

**Qualitative Study on Malaria Prevention and
Control in Oromia and Amhara Regional States in
Ethiopia**

**Report Submitted to
Academy for Educational Development (AED)
and NetMark**

By



**Addis Continental Institute of Public Health
(ACIPH)**

17 July, 2009

Acknowledgements

The study team gratefully acknowledges the regional and zonal health authorities for facilitating the study in the selected zones in Amhara and Oromia regions. Special thanks are due for AED technical staffs that were very helpful from the inception to finalizing of the study; some of them were also in the field to assist supervision. We are specially indebted to the study respondents who graciously shared their rich knowledge and experiences with the study team. We also appreciate the tireless efforts made by the field study team members who conducted the field work.

The study team consists of Yemane Berhane, Meaza Demissie, Seblewongle Lemma, Nitsehet Worku, Wakgari Deressa, Adey Araya and Tigist Shiferaw. The team gives special thanks for Seblewongel Lemma who coordinated the study project diligently.

Contents

EXECUTIVE SUMMARY	5
I. BACKGROUND.....	8
II. OBJECTIVES	13
2.1. General objective	13
2.2. Specific objectives	13
III METHODOLOGY	14
3.1. Study areas and population	14
3.1.1. <i>Description of Oromia Region</i>	14
3.1.2. <i>Description of Amhara Region</i>	15
3.2. Study Design.....	15
3.3. Target Populations	15
3.4. Sample Size and Sampling Methods.....	15
3.5. Data Sources	17
3.5.1. <i>Review of Literature</i>	17
3.5.2. <i>Data Collection</i>	17
3.6. Data Processing and Write-up	19
IV ETHICAL CONSIDERATIONS.....	20
V. RESULTS	22
5.1. Review of Malaria Literature.....	22
5.2. Brief Insight to PMTCT in Ethiopia.....	28
5.3. Result of the Qualitative Study	31
VI. DISCUSSION.....	63
VII. CONCLUSIONS and RECOMMENDATIONS.....	70
VIII. ANNEXES	74

LIST OF ABRIVATIONS

ACIPH : Addis Continental Institute of Public Health
ACTs : Artemisinin – based combination therapies
AED : Academy for Educational Development
AIDS: Acquired Immune Deficiency Syndrome
ANC: Antenatal Care
BCC: Behavioral Change Communication
CARE: Cooperative for American Relief Everywhere
DHS: Demographic and Health Survey
EDHS: Ethiopia Demographic and Health Survey
FGD: Focus Group Discussion
GFATM: Global Fund to Fight AIDS, Tuberculosis and Malaria
Govt: Government
HC: Health Center
HEWs: Health Extension Workers
HIV: Human Immune Deficiency Virus
HF: Health Facility
HSDP: Health Sector Development Plan
HSEP: Health Services Extension Program
HW: Health Worker
IDI: In-depth Interview
IEC: Information Education Communication
IRS: Indoor Residual Spraying
ITN: Insecticide Treated Net
KAP: knowledge, Aattitude and Practice
LLINs: Long lasting Insecticidal Treated Net
MDGs: Millennium Development Goals
MIS: Malaria Indicator Survey
MOH: Ministry of Health
MTCT: Mother-to-child-transmission
NGOs: Non-governmental organizations
PC: Private Clinic
PMI: President’s Malaria Initiative
PMTCT: Prevention-of-mother-to-child-transmission
RBM: Roll Back Malaria
RDTs: Rapid Diagnostic Tests
SNNPR: Southern Nation, Nationalities and People Region
SP: Sulfadoxine-pyrimethamine

EXECUTIVE SUMMARY

In Ethiopia, malaria is one of the most important public health problems, with more than three-quarters of the landmass of the country and an estimated 68% of the total population is considered at risk of malaria infections. Ethiopia is implementing a range of malaria control interventions that aim to improving access and equity to preventive as well as curative health services, which include prompt and effective malaria treatment, selective vector control using insecticide treated nets (ITNs) and indoor residual spraying (IRS). Effective and timely prevention and control of malaria epidemics is also part of the main strategies. The need for developing comprehensive and high impact communication strategies for malaria control is imperative.

Promoting the well being of mothers and children that are the main target of mortality reduction from malaria requires multifaceted interventions. One of such interventions is promoting the use of PMTCT services. Although PMTCT services are made available widely their utilization remains very low.

The objective of this formative study was to better understand the KAP of the community members towards malaria prevention and control as well as identifying behavioral determinants and barriers to design an effective communication strategy in selected zones in Oromia and Amhara Regional States. In addition, reasons for low utilization of PMTCT services are explored.

This study used a qualitative research approach to data collection based on in-depth interviews and focus group discussions (FGDs). Men and women with at least one child below the age five years in their household from the selected *kebeles*/villages (both from rural and urban), and pregnant women attending ANC services in the local health facilities participated in the study. In addition, in-depth interviews with HEWs and health personnel were conducted to understand about the health seeking behavior of communities. A total of 50 FGDs and 120 in-depth interviews were conducted for the purpose of the study.

Most community members have correct knowledge about causes, symptoms, mode of transmission and prevention methods of malaria. Some common misconceptions include transmission via utensils and eating certain food items. People have some idea about the different kinds of malaria presentations and their severity; though they don't commonly describe them correctly. Most people recognize ITN, IRS and early treatment as strategies for malaria prevention and control however the majority also believed environmental management to be effective prevention strategy. Almost all informants commonly hold positive attitude towards the use of ITN. However, ITN is not consistently used by all members of the household mainly

due to the inadequacy of the ITN. Inappropriate use and misuse of ITN is common. There is also wide spread doubt about the effectiveness when used over a long period of time. Preference to certain shape and color of ITN by some respondents was also noted. The community level ITN distributors themselves know very little about its proper use and effectiveness.

Some of the misconceptions described might modify the way people respond to malaria prevention and control. is the need to clear these misconceptions by giving clear and repeated messages is obvious. Malaria related messages should focus on causes, means of transmission and the definite possibility of cure. Distribution of ITN should also consider the size of family. Proper utilization of ITN can be ensured through availing ITN which is adequate for all members of the family,

Since health workers and HEWs are the main and preferred source of information they should be one of the targets for effective communication strategy with appropriate and updated information on malaria prevention in general. Providing adequate information on how to use ITN properly to all involved in its distribution and use is essential to make ITN a successful strategy.

IRS is highly preferred in some areas of the study because of its added effect on other household bugs. Fear of side effects and esthetic reasons are barriers to its application. Spraying should be accompanied with proper messages that emphasize the need to prioritize avoiding unnecessary suffering and death of children and family members- give value to life.

Health workers and health extension workers are the most commonly mentioned and trusted sources of information followed by community meetings indicating preference to direct face-to-face communication channels. Radio is the most accessible and preferable compared to other forms of mass media. Community members also mentioned that they get health messages through their children and recommended to have regular education program in schools.

One of the commonest causes of delay in treatment seeking is the use of traditional remedies like using different roots and plant, going to holy water or going to some traditional healers. The common barriers for prompt treatment seeking include high cost of transportation and the perceived high cost of treatment. Thus people should be aware of the consequences of delaying malaria treatment and get very clear message about the need for prompt treatment seeking from the nearest health facility, and that malaria treatment is provided freely at the local public health facilities. Messages should clearly indicate the dosage and the need to fully take the drug as prescribed by health workers.

The community member knowledge about the relation between malaria and HIV is negligible. Although they have made some tangible guesses about the relationship they have

never heard or learned from any source in the past. Education in the future should also incorporate the linkage between HIV and malaria and what measure they should take.

The ANC service is largely perceived as beneficial with little knowledge of the timing of initial visit and frequency of ANC. Traditional beliefs about what to do and what not during pregnancy hamper the use of ANC. Developing and providing appropriate messages to the whole community members including the traditional healer is very important. Inaccessibility due to distance and previous dissatisfaction in the health care giving institutions are also important causes of non-attendance. Stigma and discrimination, fear of being HIV positive, and fear of notifying status to the spouse barrier to use of PMTCT services and this requires more communication not only with women but with spouse, close family members and the community members.

Effective communication strategies must be developed using local languages and need to be properly piloted before large scale use. Print media can be potentially effective as a means of conveying clear messages to grassroots level communicators and educators and to provide illustrations of desired actions, skills, practices and behaviors.

I. BACKGROUND

Ethiopia, with an estimated 74 million people in 2007¹, is the second most populous country, after Nigeria, in Africa. Currently, the country is governed by a parliamentary Federal Government composed of nine National Regional States and two city administrative councils (Addis Ababa and Dire Dawa). The regional states and city administrations are further subdivided into *woredas* (*districts*). A *woreda* is an area delineated as the basic unit of planning and political administration at the lower level, and further sub-divided into the lowest government administrative units known as *kebeles*. About 84% of the country's total populations live in rural areas.

Ethiopia is characterized by poor health status. The potential health service coverage for 2007/08 was about 90%². In 2005, the maternal mortality ratio was estimated at 673 deaths per 100,000 live births, and infant and under-five mortality rates were high at 77 and 123 per 1,000 live births, respectively³. Utilization of antenatal and delivery care by pregnant women is essential for her survival and well-being as well as for her child. However, the rate of utilization of the antenatal care (ANC) and delivery care by pregnant women in Ethiopia is highly minimal. In 2007/08, it was indicated that only 59% of pregnant women received ANC and only 20% deliveries were attended by skilled health personnel⁴.

In Ethiopia, malaria is one of the most important public health problems, with more than three-quarters of the landmass (altitude <2000 m) of the country is either malarious or potentially malarious, and an estimated 68% (>50 million people) of the total population resides in areas at risk of malaria infections⁵. Annually, half a million microscopically confirmed cases of malaria are reported to the Federal Ministry of Health (FMOH) from basic health services. However, the actual number of malaria cases in the country is estimated to be more than 5 million each year. According to the 2007/2008 report of the (FMOH), malaria was the leading cause of outpatient visit accounting for 12% of cases and the second cause of (10%) admission next only to admissions for delivery.⁶

Plasmodium falciparum and *P. vivax* are the dominant malaria parasites distributed all over Ethiopia and account for about 60% and 40% of malaria cases, respectively⁷. Coartem

¹ CSA, 2008. The 2007 National Census Preliminary Report for Ethiopia.

² MOH. Health and Health Related Indicator. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa, 2007/08.

³ Central Statistical Agency (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. 2006.

⁴ MOH. Health and Health Related Indicator. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa, 2006/07.

⁵ Adhanom T, Deressa W, Witten KH, Getachew A, Seboxa T. *Malaria*. In: Berhane, Y., Haile-Mariam, D., Kloos, H. (Eds.), *Epidemiology and Ecology of Health and Disease in Ethiopia*. Shama Books, Addis Ababa, 2006, PP. 556–576.

⁶ MOH. *Health and Health Related Indicators*. Planning and Programming Department, Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa. 2007/2008

⁷ Ibid..

(artemether-lumefantrine) was adopted in 2004 as a first-line treatment for uncomplicated falciparum malaria. It is administered orally 2 times a day for 3 days. Coartem is one of the artemisinin-based combination therapies (ACTs) currently used in many subtropical countries for treatment of malaria. Quinine has been used for the treatment of severe and complicated malaria due to *P. falciparum*. Chloroquine has remained effective for the treatment of other malaria parasite species in Ethiopia. The widespread co-existence of *P. falciparum* and *P. vivax* over a wider geographical area in the country has been a challenge for malaria treatment due to the use of different antimalarial drug regimens for both species.

Malaria is one of the leading causes of illness and death among young children. Many children under the age of five year in malaria endemic areas die of cerebral malaria, low birth weight, respiratory distress, hypoglycemia, severe anemia or repeated convulsions⁸. Malaria is also very serious among pregnant women since their immunity is compromised due to the pregnancy. Malaria during pregnancy, if not properly treated, can cause anemia and also miscarriages, stillbirths, low birth weight and maternal deaths⁹.

Currently, a range of effective malaria control interventions are being scaled up in Ethiopia to improve access and equity to preventive as well as curative health services. These initiatives include prompt and effective treatment of malaria, selective vector control including insecticide treated nets (ITNs) and indoor residual spraying (IRS), and prevention and control of epidemics.

Health Services Extension Program (HSEP) was introduced in Ethiopia in 2003 as part of the primary health care service¹⁰. The program aims for the universal coverage of primary health care through focusing on the prevention and control of priority communicable diseases with active community participation. As of 2007/2008, 24,571 health extension workers (HEWs) have been trained and deployed in different parts of the country¹¹. By the end of 2009, 30 000 HEWs will be trained and deployed throughout the country. Each rural *kebele* of the country is expected to have one health post staffed by two female HEWs.

The coverage of health services and community-based malaria control interventions through the HSEP has been significantly improved particularly since 2005. The major activities of HEWs with regard to malaria prevention and control, as outlined in the malaria extension

⁸ Murphy SC, Breman JG. Gaps in the childhood malaria burden in Africa: cerebral malaria, neurological sequelae, anaemia, respiratory distress, hypoglycaemia, and complications of pregnancy. *Am J Trop Med Hyg* 2001; **64**(Suppl. 1-2):57-67.

⁹ Steketee RW, Nahlen BL, Parise ME, Menendez C. The burden of malaria in pregnancy in malaria-endemic areas. *Am J Trop Med Hyg* 2001; **64**(Suppl. 1-2):28-35.

