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Knowledge, attitude and practices of hotel staffs towards Ebola Virus Disease in Bole sub city, Addis Ababa, Ethiopia

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Knowledge, attitude and practices of hotel staffs towards Ebola Virus Disease in Bole sub city, Addis Ababa, Ethiopia

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This is to certify that the thesis prepared by Wondwosen Tilahun, entitled: *knowledge, attitude and practices of hotel staffs towards Ebola Virus Disease in Bole sub city, Addis Ababa, Ethiopia* and submitted in partial fulfillment of the requirements for the Degree of Master of Arts (Health Psychology**)** complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

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Abstract

Ebola Virus Disease (EVD) is a fatal illness. It has been causing health, economic, social and psychological problems on nationally, regionally as well as globally. The recent outbreak affected West Africa; it could spread to other countries, like Ethiopia, through trade and travel. Prevention was the best option. Hotel staff is one of the vulnerable groups for infectious disease like EVD. To design prevention strategy it is important to know their knowledge, attitude and practice towards EVD. Thus, the aim of this study was to assess the status of Knowledge, Attitude and Practice (KAP) of hotel staff in Bole sub city, Addis Ababa, Ethiopia. To examine this descriptive study design was employed with qualitative and quantitative data collection methods. Self-administered questionnaire was used to collect quantitative data from 9 hotels 396 staffs randomly selected. The questionnaire consisted of six sections with a total of 35 questions. The questions were intended to pertain respondents' socio demographic data, their knowledge, perception, behavior; attitude towards guest and practice towards EVD. The quantitative data were obtained from hotel managers through in depth interview. SPSS software was used to data entry and data analysis. Hence, Knowledge on the cause of EVD was good among hotel staff however their knowledge on sign, symptom were satisfactory. Majority of the staff believed that their chance of contracting EVD were low. The respondent's attitude towards guests and health professionals returned from West Africa was fearful and suspicious. Most of the staff believed that EVD could be prevented by avoiding physical contact. The possible reason to their knowledge and believe was multimedia intervention and interpersonal risk communication. Most of the respondents used television as source of information. Further study recommended on post epidemic phase risk communication material review.

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Abbreviations

AA	Addis Ababa
APA	American Psychology Association
CDC	Center for Disease Control
CRDA	Christian Relief and Development Association
CSA	Central Statistics Agency
DRR	Disease Risk Reduction
EPHI	Ethiopian Public Health Institute
EVD	Ebola Virus Disease
FMH	Federal Ministry of Health
HBM	Health Belief Model
ICT	Information Communication Technology
KAP	Knowledge, Attitude and Practice
PCR	Polymerase Chain Reaction
SARS	Sudden Acute Respiratory Syndrome
SCT	Social Cognitive Theory
SPSS	Statistical Package for Social Science
TPB	Theory of Planned Behavior
TTM	Trans Theoretical Model
TV	Television
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

Chapter One

1. Introduction

1.1. Background of the study

The world had faced different health, economic and social problems. Ebola virus disease (EVD) was one of the recent global challenges that human being was trying to tackle it. EVD, formerly known as Ebola haemorrhagic fever, is a severe, often fatal illness in humans. The illness is caused by Ebola Filovirus. The Ebolavirus genus is comprised of five species, Zaire, Sudan, Taı¨ Forest, Bundibugyo, and Reston, each associated with a consistent case fatality and more or less well-identified endemic area. Bausch and Schwarz (2014) state that, Zaire ebolavirus is known as the most lethal Ebola virus species, with case fatality ratios up to 90%.

The Ebola virus spreads in several ways. Human to human transmission was common in the recent outbreak. Ebola could spread through:

direct contact (through broken skin or mucous membranes in, for example, the eyes, nose, or mo uth) with;

-blood or body fluids (including but not limited to urine, saliva, sweat, feces, vomit, breast milk, and semen) of a person who is sick with Ebola ;

objects (like needles and syringes) that have been contaminated with the virus;

infected fruit bats or primates (apes and monkeys);

Contact with infected corpses (human or animal): Bodies of deceased patients or animals that died of EVD infection are highly contagious because of the high levels of virus in the corpses.

Indirect contact with contaminated objects and environments.

Ebola could not spread through the air or by water, or in general, by food.

The incubation period(period between exposure and development of symptoms) was 2 to 21 days

Symptoms start generally and are similar to common diseases like malaria, shigellosis or typhoid . A clinical diagnosis is therefore difficult. Symptoms develop progressively and filovirus infecti ons can kill rapidly. Fever, Severe headache, Muscle pain, Weakness, Diarrhea, Vomiting, Abdominal (stomach) pain, unexplained hemorrhage (bleeding or bruising)

Symptoms may appear anywhere from 2 to 21 days after exposure to Ebola, but the average is 8 t o 10 days (EPHI, 2014).

World Health Organization (WHO) stated that EVD first appeared in 1976 in 2 simultaneous outbreaks, one in Nzara, Sudan, and the other in Yambuku, Democratic Republic of Congo. The latter occurred in a village near the Ebola River, from which the disease takes its name. Since then EVD outbreak occurred for about 25 times. Case fatality rates had varied from 25% to 90% in past outbreaks.

The recent outbreak was first occurred in West Africa. The epicenter and site of first introduction was the region of Gue´cke´dou in Guinea's remote southeastern forest region, spilling over into various other regions of Guinea as well as to neighboring Liberia and Sierra Leone.

Three West African countries were highly affected by the EVD. These countries were suffering from negative impact of the disease. EVD was highly influencing not only the socio-cultural situation of the countries, but politico-economy of the region (UN ECA, 2014). EVD-related mortality and morbidity had shrunk the economic activity of the West Africa region in particular and the continent in general. This contraction reflected multiple cross-currents: falling

sales in markets and stores; lower activity for restaurants, hotels, public transport, construction and educational institutions; and slowing activity among foreign companies as many expatriates left, with a knocked on felt in lower demand for some services.

According to WHO situation report (3 February 2016), 28 603 confirmed, probable, and suspected cases have been reported in Guinea, Liberia, and Sierra Leone, with 11 301 deaths since the onset of the Ebola outbreak (WHO, 2015 b).

The recent outbreak of EVD in the West African countries was a clear demonstration of the potential for the outbreak to spill over to other countries, through travel and trade (WHO, 2014c).

The outbreak was more likely to be a result of the combination of dysfunctional health systems, international indifference, high population mobility, local customs, densely populated capitals, and lack of trust in authorities after years of armed conflict (Farrar and Piot 2014). Currently, no approved antiviral drug or vaccine exists against EVD although there are various experimental treatments and vaccines at various stages of testing for safety and effectiveness. (Iliyasu et al, 2015).

WHO recently declared that EVD was under control and the mortality and morbidity had been decreased. The main mood of transmission, human-to-human was controlled in Sierra Leon and Liberia.

Ethiopia is one of the non affected countries in Africa. There was no confirmed case in the country, according to Federal Ministry of Health (FMoH). However, the nation had trade, travel and tourism tie with West African countries, the risk of getting imported EVD was high. In order to prevent the EVD outbreak in the non affected countries like Ethiopia, World Health Organization recommended the following strategies. Initiate/enhance dissemination of public health information on EVD infection; prevention and control measures using multi-media

channels and inter-personal communications; engage and encourage participation of local and national opinion leaders in social mobilization activities; develop comprehensive communication strategies to improve response using lessons from affected countries; conduct rapid assessment of knowledge-attitude-practice (KAP) and community awareness of EVD; ensure active community involvement (community leaders, traditional healers, community groups) in information and awareness creation were the areas that WHO involves and provide supports (WHO, 2014d). Community awareness and active public participation was the crucial issues in the non affected countries to prevent the spread of EVD. If EVD outbreak occurred in non affected but potentially high risk country like Ethiopia, community awareness and mobilization reduced the damage of the disease.

Strengthening preparedness works were underway in Ethiopia to prevent EVD. Those works were multi dimensional. Preparing interim guideline of EVD, facilitating health center to treat EVD, identifying check points and screening passengers, creating awareness through multimedia like broadcasting spot message on EVD, training potential high risk groups like hotel staff about EVD were some of the readiness works.

1.2. Statement of the problem

Communication plays a vital role in the handling of outbreak situations in that it can mitigate fears and even influence desired behavioral modifications among a population. Effective communication develops confidence on the public. It helps to create the awareness of the society. This in turn boosts the readiness of the society at large (WHO, 2012). The Knowledge and attitude of the community towards mode of the transmission and prevention methods of EVD enhances through risk communication. Intensive health education using different channels brings attitudinal and behavioral change through time.

On the contrary, lack of appropriate communication creates fear and panic. Misinformation, in large part disseminated via the media, is likely to be responsible for unjustified fear (APA, 2014). Misinformed society may luck trust on the government and the media. Unreliable sources of information, especially on outbreak create delusion among the public.

In Ethiopia, EVD preparedness and response system had been strengthening in multidimensional. The Federal Ministry of Health (FMoH) had taken the necessary measures to prevent the spread of EVD to Ethiopia. Strengthen EVD surveillance, preparation of health facilities for quarantine and train health workers, organize public awareness programs were among the preparation to prevent EVD. A new Ebola treatment hospital with 50 beds, two health posts and ambulances had already been set and equipped with medical staffs. Preparing EVD guide line was the other major part of preparedness.

Hence, EVD was relatively a new phenomena and the research concerning the issue and the communication approach had been undergoing globally and nationally. As far as the researcher knowledge is concerned, the studies focusing on the KAP on EVD in Ethiopia in general and in Addis Ababa in particular was limited. Imported Ebola was the threat to Ethiopia, because the country had been trade and tourism relation with Ebola affected West African countries. Passengers from these countries used hotel. Hotel staffs have close contact with the guests from abroad (including Ebola affected countries). The knowledge, attitude and practice of hotel staff towards EVD were vital in preventing the disease. So assessing the status of Knowledge Attitude and Practice towards Ebola among Hotel staff in Bole sub city, Addis Ababa is the aim of this paper.

