሳቦች ማረጋገጫ**

20.የወባ በሽታን በዚህ አከባቢ አጠራር ምን ብለን መጥራት ይኖርብናል ?

መ. ማጠቃለያ :-

ዉይይቱን እንዲህ በማለት ይዝጉ :-

በእዉነቱ እጅግ አስደሳች ዉይይት ነበር ያደረግነዉ

በዉይይቱ ተጠያቂዉ ግልጽ ያላደረገዉ ነጥብ ከለ እንዲህ በማለት ይጠይቁ :- ቀደም ሲል በዉይይታችን እንዲህ..... ብለዉ ነበር ትክክል ነኝን ?

(<u>ለአወያዩ</u> :- እባክን ተጠያቂዉ በዉይይቱ ጊዜ የተሳሳተ ግንዛቤ ከለዉ መስተከከሉን እርግጠኛ ይሁኑ : እንዲሁም ተጠያቂዉ ትክክለኛዉን የጤና መረጃ በተመለከተ ያልተረዱት ነገር ከለ ይጠይቁ)

መዝጊያ :-
ተጠያቂዉን በማመስገን ዉይይቱን ይዝጉ ::

የቁልፍ ጠቋሚ ግለሰብ መጠይቅ መመሪያ 5

በሕብረተሰቡ ዉስጥ ለሚሰሩ የመድሃኒት ቤት ሰራተኞች/ባለሙያች/ባለቤቶች የሚያገለግል ቁልፍ ጠቋሚ ግለሰብ መጠይቅ

ሀ. መግቢያ

እንደምን ዋሉ? ጥሪዉን አክብረዉ በመምጣት ላቋሰግን እወዳለሁ:: እኔ .....እባላለሁ: እኔ በአ.አ.ዩ. ሜዲከል ፋከልቲ የሕብረተሰብ ጤና አጠባበቅ ት/ክፍል ለሚከዜደዉ ጥናት በመስራት ላይ እገኛለሁ:: እንደርስ ከመሳሰሉ ሰች ጋር በጤና ነክ ጉዳዩች

ያላቸዉን ዕዉቀት እንዲያከፍሉኝ ተከታታይ ዉይይቶችን በማከሄድ ላይ እገኛለሁ። በዉይይቱ የሚሰጡት ሀሳብ በዚሂ አከባቢ ለሚከሄደዉ የጤና አገልግሎት አሰጣጥ መሻሻል እጅግ ጠቃሚ ነዉ። ስለሆነም በሚነሱት ርእሶች ዙሪያ የሚሰማትንና የሚያስቡትን ሁሉ እንዲያከፍሉን እጠጽቃለሁ።
በዉይይታችን የሚሰጡት ምላሽ ሚስጢራዊነት የተጠበቀ ይሆናል። የእርስ ስምም አይገለጽም። የእርስ ሃሳብ ለአከባቢያችሁ ጠቃሚ እቅዶችን ለማዉጣት ያግዘናል። ስለዚህ በተቻለ መጠን በጥልቀትና በዝርዝር ያለትን ሃሳብ እንዲገልጹልን እጠጽቃለሁ።
ስለሆነም ማንኛዉም ጠቃሚ መረጃ እንዲያመልጠኝ አልፈልግም። እናም ዉይይቱን መቅዳት እፈልጋለሁ። ይህ በእርስ በኩል ችግር ይኖረዋል? ከስፈለገ በመጨረሻም ሊያዳምጡት ይችላሉ።

ለ. የዉይይት መክፈቻ
ከተጠያቂዉ ጋር ትዉዉቅ ማከሄድ፡ የሰዉየዉን ስም፡ ስራ፡ ሰዉየዉ ለምን ያህል ጊዜ በአከባቢዉ እንደኖረ፡ ጊዜዉን በሰፈር ዉስጥ ምን ነገሮችን በመስራት እንደሚያሳልፍ፡ እና ፍላጎቱ ምን እንደሆነ ይጠይቁ፡ በመቀጠልም እርስ ስለግል ሁኔታ ያጋሩዋቸዉ።