¹⁰ MOH. *Malaria Prevention and Control Extension Package*. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa. 2004.

¹¹ MOH. Health and Health Related Indicator. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa, 2007/08.

package¹², include educating community on mode of malaria transmission and its prevention, promotion of the use of ITNs and IRS, community mobilization on environmental management for elimination of mosquito breeding sites, epidemic monitoring and detection, and dispensing anti-malarial drugs for people with signs and symptoms of the disease.

To improve the quality of malaria diagnosis and treatment with the right anti-malarial drug, microscopic examination has been used at health centers and all hospitals in the country. Although malaria diagnosis at peripheral health services and community levels is most often based on signs and symptoms of the disease, rapid diagnostic tests (RDTs) are currently employed by HEWs and other health personnel working at health post level to assist and improve their diagnostic capacity. However, inadequate supplies of RDTs and Coartem to majority of the health posts are not uncommon, presenting a challenge to malaria treatment due to the need of different treatment modalities for *P. falciparum* (to be treated with Coartem) and *P. vivax* (to be treated with chloroquine). The MOH aims to ensure universal access for malaria diagnosis and treatment within 24 hours of onset of fever by 2010.

In line with the Roll Back Malaria (RBM) initiative and the Abuja Declaration¹³, Ethiopia has intensified its fight against malaria. Important steps have been under taken particularly to scale-up the implementation of ITNs in the country. In 2006/2007, about 18 million nets were distributed to about 9 million households in malarious areas of the country. The National Five-year Malaria Control Strategic Plan (2006-2010) for Ethiopia is to achieve 100% coverage of all ITNs targeted areas with 2 ITNs per household by 2008¹⁴. However, the national Malaria Indicator Survey (MIS) carried out from October to December 2007 indicates that in areas below 2000m, only 36.6% of the study households owned more than one long lasting insecticidal nets (LLINs)¹⁵.

Although the application of DDT for IRS has received relatively little attention particularly between 1995 and 2005, currently there has been a need for the scale-up of this intervention in epidemic prone areas in Ethiopia. Although the National Five-year Malaria Control Strategic Plan (2006-2010) is to cover 60% of malaria epidemic prone localities by 2010, many malaria epidemic prone areas are usually uncovered by IRS due to low coverage, resource constraints, lack of trained human power, lack of technical quality, low acceptance by the community and high re-plastering rate.

¹² MOH. *Malaria Prevention and Control Extension Package*. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa. 2004.

¹³ WHO. African Summit on Roll Back Malaria, Abuja, Nigeria. Geneva, Switzerland, 2000.

¹⁴ MOH. *National Five-Year Strategic Plan for Malaria Prevention and Control in Ethiopia: 2006-2010*. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa, 2006.

¹⁵ MOH. Ethiopia National Malaria Indicator Survey 2007. Federal Democratic Republic of Ethiopia. 2008.

A household cluster survey conducted in Oromia and Southern Nation, Nationalities and People Region (SNNPR) by the Carter Center in January 2007 revealed that 45.4% of the surveyed households in Oromia and 51.2% in SNNPR owned at least one mosquito net of any type and the coverage for at least one LLIN was 32.5% and 40.1%, respectively¹⁶, indicating a ten-fold increase compared to the Ethiopia Demographic and Health Survey (EDHS) 2005 results of less than 1% in these two regions¹⁷.

However, changes in the health care delivery system and provision of anti-malaria interventions by themselves might not necessarily be followed by changes in the behavior or knowledge about the causes of disease and prevention among the population. The scaling up and effectiveness of anti-malaria interventions are dependent on the local understanding, perceptions and household behavioral practices of the community. The local socio-cultural context, social and economic factors coupled with poor health service coverage and low community awareness and participation may lead to poor treatment seeking behavior and inappropriate utilization of the currently available cost-effective preventive health interventions such as ITNs and IRS. One of the problems in the implementation of effective malaria interventions is lack of adequate information about the knowledge, attitude, behavior and practice of the local community towards malaria, its prevention and control.

The MIS 2007 identified major gaps and misconceptions in the local community about the causes of malaria and the link between mosquito bite and the disease¹⁸, pressing the need for improving community understanding and practice through a comprehensive IEC/BCC approach. In the areas below 2000m in the MIS 2007 report, only about 51% of the women in the reproductive age group cited fever as a symptom of malaria, 41% reported mosquito bite as a cause of the disease and only 38% reported ITN as a malaria prevention measure. The altitude of 2000m above sea level has been traditionally considered as the upper limit of malaria transmission in Ethiopia except for highland malaria epidemics that can extend up to 2500m.¹⁹

The RBM partnership strongly recognizes the role of non-governmental organizations (NGOs) in the prevention and control of the disease. Consequently, the USAID/Ethiopia has been assisting the National Malaria Control Program of the MOH particularly after the establishment of the President's Malaria Initiative (PMI) in 2005. The PMI implementation in Ethiopia was started in 2008 and focuses on the Oromia Regional State, the largest of all

¹⁶ Shargie EB, Gebre T, Ngondi J, et al. Malaria prevalence and mosquito net coverage in Oromia and SNNPR regions of Ethiopia. *BMC Public Health* 2008; **8**:321.

¹⁷ Central Statistical Agency (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. 2006.

¹⁸ Ibid.

¹⁹ Adhanom T, Deressa W, Witten KH, Getachew A, Seboxa T. *Malaria*. In: Berhane, Y., Haile-Mariam, D., Kloos, H. (Eds.), *Epidemiology and Ecology of Health and Disease in Ethiopia*. Shama Books, Addis Ababa, 2006, PP. 556–576.

administrative regions in the country encompassing about one-third of its land mass and population.

Efforts are being intensified to provide support to the FMOH by bringing a mix of skills, experience, and creativity to the design and implementation of high impact communication strategies for malaria control. Efforts include strengthening the capacity of regional, *woreda*, and *kebele* structures in Ethiopia to create sustainable cost-effective anti-malaria interventions that help achieve the following objectives:

- Establishing a culture for LLIN, including increased demand for its ownership, correct and consistent use, especially among the most vulnerable groups such as children under the age of five years and pregnant women.
- Increasing community awareness about the effectiveness of IRS and reduction of re-plastering rate.
- Improving treatment-seeking behavior for malaria (e.g., timeliness, appropriateness).
- Increasing community awareness and knowledge regarding malaria diagnosis, treatment, prevention, and control.
- Integrating HIV/AIDS programming with the activities of the PMI in Ethiopia to boost antenatal care (ANC) visits and enroll women in prevention-of-mother-to-child-transmission (PMTCT) services in Oromia and Amhara Regional States.

C-Change is interested in measuring the uptake of messages in both malaria prevention and control including ANC uptake by pregnant women at PMTCT sites. To do so, C-Change undertook a study prior to launching communication activities. Effective communication is the basis of behavior change for the uptake of interventions. The goal of this study was, therefore, to better understand the knowledge, attitude and practice (KAP) of the community towards malaria prevention and ANC uptake by the pregnant women to design an effective communication strategy in malaria prevention and control including communication activities designed to help increase ANC attendance by pregnant women. This report outlines the findings of a qualitative study carried out during the months of April and June 2009 in Oromia and Amhara Regional States in Ethiopia and is supplemented by literature review.

II. OBJECTIVES

This study was undertaken with the following general and specific objectives.

2.1. General objective

The general objective of the study was to collect baseline information to better understand the KAP of the community members towards malaria prevention and control including the uptake of ANC among pregnant women and help fill the gaps and identify key behavioral determinants to design effective communication strategy in the six study zones in Oromia and Amhara Regional States.

2.2. Specific objectives

1. To review relevant literature on malaria in Ethiopia with particular emphasis on the standardized studies with national or regional coverage
2. To assess the KAP of community members regarding causes of malaria and its mode of transmission
3. To identify behavioral determinants and perception of the community about malaria prevention and practice
4. To identify key behavioral barriers for use of ITNs and promotion of net culture
5. To understand the perceptions of the community about IRS , explore existing practices and identify barriers to use of IRS
6. To identify and prioritize appropriate communication channels/ media for malaria prevention and control messages
7. To explore barriers to early treatment seeking behavior and sources of treatment for malaria
8. To assess community perceptions regarding groups most at risk of malaria
9. To understand community perception about the linkages of malaria with HIV/AIDS
10. To explore barriers associated with acceptance and uptake of ANC and PMTCT services
11. To recommend strategies for scaling-up malaria communication interventions in four study zones in Oromia and two zones in Amhara Region.

III METHODOLOGY

This section provides the description of the study areas and the process through which the qualitative study was carried out.

3.1. Study areas and population

This study was carried out between April and June 2009 in six zones (four zones in Oromia Regional State and two zones in Amhara Regional State). The four zones selected from Oromia Region for this study are Arsi, West Arsi, East Shewa and Jimma. The study zones from Amhara Region include East Gojjam and North Gondar. AED/C-Change project in Ethiopia currently focuses its malaria prevention and control interventions in the aforementioned four zones in Oromia, but in the future, it plans to cover most of the zones in Oromia and beyond.

3.1.1. Description of Oromia Region

With an estimated population of 27.2 million in 2007²⁰, the Oromia Region is the largest administrative region in Ethiopia. About 37% of the country's population lives in Oromia Region and only about 13% of the population in Oromia resides in urban areas. The Region has 17 administrative zones further divided into 297 *woredas* (districts), nine special towns and 7064 *kebeles*. Each *kebele* is again further divided into *sub-kebeles*/villages.

Infant and under-five mortality rates for Oromia were high at 76 and 122 per 1,000 live births, respectively²¹. According to the 2006/07 MOH report, there were 22 hospitals, 197 health centers and 1985 health posts owned and operated by the government. In addition, there were eight hospitals, five health centers, and 195 private clinics operated either by non-governmental organizations (NGOs) or other governmental organizations. Health professionals to population ratio in Oromia are generally low with one physician generally serving about 183,000 people (1:10,000 according to WHO standard)²².

Malaria is the most important public health problem in Oromia Region. It is widely distributed in about 82% of the *woredas* in the region.. Malaria in the region accounts for about 17% of outpatient visits, 15% of admissions and more than 25% of hospital deaths. More than 50% of the annual malaria cases and deaths in Oromia are reported mainly from East Shewa, Arsi, West Arsi and Jimma zones..

²⁰ CSA, 2008. The 2007 National Census Preliminary Report for Ethiopia.

²¹ MOH. *Health and Health Related Indicators*. Planning and Programming Department, Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa. 2006/2007.

²² Ibid.

3.1.2. Description of Amhara Region

With a population at 17.2 million people, Amhara Region is the second most populous region in Ethiopia next to Oromia, with about 88% of the population living in rural areas²³. Children under the age of five years constitute about 16% and approximately 23% are women from 15-49 years. The corresponding infant and under-five mortality rates of the region are estimated at 94 and 154 per 1000 live births, respectively. Malaria, is one of the major causes of morbidity and mortality, disproportionately affecting the most vulnerable and under-served group of the population..

3.2. Study Design

This study used a qualitative research approach to data collection based on in-depth interviews and focus group discussions (FGDs). Qualitative research approach helps to understand the ‘how’ and ‘why’ of the community perceptions and practices through probing views of malaria as a risk to health, understanding of malaria transmission and mosquitoes, treatment seeking behavior, population group perceived to be vulnerable to malaria, attitudes and practices of the use of malaria preventive measures and uptake of ANC services by pregnant women to design and develop effective IEC/BCC messages.

3.3. Target Populations

Men and women with at least one child below the age of five years in their household from the selected *kebeles*/villages (both from rural and urban) were recruited and they participated in the individual in-depth interviews and FGDs. In addition, pregnant women who came for follow up of ANC services to the health centers found in the study area participated in the FGDs for pregnant women. It was believed that they would have more experience with malaria and would be able to contribute more to the interviews and discussions. In addition, in-depth interviews with key informants such as HEWs and health personnel from the health centers were conducted to understand about the health seeking behavior of communities around their catchment areas.

3.4. Sample Size and Sampling Methods

To obtain fairly wide views of the target population, we conducted a total of 50 FGDs and 120 in-depth interviews based on the principle of purposive sampling.

²³ CSA, 2008. The 2007 National Census Preliminary Report for Ethiopia.

The study was conducted in eight *woredas* in Oromia and two *woredas* in Amhara Region. From each of the four study zones in Oromia region, two *woredas* per zone and from the two zones in Amhara region one *woreda* per zone were purposively selected, mainly based on their malaria endemic level. In each *woreda*, five FGDs and twelve in-depth interviews were conducted in one rural and one urban *kebele*. Pre-determined and purposive heterogeneous (rural Vs urban; women Vs Men; Lay Vs professionals) sampling strategy was used to select individuals for the study. The number of participants in each FGD was six to eight; homogeneity of group members was the main criteria for selection. Participants of the FGDs and in-depth interviews were permanent residents with good knowledge of the area. The following table and figure provides a summary of the list of study zones and number of *woredas* with their corresponding number of FGDs and in-depth interviews conducted for this study. The specific *woredas* that were selected for the study are shown in Annex 1.