1.3. Objectives of the study

1.3.1. General Objective

The general objective of the study is to assess the status of Knowledge, Attitude and Practice towards Ebola Virus Disease among hotel staff in Bole sub city, Addis Ababa, Ethiopia.

1.3.2. Specific Objectives

-To explore knowledge of the staff towards EVD

-To assess attitude hotel staff towards EVD

-To examine practice of the hotel staff towards EVD

1.4. Significance of the study

Even though there was no confirmed EVD case in Ethiopia, as Federal Ministry of Health (FMoH) announced, it had been a global as well as national concern and created socio-economic problems. According to WHO, communication was one of the key areas of readiness. To effectively communicate the public about the risks there must be strategies and plans. This study assesses and analyzes the status of the risk communication of EVD and KAP of hotel staff. Doing this may have the following significances:

- To plan communication strategy that increase knowledge of hotel staff towards EVD
- To prepare document that serve as prevention guideline of hotel staffs to protect themselves and other from contagious diseases
- To change attitude and behavior towards EVD
- To serve as base line for further studies

1.5. Scope of the study

The EVD outbreak starts from West Africa and expands elsewhere. Addis Ababa, the capital city of Ethiopia, hosts many international and national offices and conferences. The nation's main airport is located in Addis Ababa and through this station many passengers from the world passed by to their destination. Whether they transit to other country or stay in the capital, the travelers was under active EVD surveillance. It is expected that the main mode of EVD transmission is from human-to-human. Travelers from Ebola affected countries were screened at air and land crossings. All travelers were expected to fill the form to be traced and screened for about 21 days. Every day they were checked for EVD.

Geographically this study delimited to Addis Ababa, Bole sub city. The researcher selected the study area purposively. First, in this sub city that Bole International Airport is found. Using the airport passengers travel from one country to other, even EVD affected countries to non EVD affected and vice versa. Second, there are many guest houses and hotels in Bole sub city. In these international hotels guests from abroad can stay for days or weeks. In short, these are among the reasons why Bole sub city is selected for this study.

Thematically, this research focused on KAP of hotel staff towards EVD. EVD surveillance, case management and using personal protective equipment are some of the prevention measures. It is known that the prevention aspect of EVD has multi sector features. To design and implement communication strategy the survey result is very important.

1.6. Operational definitions

Hotel staff is any employee working in the hotel industry (reception, food and beverage expert, guard, driver…)

Comprehensive knowledge is the complete awareness towards EVD cause, transmission and prevention mechanism.

Chapter Two

2. Review of related literature

2.1 Nature of hotel business

According to Encyclopædia Britannica definition, Hotel is building that provides lodging, meals, and other services to the traveling public on a commercial basis. Hotels serve as a "home away from home" for the travelling public. In addition, hotel serve as business exchanges, centers of sociability, places of public assembly and deliberation, decorative showcases and vacation spots.

The history of hotel dated back to the ancient civilization. Institutions were built to serve travelers in Greco-Roman culture for recuperation and rest at thermal baths. During the middle Ages various religious orders at monasteries and abbeys would offer accommodation for travelers on the road.

The precursor to the modern hotel was the inn of medieval Europe, possibly dating back to the rule of Ancient Rome. These would provide for the needs of travelers, including food and lodging, stabling and fodder for the traveler's horse(s) and fresh horses for the mail coach.

As service provider in the hospitality industry, hotels have provided different facilities to their customer. The industry is unique in its nature which tends to be service-oriented. According to Chan and Mackenzie (2013), it has four distinct features in the service delivery processes. These are described as follows:

I, product service mix

A successful hotel or hospitality business does not only count on its products and services, but also how they are delivered. The qualities of staff and the way they deliver the service are often

more important than the tangible products in making a hospitality experience satisfactory or unsatisfactory. Hence, the two features can contribute to the total experience in the service delivery process.

II. Two way communication

To achieve service excellences in the hospitality industry, two-way communication is one critical factor which requires the involvement and participation of both customers and service staff in the service delivery process.

III. Relationship Building

Building long term relationship with customers can benefit the organizations for generating stable revenues regardless of the instability of seasons and at the same time, developing brand reputations through positive word-of-mouth of the repeated customers. In order to develop brand loyalty, different methods are currently applied by the lodging and food service sectors, such as membership programs which give privileges and incentives to frequent customers.

IV. Diversity in Culture

Staffs who work in a hospitality organization always have interactions with customers from different regions or to work and corporate with other colleagues who may have different backgrounds or cultures.

2.2 Hotel in Ethiopia

The hotel industry has relatively shot history in Ethiopia. In connection with modernization the first modern hotel was opened in the 19th century. ItegueTaitu hotel, which was built in 1898 (E.C.) at the center of the city (piazza), is the first hotel in Ethiopia.

Currently, with the emergence of new and modern hotels in the country, the number has grown considerably and there were 500 star rated hotels in Ethiopia. And out of these 116 hotels are found in Addis Ababa, Ministry of culture and tourism (2010), out of these 116 star rated hotels, the international chain hotels are only three in number. These are Hilton Addis, Sheraton Addis, and Radisson Blue hotel.

The hotel industry has direct relation with tourism sector development. As the country's natural and historical tourist sites are more exposed to the world the tourists flow also increase dramatically. Hotels in Ethiopia have increased sharply over the last few years. While tourist accommodation is available as the major attraction, improvement as well as new construction is taking place.

According to ministry of culture and tourism there are 140 hotels in Addis Ababa. Most of these hotels concentrated around Bole international airport in bole sub city (Abrham, 2015).

2.3 Hotel staff and their disease vulnerability

According to Emergency Management Office of Nova Scotia (EMO NS) (2010), hotel staffs are one of the susceptible populations to infectious disease. Due to the transient nature of guests, hotel staff may be exposed to a number of people during any 24hour period, making them vulnerable depending on the mode of transmission of certain diseases. Staff often has close contact with guests through airborne particles and direct contact as they clean sheets, bathrooms and objects the guest may have had contact with (EMO NS, 2010). In this regard, EVD is not exceptional disease.

Currently, most countries have designed and implemented workplace health and safety programs. Decades ago the program was given little attention. The emergence of AIDS during

the 1980s changed the trained. The communication and social mobilization works raised awareness of blood borne diseases among staff of different industries. Most staff in any industry now cannot imagine handling blood without wearing appropriate gloves. Similarly, The SARS crisis of 2003 heightened the need to address other infectious diseases in workplace health and safety programs.

The government of Hong Kong believes that, the hotel staff is vulnerable to EVD. Thus center for health protection (CHP) needs the hotel staff cooperation to prevent and control EVD. To do so CHP provides training with the aim of knowledge enhancement towards EVD. Frontline staff is given more emphasis on the training to enhance alertness and awareness

(CHP, 2014).

Workers in healthcare are at greater risk of exposure to infectious diseases. Staffs working in Hospitality industry are also at risk of exposure to infectious diseases. Contact diseases like EVD are one of the risk to hotel staff. Contact diseases are infectious diseases transmitted through direct or indirect contact with viruses. Direct contact includes physical contact with an infected person, including contact with blood and body fluids. Indirect contact involves touching something in the environment that has been contaminated by an infected person, usually an object or surface area (for example, telephones, computers, doorknobs, elevator buttons, used tissues, or contaminated medical equipment). The contaminated hands then deposit the virus on the next object or person that they touch (WorkSafeBC, 2009).

Countries like British Columbia, organize Workers' Compensation Board to implement work place health program. According to the board workers and company managers have

responsibilities to protect their and their customer's health. To help reduce their risk of exposure to infectious pathogens, workers expected to do the following:

•Attend education and training sessions.

• Follow safe work procedures, including hand washing and wearing personal protective equipment (PPE), if applicable.

•Seek immediate first aid and medical attention after an occupational exposure.

• Report exposure incidents to supervisors or managers (WorkSafeBC, 2009).

Employers are required to fulfill the following responsibilities.

• Identify infectious diseases that are, or may be, in the workplace.

• Develop and implement an exposure control plan, when required

• Inform workers about how they may be exposed to infectious diseases in the workplace.

• Educate, train, and supervise workers on safe work procedures, including hand washing and the proper use of personal protective equipment (PPE).

• Offer vaccinations to workers who are at risk of occupational exposure.

• Purchase safety-engineered medical devices, where appropriate.

• Tell workers to seek medical attention, as required (WorkSafeBC, 2009).

2.4 Theories and models of health behavior

Theories and models of health behavior and their application can be categorized into different societal status: Individual, interpersonal and community levels. Health belief model, theory of planned behavior and stages of change are mostly applicable at individual level. Social cognitive theory of behavior changes is applicable at interpersonal level. At community level

diffusion of innovation is the appropriate model to be applied. Let us briefly look at each model and its construction starting from model applicable at individual level.

2.4.1 Health belief model

Scholars use various behavior theoretical models to analyze some kind of behavior. Different health behavior models have used to shed light on the link between perception and the likelihood to take action. Health belief model (HBM) is one such cognitive model. The HBM contains several primary concepts that predict why people will take action to prevent, to screen for, or to control illness conditions; these include susceptibility, seriousness, benefits and barriers to a behavior, cues to action, and self-efficacy. If individuals regard themselves as susceptible to a condition, believe that condition would have potentially serious consequences, believe that a course of action available to them would be beneficial in reducing either their susceptibility to or severity of the condition, and believe the anticipated benefits of taking action outweigh the barriers to (or costs of) action, they are likely to take action that they believe will reduce their risks. Hence, the HBM has been used extensively to determine relationships between health beliefs and health behaviors, as well as to inform interventions (Champion, & Skinner, 2008).