ሐ. ቃለ መጠይቅ
በዚህ አከባቢ ስላለዉ አንዳንድ የጤና ችግሮች ጥቂት ጥያቄችን ልጠይቅት እፈልጋለሁ

- **ስለ የበሽታ ምልክቶችና አደገኛነት ያላቸዉ ዕዉቀት**

1. በዚህ አከባቢ ዕድሜያቸዉ ከ 5 ዓመት በታች የሆኑ ህጻናትን የሚያፎቁ 3 ዋና ዋና የጠ ,ና ችግሮችን ቢገልጹልኝ? (እንደችግሩ መጠን በቅደም ተከተል ያስቀምጧቸዉ)
2. የወባ በሽታ በአንባቢያችሁ በህጻናት ላይ የሚከሰት ዋነኛ የጤና ችግር ነዉን? (በተራ ቁጥር 1 ምላሽ ዉስጥ ከልተጠቀሰ)
3. በዚህ አከባቢ ሌሎች ትኩሳትን የሚያስከትሉ የሚታዩ በሽታች ምን ምን ናቸዉ? የትኩሳቱ መንስዔ ምንድን ነዉ?
4. ከላይ ከተጠቀሱት ትኩሳትን የሚያመጡ በሽታች መከከል በዚህ አከባቢ ለህይወት አደገኛ የሆኑት የትኞቹ ናቸዉ ? (ያስታዉሱ ፡ ዕድሜያቸዉ ከ 5 ዓመት በታች ላሉ ህጻናት ?)
5. ከዚህ ቀደም እንደተመለከትነዉ አንድ ህጻን ልጅ በወባ ሲያዝ/ሲታመም እናቶች ባህላዊ መድሃኒትን ለታማሚዉ ይሰጣሉ ፡ በቀዝቃዛ ዉሃ በእስፖንጅ/በጨርቅ ህጻኑን ማርጠብ ወይንም የህመም ማስታገሻ መድሃኒት(ፓናዶል) ይሰጣሉ ፡ እንዲሁም ክሎሮክዊን/ፋንሲደር የተባሉ የወባ መድሃኒት በመግዛት ብቻ ለሽጻናት መስጠት ወይም ደግሞ እንደ መጨረሻ መፍትሄ ወደ ህክምና ተቋም መዉሰድ የመሳሰሉትን የመፍትሄ እርምጃችን ይወስዳሉ ፡ ይህ የሚሆነዉ ለምን ይቋስለታል ?
6. ከዚህ ቀደም እንደተመለከትነዉ አንድ ህጻን ልጅ በወባ ሲያዝ/ሲታመም እናቶች ባህላዊ መድሃኒትን ለታማሚዉ ይሰጣሉ ፡ በቀዝቃዛ ዉሃ በእስፖንጅ/በጨርቅ ህጻኑን ማርጠብ ወይንም የህመም ማስታገሻ መድሃኒት(ፓናዶል) ይሰጣሉ ፡ እንዲሁም ክሎሮክዊን/ፋንሲደር የተባሉ የወባ መድሃኒት በመግዛት ብቻ ለሽጻናት መስጠት ወይም ደግሞ እንደ መጨረሻ መፍትሄ ወደ ህክምና ተቋም መዉሰድ የመሳሰሉትን የመፍትሄ እርምጃችን ይወስዳሉ ፡ ይህ የሚሆነዉ ለምን ይቋስለታል ?
7. እናቶች አንዳንድ የጤና ችግሮች በህጻናት ላይ ሲያጋጥማቸዉ ወደ ጤና ድርጅት ህጻኑን ይዘዉ ፈጥነዉ

የሚሄዱበት ሁኔታ ይታያል (ለምሳሌ ፡ እባብ ሲነደፉ) እንደዚሁ ሁሉ በወባ ሲታመሙ ይህ የማይሆነዉ ለምን

ይመስላችኋል ? (ምላሻቸዉ ፡ እባብ ገዳይ ስለሆነ ፡ ከሆነ ፡ የወባ በሽታስ ? ብለዉ ይጠይቋቸዉ)

- **ስለ የበሽታ መንስዔ**

8. በዚህ አከባቢ የወባ በሽታ አስቸጋሪ የሚሆንበት/በስፋት የሚዛመትበት ወቅት/ጊዜ የትኛዉ ነዉ ? (ያስታዉሱ ፡
   በወባ በሽታ እና በወባ ትንኝ መከከል፡
   በወባ በሽታ ፡ በወባ ትንኝና በዝናብ ወቅት መከከል ፡
   በወባ በሽታ ፡ በወባ ትንኝ ፡ በዝናብ ወቅት እና የምርት ወቅት መከከል ያለዉ ግንኙነት/ተዛምዶ ምንድን ነዉ ? የማሽላ አገጸስ ? ማንሳና ሌሎች ፍራፍሬችስ ?)
9. በእርስ አመለከከት/እይታ ፡ የአከባቢዉ ሕብረተሰብ የወባ በሽታ መንስዔዉ ምንድን ነዉ ብሎ የስባል?

- **የመረጃ ምንጮችና በተግባር ሊዉል የሚችል የአከባቢዉ ሃብቶችመገኛ**

10. በአከባቢያችሁ ሰች ስለወባ በሽታ መረጃ የሚያገኙት ከየት ነዉ ? (ያስታዉሱ ፡ ስለ መከላከያ ዘዴች ፡ ስለ ህክምናዉ)
11. የትኞቹን የመረጃ ምንጮች በይበልጥ ያምኗቸዋል ? (ያስታዉሱ ፡ በጣም ከሚያምኗቸዉ እስከ ዝቅተኛዉ በደረጃ ያስቀምጧቸዉ)
12. በዚህ አከባቢ ወባን በሚገባ ለመከላከልና ለመቆጣጠር የሚያስችሉ በተግባር ሊዉል የሚችል ምን ሃብት አላችሁ ? (የሚከተሉት ከልተጠቀሱ ያስታዉሱ ፡ መኖሩንና መጠቀም መቻላቸዉን ፡ የወባ መከላከል/የጤና ኮሚቲ ፡ የተዘዋዋሪ ፈንድ/የገንዘብ ምንጭ/ ለወባ መከላከል ፡ ሃይማኖታዊ ድርጅቶች ፡ ሕብረተሰብ አቀፍ ድርጅቶች ፡ መንግስታዊ ያልሆኑ ድርጅቶች ፡ ወዘተ)