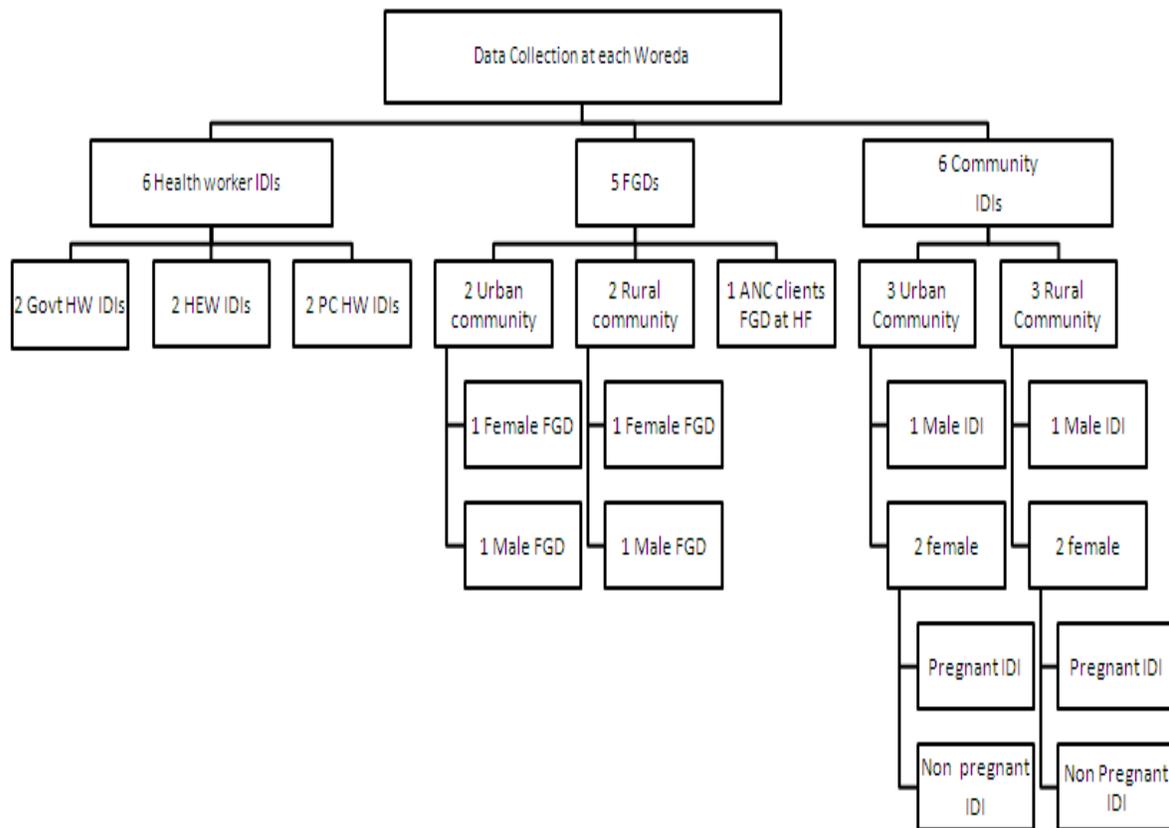


Figure 1: Description of Data collection in a Woreda for the qualitative study conducted in Oromia and Amhara Regions Ethiopia, June 2009

3.5. Data Sources

This report is compiled based on two main sources of data: review of literature and qualitative data collected from different groups of study participants. The literature review encompasses experiences in Ethiopia.

3.5.1. Review of Literature

Literature review of studies that have already been carried out on malaria in Ethiopia was done; to better understand about malaria situation in the country, community perception about malaria transmission and its prevention, health seeking behavior, sources of treatment, sources of information, availability and accessibility to effective prevention such as ITNs and coverage of anti-malaria interventions. The main sources of data used in this review were those with standardized national or regional coverage such as the MIS 2007, the EDHS 2005 and the 2007 Carter Center study. In addition, other local studies and relevant MOH guidelines and policy documents were reviewed to enrich the document.

3.5.2. Data Collection

Semi-structured interview and discussion guides for in-depth interviews and FGDs were developed and used during the discussions and interviews. The guides were originally developed in English and then translated into the local languages (*Afan Oromo* and *Amharic*) for data collection. Translation into *Afan Oromo* was verified with the help of research assistants and further checked by one of the researchers who is native Oromifa Speaker. Interview and discussion guides that are prepared in English, Amharic and Oromiffa languages are annexed.

Based on the objectives of the study, the main themes of the guides include sections on the causes of malaria and its transmission, local terminologies of malaria, symptoms suggestive of malaria, main health care providers in the area, determinants and perception of the community about malaria prevention and practice, perception and use of ITNs, perception regarding IRS, sources of health information and communication channels for malaria, treatment seeking behavior for malaria, sources and availability of anti-malarial drugs for the community, perception about the vulnerability of children and pregnant women to malaria, perception and risk of malaria during pregnancy, link of malaria with HIV/AIDS, and acceptance and practices regarding ANC and PMTCT services. Based on the comment we received from AED we have also included questions on institutional delivery. The interview guides also included many probes under each theme, aimed at determining the knowledge of key informants and community members on the above mentioned topics

The discussion and interview guides were piloted in a similar community around Bishoftu Town, 45 km east of Addis Ababa before being used for actual data collection. All the discussions and in-depth interviews with the FGD discussants and individual or key informants were conducted using the local language by 19 trained qualitative researchers. Recruitment of field staff, with educational background of at least one degree in public health or social science was done through newspaper advertisement and internal notice. Data collectors and supervisors were recruited and trained for three days in Addis Ababa on the use of guides, selection of study participants and recording of the deliberations. All moderators of the FGDs were assisted in the field by a note taker, as four individuals were sent to each woreda in groups of two. With consent of the participants, all the discussions and interviews were tape recorded. Socio-demographic characteristics of the participants such as age, sex, occupation, religion, marital status and education were documented. The field data collection was conducted from April 22 to May 06, 2009. Supervisors from ACIPH went to many of the field sites to oversee the data collection process; supervision was concentrated at the beginning and in the middle of data collection period.

A woreda co-coordinator, who was familiar with the local malaria situation, was identified from each woreda who in turn helped select a field guide, who intimately knew the area as well as the community. The woreda co-coordinator helped select the rural kebeles with high malaria endemic level. As much as possible, rural kebeles that were high in malaria prevalence levels, and which were far away from towns were selected in order to keep the distinctiveness of rural populations. The woreda co-coordinator and the field guide were involved with the team members in selection of in-depth interview and FGD participants.

Recruiting participants for FGD among women coming for ANC posed a challenge, as pregnant women came at different times to health center; thus, requiring rescheduling of FGDs and needing to wait for longer periods. Due to different commitments of the health workers, polio, HIV campaigns, in-depth interviews with health workers' needed to be rescheduled or hurried in other areas. On the other hand, it was not possible to get male participants for the in-depth interview and FGDs on market days, again requiring changes.

The interviews were conducted as much as possible in the natural settings, keeping the privacy of the individuals, mostly at homes of community members, and in the private offices of health personnel. FGDs were conducted in selected quiet places around where most of the participants lived. For pregnant women coming for ANC, a room was arranged in the health center that was wide enough to accommodate every one and private enough to contain the information being discussed in the room.

The average duration of interviews was from 30 minutes to 1 hour and half, the shortest being 18 minute and the longest being 2 hours and 20 minutes. While for FGDs, the interval was from 50 minute to 3 hours & 40 minute, with the longest interview lasting 3 hours & 40 minute.

3.6. Data Processing and Write-up

Data were transcribed in the language of the interview and then translated into English for analysis. The transcription was made word-for-word from the audio tapes. When necessary the transcripts were supplemented by field notes to clarify issues. Correctness of transcription was checked for 10 % of all the audio tapes. Afan Oromo transcriptions were checked by Dr Wakgari while the Amharic ones were checked by ACIPH staff. Minor corrections, such as incomplete forms or responses to the questions, were communicated to research assistants and were corrected on subsequent transcriptions. The large amount of qualitative data needed more time than planned for transcription and translation and more people were hired to facilitate the process. Data entry clerks were entering the Amharic, Afan Oromo and English transcripts into MS WORD as each interview and FGD was submitted (Figure 2).

In the mean time, English transcripts were read and re-read to develop codes that identify important and common concepts related to the main themes of the study (basic content analysis was done). Data analysis was mainly done based on the thematic approach that involves organizing from the collected information into meaningful category. An “Open Code” computer program was used for sorting information, looking for patterns, similarities, differences or contradictions. Finally, some quotes that could explain the context of malaria were identified and presented in the respondents’ own words to give more insight into the perceptions and practices of the community. Field notes and original transcripts were looked upon when more information/ clarity are needed during coding, analysis and write up.

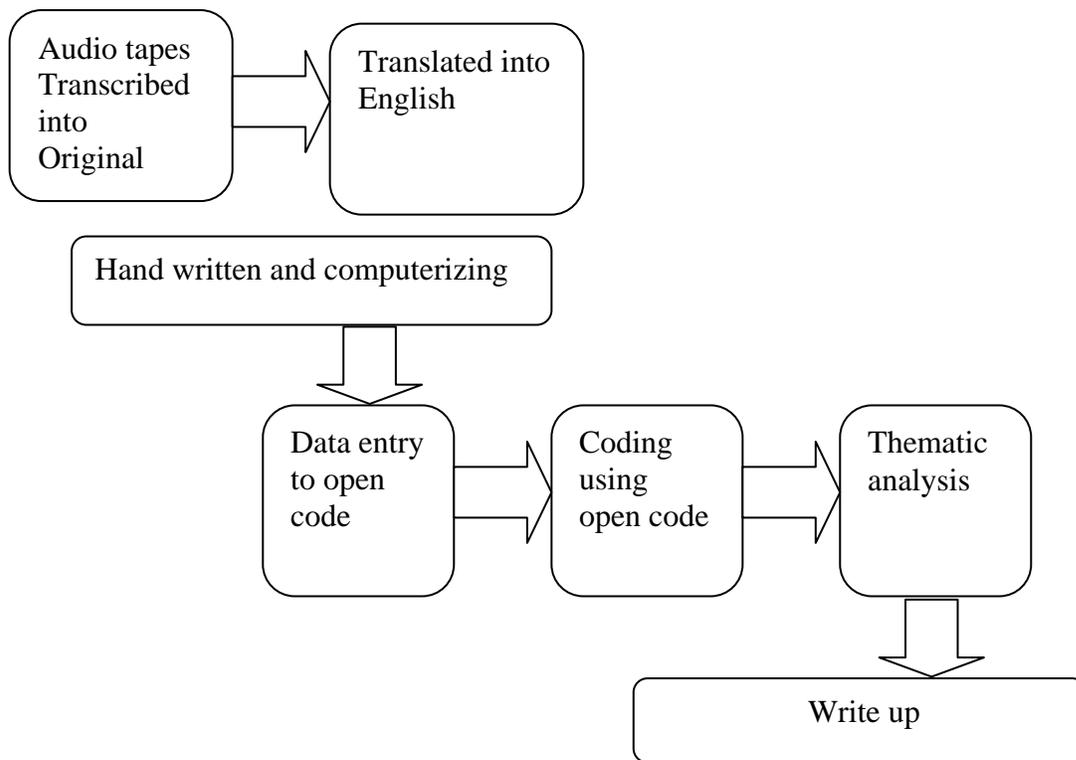


Figure 2: Diagrammatic Representation of Data Processing Steps

IV. ETHICAL CONSIDERATIONS

Ethical approval was obtained from the institutional review board of the Addis Continental Institute of Public Health (ACIPH) in Addis Ababa. Permission to undertake the survey was obtained from the regional, zonal, *woreda* and *kebele* administrative authorities. Official letters from the Regional Health Bureaus and the AED/Net Mark project were written to the study zones and *woredas*. Informed consents were also obtained from the study participants after explaining the purpose of the study. Participation of all respondents in the survey was strictly voluntary. Measures were taken to assure the respect, dignity and freedom of each participating individual in the survey. During training of data collectors, emphasis was placed on the importance of obtaining informed consent (orally), and avoiding coercion of any kind. Appropriate measures were taken to assure confidentiality of the information both during and after data collection. Data collection in health facilities were conducted without disrupting the normal day-to-day activities of the facilities in as much as possible.

V. RESULTS

5.1. Review of Malaria Literature

The literature review on the malaria situation in Ethiopia indicates that a range of highly effective interventions to prevent and treat the disease are currently being scaled up in the country although the coverage indicators are still far from the targets. Nonetheless, recent work also shows that coverage of interventions is below program targets. The current malaria prevention and control interventions are guided by the National Strategic Plan for Malaria Prevention and Control (2006-2010)²⁴ as the next plan 2011 - 2015 is not yet completely finalized. It is formulated based on the Third Health Sector Development Plan 2005-2010 (HSDP III) of the country and is also in line with the RBM Abuja targets and the MDGs (To reduce malaria burden (morbidity and mortality) by 50% by 2010.)

The current period of the National Malaria Control Strategic Plan (2006-2010) is characterized by the availability of significant resources particularly from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and massive scale-up of effective anti-malaria interventions such as LLINs, adoption and use of artemether- lumefantrine Coartem (R) as a first line malaria treatment, an increasing interest in the revitalization of the application of IRS and the launch of HSEP at the village level. Ethiopia is one of the few countries in Africa with a very long tradition of the application of IRS.