According to the health belief model, behavior change of an individual in response to a threat is determined by the individual's perception of his/her vulnerability to the condition, the severity of the condition should he/her be affected, and the effectiveness and outcomes/benefits of the particular behavior or actions. These beliefs are also reinforced by stimuli also known as 'cues to action' that motivates the individual to adopt the new behavior or action.

The triggering stimuli may be internal or external. By internal we mean being personally affected during a pandemic or/and the influence media reporting is the external one. Additional factor to this model is the individual's confidence or self-efficacy in their capacity to take action.

Other factors known to indirectly influence an individual's perception include: the educational level; social variables; proximity to current outbreaks; and how the authorities handled the situation in previous outbreaks/emergency situation (Ejiugwo, 2013).

2.4.2 Social cognitive theory (SCT)

The model focus on interpersonal level is characterized by environment influences human behavior and social interaction determines the action and belief of group of people. In social cognitive theory learning is defines as an internal mental process that may or may no to be reflected in immediate behavioral change.

Social cognitive theory (SCT) highlights the idea that much of human learning occurs in a social environment. By observing others, people acquire knowledge of rules, skills, strategies, beliefs, and attitudes. Individuals also learn about the usefulness and appropriateness of behaviors by observing models and the consequences of modeled behaviors and they act in accordance with their beliefs concerning the expected outcomes of actions. Social cognitive theory is a direct response to Behaviorism (Bandura, 1989).

2.5 Concept of Knowledge, Attitude and Practice

2.5.1 Knowledge

The first philosophical attempt to define knowledge in Plato's dialogue of described knowledge as "justified true belief". "Knowledge is not a picture or representation of reality; it is much more a map of those actions that reality permits. It is a repertoire of concepts, semantic relationships and actions or operations that have proven to be viable for the attainment of our goals.

Knowledge is defined as a set of structural connectivity patterns. Its contents have proven to be viable for the achievement of goals (Meyer and Sugiyama, 2006). Knowledge has been conventionally defined as beliefs that are true and are justified. It is reasonable to think of a "true" belief as one that is in accord with the way in which objects, people, processes and events exist and behave in the real world. To be called knowledge the belief must not only be correct, but also must be justified.

It is commonly accepted that people behave in accordance with their knowledge and beliefs (Hunt, 2003). According to Blanchard and Thacker (2009, sited in Radwa, 2012) knowledge is an organized body of facts, principles, procedures, and information acquired over time.

2.5.2Attitude

Attitudes have been defined in a variety of ways, but at the core is the notion of evaluation. Thus, attitudes are commonly viewed as summary evaluations of objects (e.g. oneself, other people, issues, etc) along a dimension ranging from positive to negative (Petty, Wegener and Fabrigar, 1997). Some scholars have different view point regarding attitude.

Attitude according to Gumucio, (2011) is a way of being, a position. These are leanings or "tendencies to….". This is an intermediate variable between the situation and the response to this situation. It helps explain that among the possible practices for a subject submitted to a stimulus, that subject adopts one practice and not another. Attitudes are not directly observable as are practices, thus it is a good idea to assess them.

2.5.3 Practices

Practices or behaviors are the observable actions of an individual in response to a stimulus. This is something that deals with the concrete, with actions (Gumucio, 2011).

2.6 Knowledge, Attitude and Practice survey

KAP survey is a representative study of a specific population to collect information on what is known, believed and done in relation to a particular topic (Shah et al, 2011).

KAP studies can be used for diagnostic purposes for which they describe the population's current knowledge, attitude and practice. Secondly they can be implemented to increase insights in a current situation and help design appropriate specific interventions. Thirdly, they can be used as an evaluation tool to evaluate the effectiveness of certain interventions or programs (Vandamme, 2009). In short Knowledge, attitude and practice are interlinked each other.

The Knowledge possessed by a community refers to their understanding of any given topic EVD in this case. Attitude refers to their feelings towards this subject, as well as any preconceived ideas that they may have towards it. Practice refers to the ways in which they demonstrate their knowledge and attitude through their actions. Understanding the levels of Knowledge, Attitude and Practice will enable a more efficient process of awareness creation as it will allow the program to be tailored more appropriately to the needs of the community (Kaliyaperumal, 2004).

Chapter Three

3. Method

3.1. Study Area

Addis Ababa, the capital of Ethiopia, is situated at the center of the country. The city is geographically located at 9:03N degree 38.74E degrees. It is located on a plateau at about 23000m above sea level, with a rising peaks at the Entoto mountains in the northern part of the city reaching above sea level 3000m. Moreover, it has a mean annual temperature of 160 degree Celsius and with an average annual rainfall of 1200mm, Addis Ababa enjoys a mild climate with its day time temperate rarely goes beyond 26 degrees and falls below 7 degrees.

Addis Ababa is a rapidly growing urban city both in terms of population and economy. It could be seen the dynamism of the city in various aspects. Besides, it is the largest city in Ethiopia. Its population composed of different nations and nationalities. According to 2007 census the city has 2,738,248 inhabitants.

Addis Ababa is sub divided into 10 sub cities namely: Kolfe Keranio, Yeka, Nefas Silk Lafto, Bole, Gullele, Addis Ketema, Qirkos, Arada , Lideta, Akaki Kaliti. These sub cities, in turn administratively divided into *Woredas*. The average *Woreda* that each sub city constitutes is 10.

Bole sub city is one of fast growing trade, travel and hotel corners of the city. The sub city has11 *Woreda* with a total population size of 308,741, according to national census of 2007.

3.2. Study design

In order to achieve the main goal of the study, descriptive study design with both quantitative and qualitative methods employed to collect data from hotel staff. The quantitative methods used structured questionnaire while the qualitative method employed in-depth interview.

Quantitative method was considered appropriate for this study because it allowed a formal and systematic approach to collect information on the hotel staff's knowledge and attitude about Ebola Virus Disease (EVD).

The qualitative research approach was also essential method to describe the practices of hotel staff from the supervisor's point of view about EVD.

3.3. Population, Sample, Sampling

The study populations are hotel staff working in Bole Sub city, Addis Ababa. In addition, communication and media experts and health workers were interviewed to support the data qualitatively. There are 68 star hotels in Addis Ababa 18 of them are found in Bole sub city. The researcher randomly selected 9 hotels from the study area. These hotels have 1234 staff in total.

Number	Hotel	staff
1	Saro maria	119
2	Friendship	160
3	Beer garden	128
4	Wassamar	139
5	Monarch	110
6	Kaleb	165
7	Kz	93
8	Kenenisa	165
9	Syonat	155
Total		1234

A generic formula of n=Z2.P(1-P)/d2 was used to determine the sample size (n) of 384 for this study where Z is a Z-score at 95% confidence level, P is a population estimate (50%) and d is 5%

margin of error. Population proportion sampling calculation was then applied to allocate sample sizes.

This study's sample population 421 excelled the minimum sample size 384. 421 questioners were distributed 408 were collected and during data clearance 12 were rejected due to inconsistency. Hence, the study used 396 questioners for analysis.

In addition, 3 communication and media experts and 3community health experts are included in the study. The study was carried out from April 1to June 20 2015.

3.4. Instruments

The researcher use both primary and secondary sources for data collection. The primary data was collected from:

Key informants interview: interview was conducted with 3 human resource managers of the hotel. They were interviewed about the attitude and practices of hotel staff towards EVD. How the staff interact with guest, how they use personal protective equipment.

Observation: the hotel staff behavior and attitude towards infectious disease including Ebola was observed. How the staff interact with the guest, how the staff use personal protective equipment was carefully watched.

Questionnaires: The questionnaire was developed after reviewing the relevant literature. A number of questions that can address the objectives of the study were gathered and adopted from previous similar studies on KAP surveys from different countries (West African nations like Serra Leon and Liberia). Changes were made to adopt the questionnaire to the current research objectives and context. The questionnaire was prepared in English and then translated to local

language, Amharic by the researcher. Then the translation was checked by language expert from AAU.

In addition, a short pilot of the questionnaire was carried out in two hotel staffs in Arada sub city. The staff at study area expected to administer the questioner so that the participants' knowledge, attitude and behavior towards EVD and risk communication were analyzed. The questioners were pre-tested in an assigned voluntary group to check the appropriateness of the tool.

The secondary data sources were official documents, media products and other sources. The case reports and audio-visual recordings were among the major documents analyzed for the study.

3.5. Data Analysis

Depending on the nature of the collected data, different statistical techniques were employed. The data obtained from the closed-ended questionnaire were entered by the researcher. To meet the objective of the study, Statistical Package for Social Science (SPSS) was used for data entry and analysis. Data editing and cleaning had done to assess data quality before the actual analysis. Data cleaning executed to check accuracy, outliers, consistencies, and missing values. Accordingly, incorrect entries identified and re-entered. With the help of this program SPSS, the obtained data summarized using descriptive analysis design. Simple frequency counts used to check the missing values and outliers. To examine the distribution of individual variables univariate analysis employed. In addition, percentage means, standard deviations were used to describe the study population in relation to socio-demographic and other relevant variables.

3.6. Ethical Consideration

The study was conducted after securing approval from the Addis Ababa University, School of Psychology health psychology program unit and from Addis Ababa health bureau. The purpose of the study was explained and all information provided by the respondents was kept confidential to maintain their privacy. The individual autonomy was respected. Participation in this survey was voluntary and they could choose not answer for any particular question or all of the questions. However, their participation in this study was very encouraging. Finally, it was ensured that individuals and communities would benefit from the results

Chapter Four

4. **Result**

4.1 Quantitative findings

4.1.1 Socio demographic characteristics

The numbers of male and female respondents were almost equal. Females were slight higher than males (51.5%). Mean age of the respondents was 30.74 (SD 6.72) and minimum age 20 to maximum age of 54 years. The largest percent of the respondents were in the age group of 26-35 (49.5%). From the total respondent married respondent were dominant (53%).