- **የህክምና አሰጣጥ ዘዴች**

ከዚህ በመቀጠል ጥቂት ጥያቄችን እናንተ በምትሰሩበት ህረተረሰብ ስላለዉ የወባ ህክምና አሰጣጥ ለመጠየቅ እፈልጋለሁ

13. በዚህ አከባቢ ሰች ዕድሜያቸዉ ከ 5 ዓመት በታች ያሉ ህጻናትን ወባ ሲይዛቸዉ ህብረተሰቡ ለማከም ምን ይጠቀማሉ ? ከነዚህስ የበለጠ ዉጤታማዉ የትኛዉ ነዉ ? የትኞቹ አሉታዊ /አንታዊ ተጽዕኖ ያመጣሉ ?
14. ለህጻናት የተሰጠዉ ህክምና ዉጤታማ ነዉ ወይም አይደለም ለማለት የሚቻለዉ እንዴት ነዉ ? (ያስታዉሱ፡ አንድ መድሃኒት ያለመስራቱን/ያለማዳኑን አዉቀዉ ወደ ሌላ የመድሃኒት ደረጃ ለመሄድ የሚወስኑት እንዴት ነዉ? ህክምናዉ ዉጤታማ ነዉ/አይደለም የሚሉትን እንዴት ነዉ የሚተረጉሙት?)
15. በወባ ለተጠቃ ከ 5 ዓመት በታች የሆነ ሕጻን ምን ዓይነት መድሃኒት ያዙለታል ? የመድሃኒቱ አወሳሰድ መጠንስ እንዴት ነዉ ?
16. ልጇ በወባ የታመመባት እናት ወደ እናንተ መድሃኒት ለመግዛት ብትመጣና መግዛት የፈለገችዉ ከትክክለኛዉ የአወሳሰድ መጠን ያነሰ መድሃኒት ቢሆን ምን ያደርጋሉ?

- **የፀረ-ወባ መድሃኒት ፖሊሲ**

17. ህጻናትን ለማከም ስለሚያገለግለዉ የፀረ-ወባ ፖሊሲ መመሪያ ሰምተዉ ያዉቃሉን ? ምን ሰምተዋል ?(ምላሹ አልሰማሁም ከሆነ ወደ ጥያቄ ቁጥር 19 ይዝለሉ)
18. የፀረ-ወባ ፖሊሲ መመሪያን ለመተግበር የጤና ጥበቃ ሚኒስቴ ር ምን አይነት እገዛ ያደርግላችኋል ?
19. አንደ የመድሃኒት ቤት ሰራተኛ/ባለሙያ በፖሊሲና መመሪያዉ መሰረት የታዘዙትና አማራጪ ተብለዉ የቀረቡት መድሃኒቶች ዉጤታማ ናቸዉ ብለዉ ያምናሉ?

- **የቃላትና የህመም ጽንሰ-ሃሳቦች ማረጋገጫ**

20. የወባ በሽታን በዚህ አከባቢ አጠራር ምን ብለን መጥራት ይኖርብናል ? በወባ ትንኝና በወባ በሽታ መከከል ያለዉን ግንኙነት/ተዛምዶ እንዴት ያዩታል? ሌሎች ሰችስ ይህንን ያዉቁት ዘንድ እንዴት ያስረዷቸዋል?

መ. ማጠቃለያ :-

ዉይይቱን እንዲህ በማለት ይዝጉ :-

በእዉነቱ እጅግ አስደሳች ዉይይት ነበር ያደረግነዉ

በዉይይቱ ተጠያቂዉ ግልጽ ያላደረገዉ ነጥብ ከለ እንዲህ በማለት ይጠይቁ ፡- ቀደም ሲል በዉይይታችን እንዲህ..... ብለዉ ነበር ትክክል ነኝን ?

(<u>ለአወያዩ</u> ፡- እባክን ተጠያቂዉ በዉይይቱ ጊዜ የተሳሳተ ግንዛቤ ከለዉ መስተከከሉን እርግጠኛ ይሁኑ ፡ እንዲሁም ተጠያቂዉ ትክክለኛዉን የጤና መረጃ በተመለከተ ያልተረዱት ነገር ከለ ይጠይቁ)

መዝጊያ ፡-
ተጠያቂዉን በማመስገን ዉይይቱን ይዝጉ ::

ANNEX IX- MAP OF DEMBIA DISTRICT AND THE COUNTRY