Additional interim targets, as indicated below, are also included in the National Strategic Plan (2006-2010)²⁵:

- Achieve 100% universal access to effective and affordable anti-malarial treatment by 2010;
- Achieve 100% coverage of households at risk from malaria at least with two ITNs per household by the end of 2008;
- Strengthen malaria prevention and control services provided to pregnant women in 100% of the ANC clinics by 2010;
- Cover 60% of malaria epidemic prone villages targeted for IRS by 2010; and
- Detect and contain 80% of malaria epidemics within two weeks of onset by 2010.

The above objectives could be achieved through effective implementation of the available prevention and control tools. Except malaria diagnosis and treatment services which

²⁴ MOH. *National Five-Year Strategic Plan for Malaria Prevention and Control in Ethiopia: 2006-2010*. Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa, 2006.

²⁵ Ibid.

are delivered at all levels of the health care system in the country (including those in malaria-free areas), the application of the interventions such as ITNs and IRS are mainly limited to malaria endemic areas below 2000m altitude which demands a thorough analysis and understanding of the epidemiology of the disease.

Moreover, the review and evaluation of the current status of malaria indicators from the various studies carried out at national or regional levels help to identify the gaps and guide malaria control program through proper planning and execution of anti-malaria interventions. Therefore, this section of the document presents the findings of the literature review on malaria in Ethiopia mainly based on the available national or regional representative studies. Other locally but relevant studies were also reviewed to improve the content and coverage of the report.

5.1.1. Ethiopia Demographic and Health Survey 2005

According to the first nationwide Demographic and Health Survey (DHS) of Ethiopia conducted in 2000, only 1% of the households in the country had any type of mosquito net, with 31% in Afar and 12% in Gambella Region²⁶. During this national survey, only few of malaria related questions were included. The details of key malaria intervention indicators were included in the EDHS 2005, and according to this report, about 6% of the 13,721 surveyed households owned at least one mosquito net (whether treated or untreated), with high variations between urban (11%) and rural (5%)²⁷. Mosquito net ownership was highest in the Gambella Region (31%) and lowest in Addis Ababa (1%).

In 2005, the proportion of households with at least one and two or more ITNs was 3.4% and 0.3%, respectively. It is important to note that Ethiopia had been very far from the Abuja target of 60% of people at risk of malaria protected by ITNs. For Oromia Region the EDHS estimate of the coverage of households with at least one and two ITNs was 1.9% and 0.1%, respectively. Similarly, 1.3% and 0.3% of the households in Amhara Region owned at least one and two or more ITNs, respectively.

The EDHS 2005 also showed that just about 2% and 1.5% of children under the age of five years slept under any mosquito net and an ITN, respectively, the night before the survey. Although the use of ITNs by pregnant women is very critical in saving the lives of both the mother and child, and the coverage of this intervention in Ethiopia was extremely below the Abuja target of 60% for pregnant women by 2005. The percentage of pregnant women who slept under an ITN the previous night before the survey was about 1% in 2005, with urban women

²⁶ Central Statistical Authority (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2000*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority ORC Macro. 2001.

²⁷ Central Statistical Agency (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. 2006.

more likely (6.4%) to sleep under ITNs than their rural counterparts (0.8%). Most regrettably, <1% of under five children and pregnant women in Oromia and Amhara Regions, the two biggest and populous regions in the country, slept under an ITN the previous night.

However, it is important to note that the EDHS 2005 was undertaken before a major scale-up of malaria prevention and control interventions in Ethiopia, which started since the end of 2005. The number of LLINs distributed to the households in malarious areas, for example, has increased more than 10-fold from 2005 to 2008.

According to the EDHS 2005, only 8% of the dwellings of the households located in areas between 1000–2000m altitudes included in the survey were sprayed with insecticide in the six months preceding the survey, and this was 2.1% for Oromia and 2.8% for Amhara²⁸. The report also showed that of 10,000 under five children included in the survey, about 19% had fever in the two weeks preceding the survey, of whom only 3% received anti-malarial drugs. However, <1% of children with febrile illness within the last two weeks had taken an anti-malarial drug within 24 hours of the onset of symptoms, with much lower in rural than in urban areas.

5.1.2. Ethiopia National Malaria Indicator Survey 2007

The 2007 Malaria Indicator Survey (MIS) was the first nationwide representative assessment of key malaria interventions in Ethiopia²⁹. The survey includes ownership and utilization status of ITNs, prevalence of malaria and anemia, treatment seeking behavior and malaria knowledge among women. The MIS 2007 was carried out during peak malaria transmission season from October to December, and identified an unprecedented large-scale implementation of malaria prevention and control interventions compared with the EDHS 2005 report. The survey also revealed malaria prevalence of 0.9% for areas below 2000m and 0.1% for areas above 2000m.

The MIS 2007 identified major gaps and misconceptions in the local community about the causes of malaria and the link between mosquito bite and the disease, pressing the need for improving community understanding and practice through a comprehensive IEC/BCC approach. In areas below 2000m altitude in the MIS 2007 report, only about 51% of the women in the reproductive age group cited fever as a main symptom of malaria, 41% reported mosquito bite as

²⁸ Central Statistical Agency (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. 2006.

²⁹ MOH. *Ethiopia National Malaria Indicator Survey 2007*. Federal Democratic Republic of Ethiopia. 2008

a cause for transmission of the disease and only 38% reported ITN as an effective malaria preventive measure³⁰.

The altitude of 2000m above sea level has been traditionally recognized as the upper limit of malaria transmission in Ethiopia except for highland fringe malaria epidemics that can extend up to 2500m. Therefore, the areas above this limit are not part of the current campaign for the massive scale-up of malaria prevention and control interventions in the country.

The free distribution of ITNs in Ethiopia particularly since 2005 has significantly increased the coverage of this intervention. The RBM coverage indicators for ITN possession and use were markedly higher in the MIS 2007 report compared with the EDHS 2005. For areas below 2000m, about 66% of the sampled households owned at least one ITN and 65% of them possessed at least one LLIN, which showed a marked increase in ITNs coverage than the EDHS 2005 estimate of less than 6% for any net. The proportion of households with two or more ITNs increased from <5% in the EDHS 2005 to 36.6% for more than one LLINs in the 2007 report. Just over 42% of pregnant women and about 41% children under the age of five years slept under LLINs the previous night in the latter report.

There has been a great conviction that the massive scale-up malaria prevention and control interventions might have had a tremendous impact on malaria morbidity and mortality in the country. According to the MIS 2007 report, the malaria prevalence determined by blood slide microscopy was unprecedented, 0.7% at national level (0.6% for Amhara and 0.3% for Oromia Region). The prevalence was 1.2% for program targeted areas compared with 0.3% in non-targeted areas. Overall, the prevalence was higher at areas below 2000m (0.9%) than above 2000m (0.1%) and in rural (0.8%) than urban (0.3%) areas.

In the MIS 2007, the coverage of households for at least one LLIN for Oromia Region was about 41%, which is significantly lower than the national average of 53%. Only about 21% of the households in the region possessed two or more LLINs compared with the national average of about 41% in program targeted areas. In Oromia, about 24% (national average: 42%) of <5 children and 28.7% of pregnant women (national average: 40.3%) slept under LLINs the night preceding the survey. Based on the findings of the MIS 2007 report, Oromia is lagging behind almost all of the Regional States in the country. However, it is difficult to judge whether the differences were statistically significant or not since the point estimates were not provided with their interval estimates.

In Amhara Region, about 72% of the surveyed households owned at least one LLIN, and the corresponding value for two or more LLINs was 43.8%. About 49% of children under the

³⁰ Ibid.

age of five years and pregnant women in the region slept under an LLIN last night. The report also revealed that 73.5% of households in Amhara and 43.7% of households in Oromia were protected by at least one LLIN and/or IRS. The MIS 2007 report showed that the coverage of key malaria indicators in Amhara Region was higher than other Regional States in Ethiopia.

The MIS 2007 report also revealed that progress in terms of access to prompt treatment with appropriate anti-malarial drugs was very poor. In areas below 2000m, of children under the age of five years with reported fever within the last two weeks preceding the survey, about 12% received anti-malarial drugs, 4.8% took anti-malarial drugs within 24 hours of the onset of fever and 16.3% visited health care providers within 24 hours of fever onset. Only 6.6% of children with fever in Oromia and 6.1% in Amhara overall received an anti-malarial drug, and <3% of the children with fever in both regions took anti-malarial drugs on the same or next day.

5.1.3. The Carter Center Survey, December 2006 - January 2007

A household cluster survey conducted in Oromia, Amhara and Southern Nation, Nationalities and People Region (SNNPR) by the Carter Center in January 2007 revealed that 45.4% of the surveyed households in Oromia and 51.2% in SNNPR owned at least one mosquito net of any type and the coverage for at least one LLIN was 32.5% and 40.1%, respectively³¹, indicating a phenomenal increase compared to the EDHS 2005 results of <1% in the two regions. The mean number of any net and LLIN per household was 0.7 and 0.5, respectively.

Overall, the study revealed that about 27% of children less than five years of age and 32% of pregnant women slept under an LLIN the previous night. With regard to the Oromia Region, 25% of under five children and 29% of pregnant women slept under an LLIN last night, much lower than that of the SNNPR corresponding figures (32% vs. 37%, respectively). However, there were no statistically significant differences in the proportions of less than five children and pregnant women sleeping under any net or LLIN between the two regions.

The Carter Center Survey also reported malaria prevalence for Oromia, Amhara and SNNPR regions using blood slide microscopy. The overall malaria prevalence for the three regions was 4.1% (95% CI 3.4-5.0%), but when disaggregated by region it was 0.9% (95% CI 0.5-1.6%) in Oromia, 4.6% (95% CI 3.8-5.7%) in Amhara and 5.4% (95% CI 3.4-8.5%) in SNNPR³². Compared with light microscopy, Para Screen RDT underestimated the prevalence of malaria and showed higher specificity (98.5%, 95% CI 98.3-98.7) but lower sensitivity (47.5%, 95% CI 42.8-52.2%). RDT for *P. falciparum* diagnosis at peripheral health facilities has been

³¹ Shargie EB, Gebre T, Ngondi J, et al. Malaria prevalence and mosquito net coverage in Oromia and SNNPR regions of Ethiopia. *BMC Public Health* 2008; **8**:321.

³² Endeshaw T, Gebre T, Ngondi J, et al. Evaluation of light microscopy and rapid diagnostic test for the detection of malaria under operational field conditions: a household survey in Ethiopia. *Malaria Journal* 2008; **7**:118.

widely promoted in Ethiopia particularly to minimize inappropriate treatment of non-malarial febrile illnesses.

5.1.4. Other Locally Relevant Malaria Surveys

A nationwide baseline survey carried out in January and February 1999 to assess the implementation of ITNs in malaria endemic areas of Oromia, Amhara and SNNPR Regions in Ethiopia revealed that only about 5% of the households had at least one mosquito net³³. A study conducted in 2006 in Wonago Woreda in SNNPR showed that 58% of children under the age of five and 75% of pregnant women slept under an ITN the previous night among 638 households freely supplied with ITNs³⁴.

In a community-based cross-sectional study in Tigray, 59% of households with pregnant women owned at least one ITN, and 58% of pregnant women and 36% of under five children slept under a net the night before³⁵. At the end of 2005, the researchers at Aklilu Lemma Institute of Pathobiology at Addis Ababa University carried out a community-based household survey in eight regional states and Dire Dawa City Administration Council³⁶. The study revealed that more than 95% of the surveyed households in Oromia and Amhara Regions had at least one ITN and more than 85% of the respondents slept under an ITN the preceding night.

³³ Jima D, Tesfaye G, Deressa W, et al. Baseline survey for the implementation of insecticide treated mosquito nets for malaria control in Ethiopia. *Ethiop J Health Dev.* 2005; **19**:16-23.

³⁴ Dagne G and Deressa W. Knowledge and utilization of insecticide treated mosquito nets among freely supplied households in Wonago Woreda, Southern Ethiopia. *Ethiop J Health Dev.* 2008; **22**:34-41.

³⁵ Belay M and Deressa W. Use of insecticide treated nets by pregnant women and associated factors in a pre-dominantly rural population in northern Ethiopia. *Trop Med Int Health.* 2008; **13**:1303-1313.

³⁶ Animut A, Gebre-Michael T, Medhin G, et al. Assessment of distribution, knowledge and utilization of insecticide treated nets in selected malaria prone areas of Ethiopia. *Ethiop J Health Dev.* 2008; **22**:268-274.

5.2. Brief Insight to PMTCT in Ethiopia

5.2.1. Burden of HIV in women and children

Worldwide, there are approximately 39.5 million people living with HIV/AIDS, including an estimated 17.7 million women and 2.3 million children under the age of 15³⁷. Women currently represent the population with the fastest increase in HIV infection rates; in the hardest hit countries of Sub-Saharan Africa, more than 60% of all new HIV infections are occurring in women, infants, and young children.

Every day, 1,400 children under the age of 15 are infected with HIV. In 2005 alone, an estimated 540,000 children were newly infected with HIV, with approximately 90 % of these infections occurring in Sub-Saharan Africa. Without appropriate care and treatment, more than 50 % of newly infected children will die before their second birthday.