The majorities of the participants learnt higher education of which 189 (47.7%) holding certificate and/or college diploma while117 (29.5%) were university degree holders.

The number of reception experts 114(28.8%) were higher compared to the other occupational status in the hotel.

Table 1: *Socio-demographic characteristics of hotel staffs in Bole sub city, Addis Ababa, June 2015*

Characteristics	**Frequency (n=396)**	**Percent**
Sex	**192**	**48.5**
Male		
Female	204	51.5
Age in years		
≤25	110	27.8
26-35	196	49.5
36-45	77	19.4
≥46	13	3.3
Marital status		
Married	210	53
Unmarried	183	46.2

Divorced	3	8
Educational status		
Primary	6	1.5
Secondary	40	10.1
Preparatory	42	10.6
Diploma	189	47.7
Degree	117	29.5
Occupation		
Reception	114	28.8
Guard	16	4.0
Janitor/messenger	7	1.8
Room service	37	9.3
Hostess/waiter/ cook	76	19.2
Administrative worker	81	20.5
Others	65	16.4

4.1.2 Awareness and Knowledge of cause, signs, symptoms and transmission

Nearly all (99.5%) respondents heard about Ebola prior to the study time. Majority (92.9%) of the respondents were aware of the cause of EVD is virus.

Table 2: *Knowledge on causes of Ebola (n=396)*

Question	**Answer**	**Frequency**	**(%)**
What causes Ebola?	Virus	368	92.9
	God or higher power	38	9.6
	Evildoing /Sin	4	1.0

Regarding the transmission, majority (63.1%) of the respondents knew that body fluid transmitted the disease (direct contact with Ebola patient's bodily fluid).

Table 3: *Knowledge on mode of transmission of Ebola (n=396)*

Question	**Responses**	**Frequency**	**(%)**
How does a person get Ebola?	By air	119	30.1
	Bad odor or smell	31	7.8
	Infected Bodily fluid (Saliva, blood urine…)	250	63.1
	Physical contact with an infected	304	76.8

Table 4: *Knowledge on Signs and symptoms of Ebola (n=396)*

Character	**Frequency**	**percentage (%)**
Fever	330	83.3
Severe headache	314	79.3
Muscle pain	234	59.1
Weakness	300	75.8
Diarrhea/Vomiting	269	67.9
Rash	181	45.7
Bleeding (internal or external)	292	73.7

The most common symptoms of EVD, according to the respondents, was fever (83.3%) followed by Severe headache (79.3%).

Majority (85.6%) of the respondents believe that Ebola is a preventable disease. The prevention mechanisms are different according to the respondents; avoiding physical contact is the major one (72.2%).

Table 5: *Knowledge on method of prevention of Ebola (n=396)*

Question	Responses	Frequency	(%)
How One can prevent himself from getting Ebola?	Using traditional medicine	38	9.6
	Avoiding physical contact with Ebola infected person	288	72.7
	Washing hands with soap after touching infected person or area	118	29.8

4.1.3 Risk Perception and belief

About half (53.5%) of the respondents believe that they were not at risk of getting Ebola. They think their risk of getting Ebola labeled as law 238 (60.1%).

Figure 1: *Level of risk getting Ebola among hotel staffs in Bole sub city, Addis Ababa*

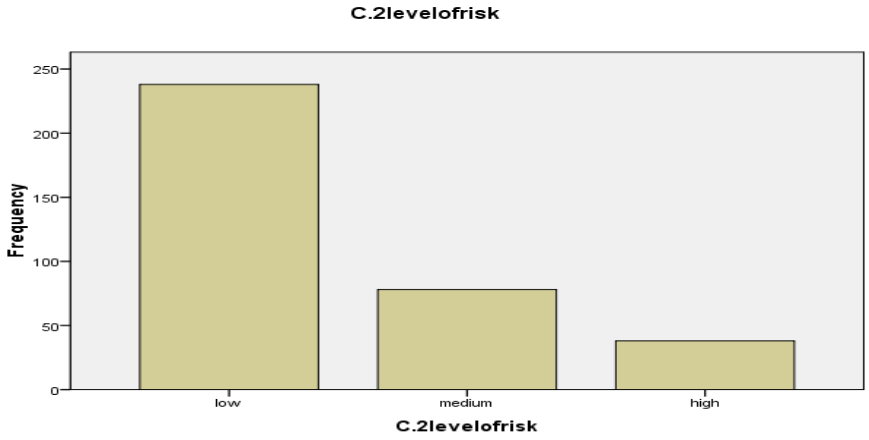


Table 6: *Perception on risk of getting Ebola among hotel staffs in Bole sub city, A. A (n=396)*

Question	Responses	Frequency	(%)
	I work as receptionist in the hotel where foreign gusts stay for long	93	23.5

Why do you believe that you are at risk?	I work as security officer	16	4.0
	I work as cook and waiter staff	63	15.9
	I work as hotel room manager	37	9.3
	I work as cleaning expert in the hotel	17	4.3

Some hotel staffs in Bole sub city believe that they are NOT at risk of getting Ebola.

Table 7: *Perception of hotel staffs NOT at risk of getting Ebola*

Character	Frequency	percentage (%)
I am not a health care or medical professional	24	6.1
I don't live in an area where there is Ebola	157	39.6
I don't come in contact with someone with Ebola	47	11.9
God is protecting me	100	25.3

4.1.4 Behavior and practice

About half (54.8%) of the respondents had taken action to prevent themselves from Ebola transmission like avoiding physical contact (44.4%) and wash their hand (42.2%).

Table 8: *Actions taken to avoid being infected*

Question	Responses	Frequency	(%)
In what ways have you taken actions to avoid being infected?	I wash my hands with soap and water more often	167	42.2
	I wear gloves	90	22.7
	I try to avoid physical contact with people I suspect may have Ebola	176	44.4

Most (71.7%) of the respondents said they would go to health center if they experienced fever. and the favorable mode of transport was using ambulance (22.5%) on the contrary no one need to use public bus.

Table 9: *Mode of transport to get health center (if experiencing fever)*

Character	Frequency	percentage (%)
Walking	62	15.7
A friend or family member will take me	59	14.9
Private car	32	8.1
Public taxi	49	12.4
Public bus	-	-
I would call for an ambulance	89	22.5

Table 10: *DON'T want to go to health center (if experiencing fever)*

Character	Frequency	percentage (%)
I have no money / can't afford to pay	-	-
I believe the hospital is contaminated with Ebola	-	-
I prefer to go to a nearby pharmacy instead	41	10.4
I prefer to go to a traditional healer	3	8
I prefer to go to a spiritual healer	56	14.1

Below half (39.4%) of the respondents would go to health facilities within a day if they experienced fever.

Figure 2: *How long wait to go to health center(if experiencing fever)*

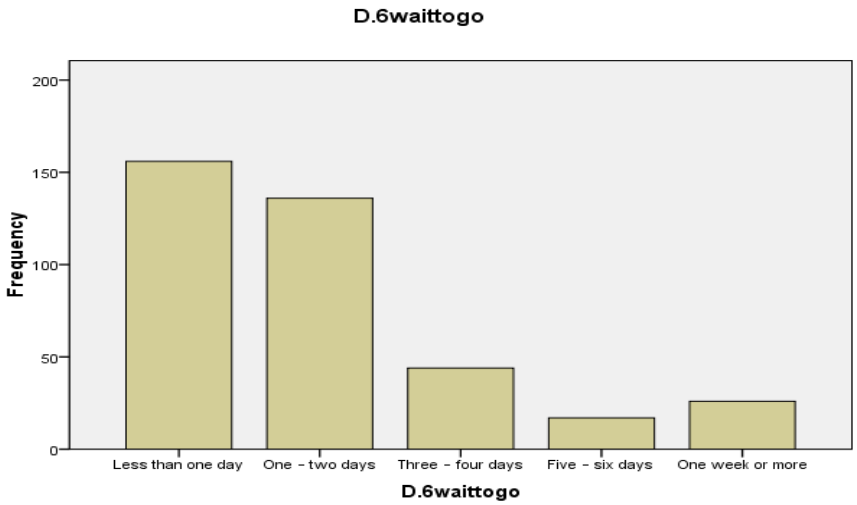


Table 11: *The first actions to be taken (if touching Ebola suspected person)*

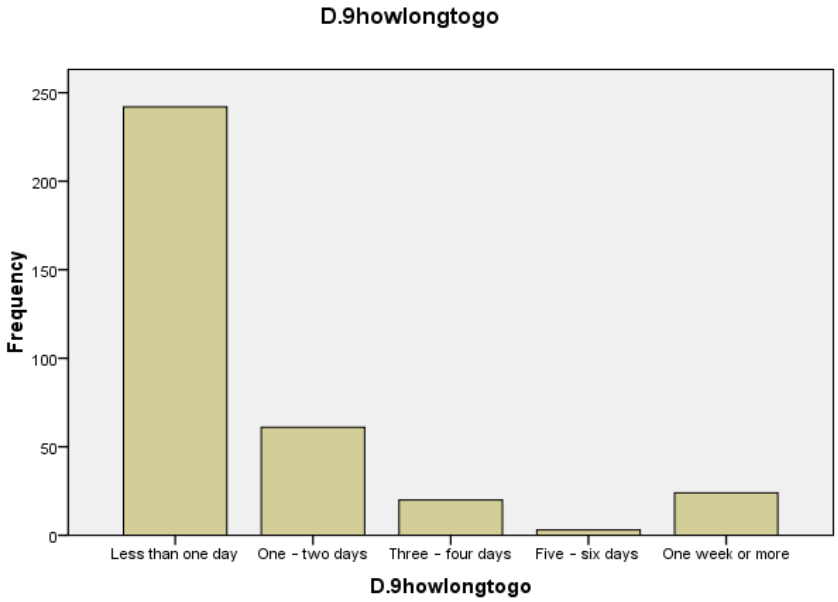
Question	**Responses**	**Frequency**	**(%)**
What would be the first thing you do if you touch a person suspected of Ebola?	Don't tell anyone	5	1.3
	Wash my hands	119	30.1
	Tell family or friends	63	15.9
	Call the hot line number/8335	157	39.6
	Take own medicines	8	2.0
	Go to the health centre or Ebola care centre or ETU	238	60.1

Most 308(77.8%) of the respondents would go to the health facility/Ebola Treatment Unit if they suspect that they may have contracted Ebola. Few respondents would not go to the health facilities if they suspect they have get Ebola. Their reasons are different.

Table 12: *DON'T want to go to health center (if suspect having contracted Ebola)*

Character	Frequency	percentage (%)
I have no money / can't afford to pay	34	8.6
I believe the hospital is contaminated with Ebola	10	2.5
I prefer to go to a nearby pharmacy instead	6	1.5
I prefer to go to a traditional healer	5	1.3
I prefer to go to a spiritual healer	15	3.8

Figure 3: *How long wait to go to health center(if suspect having contracted EVD)*



Ebola)

4.1.5 Information Channels, Networks and Sources

Table 13: *Source of information about Ebola*

Question	Responses	Frequency	(%)
How did you hear or learn	Radio	257	64.9
	Television	330	83.3

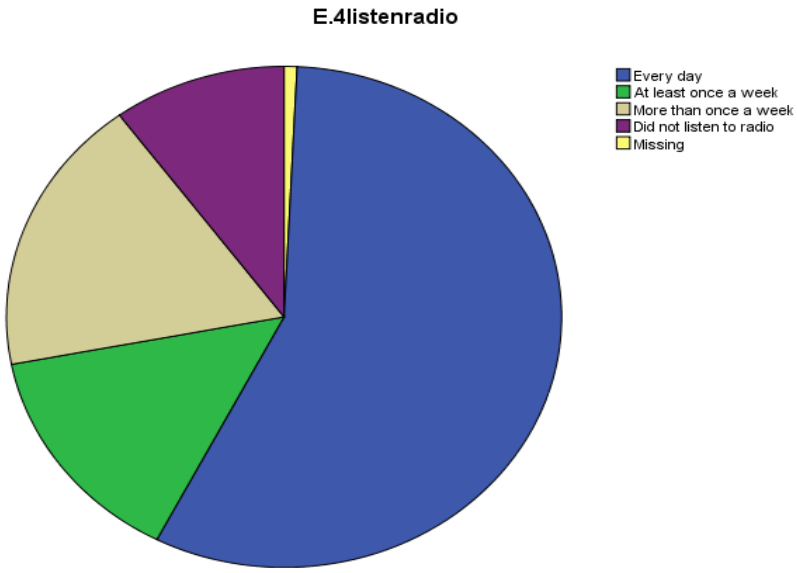
about Ebola?	Newspaper / Flyers / Brochures /Posters/Other print materials	178	44.9
	health extension workers	127	32.1
	Religious venues (Church / Mosque / other	62	15.7
	Community meetings/iddir,Equb	43	10.9
	Relatives/Friends/Neighbors/Community members	101	25.5
	Internet / Blog / Website / Social Media/Facebook	220	55.6
	Government/ Ministry of Health	158	39.9
	Health professionals	128	32.3

Table 14: *Preferable Source of information and channel about Ebola*

Question	**Responses**	**Frequency**	**(%)**
Who do you trust or give you reliable health information?	Radio	215	54.3
	Television	233	58.8
	Newspaper / Flyers / Brochures /Posters/Other print materials	152	38.4
	health extension workers	131	33.1
	Religious venues (Church / Mosque / other	108	27.3
	Community meetings/iddir, Equb	58	14.6

	Relatives/Friends/Neighbors/Community members	82	20.7
	Internet / Blog / Website / Social Media/Facebook	200	50.5
	Government/ Ministry of Health	166	41.9
	Health professionals	177	44.7

Figure 4: *Radio listening trade among hotel staffs in Bole sub city, Addis Ababa*



During the last three months prior to data collection the respondents listened the Ebola messages through the Radio. 304(76.8%) heard Ebola message from the Radio.

4.1.6 Attitudes towards foreigners and health professionals came back from West Africa

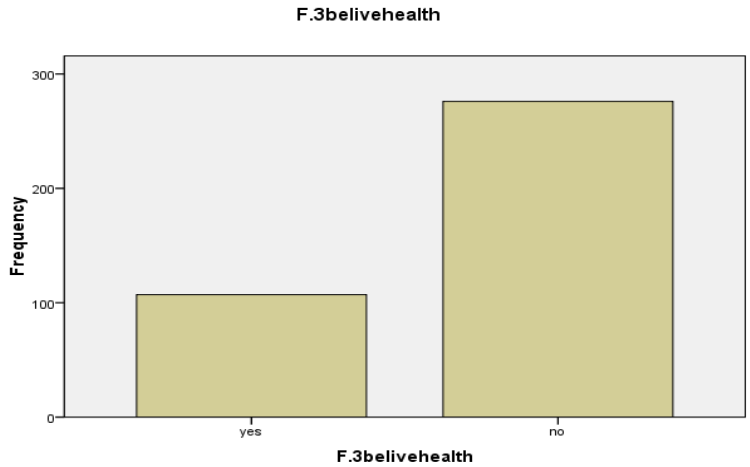
Table 15: *Respondent's feeling (When they meet guests from Ebola affected countries)*

Character	Frequency	percentage (%)
Fear	144	36.4
Suspect	228	57.6
Happiness	48	12.1

Table 16: *Respondent's feeling (When they meet Health Professional from Ebola affected countries)*

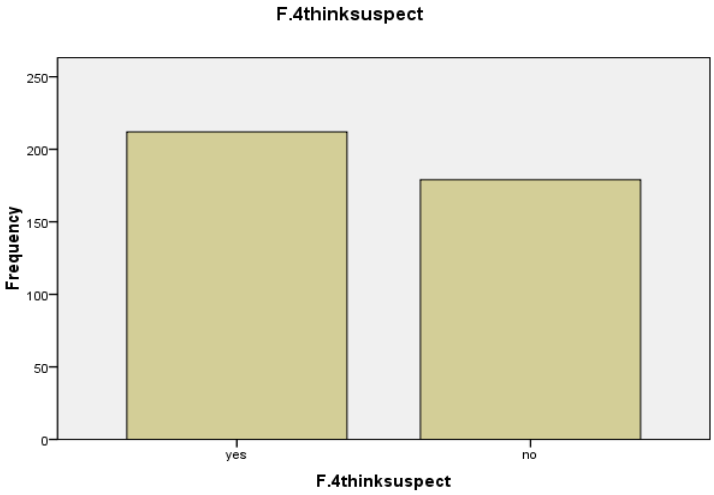
Character	Frequency	percentage (%)
Proud	206	52.0
Anxiety	144	36.4
Pleasure	62	15.7

Figure 5: *Respondent's attitude towards Health Professional from Ebola affected countries*



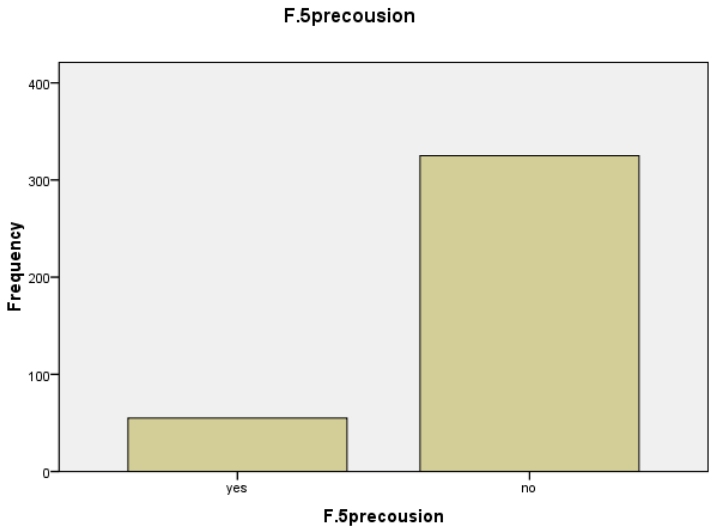
Q: Do you believe that health professionals (working in Ebola affected countries) can be cause of disease without symptom?

Figure 6: *Respondent's attitude towards Health Professional from Ebola affected countries*



Q: Do you think a gust from abroad and having high fever could be suspected for Ebola?

Figure 7: *Respondent's attitude towards Health Professional from Ebola affected countries*



Q: Would you welcome health professionals from Ebola affected West African countries without precaution?

4.2 Qualitative findings

The qualitative data were collected from key informant using interview. The informants were Hotel managers who supervise the daily activities of other hotel staff.

The data can broadly categorized into two main focus areas: Knowledge enhancement and practical demonstration

4.2.1 Knowledge enhancement

One of the goals of training was to inform and educate hotel staff towards Ebola Virus Disease. To fully understand the sign, symptom and prevention of EVD training and briefing were organized by Ministry of health and Addis Ababa health office. The training was given by nurses of the office who got the training of trainee prior to the training. Hotel staff who attained the training had mixed feeling. One of the hotel human resource managers remembered the situation.