MTCT can occur during pregnancy, birth or through breastfeeding. As a mode of transmission MTCT accounts for more than 10 % of new infections globally. Over 90 % of new infections in infants and young children occur through MTCT. In the absence of interventions, the risk of MTCT is 20-45% with the highest rates in populations with prolonged breastfeeding.

Ethiopia is one of the ten countries which contribute for two thirds of all MTCT infections. Others being South Africa, Uganda, Kenya, Tanzania, Zimbabwe, Mozambique, Nigeria, Democratic Republic of Congo and India³⁸

5.2.2. Overview MTCT of HIV in Ethiopia

The National adult HIV prevalence in Ethiopia is estimated to be 2.1 % (7.7% in urban and 0.9% in rural areas). Highest prevalence occurs in the 15-24 age groups and prevalence is higher among females than males in both urban and rural areas. Ethiopia is home to the third largest number of the world's people infected with HIV, after India and South Africa, with an estimated 1 million Ethiopians living with HIV/AIDS. Of these 96,000 are children under the age of 15, the majority of whom have acquired the infection from their mother during pregnancy, labor and deliver and /or breast feeding .In 2007 there were 75,000 HIV-positive pregnant women.³⁹

³⁷WHO,. Prevention of Mother -to -Child Transmission (PMTCT), Briefing Note,2007. Geneva: WHO

³⁸ WHO,A Report Card on Prevention of Mother – to – Child Transmission of HIV/AIDS and Pediatric HIV Care and Treatment,2005

³⁹ MOH, .AIDS in Ethiopia, Sixth Report.,Federal Democratic Republic of Ethiopia, Addis Ababa,2006

The guideline for the prevention of Mother-to-Child Transmission of HIV in Ethiopia, 2007 recommends different approaches for each mechanism of HIV transmission in children.⁴⁰

Primary prevention of HIV infection

Preventing spread of HIV to parents and potential parents such as adolescents, and unmarried persons are the most effective way to ensure that HIV will not be transmitted to children.

Prevention of unintended pregnancies in HIV positive women

Prevention of unintended pregnancies in the general population is critical to prevention of transmission of HIV to children because many women and men do not know their HIV status. Increasing family planning among HIV positive women is a major method of preventing HIV in children and is cost effective.

Prevention of HIV transmission from HIV positive women to their infants

PMTCT services should be available to all pregnant women attending antenatal clinics. Quality antenatal, delivery and post partum care should be provided to all women, irrespective of HIV status.

5.2.3. Knowledge of MTCT

According to EDHS 2005, majority of the population, 69 percent of women and 75 percent of men know that HIV can be transmitted by breastfeeding; only slightly more than around one-fifth of women and one-fourth of men know that the risk of MTCT can be reduced through the use of certain drugs during pregnancy. Twenty percent of women and 26 percent of men are aware of both aspects of MTCT transmission. There are marked differences in MTCT knowledge as reported, among women and men by age, marital status, residence, education, and wealth. Knowledge about mother-to-child transmission is highest among men and women living in urban areas.⁴¹

Although more women are aware that HIV can be transmitted through breast feeding in Oromia region than in Amhara (78% versus 62%), a similar proportion of males know about MTCT through breast feeding (76% versus 75 %) in these regions. But when knowledge of mothers taking special drugs during pregnancy to prevent MTCT, in addition to knowledge of

⁴⁰ MOH, Guidelines for PMTCT of HIV in Ethiopia.,Federal Democratic Republic of Ethiopia; 2007

⁴¹ Central Statistical Agency (Ethiopia) and ORC Macro. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. 2006.

transmission through breast feeding is added, similar levels of knowledge is observed for men and women residing in both regions.

5.2.4 Availability and Utilization of PMTCT Service

In 2007/2008 a total of 719 health facilities across the country were providing PMTCT services, out of which 168 facilities were in Amhara region and 204 in Oromia region. In the same year a total of 429,310 pregnant women attended ANC at the above mentioned facilities in all regions, out of which 68.1 % were counseled and a further 74 % of the counseled were actually tested for HIV. In Amhara region the number of clients attending ANC was 72,515 eighty five percent of whom were counseled and 76 % of those counseled were actually tested for HIV. More pregnant women attended ANC in facilities where PMTCT was available in Oromia region (128,965 women), 68.1 % were counseled and 78 % of the counseled were tested for HIV. More proportions of HIV positive pregnant women were willing to take Nevirapine in Amhara than in Oromia region, ie 53.2 % Vs 42.1 %.⁴²

⁴² MOH. *Health and Health Related Indicators*. Planning and Programming Department, Federal Democratic Republic of Ethiopia Ministry of Health, Addis Ababa. 2007/2008.

5.3. Result of the Qualitative Study

In this study, a total of 400 community members and 60 health personnel / key informants participated, from both Amhara and Oromia Regional States. Information gathered from informants was summarized by thematic area and is presented below.

5.3.1. Knowledge about Malaria

In both Regions, all the informants have heard about malaria. In Oromia region, malaria was known as “*Busa*”, while others knew it as “*Legida*”. The meaning of both words is fever. People from Jimma and East Shoa also called it as “*Hurguftu*” and “*Shekero*” meaning shivering. In Amhara region the disease was known by the local name “*Woba*”. Particularly low land inhabitants referred to it as “*Nidade*”, meaning high fever. The local names given in both regions reflected the most frequent symptoms that people identify malaria with.

Knowledge of Community about Causes of Malaria and its Transmission

The majority of respondents’ knew that malaria is caused by a mosquito bite without specifically identifying any biological causative agent; meaning they do not refer to the malaria parasite itself. In the following section description of the causes and factors related to transmission of malaria, as mentioned by respondents are presented.

Poor environmental hygiene was the most commonly cited cause of malaria by the participants. The presence of swampy area, animal dung, and dirty cooking utilities in the compound were also reported as possible causes. However few respondents considered the sole presence of poor environmental hygiene, as a cause of the disease in the absence of mosquito bite. This was consistent both in urban and rural settings and among respondents from both Oromia and Amhara regions. Many informants also considered poor personal hygiene, as a cause of malaria; for instance a female respondent from urban Liben Chukala said “*what I know is malaria occurs due to lack of personal hygiene such as, failure to cut hair and nail, failure to wash kitchenware, failure to control flies, not washing cloths*”. Female FGD participants from rural Shebe also mentioned “*Malaria can be caused by not keeping our homes and toilets clean and by not washing our hands after using the toilet*”. “*What I know is this: if I care for my children, wash their cloths, give them food on time and keep my house clean, then malaria will not attack us*” (Female FGD participant, Shebe urban). “*Due to scarcity of clean water, we do not wash our hands before eating and also do not wash our cloths, inturn the mosquito then sniffs dirty area and comes*” (Female participant, Siraro urban).

Environmental pollutions and climatic conditions were also considered as important factors in the causation of malaria. A few people considered smoke, exposure to bad smell, cold weather and staying in desert as causes of malaria.

Very few informants from Amhara and Oromia mentioned that malaria is associated with consumption of certain food items. A male FGD discussant from rural Liben Chukala said *“Eating a steam of a plant such as sugar cane, eating peas and fruits can cause malaria...most of the time children are affected by malaria since they eat sugar cane and roasted peas”*. Malnutrition is also considered as a cause for malaria. *“In my opinion if a person doesn’t get food on time and if he/she gets hungry then he/she may lose his/her appetite then they may acquire malaria”* (Female participant, Shebe urban).

There are two groups of opinions about malaria transmission raised by the informants. Many believe that malaria can be transmitted from a sick to a healthy person via mosquito bite. Some informants have also mentioned that malaria is transmitted by not practicing preventive activities such as utilization of bed nets, not cleaning their environment and not getting good medical treatment.

On the other hand, some respondents, especially those from non-endemic areas, do not understand the malaria transmission. *“Malaria is not influenza; it doesn’t transmit from person to person”* (Female FGD discussant Liban Chukala, Urban). *“Malaria does not transmit from person to person by mosquito; the mosquito bites a person and feed on his/her blood however, that does not mean the mosquito transmits malaria when biting the next person”* (Male FGD discussant, Lumame, Urban). *“Malaria remains there in a person ... it just cause sweating but does not transmit to healthy person”* (Female FGD discussants Azezo, Rural). Such misconceptions mean that an infected person/sick person is not regarded as a threat for the people around as source of infection.

Another kind of misconception related to means of malaria transmission is that some respondents believe sharing dishes and cups with a sick person can transmit the disease. A few believe that malaria can be transmitted through breath, and direct body contact with the sick person... *“Malaria transmits thorough body contact, when a sick person sleeps with a healthy one”* (Male FGD discussant, Liban Chukala, Rural). *“Malaria transmits from person to person; for instance, if I get sick my child will also get sick because I breast feed.”* (Female FGD discussant, Limu Seka, Urban)... *“Malaria transmits from person to person thorough breathe, sharing cups with infected person and body contacts”* (Female in-depth interviewee, Liban Chukala, Urban). *“Malaria transmits from person to person through fever when there is body contact with sick person”* (Female interviewee, Liban Chukala, Rural). *“Louse, contamination*

through sweat, and eating with sick person, make us get the disease” (Male in depth interviewee, Limu Seka, urban).

It seems that the majority of the respondents have correct knowledge about the role of mosquito in the transmission of malaria. The findings presented above also illustrate the wide spread misconceptions about malaria transmission. These could hamper timely intervention resulting, in grave outcome due to delayed health facility care seeking. As people’s knowledge about causes of malaria influences the prevention mechanism they may choose, it is important to craft clear messages about the specific cause of malaria and the factors facilitating transmission and spread.

Knowledge about Symptoms of Malaria

Majority respondents, identified fever, vomiting, loss of appetite and shivering (chills) as main symptoms both in adults and children. Some also stated back pain, headache, feeling thirst, fatigue and yellow urine. They could recognize fever in their children by physically touching them or if the mother is breast feeding, she feels the hot breath which comes out of her child and if these symptoms are especially in the transmission season the suspect is more. Some put it as, *“I do have a 2 years old baby, I observe that when he has fever, he stops breast feeding and he has also other symptoms such as vomiting, diarrhea and shivering (chills) then I know he has malaria”* (Female FGD participant, Azezo, Rural). *“When children have malaria, they can not hold their head, they refuse breast feeding, and mostly they have vomiting rather than diarrhea”* (Female FGD discussant, Arsi Negele, Urban).

These symptoms were more or less similar across urban and rural residents of the two regions. Whenever one or two of the above symptoms were seen in a person they suspect malaria. However, few from Oromia region considered Malaria in children as *“Likift”* (being possessed by evil spirit); when there is very high fever and the child develops convulsion, these people believed that this was not something which could be treated with modern medicine. So they might delay treatment seeking. *“When a mother breast feed her child she feels the high temperature. The child’s behavior changes frequently and become delirious. We call this kind of sickness in children as “Likieft” caused by devil and there is no cure for it”* (Male participant, Liben Chukala rural).

It is encouraging that most informants have good knowledge of malaria symptoms and most can identify fever as a symptom of malaria. Besides as parents, most informants recognize malaria in their children, whenever they detect unusually high body temperature. However a few individuals surveyed misunderstood the symptoms for other health problems. Thus, encouraging those people with appropriate knowledge and clearing of misconceptions is essential, as the

correct identification of malaria symptoms, is an important step in early treatment seeking behavior.

5.3.2. Knowledge and Practice of Malaria Preventive Activities

Environmental Management

Environmental management was the most popular malaria prevention method discussed by informants from both Oromia and Amhara regions. The informants described it as, destroying mosquito breeding sites; clearing stagnant water, covering spring water, eradicating dirt from the compound. If accumulated water could not be removed, spraying “used motor oil” has preventive effect. Some mentioned they disposed off waste, by burning or burying it, in holes dug far from their house. They also prepared toilet properly, as a toilet which was not dug properly could accumulate water and thus be a good breeding site for mosquito. In addition, they separated their house from their cattle’s/livestock since fecal matter from animals results in favorable environment for mosquito breeding. *“In my age I did not encountered someone spraying DDT in urban area however I know they spray in rural area. But we protect ourselves from malaria with what we have. If there is stagnant water in our surrounding we eradicate it and the like”* (Male participant Liben Chukala urban). *“We can prevent malaria through cleaning our environment so as to reduce the reproduction of malaria, by separating the living area of cattle and human beings because it creates conducive environment for mosquito”* (Male participant, Limu Seka rural).

Mobilizing the community to carry out such activities to prevent malaria was frequently mentioned in Lumame, Amhara. The informants from Lumame stated that they clean their environment, destroy swampy areas on regular basis mostly weekly. Those from rural Lumame said the association established for the purpose of malaria prevention, together with the health extension workers, mobilized the community and carried out preventive activities. Another informant had also mentioned that there were times when Idirs mobilizing their members for such preventive activities. *“Once a week, we go out and destroy places where mosquito reproduces; each village does that accordingly”* (Male participant, Lumame rural).

In addition to environmental management, some informants considered keeping personal hygiene as a good malaria preventive mechanism. Female respondent from bosset, urban said that, *“we keep our personal hygiene, including washing our face and hair ... and keeping our clothing clean...”*

Few informants did not know any method of malaria prevention and did not believe that it is preventable. A female informant from Shebe, urban, said that, *“It is impossible to prevent malaria; we lost so many, children, and family members in the past”*. A pregnant woman from

Limu Seka, Urban has also said that, *“It is not possible to prevent malaria; we can only take medication when we have the disease”*.