> *The Bole sub city health workers came and inform us who they were and what they wanted. As I heard the word Ebola, I was disturbed. They asked me to collect the staff at the conference hall for training. In turn, I ordered the coordinators to inform and come together with their subordinates. Then health workers started briefing the overview of the then current and hot issue, Ebola. They explained the sign, symptom and prevention methods of Ebola. Then they gave us the chance to raise questions and suggestion. At firs some of us shocked and some other disturbed when we hear about Ebola. I personally suspected that Ebola occurred in our country. I asked the trainees whether the disease occurred or not to tell us frankly. But they assure that there was no the issue.*

The other senior hotel staff complained on the health workers efficiency. Since the nurses were too young he didn't confident on their knowledge rather he used different mechanism to update himself and inform other staff about the global and local situation of EVD. He didn't satisfy with the training.

> *It was just a onetime short briefing not formal training. The nurses from the sub city health office distributed brochure that explained about Ebola. They informed us the hot line or free telephone line to ask further information and suggestion. That was all I remember. To know more about Ebola I browse internet, watched TV news and program and listened radio show. I even update our staff about the situation.*

4.2.2 Practical demonstration

The other category of the data obtained from interview focused on practice of hotel staff. Most of their practice was depend highly on their knowledge and understanding of the nature of the disease. One of the hotel shift supervisor explained the situation as follows:

> *The training helped us to understand easy ways of Ebola prevention. How to wash our hands properly, how to use personal protective equipments and how to minimize contact with customers were the good parts of the training. Their demonstration and explanation was attractive. Their answers for our questions were clear and satisfactory. Our staff behave just they showed us in customer service providing process. However, some staff didn't use personal protective equipment like hand glove properly or they didn't wash their hand effectively. I and other supervisors strictly follow their behavior and practice with regard to Ebola prevention.*

Chapter Five

5. Discussion

Globalization makes the world as small village. What happened in one corner of the globe may reach and affect the other part of the world. Incidence like Ebola outbreak creates panic, anxiety and delusion to the other tip of the continent. To carefully handle the information to the community it needs well researched and organized risk communication institution. Designing risk messages is the vital task in risk communication process. Using multimedia is an advantage to communicate health risk in an easy way. Effective risk communication makes the public aware of the risk and changes their behavior towards EVD outbreak. Orient and announce the most venerable group of the society is crucial when outbreak occurs.

KAP study is also very important to know the level of understanding of some segment of the society and make intervention based on the findings of the study. The findings of this study prevail that socio demographically male and female respondents were almost equal in number. Most of the respondents attained higher education institution and were certificate and diploma holders. Nearly all respondents heard about Ebola prior to this study. Their knowledge about the cause of EVD is quite good. The sub city health office experts made orientation to the hotel staff in the localities. As the mental noise model indicates, this kind of person to person risk communication may help the staff to have knowledge on EVD. Regarding comprehensive knowledge of mode of transmission, the respondent's awareness was inadequate. The comprehensive knowledge on sign and symptom was moderate. Majority of the respondents believe that EVD was a preventable disease. They also believe that avoiding physical contact with the suspected person or confirmed patient was the major intervention to prevent getting the disease.

Most hotel staffs in Bole sub city believe that their risk of getting Ebola was law. The possible reason was individual level of EVD risk perception. Their Health belief model Ebola was a matter of West African countries. Most of the respondents use Television as their source of information.

The respondents perceive that going to health center as early as possible was advantageous when they experienced fever or touch Ebola suspected person.

Their attitude towards foreign gusts especially from West Africa was suspicious. However, they feel proud when they see Ethiopian health professionals, fighting Ebola, came back from West Africa.

Chapter six

6. Conclusion and recommendation

6.1 Conclusion

When Ebola outbreak occurred in West Africa Ethiopia was preparing itself to fight EVD. One of the preparedness works was organizing national Ebola committee. Under this main committee there were many sub committees which undertook different tasks.

Delivering training to high risk professionals was one of the tasks. Health professional, as a high risk groups, were given the training of trainee on EVD.

Community conferences were arranged. Hotel staffs were one of the target communities addressed by such program. Hence they were trained and oriented by community health workers of Bole sub city. As a result their awareness of EVD was good. However, the hotel staffs comprehensive knowledge about EVD causes, signs, transmissions and preventions was moderate.

The hotel staff attitude towards health professional and guest were fear and suspicious. The staff practice to prevent EVD was also moderate. They kept their distance to minimize contact with guest. Their hand washing practice was satisfactory. Their personal protective equipment use was low.

6.2 Recommendations

- To enhance the comprehensives knowledge of the hotel staff towards infectious disease including Ebola, multi channel health and safety education should be given frequently. To do so professional health educator or safety expert should be hire in the hotel.

- Work place health and safety program should be designed and implemented in the hotel set up. The hotel staff is vulnerable groups to contact and infectious disease. So regular training should be given to the hotel staff for the sake of their own and customers health and safety. How to use personal protective equipment, how to minimize body contacts with guests and customers must be included in the training.

- Hotel owners should supply appropriate personal protective equipment for the staff. Checking how properly the staff use the equipment is also very important

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Appendices 1

Addis Ababa University

Graduate Studies

School of Psychology

Dear All

Currently, Ebola is a global public health problem. Even though Ethiopia is Ebola free country, risk communication towards the disease is crucial for prevention actions. Bearing this in mind, I try to figure out the Knowledge, attitude and practice towards Ebola among hotel staffs in Bole sub city, Addis Ababa, Ethiopia. The thesis entitled ***"Knowledge, Attitude and Practice of hotel staff towards Ebola in Bole sub city, Addis Ababa, Ethiopia"*** is conducted for the partial fulfillment of Master Degree in Health Psychology. This questioner is prepared to collect data for the study. Your honest and genuine answer to these questions will have a great value to the research outcome. Your answers are completely confidential. You are not supposed to write your name. Circle the numbers corresponding suggested answers. I would greatly appreciate your help in responding to this questionnaire.

A. SOCIO-DEMOGRAPHICECTION				
A.1	Age	In number…….		
A.2	Sex	Male	1	
		Female	2	
A.3	Marital status(circle one answer)	Single/ never married	1	
		Married	2	
		Divorced	3	
A.4	What is the highest educational level completed? (circle one answer)	Elementary (1 -8)	1	
		Secondary(9-10)	2	
		Preparatory (10 -12)	3	

		College Diploma or Certificate	4	
		University (Bachelor, Masters,Doctorate)	5	
		Others,specify:_____	6	
A.5	What is your current position in the hotel?	Receptionist	1	
		Security officer	2	
		Janitor/messenger	3	
		Room service	4	
		Hostess/waiter/ cook	5	
		Administrative worker	6	
		Others_____		
B. AWARENESS AND KNOWLEDGE OF CAUSES, SIGNS, SYMPTOMS &TRANSMISSION				
B.1	Have you ever heard or learnt of Ebola before (prior to this interview)?	Yes	1	
		No	2	
B.2	What causes Ebola?(select all applicable choices)	Virus	1	
		God or higherpower	2	
		Evildoing /Sin	3	
		Other(specify)	4	
B.3	How does a person get Ebola?(select all applicablechoices)	Byair	1	
		Bad odor or smell	2	
		Infected Bodily fluid (Saliva, blood urine…)	3	
		Physical contact with an infected person	4	
		Others_____	5	
B.4	What are the main signs and symptoms of someone infected with Ebola?(select all mentioned/that apply)	Fever	1	
		Severe headache	2	
		Muscle pain	3	
		Weakness	4	
		Diarrhea / Vomiting	5	
		Rash	6	
		Bleeding (internal orexternal)	7	
		Others_____	8	

B.5	Can someone prevent himself from getting Ebola?	Yes	1	
		No	2	
B.6	How One can prevent himself from getting Ebola?	Using traditional medicine	1	
		Avoiding physical contact with Ebola infected person	2	
		Washing hands with soap after touching infected person or area	3	
C.RISKPERCEPTIONSANDBELIEFS				
C.1	Do you think you have the risk of getting Ebola?	Yes	1	Got C2
		No	2	
C.2	What level of risk do you think you have in getting Ebola?	Low risk	1	
		Medium risk	2	
		High risk	3	
C.3	Why do you believe that you are at risk?	I work as receptionist in the hotel where foreign gusts stay for long	1	
		I work as security officer	2	
		I work as cook and waiter staff	3	
		I work as hotel room manager	4	
		I work as cleaning expert in the hotel	5	
		Others_____	6	
C.4	Why do you believe that you are NOT at risk?	I am not a health care or medical professional	1	
		I don't live in an area where there is Ebola	2	
		Idon't come in contact with someone with Ebola	3	
		God is protecting me	4	
		Others_____	5	
D. BEHAVIOURS ANDPRACTICES				
D.1	Have you taken any action to avoid being infected by Ebola?	Yes	1	Got D2
		No	2	Got D3

D.2	Inwhatwayshaveyouchangedyourbehaviorortakenactionstoavoidbeinginfected?	I wash my hands with soap and water more often	1	
		I wear gloves	2	
		I try to avoid physical contact with people I suspect may have Ebola	3	
		Others_____	4	
D.3	If you had a fever would you go to a health facility/ Ebola Treatment Unit?	Yes	1	Got D4
		No	2	Got D5
D.4	How would you get there?	Walking	1	Got D6
		A friend or family member will take me	2	
		Private car	3	
		Public taxi	4	
		Public bus	5	
		I would call for an ambulance	6	
		Others:_____	7	
D.5	If NO – Why Not?)	I have no money / can't afford to pay	1	Go D7
		I believe the hospital is contaminated with Ebola	2	
		I prefer to go to a nearby pharmacy instead	3	
		I prefer to go to a traditional healer	4	
		I prefer to go to a spiritual healer	5	
		Others_____	6	
D.6	If you had a fever, how long would you wait before going to a health facility?	Less than one day	1	
		One – two days	2	
		Three – four days	3	
		Five – six days	4	