Traditional Malaria Preventive Activities

There are traditional activities which are believed to have preventive effect against malaria. Some of them are still practiced while some are outdated according to our informants. These are eating garlic with green paper, drink gourd juice and avoiding eating vegetables such as tomato during rainy season to prevent malaria. According to the informants, these have both curative and preventive effect. There is also a home remedy called *“haregresa”*, this is a root of a small plant, they drink its juice. There are also local plants such as *“Dumuga”*, and *“Endode”* used to prevent malaria. When malaria epidemic arise they smoke *“Dombaya”* and *“Goetzenni”* leaf. A female respondent from Azezo said that they polish the floor of their house with *“Tinjit”* which is produced from butter. *“When the epidemic starts we protect ourselves by smoke of ‘Dombeya’, ‘Goetzenni’ leaf and by using bed net”* (Male participant, Shebe urban). Another participant has also said the following, *“previously they used ‘Haregresa’ which is a kind of plant, the root of a small plant, and they drink it after squeezing thinking that it will prevent malaria”* (Male participant Arsi Negele urban).

Chemical Preventive Methods: IRS Knowledge and Practice

Spraying DDT is another prevention method informants described and most respondents know IRS as a chemical which kills mosquito. However, the awareness about IRS varies from urban to rural depending on their experience. In the urban areas the respondents they either remember IRS from their past experience in the rural areas or heard about it from others otherwise they have never had a chance to see or experience the IRS. *“Now a day all the community members want to spray their home but it did not spray. We saw DDT spraying in the neighborhood we asked them to spray our home as well but they told us that we are no more in rural territory. Since our kebele is recently included under municipality”* (Male participant, Azezo urban). Similarly most informants from rural Amhara sites had also mentioned that they have not seen or experienced IRS. Thus, they do not talk about it much rather some informants from both regions mentioned some kind of chemical spray when they are asked about IRS. This is a chemical that they buy from shops for themselves and spray it whenever there is flea and other bed bugs infestations however, they are not sure of its effectiveness against mosquito.

“So far, we have not seen DDT being sprayed in the town. They selectively spray places where the epidemic happens regularly such as the area around Gibe River. Here they just give us bed net” (Male informant Limu Seka Urban).

According to the rural informants, the IRS is not sprayed on regular basis. Some said it is sprayed once a year, some every six month and others said it is sprayed whenever the malaria epidemic is high. September to November and June are mentioned as times when mosquito becomes rampant and IRS is sprayed. One male FGD discussant from Shebe expressed his disappointment with laughter as, *“After malaria become rampant, the epidemic becomes highly spread and so many people get ill, they come and spray”*. The above quotation indicates untimely spraying of IRS which may make people unwilling to IRS next time.

All the respondents who happen to have experience with IRS said that people from the government come and spray their house. During spraying, community members involved in packing their equipments keep their domestic animals in closed place, fetch water and even cook food for the men who do the job. After their house is being sprayed they will wait for some hour and will mop the house to remove dead insects and other bugs; This process is more or less similar in all rural sites in Oromia and a few urban sites where people said they had IRS once. *“I take my furniture and other equipments out side my home and after the DDT is sprayed I wait for some time and take my equipments back”* (Female participant, Shebe urban). A female participant from rural Azezo said that, *“...when IRS is sprayed. We take out our equipment; we stay outside our home for few hours and keep our hens away while it is being sprayed”*.

Perception of Community about IRS

Although most informants said they are willing to open their door when the men who do the spraying come, they did not deny that there are some people in their community who refuse IRS spraying. Some of the reasons mentioned by the informants are related with perceived effectiveness of IRS against mosquito and other bugs, health hazard associated with IRS, the inconveniences such as work load during the spraying on the community and its effect on the appearance of their house since it stains the wall.

Although most had positive attitude towards the benefit and effectiveness of IRS as a malaria prevention method, there were some who had reservations on its effectiveness. They said it does not kill mosquito, as the sprayed DDT solution is a diluted one and was not effective as it was not sprayed every 6 months. So these people totally refused the spraying. *“It was sprayed last summer; some people refused to let their house be sprayed, because they considered it as ash which could not kill insects”* (Male, Liben Chukala, and Rural). *“Those who do not have knowledge about it close their door when the men who spray IRS come to their village. They said we do not see its benefit except its harm. Some also said it brings bed bugs and sometimes they equate IRS with spraying flies”* (Male, Arsi Negele, Rural).

Perceived health hazards of IRS was another factor which made some people refuse IRS. Though most agreed that, it does not have any health hazard so long as it is used properly from

the time that it was sprayed. People should make sure that all their kitchenware are far from their home during spraying, they should also avoid any contact with the left over on the wall and the floor; if there is, they should make sure that they wash their hand. One female FGD participant from rural Lumame, said, *“Isn’t it to prevent malaria that the walls are sprayed? ... if it gets things in the house, then we have a problem, if it is sprayed on the kitchenware, then it might kill us because it is poison ... isn’t it because it is poisonous that it kills mosquito?...”* a male participant from rural Arsi Ngele said, *“Up to now I haven’t encounter any harm because of DDT both on my self and my domestic animals, also I do not have any fear for the future as well”*. Those people who fear the poisoning effect of IRS put their opinion as follows, *“chemical on the chair and walls in the house may affect children when they touch with their hands. We worry for our children when ever DDT is sprayed in the house”*. Apart from its poisoning effect, those who refuse IRS mentioned that IRS can cause breathing problem, body rash (allergy) and burning sensation. A female participant from Bossete urban said the following, *“... for instance my husband has sinus (sinusitis) If we let our house sprayed by DDT, his problem might get worse. So it is better if there are any other preventive methods other than DDT”*.

The other problem associated with IRS is the inconvenience and work load created when people prepared their house for spraying. People have to remove their belongings from their house before IRS is sprayed and get it back inside after spraying is completed. Some people considered this as a tiresome work and they close their door or runaway till the men finish spraying the other houses in the area. In addition some also mentioned, it ruin the appearance of their house as it stains the walls and floor and they are not comfortable to live like that. *“There may be many people who refuse as they do not want to put their belongings outside because it is tiresome”* (female participant, Azezo urban).

Re-plastering of house after spraying was another practice that some did intentionally while others did it unknowingly. Most informants said that they did not re-plaster or paint their house after spraying for at least six months, as to do so will reduce the effectiveness of IRS. After that, they could re-plaster as the IRS was no more effective. Few also mentioned they will wait three months after the spraying, to do any kind of remaking their house. Re-plastering or re-painting walls during New Year or whenever there was some kind of ceremony such as weeding had been reported, irrespective of the duration of IRS. *“There are people who re-plaster their walls after DDT spray immediately while others wait for six month before re-plastering”* (Male Liben Chukala rural).

According to the informants, some of the people who re-plaster their house after IRS did it on purpose to show their refusal knowing that it will reduce its effectiveness. These were the people who did not want spraying in the first place though they did not show it during the spraying. They re-plastered after the men left. There are also some people who do re-plastering

due to lack of awareness. Female participants from Rural Azezo said that, *“The cementing and covering the house has nothing to do with DDT effectiveness, the chemical is already sprayed and there is no problem”*. *“The chemical can prevent until six month but what we think is that it has already killed the insects the first day it is sprayed and we do not need to wait the whole six month to re-plaster”*. Another female participant from rural Bosset said that, *“after IRS sprayed we will wait for three hours out side our home then we do not do any re-plastering until three days then we re-plaster”*.

It seems that there was no consensus on how long IRS should be left untouched, before doing any reforming on the walls and this is something that people should be taught about, for IRS is to be effective. In addition, those who do not re-plaster their house to keep the effectiveness of IRS should be encouraged so that proper utilization can be enhanced.

Utilization of ITN

ITN is a malaria prevention tool known by the community as “Agober” or “Zanzira” to mean bed net in local language. Almost all participants heard about or seen ITN; it is distributed by the government. Most reported that they have ITN, some use it for its primary purpose and some use it inappropriately. The following table shows some of the malpractices related to ITN in both regions and urban to rural variation.

Table 1: Improper Use of ITN among the Community in Amhara and Oromia Regional states, Ethiopia, June 2009

Region/Residence	Malpractice related to ITN	Quotations
Amhara/Rural	Spread it on a floor and use it to dry cereals on it	<i>“They take it out side and use it to make sorghum dry”</i> Azezo, Female
	Bed spread	<i>“Some people don’t have a rug and when they found this bed net looking good, they spread it out on the surface of their bed and sleep on it”</i> Azezo Female
	Use it as a rope	<i>“some times some people twist the bed net and use it as a rope for loading and tie goods on a donkey”</i> Azezo Female
	Put it idle	<i>“When they gave us, they used to say, if you do not use the bed net, you are going to be asked. When some people hear this some took ITN to their home and put it fearing that they will be asked to pay if it is torn down...then people from the government has told us in the gatherings. They told us that if it is torn, you are not going to pay. It is a gift”</i> Lumame Male
Amhara/Urban	put on the market or	<i>“When bed net is distributed, they give no education and some</i>

	put it idle	<p><i>sold it as they do not know its use” Azezo Female</i></p> <p><i>“there is poverty in the community so when they get bed net sine there is poverty, they sell it and buy beans, peas and chickpea” Azezo male</i></p>
	Clothing such as scarf, head cover....	<i>“Some use it as scarf and others to cover “Mesobe” traditional home made equipment used to put bread” Azezo Female</i>
	Carpet, curtain and mat	<i>“We do not know the use of ITN; we even do not know how to hang it so many use it as a mat...”... “Some use it as a curtain too... I saw people use it as carpet and put tomato on it in the market...” Azezo and Lumame Female</i>
Oromia/Rural	Bed sheet, scarf, head cover	<p><i>“There are people who use bed net under their blanket They are seriously wounded by chemicals in our locality” Liben Chukala Male</i></p> <p><i>“People cut the bed net and use it for different purpose such as Muslim scarf” Limu Seka Male</i></p>
	Grain sack , Rope and Curtain	<p><i>“People use bed net for other purposes like for ropes to tie and load materials on a donkey and as grain sack and also as curtain because it is not soaked in a chemical and no more effective for mosquito” Liben Chukala Male</i></p> <p><i>“Mosquito are coming to home during night time we can use ITN by hanging over our doors to kill mosquito which are coming to home” Liben Chukala Male</i></p>
Oromia/Urban	Use it as head cover or scarf	<i>“We see people in the market places using it as head cover. We also heard a woman who lost her hair because of the chemical.” Liben Chukala Female</i>
	Use it as rope, Putting the Bed net idle or selling	<i>“Why we cover it? No one use it. Every body put it in kitchen house as it is packed. They even use it as rope to tie their donkey it is strong.” Liben Chukala Male</i>
	Using it as bed sheet or curtain	<i>“First of all they do not understand its use so they use it as scarf, and as bed sheet saying it kills flea so they sleep on it” Shebe Female</i>

According to some participants, in the households where there are adequate number of ITNs for all members of the family, they would all sleep under the bed net at night. Other wise children and pregnant woman were given priority to sleep under ITN when there was no adequate number of ITNs. However when a guest was in the house, children, were not given

priority. Some informants had also said that priority was given for parents to sleep under the ITN.

People did not use ITN regularly and this was somewhat similar for both urban and rural residents. They started using ITN when mosquito or other insects appeared in their compound, especially during rainy season. *“We do not use ITN regularly unless mosquito is rampant in our village; the reason is that while we use, it creates heat and disturb sleep especially our children”*. Some mentioned they use it regularly except that they remove it when it gets dirt to wash it. Male participant from rural shebe said, *“We use it regularly because the disease has no specific time for transmission in the community; we only take it down when we want to wash it”*. As opposed to those people who live in lowlands, those who consider their residence high land do not care much using the ITN on a regular basis (e.g. Lumame, Amhara Region).

5.3.3. Key Behavioral Barriers for Use of ITNs and Promotion of Net Culture

The informants appreciated the government’s effort; free distribution of the ITNs. However, they believed that the number distributed to each household was not adequate for every member of the family to sleep under. They received ITN from Kebele and health facilities free of charge. Some said they need more ITN distribution as what they currently have, are not enough for all members of the household. Otherwise, most agreed that they have enough. In some communities, such as Lumame, people refused to accept ITN during distribution fearing that they may be asked for payment in the future. One female participant from rural Lumame described it as, *“those who refused to take ITN were saying that there is no strong malaria in high land ...it doesn’t prevent it...they are just going to get us in debt”*. Unlike IRS, the availability of ITN was more or less the same across urban and rural residences.

According to the informants, availability of ITN was an important contributing factor that affected household use. There were some people who did not have it at all, while some had inadequate numbers of ITNs. Thus, availing ITN is something which should be considered seriously. *“We do not use ITN regularly because there is shortage”* (Female participant Bossete rural). *“They provided as two bed nets in 1999 E.C. for a house hold with out considering the family size of each household”* (Male participant Limu Seka rural).

One major barrier for the use of ITN was people’s knowledge as described by respondents; they used it as a bed sheet, scarf and curtain. People also did not like to sleep under the bed net just because they did not feel comfortable, as one respondent described, *“If you take me, I don’t like to sleep under the bed net because I don’t feel comfortable; I assume there are many like me”*.

Improper utilization due to lack of knowledge about the use of ITN was common. In some localities where ITN was given, the distributors from the Kebeles' had no or little knowledge about ITN and about how it should be used. Thus, these people could not give much information to the community while distributing the ITNs. The community members recommended that it would have been better if the ITN was distributed through health facilities. *"The community should be told what to do with ITN during distribution... the providers should unpack the ITN and demonstrate how it can be used, that would help proper use"* (Female participant Azezo urban). Another participant from urban Bossete said the following, *"While providing us with ITN, the providers do not aware us on how to use it. This is what makes us not to use ITN"*.

Perceived Effectiveness /Benefit

The community's perception about its benefit and effectiveness determined the use of ITN. Both urban and rural residents of the two regions agreed that ITN is not only effective against the malaria transmitting insect - mosquito but also against other bugs. Some participants described it as follows, *"Bed net is essential to protect ourselves from malaria infection; it kills mosquito... some people are buying bed net when the previous one loses its effectiveness..."* (Male participant, Liben Chukala, rural) *"As long as our environment is not clean from the mosquito, we need to use the ITN. We have no any option; besides, the ITN also protects us from being bitten by other insects as well"* (In-depth interview respondent). Another participant said the following, *"... before the bed net distribution, this area was highly affected by malaria. Now there is change; malaria is no more epidemic here"* (Male, Shebe rural). There was similar perception about the effectiveness of ITN against mosquito and other bugs in both urban and rural communities. They compared the malaria situation during the time before and after introduction of bed net. Male respondent from urban Lumame said that, *"my wife and I used to catch malaria repeatedly. After we started using bed net, it stops; we are no more affected by malaria"*. Some urban respondents had compared the effectiveness of ITN with IRS as follows, *"when DDT is sprayed it may stay effective for two or three days but bed net use more than this as long as adequate advice is provided during distribution"* (Male, Shebe Urban).

Although most had positive attitude about the benefit of ITN, some people doubt its effectiveness especially after being used for sometime. These people argued that the ITN has to be re-soaked as they have used and washed it repeatedly, which makes it lose its effectiveness. There were some people who do not perceive ITN as effective prevention method against mosquito and few also said that it caused bed bugs and flies instead of eradicating them. The doubt about the effectiveness of ITN has little variation across urban and rural residents. In rural, the informants acknowledge the effectiveness of ITN and suggest re-socking, to make it more effective. While those residing in urban areas that doubt its use, strongly disbelieve it's

effectiveness at all. A female participant from Azezo urban put it as follows, *“my child and I used ITN, I usually buy a chemical with 5 birr to re-soak it regularly; however, thirteen days ago, my child had malaria. This ITN including its chemical is valueless. Malaria may attack those who use ITN while those who do not use may not be attacked”*.

Perceived Side Effect of ITN

There are two kinds of ideas about the side effects of ITN in the community. There are some people who do not consider the complaint associated with ITN as a side effect since they think that these side effects are results of improper utilization of ITN; these complaints are skin problems due to body contact with ITN and the discomfort that ITN causes when a person sleeps under it (such as feeling hot and poor ventilation). *“If one sleeps under the bed net, it will be very hot and feels like you are burning, it is the chemical which makes it this way. So the ITN has to be stretched on the bed, and should be fastened with nail so that it will give enough space”* (Male participants Lumame). On top of this, allergy to upper respiratory system is also documented. *“I am provided with ITN but it has problem to my health, it sneezes me; it also irritates my face”* (Female participant, Bossete Urban). Thus, they suggest proper use such as preventing any skin contact as a solution. The other is, there are people who recognize these side effects as problems which influence their utilization of ITN. *“The reason for not using ITN on continual basis is, while using ITN, it creates heat and disturbs children from sleep”* (Female participant Bossete rural).

It is hopeful that people recognize the side effects as manageable or preventable. However, since this has influence on utilization, every individual should be advised on proper use as well as the possible short comings when they are provided. Hence, they can prepare themselves for any possible side effects and they will not consider quitting use of ITN as a solution. On top of this, they will be able to recognize any unprecedented side effects and can easily seek medical help.

Preference of the Type of ITN

Preference to specific shape and color of ITN is one of the contributing factors which influence utilization. So far, what has been mostly distributed in the community is the green or blue and rectangular one. They have seen a white one with conical shape in other places and it used to be distributed for pregnant women. They also describe ITN interims of size as big and small. Most people do not care about the color of ITN as long as it is soaked with the preventive chemical. But, there are a few people who prefer the green ITN since it doesn't get dirty easily and they think that it is more effective than the white one. *“I prefer the green one because the white one can get dirty easily”*. *“I prefer the green one since we know the use is better”* (Female participants, Lumame rural). Their preference to the type of ITN is related with its convenience

whenever they hang it. Many people both in rural and urban area prefer the circular or conical one since it is easier for them to hang it. *“As to me, I prefer the conical one than the rectangular since it is simple to hang it with out affecting the design of the house.”* (Male participant, Azezo Urban) *“In our community not all people use bed made of wood or metal, they sleep on bed made of mud. So the conical can fit for any kinds of beds we have while the rectangular does not fit for bed made of mud”* (Male participant, Liben Chukala, Urban). Similarly, male participant from rural Liben Chukala said that, *“The type of ITN distributed is rectangular in shape this kind is not suitable to hang because its size does not fit with the rural huts”*. On top of this, poor ventilation is another reason mentioned by few people for not preferring the rectangular ITN as well as ITN as a whole. Female participants from urban Bossete said that, *“I prefer the conical one since the rectangular one does not allow good air ventilation for my children”*. *“I prefer the conical and white one, because it is easy for use and allows fresh air”*. A male participant from rural Shebe has also said that, *“the rectangular ITN is not well ventilated...”*

According to the informant even though they are not provided with choices of ITN, they know what they prefer. Thus, either these people should be provided with the type of ITN they prefer or they should be educated on how they can hang properly and use it with out the inconveniencies they mentioned.

Perceived Seriousness of Malaria

Malaria is considered as a serious problem in both urban and rural community across the two regions. However, not all people perceive it as serious disease. It kills so many people, it has affected their day to day activity, reduce their productivity and their economy. It is also a reason for collapse of households and making children orphan. *“In this area, so many people are affected by malaria. As epidemic, it kills many people. Children left with out parents and many houses are disintegrated”* (Female participants Limu Seka urban). *“Here we are all farmers, this disease become serious during summer and people get sick and stayed home and miss many working days from their farm...”* Some said it makes a person mad since it attacks head. There is a perception that there are two kinds of malaria, red and yellow, and people believe that the yellow one is highly transmittable and difficult to cure. According to the participants, the one that attacks the head is called yellow malaria. This is the name given for cerebral malaria. This type of malaria can kill a person with in a few days unless the person gets medical care early. *“As to me, there are two kinds of malaria, red and yellow; it is possible to be cured from the red”* (Respondent from Amhara region). *“If you catch the yellow malaria, it can be ‘Yelet mot’ which means yellow malaria can kill in one day.”*

People compare the severity of malaria with other diseases such as HIV and most agree that it is more severe than any of the disease they know including HIV. *“Malaria is serious*

disease and people are afraid of it more than HIV; HIV gives you time but not malaria” (Female participants Bossete urban). “There are people who live with HIV with out taking any drug but not with malaria”. According to the participants the most worrying thing about malaria is its seriousness in children; some stated it as, “previously, our father used to say there was a place where malaria was very rampant, called ‘Beyemu’; it is not far from where we live. Now, there is a saying here “if a person has many children let he takes them to ‘Beyemu’” (Male participant urban Ziway Dugda). This is to mean that if the person thinks that the number of children he has is many, he can take them to ‘beyemu’ so that malaria kills them one by one. People also said that they get worried when a pregnant woman catches malaria. “What worries me most is the damage that malaria cause in children and pregnant because a pregnant woman can not take drug for malaria during pregnancy.” (Female participant Liben Chukala Urban) Some also explained that seriousness of malaria is more in rural compared to urban; “In the year 1997 to 1998 E.C., there was a problem of malaria in rural areas, it killed so many people, in some family there was no one to take care of the sick” (Female participant Azezo urban).

There are some people who do not consider malaria as a serious problem any more. They compare malaria seriousness years before and said it is getting better. According to the informants the change in the severity of malaria is associated with the increasing availability of health care especially in rural areas and as there have been preventive works carried out both by the government and community. *“Previously, it was spread at alarming rate and killed a lot of people” (Male participant, Azezo urban). “Now adays malaria doesn’t exist any more since we have received bed net and clean our environment.” (Female participant Azezo rural) another participant said the following, “2 to 3 years ago malaria was serious in this area but now, woreda health office reduce it by distributing bed net and spraying DDT.”(Male participant Bossete urban) some people from Amhara region said that malaria is not a serious problem in their locality. The reason is that they are living in high land and they did not face serious problem yet. However, some do not deny that it is becoming a problem in the high land also. “... but the disease does not affect us much. It is only in the low land...”... “It is for those who live in low land that the government is spraying DDT because it is not that much serious.” (Female participants Lumame rural) another participant put it as follow, “the problem is serious still, it is not comparable to that of low land areas”... malaria is becoming serious in this area previously; it was in low land now it is coming to the high lands.” (Male participants, lumame Rural)*

It is believed that people’s perception about seriousness of the problem can initiate people to take preventive measures such as utilization of ITN, early treatment seeking and so on. Except a few informants, most perceive the seriousness of malaria; even those who said the seriousness of malaria is changing, they associate the change with the introduction of preventive actions. However, there is a still a room for intervention in this area, since those people who

could not see the seriousness of malaria should be made aware of the problem before it comes to the fore again.

5.3.4. Communication Channels/ Media for Malaria Prevention and Control Messages

Sources of Information

Respondents reported that the common sources of information for malaria are; health facilities (health centers and health posts mainly), local social networks organized as *Iddir* or around religious organizations and the various radio channels.

The Ethiopian radio both in Amharic and Oromiffa languages is the most frequently listened channel in Amhara and Oromia regions, respectively. Radio is common in rural areas as other media are not widely available and most of the community members can't read. FGD discussant from Zeway Dugda said that, *"though TV can give us clearer information with visual aid...what we have is radio... we listen to the radio often and get much information from it"*. Another respondent from Arsi rural area said that, *"there are some TV programs but we are in rural area and we don't get TV often... we watch that only when we go to urban area Asela"*. In urban areas TV is mentioned as source of information more often than in rural areas. A few respondents in urban areas also mentioned magazine and pamphlets as useful source of information.

According to the informants, these channels transmit messages about malaria, its cause, treatment and prevention. In most of the study areas, community members do not mention print media indicating that it is not commonly used channel of communication. When asked, few participants believe that the print media are useful but they don't have access to print materials. A respondent from Zeway Dugda urban area mentioned that, *"Usually we watch TV about HIV and malaria but we don't get newspaper here"*. Another respondent from Shebe rural said that, *"if we get oromiffa newspaper, we read but it doesn't reach us"*. Male FGD participant from Azezo rural area explained that most people in reality lean towards information from HEWs and radio. *"We get information from HEWs because most of the community is not educated; even those who say that they can read newspaper, don't read it all therefore, they listen to the radio or they listen to HEWs"*.

Social network such as Iddirs, community and religious gatherings are also useful channels to communicate health information. Health workers also use this channel to pass on health messages. Female FGD participant in merti- Abomassa described, *"we get information from health stations and we are given information during kebele meetings; Kebeles purposely call for meetings and educate the people. Information about malaria is also told on idir"*.

Similarly, religious gatherings in churches and mosques are also suggested as suitable medium of communication since large population can be gathered at the same time. These gatherings are arranged whilst the people have enough time for their worship and therefore, they have time to listen to the messages patiently after that. *“Many people go to church on Sundays; they give us education after that”* (Azezo rural male FGD participant). And another respondent from Jimma Lemu Seka area said that, *“it is good if the teachings are on Sundays for Christians and Fridays for Muslims after we pray”*.

Lessons given in schools are also indirect means of information as children go to school and are taught about malaria. Schools are also one spot by influencing parents’ behavioral change through their children: Children come to their home and deliver their knowledge to their parents. *“Information transmitted in schools is good, because children from many houses gather there and the message can be transmitted to their parents easily”* (Shebe male FGD participant). Another female respondent from the same area described the importance of children as their source of information. *“We get information from our children who are attending school; they teach us to keep our environment clean”*.

Health facilities give health education every day before starting their daily routine. Community members who come to get medical treatment listen to these lessons. FGD participant from Merti described this as, *“we get information from health stations; in the mornings, they give education and we listen to that”*. Male respondent from Shebe said that, *“Health professionals are more preferable and in the future it is better if information is transmitted through them”*.

On the other hand, in rural communities, HEWs play an important role in mobilizing the community. They give health education by their outreach programs. They also deliver the message as being part of the community. One HEW from Lemu Seka woreda said that, *“the community has accepted us. We have also accepted them and we feel as if we are together”* (Female FGD respondent Azezo rural). *“Since the HEWs come to our area, we keep our hygiene, we use ‘Zanzira’ or bed net, and we collect our dry wastes in a specific area. I think the community has reached the level of understanding about malaria”*. Participant from Bosset stated *“we get information about malaria from health post. HEWs are our source of information. Sometimes we watch TV programs about malaria but most of the time we get the information from HEWs. They are also very close to us when we encounter any health problem”*.