		One week or more	5	
D.7	What would be the first thing you do if you touch a person suspected of Ebola?	Don't tell anyone	1	
		Wash your hands	2	
		Tell family or friends	3	
		Call the hotline number/8335	4	
		Take own medicines	5	
		Go to the health centre or Ebola care centre or ETU	6	
D.8	Would you go to the health facility/Ebola Treatment Unit if you suspect that you may have contracted Ebola?	Yes	1	Got D9
		No	2	Got D8a
D.8a	If no, why not?	I have no money / can't afford to pay	1	Got D10
		I believe the hospital is contaminated with Ebola	2	
		I prefer to go to a nearby pharmacy instead	3	
		I prefer to go to a traditional healer	4	
		I prefer to go to a spiritual healer	5	
		Others_____	6	
D.9	If yes, how long would you wait before going to a health facility/Ebola Treatment Unit?	Less than one day	1	
		One – two days	2	
		Three – four days	3	
		Five – six days	4	
		One week or more	5	

E. INFORMATION CHANNELS, NETWORKS AND SOURCES				
E.1	How did you hear or learn about Ebola?	Radio	1	
		Television	2	
		Newspaper / Flyers / Brochures /Posters/Other print materials	3	
		Health extensionworkers	4	
		Religious venues (Church / Mosque / other)	5	
		Community meetings/iddir,Equb	6	
		Relatives/Friends/Neighbors/Co mmunity members	7	
		Internet / Blog / Website / Social Media/Facebook	8	
		Government/ Ministry of Health	9	
		Health professionals	10	
		Others	11	
E.2	Through what ways would you prefer to get information on Ebola?	Radio	1	
		Television	2	
		Newspaper / Flyers / Brochures	3	
		Health extension workers	4	
		Religious venues (Church / Mosque /	5	
		Community meetings/Iddir,Iqub	6	
		Relatives/Friends/Neighbors/Co mmunity members	7	
		Internet / Blog / Website / Social Media/Facebook	8	
		Government/Ministry of Health	9	
		Health professionals	10	
		Others	11	
E.3	Who do you trust to give you reliable health information?	Government/Ministry of Health	1	
		The Media (TV, Radio, Newspaper…)	2	

		Health and medical professionals	3	
		Relatives and friends	4	
		Religious leaders (e.g. pastor,Imam)	5	
		Health extension workers	6	
E.4	Duringthelast3monthshowoftenhaveyoulistenedtotheradio?	Everyday	1	
		At least once a week	2	
		More than once a week	3	
		Didnotlistentoradioinlast3months	4	
E.5	Inthepast3months,haveyouheardanymessagesonEbolaontheradio?	Yes	1	
		No	2	
F. **ATTITUDES TOWARD FORNIER AND HEALTH PROFESSIONAL CAME BACK FROM WEST AFRICA**				
F.1	What do you feel when you meet a person from Ebola affected countries (West Africa countries: Sera lion, Liberia, Guinea , ,,,,)	Fear	1	
		Suspect	2	
		Happiness	3	
		Other specify	4	
F.2	What do you feel when you see health professionals working in Ebola affected countries?	Proud	1	
		Anxiety	2	
		pleasure	3	
		Other specify	4	
F.3	Do you believe that health professionals (working in Ebola affected countries) can be cause of disease without symptom?	Yes	1	
		No	2	
F.4	Do you think a gust from abroad and having high fever could be suspected for Ebola?	Yes	1	
		No	2	

F.5	Would you welcome health professionals from Ebola affected West African countries without precaution?	Yes	1	
		No	2	

Apendices 2

አዲስ አበባ ዩኒቨርሲቲ

ድህረ ምረቃ ት/ክፍል

የሳይኮሎጂ ት/ቤት

ውድ ተሳታፊዎች

በአሁኑ ወቅት የኢቦላ ቫይረስ በሽታ አለማቀፍ የህብረተሰብ ጤና ችግር ነው።ኢትዮጵያ ከበሽታው ነፃሀገር ናት።ሆኖም ስለ ኢቦላ በሽታ ያለ እውቀት፣አመለካከት እና ተግባር ማጥናት አስፈላጊ ሆኗል።ስለሆነም"*በቦሌ ክፍለ ከተማ የሚገኙ የሆቴል ባለሙያዎች እና ሰራተኞች ስለ በሽታው ያላቸው እውቀት፣አመለካከትእናተግባር*" በሚል ርእስ በጎልጎ ሳይኮሎጂ(Health Psychology)የሁለተኛ ዲግሪ መመረቂያ ፅሁፌን በማዘጋጀት ላይ እገኛለሁ።ስለሆነም ለጥናቱ መረጃ ማሰበሰቢያ መጠይቅ ተዘጋጅቶ ቀርቧል። እርስዎም ለጥያቄዎቹ የሚሰጡት ትክክለኛ ምላሽ ለጥናት ውጤቱ ከፍተኛ ዋጋ ይኖረዋል።እርስዎ የሚሰጡት ምላሽ ፍፁም ምስጢራዊነቱ የተጠበቀ ነው።ስምዎን መፃፍ አያስፈልግም።በጥያቄዎቹ ትይዩ ምላሽ ሊሆኑ የሚችሉ ምርጫዎች በተራ ቁጥር ተዘርዝረዋል፤ቁጥሩ ላይ ብቻ ያክብቡ።መጠይቁን ለመሙላት ፈቃደኛ ስለሆኑ ከልብ አመሰግናለሁ።

ሀ.የማህበራዊ ሁኔታ መግለጫ				
ሀ.1	እድሜ	**በቁጥር ይግለፁ**……		
ሀ.2	ፆታ	ወንድ	1	
		ሴት	2	
ሀ.3	የጋብቻ ሁኔታ	ያላገባ/ች	1	
		ያገባ/ች	2	
		በፍቺ የተለያየ/ች	3	
ሀ.4	የትምህርት ደረጃ	አንደኛ ደረጃ(1 -8)	1	
		ሁለተኛ ደረጃ(9-10)	2	
		መሰናዶ (10 -12)	3	
		የኮሌጅ ሰርተፍኬት ወይም ዲፕሎማ	4	
		የዩኒቨርሲቲ ዲግሪ	5	
		ሌላካለ ይገለፅ__	6	

ሀ. 5	በሆቴሉ የስራ ድርሻ	እንግ ዳተቀባይ	1	
		ጥበቃ	2	
		ዕዳት/ተላላኪ	3	
		ምግብ ዝግጅት /አስተናጋጅ	4	
		አልጋክፍል	5	
		የአስተዳደር ሰራተኛ	6	
		ሌላ ካለ ይገለፅ…… ……..	7	
ለ. ስለኢቦላ በሽታ ግንዛቤ እና እውቀት (መንስኤ፣ምልክትእናመተላለፊያ መንገድ)				
ለ. 1	ከዘህ መጠይቅ በፊት ስለኢቦላ ሰምተው ያውቃሉ?	ሰምቻለሁ	1	
		አልሰማሁም	2	
ለ. 2	የኢቦላ በሽታ መንስኤ ምንድነው? (መልስ ነው የሚሉትን በሙሉ ይምረጡ)	በአይን የማይታዩ ረቂቅ ተህዋስያን /ቫይረስ/	1	
		የፈጣሪቁጣ	2	
		ንጠኢት	3	
		ሌላካለ ይግለፅ…… ……	4	
ለ. 3	የኢቦላ በሽታ መተላለፊያ መንገድየሆነው የቱ ነው? (መልስ ነው የሚሉትን በሙሉ ይምረጡ)	በአየር	1	
		በመጥፎ ሽታ	2	
		በቫይረሱ የተበከለ የሰውነት ፈሳሽ	3	
		በበሽታው ከተያዘ ሰው ጋር ንክኪ መፍጠር	4	
		ሌላ ካለ ይጥቀሱ	5	
ለ. 4	በኢቦላ በሽታ የተያዘ ሰው የሚያሳያቸው ዋና ዋና ምልክቶች ምን ምን ናቸው ? (መልስ ነው የሚሉትን በሙሉ ይምረጡ)	ትኩሳት	1	
		ከፍተኛ ራስ ምታት	2	
		የጡንቻ ህመም	3	
		የሰውነትመዛል/ድካም	4	
		ተቅማጥእና ትውከት	5	
		የቆዳ ላይ ሽፍታ	6	
		ውስጣዊ ወይም ውጫዊ መድማት	7	
		ሌላ ካለ ይጥቀሱ_____	8	
ለ. 5	የኢቦላ በሽታን መከላከል ይቻላል?	አዎ	1	
		አይቻልም	2	
ለ. 6	የኢቦላ በሽታን እንዴት መከላከል ይችላል?	ባህላዊ መድሀኒት በመጠቀም	1	
		በኢቦላ ከታመመ ሰው	2	

		ፈሳሽ ንክኪ በመራቅ		
		እጅን በመታጠብ	3	
ሐ. ስለ ኢቦላ በሽታ ስጋት፣እምነት እና አመለካከት				
ሐ .1	በኢቦላ በሽታየመያጋለጥ ስጋት አለዎትን?	አዎ	1	ወደ ሐ.2 ይሂዱ
		የለኝም	2	
ሐ .2	በኢቦላ በሽታ የመጋለጥ ስጋት መጠን ምን ያህል ይሆናል ብለው ያስባሉ ?	አነስተኛ	1	
		መካከለኛ	2	
		ከፍተኛ	3	
ሐ .3	በኢቦላ በሽታ የመጋለጥ ስጋት ውስጥ መሆንዎን እንዴት አመኑ?	ሆቴል ውስጥ በእንግዳ ተቀባይነት ስለምሰራ	1	
		የጥበቃ ስራ ስለምሰራ	2	
		በሆቴል ውስጥ የምግብ ዝግጅት ስለምሰራ	3	
		በሆቴሉ የመኝታ ክፍል ውስጥ ስለምሰራ	4	
		በሆቴሉ የፅዳት ስራ ስለተሰማራሁ	5	
		ሌላይገለፅ_____	6	
ሐ .4	በስጋት ውስጥ አለመሆንዎን እንዴት ሊያምኑ ቻሉ?	የጤና ባለሙያ ስላልሆንኩ	1	
		ኢቦላ ያለበት አካባቢ ስለማልኖር	2	
		በኢቦላ ከተጠቃ ሰው ጋር ስለማልኖር	3	
		ፈጣሪ ስለሚጠብቀኝ	4	
		ሌላካለ ይገለፅ__	5	
መ. የባህሪ ለውጥእናተግባራት				
መ .1	በኢቦላ ላለመያዝ የወሰዱት ጥንቃቄ አለ?	አዎ	1	ወደመ. 2 ይሂዱ
		የለም	2	ወደመ. 3 ይሂዱ
መ .2	ራስዎን ከበሽታው ለመከላከል የወሰዷቸው ጥንቃቄዎች ምንድን ናቸው?	ሁልጊዜእጄን በውሀ እና በሳሙና እታጠባለሁ	1	
		ጓንት እጠቀማለሁ	2	
		በኢቦላ ይያዛሉ ብዬ	3	

		ከምጠረጥራቸው ሰዎች ጋር አልነካካም		
		ሌላካለ ይገለፅ__	4	
መ.3	ትኩሳት ቢኖርብዎ ወደ ጤና ተቋም ወይም ኢቦላ ህክምና ማእከል ይሄዳሉ?	እሄዳለሁ	1	ወደ መ.4 ይሂዱ
		አልሄድም	2	ወደመ. 5 ይሂዱ
መ.4	እሄዳለሁ ከሆነ መልስዎ እንዴትይሄዳሉ?	በእግር	1	
		ጓደኛ ወይም የቤተሰብ አባል ይወስደኛል	2	
		በግል መኪና	3	
		በታክሲ	4	
		በህዝብ ማመላለሻ አውቶቡስ	5	
		አምቡላን ስእጠራለሁ	6	
		ሌላካለ ይገለፅ__	7	
መ.5	ወደ ጤና ተቋም ካልሄዱምክንያትዎ ምን ምን ሊሆን ይችላል?	ገንዘብ ስለሌለኝ	1	ወደመ 7 ይሂዱ
		ጤናተቋመራሱበኢቦላየ ተበከለነውብዬስለማምን	2	
		በአቅራቢያዬያለፋርማሲ ብሄድይሻለኛል	3	
		የባህልመድሃኒትአዋቂዎ ችጋርመሄድእመርጣለሁ	4	
		መንፈሳዊአገልግሎትየሚ ሰጡጋርብሄድእመርጣለ ሁ	5	
		ሌላካለ ይገለፅ__	6	
መ.6	ትኩሳት ቢኖርብዎ ወደ ጤና ተቋም ከመሄድዎ በፊት ምን ያህል ጊዜ ታግሰው ይጠብቃሉ ?	በሰዓታት ውስጥ	1	
		አንድ -ሁለት ቀናት	2	
		ሦስት -አራት ቀናት	3	
		አምስት- ስድስት ቀናት	4	
		አንድ ሳምንት እና ከዚያበላይ	5	
መ.7	በኢቦላ የተጠረጠረ ሰው ቢነኩ በመጀመሪያ የሚያደርጉት ምንድን ነው?	ለማንም አልናገርም	1	
		እጀን እታጠባለሁ	2	
		ለቤተሰቤ ወይም ለጓደኛዬ	3	

		እናገራለሁ		
		በነፃ ሰልክ መሰመር 8335 እደውላለሁ	4	
		መድሃኒት እወስዳለሁ	5	
		ወደ ጤና ተቋም ወይም ኢቦላ ህክምና ማእከል እሄዳለሁ	6	
መ.8	በኢቦላ ተይዣለሁ ብለው ቢያስቡ ወደ ጤና ተቋም ይሄዳሉ?	እሄዳለሁ	1	ወደመ.9 ይሂዱ
		አልሄድም	2	ወደመ.8i ይሂዱ
መ.8i	ወደ ጤና ተቋም ካልሄዱምክንያትዎ ምን ሊሆን ይችላል?	ገንዘብ ስለሌለኝ	1	
		ጤና ተቋሙ ራሱ በኢቦላ የተበከለ ነው ብዬስለማምን	2	
		በአቅራቢያዬያለፋርማሲ ብሄድይሻለኛል	3	
		የባህልመድሃኒትአዋቂዎችጋርመሄድእመርጣለሁ	4	
		መንፈሳዊአገልግሎትየሚሰጡጋርብሄድእመርጣለሁ	5	
		ሌላካለ ይገለፅ__	6	
መ.9	አዎከሆነመልስዎ፣ወደጤናተቋምከመሄድዎበፊትምንያህልጊዜታግሰውይጠብቃሉ?	በሰዓታት ውስጥ	1	
		አንድ -ሁለትቀናት	2	
		ሦስት -አራትቀናት	3	
		አምስት- ስድስትቀናት	4	
		አንድሳምንትእናከዚያበላይ	5	
ሠ. የኢንፎርሜሽንማግኛመንገድ እናየመረጃምንጭ				
ሠ.1	ስለኢቦላእንዴትሰሙወይምአወቁ?	ከራዲዮ	1	
		ከቴሌቪዥን	2	
		ከጋዜጣ/መፅሄት/በራሪወረቀት/ የህትመትውጤቶች	3	
		ከጤናኤክስቴንሽንሰራተ	4	

		ኞች		
		ከእምነት ቦታዎች	5	
		ከእድርእቁብስብሰባ	6	
		ከዘመድ/ጓደኛ/ጎረቤት	7	
		ከኢንተርኔት/ዌብሳይት/ማህበራዊሚዲያ(ፌስቡክ)	8	
		ከመንግስት/ከጤናጥበቃ ሚ/ር/ዕ/ቤት	9	
		ከጤናተቋማት ባለሙያዎች	10	
		ሌላካለ ይገለፅ__	11	
ሠ.2	ስለኢቦላበምንአይነትመንገድመረጃቢያገኙይመርጣሉ?	በራዲዮ	1	
		በቴሌቪዥን	2	
		በጋዜጣ/መፅሄት/በራሪወረቀት/ የህትመትውጤቶች	3	
		ከጤናኤክስቴንሽንሰራተኞች	4	
		ከእምነት ቦታዎች	5	
		ከእድርእቁብስብሰባ	6	
		ከዘመድ/ጓደኛ/ጎረቤት	7	
		ኢንተርኔት/ድህረገፅ/ማህበራዊሚዲያ(ፌስቡክ)	8	
		ከመንግስት/ከጤናጥበቃ ሚ/ር/ዕ/ቤት	9	
		ከጤናተቋማት ባለሙያዎች	10	
		ሌላካለ ይገለፅ…… ……	11	
ሠ.3	ትክክለኛየጤናመረጃይሰጠኛልብለውየሚያምኑትየቱንነው?	መንግስት/ከጤናጥበቃሚ/ር/	1	
		ሚዲያ (ቲቪ፣ራዲዮ፣ጋዜጣ…)	2	
		የጤናባለሙያዎች	3	
		ዘመድእናጓደኛ	4	
		የሀይማኖትመሪዎች (ቄስ፣ፓስተር፣ኢማም)	5	
		የጤናኤክስቴንሽንሰራተኞች	6	

ሠ.4	ባለፉት 3 ወራትስምንያህልጊዜሬድዮሰምተዋል?	በየቀኑ	1	
		በሳምንትአንድጊዜብቻ	2	
		በሳምንትከአንድጊዜበላይ	3	
		ምንምጊዜ አልሰማሁም	4	
ሠ.5	ባለፉት 3 ወራትስለኢቦላበሽታ የሰሙትመረጃወይም መልእክትአለ?	አለ	1	
		የለም	2	
ረ. ለእንግዶችእናከምእራብአፍሪካስለተመለሱየጤናባለሙያዎችያለአመለካከት				
ረ.1	በኢቦላ ከተጠቁ ሀገራት የመጣሰውሲያገኙየሚሰማዎትምንድን ነው?	ፍርሃት	1	
		ጥርጣሬ	2	
		ደስታ	3	
		ሌላካለ ይገለፅ…… ……	4	
ረ.2	ከምእራብአፍሪካየተመለሱኢትዮጵያውያንየጤናባለሙያዎች ንቢያገኙምንይሰማዎታል?	ኩራት	1	
		ፍርሃትእናጭንቀት	2	
		ደስታ	3	
		ሌላካለ ይገለፅ…… ……	4	
ረ.3	ከምእራብአፍሪካየተመለሱኢትዮጵያውያንየጤናባለሙያዎች የኢቦላምልክትሳያሳዩበሽታውንያስተላልፋሉብለውያምናሉ?	አምናለሁ	1	
		አላምንም	2	
ረ.4	ከማንኛውም ውጭ ሀገርየመጣእንግዳከፍተኛትኩሳትቢኖረውበኢቦላበሽታ መጠርጠርያለበትይመስልዎታል?	ይመስለኛል	1	
		አይመስለኝም	2	
ረ.5	በኢቦላከተጠቁሃገራትየተመለሱየጤናባለሙያዎችያለጥንቃቄልንቀርባቸውእንችላለንብለውያምናሉ?	አምናለሁ	1	
		አላምንም	2	

Questions to key informants

Do you think that the training help the hotel staff to aware about EVD?

Do you think that the training and orientation to hotel staff make behavioral change to the trainees?

Do you think that effectively communicate the risk of EVD to hotel staff?

What kind of words do you use when you develop message and communicate risk?

What were frequently asked questions about EVD by hotel staff?

What was your credible source of information about Ebola?

How do you evaluate the status of KAP of hotels staff towards EVD?