Generally, this channel, health sector channel, is the more trusted as the community believes that they are knowledgeable and any misunderstanding can be cleared at the spot by asking questions face to face. Moreover, HEWs live within the community and they have personal attachments which lead to community acceptance. Male FGD discussant from Merti area said that, *“we listen to radio, we watch TV but the people believe health workers; if they say*

malaria epidemic has come, they make us understand". Female respondent from Lumame urban area described the community's trust on health professionals as, *"there are advertisements on TV and radio ...but the community believes what health professionals tell them during meetings. We want them to tell us more about malaria during kebele or idir meetings"*. Another participant from rural Lemu Seka said that *"I prefer practical things; for example. Radio is theory; I can't watch it but listen. But if they come from woreda, they communicate face to face and it is practical. They tell me which thing is lacking which thing should be improved etc. and what I see is greater than what I listen"*.

Though there is no consensus about which day of the week and what specific time is convenient for transmitting information about malaria, radio and TV programs during weekends and evenings are preferable by most of the respondents. Moreover, religious gatherings on Sunday and Fridays after religious preaching are also suggested suitable by most participants.

It appears that most direct information sources such as health facilities/workers, recognized public events, and the media are the most widely practiced and preferred channels by the communities. As the health sector sources are the most trusted communication media, training of health workers in communication skills through workshops and trainings to enable them deliver the right and key messages on malaria is recommended. Written messages (print media) are not widely known and difficult to make judgment about their usefulness. Literacy and accessibility of published media may be factors affecting the utilization of print media. On the other hand, there may be a need to increase access of publications (broachers, newspaper, magazine etc) about malaria for health workers to update them on current health situations. Interpersonal communication between health staff and community may also be supported by posters. In general, messages need to be developed for widely accessible channels and appropriate piloting is necessary before investing too much on channels/communication media that have not been used widely. Developing appropriate messages and communication aids for local and media communicators might be useful to ensure transmission of clear messages to the community through commonly accessed channels.

5.3.5. Barriers to Early Treatment Seeking Behavior and Sources of Treatment for Malaria

Early Health Seeking Behavior of People

Majority of the health workers said that people in their locality prefer to go to health facility first, though this may vary from place to place, *"They come to both to the Health Center and Malaria treatment site (this site is found in the health compound and functions only to test and treat Malaria patients)"* (Health worker Arsi Merti). *"For any type of disease the community seeks healthy facility and are well treated there...they prefer public health station and not*

traditional treatment ... When the community suspects malaria they seek health facility” (Health extension worker, Bosset). Another health worker from Limu Seka has this to say “The health seeking behavior of this community is very good, they know deeply about their health problems; even they know the symptoms, of some diseases like of malaria, so that they go to the health care facility immediately, when taken ill”.

Similarly the participants from the community have also mentioned that people in their community first go to health facilities. *“We want to go to the health facility immediately; every body goes there when they get sick. No one passes the day or a night because this disease gets worse”.* Some informants said that not all people seek medical care after they witness symptoms of malaria. Self treatment with home remedies and modern medicine like tetracycline (Amhara) is reported. There are also some people who go to other places before they seek medical care. A community participant from Lumame site reported that *“people first go to holy water before they visit health facility for diseases other than malaria”* and those from East Shoa mentioned that *“there is this person who will be asked for forgiveness when someone in the family get sick”.* So, they first visit this person; they even prepare traditional remedies to cure the disease and people go to the health facility if the disease gets serious.

Eating garlic and ginger are the most common home remedies practiced in many places. According to some informants, the first thing some people consider when they have fever is *“miche”* which is fever related to exposure to direct sun. Informants in Liben Chukala have said *“we burn ‘Dhumogaa’ tree root smoked in the house so that the patient can smell it”,* drink boiled *‘haregressa’* local plant, and drink papaya leaf boiled every morning. *“There are also people who immerse themselves in cold water in big container, in early morning to cure Malaria”* as told by male participant from a rural Liben Chukala. These practices are more or less similar in both Amhara and Oromia.

In some places, they use cheese which has been kept for long time such as 7-10 years to treat malaria. They also drink *‘Damakese’* green leaf plant with melted butter. *“There is a home made treatment, most of the time it is given when yellow malaria is suspected; it is made of cow milk and we call it ‘metata kibe’ it is kept for seven years before use and the sick person will drink it and this remedy will take out the disease by inducing diarrhea and vomiting”* (Male participant urban Lumame).

There are some people who agreed that things are changing on this regard. People are going to health facility instead of sitting at home; they are seeing the change on themselves. *“I used to live in a countryside once upon a time while I was there I got sick, I had fever and I stayed home without seeking a medical care. Finally, I became very weak and my family took me to health center carrying me. Now, I will never do that again”* (Female FGD participant, Bosset,

urban). Another informant from lumame has said this *“now is very different, we run to health facility whether the person who is sick is a child or older”*.

The informants also acknowledge the consequences of delay after a person develop symptoms of a disease. For some people when they lack money to go to health facility, the alternative is self treatment taking home remedies. Among the traditional remedies used in different localities like in Arsi, one respondent said, *“We first beg the creator “Waqqa” to cure the patient like our ancestors used to do”*. A female respondent from Azezo said that *“traditionally, we use October honey with butter and this will cure the disease by inducing diarrhea and vomiting”*

Economic problems and distance of health facility are among the commonly reported reasons for delay to seek for medical care. Some hesitate to go to health facility hoping they would get better. According to the informants, illiteracy is also another barrier which hinders the community from getting early treatment for malaria as well as other diseases.

Some community respondents, who experienced un-satisfactory service in government health facilities delay for few days hoping the symptoms will subside, but if the symptoms persist, they go to private facility away from their locality.

In addition, perceived severity of malaria is also an important factor which shapes the health seeking behavior of the community. In this regard most believe that malaria is a serious problem except some people who live in Amhara, Azezo and Lumame. According to the informants, not only the community members but also the government has given less attention for malaria in these two areas. *“We don’t give attention for malaria; there are some places where people give attention but not us. Accordingly, there is a difference among kebeles in the distribution of bed nets”*(Female participant urban Azezo).

Proper Use of Malaria Drug

After seeking medical care one must take the treatment given appropriately in order to recover fully from the illness. The informants added that a person should take proper food as well to get cured. Not all people take malaria drugs properly; some take the full dose and some stop taking when they start feeling better. The respondents said that this is more common among rural dwellers compared to urban ones. One female informant from Limu Seka said that *“We do not have the habit of visiting health facility, when we get sick, we borrow some drug from our neighbors and use it...”* another participant has also said the following *“... in rural areas the health extension workers distribute anti-malaria drug. They advice the community while they give the drug at the spot; however, some may stop using it after taking half of it and when some one in the household get sick they give the drug”* (Male FGD participant Shebe, urban).

Some of the reasons for not taking a full dose are feeling better after taking half of the dose; perceived health hazard after taking full dose and usually complaining of headache, breathing problems, temporary hearing problems and gastric discomfort.

Most health workers interviewed agreed that there are many people who do not take anti malaria drug properly; despite the counseling the health workers are providing while prescribing the drug. The health workers provide the patients information on course of drug, possible side effects of the drug and consequences of not taking full course. *“I don’t think all people use anti-malaria drug properly; however, we are providing counseling to enhance their awareness”* (Health worker Leben Chukala). *“...there are some community members who do not use malaria treatment properly. These are people who have less information about malaria”* (Health worker Lumame). Another health worker from Limu Seka added the following, *“...people do not take it (anti-malaria drug) properly; they share the drug for all household members with malaria especially for children and sometimes they even save it for another day”*.

Health workers also share the reasons for non compliance mentioned by the community; it seems that feeling better after taking some of the drug is the most popular reason for non compliance. *“...after taking the drug for a day or two, the fever and headache will go away then they discontinue...”* (Health worker Siraro) Health workers stated that bitter test of a drug and experiencing some side effects such as epigastric pain are also the complaint. *“Some complain epigastric pain and stop taking the drug”* (Health worker Arsi Negele) a health worker from bossete added that, *“...some people do not complete the dosage; they say the drug has bitter test”*.

Some health workers approve that people take their medicine properly and non compliance to anti-malaria drug is no more a problem as they are providing them with the proper information and make follow up visit. *“They (patients) may miss the timing while taking the drug; otherwise, they will finish the full dosage”*. *“They use malaria drug properly as they are told when and how much to take the drug and the drug’s side effect by the health workers”* (Health workers Limu Seka). A health worker from Shebe said *“yes, they use anti-malaria drug properly because after we give them the drug we make follow up”*.

Some informants are able to identify anti-malaria drugs by their names, such as Coartem. They have also described how it is used. *“I think Coartem tablet is taken for three days; four tablet at a time, twice a day. I myself after taking the first three doses I will stop; no one completes it”* (Female FGD discussant Limu Seka, urban). Another female participant from Azezo *“It’s called Fansidar or Chloroquine. I think 4 or 2 tablets are taken. I don’t know as I never had Malaria”*. A male participant from rural Liben Chukual has said *“the drug is used based on the prescriptions. It is also provided according to the age of the patient. We break the*

tablet for children". There are some respondent who are able to correctly state the dosage and the number of days that the drug should be taken *"We use the drug according to the health workers prescription; in the first and second day we take four tablets, and on the third day, we take two"*. The participants are able to describe anti- malaria drugs calling by name and the dosage irrespective of the correctness of the dose. This shows that people are familiar with these drugs since malaria is one of the prevalent diseases in the country. Even so, counseling during prescribing ant-malaria drugs should always be encouraged and strengthened including the possible consequences of not taking full dosage on their health as well as on future effectiveness of the anti-malaria drug against malaria parasite.

The evidence from both the community informants and health workers suggested that non compliance to anti-malaria treatment is not uncommon in their community. Health workers have emphasized the importance of providing information about the drug while prescribing and this should get more emphasis than before; besides, teaching aids such as pectoral aid can be designed to make the counseling more attractive and informative.

Availability of Anti malaria Drug and Financial Accessibility of Service

There are different opinions with regard to availability of anti-malaria drug between health workers and community members. The health workers mentioned that they have encountered shortage once but most of the time, they have plenty and they have also reported that treatment of malaria is given free of charge in the government health facilities. Patients pay only for registration card and laboratory investigation which ranges from 2 to 6 birr. *"There is no problem of drug availability here; we receive drug every three month and change the expired drug immediately"* (Health worker Merti health center). *"There is no problem of anti-malaria drug; however, at this time there is shortage since the drug is expired and we are waiting for the new drug to arrive"* (Health worker Zeway Dugda).

However, some community respondents reported that drugs are usually unavailable in government health facilities and they are forced to buy anti-malaria drugs from outside. A male participant from Limu Saeka said *"here we have health post which provides health service for the rural community however we do not get anti-malaria drug here so we are forced to buy it from private clinic."* A female respondent from Arsi Negele added that, *"most of the time there is shortage of drug in this health center; I saw many things when I and my children get sick. They tell us that we are diagnosed and have the disease (malaria) however; they say the drug is not available here. This happens to me three times; they give you some cheap drug and send you to buy the rest from private pharmacies where the drug is much more expensive"*.

In addition, as has been mentioned earlier most community members have reported financial problem as a reason for not seeking medical care early. They fear that the service

charge at health facilities are costly and may not be affordable while the service is being provided free.

5.3.6. Community Perceptions Regarding at Risk Groups and Malaria during Pregnancy

Children and pregnant women are the ones that are believed to be susceptible to malaria. Some of the reasons mentioned for the susceptibility of children are, that they have no strength to withstand the disease and they need their parents' decision to go to health facility at which time the illness gets serious. In addition, they are easily exposed to malaria since they do not wear clothes during the night time which exposes them to mosquito bite. *"When I think of malaria what worries me most is about children. They can not tell about their illness immediately for this reason, we delay to take them to health facility"* (Female participant, Bossete, urban). *"Mosquito bite children on their stomach and their stomach swell, it is a big problem here"* (Male participant urban Zeway Dugda).

Pregnant women are also mentioned by most respondents and the reason indicated for their vulnerability was their being unable to take anti-malaria drugs during pregnancy and weak resistance to any illness during pregnancy. *"When my daughter was five months pregnant, she developed nose bleeding and shivering, then we took her to the health facility and they gave her a very strong drug; we didn't know her pregnancy status, she aborted. Had it not been for God, we would have lost our daughter"* (Female participant, Liben Chukala, urban). Another female interviewee from Liben Chukala has said the following, *"when I think about malaria what worries me most is its grave outcome to children and especially to pregnant women, because it is difficult for pregnant women to take drugs when getting malaria"*.

5.3.7. Community Perception about the Link between Malaria and HIV

No direct link between HIV and malaria is observed by most respondents, each disease with its' own method of transmission, one not leading to the other or increasing susceptibility. *"If a person has HIV, and prevents malaria like any other person, then he will only have HIV"* (Male FGD participant Merti). *"Malaria is malaria, there is no difference (in those with HIV) except that, and they are carrier. I know that mosquito does not transmit HIV"* (Male participant rural, Zeway Dugda). *"I don't think there is a link between malaria and HIV (malaria in HIV positive people) as the diseases are different... HIV positive people are not vulnerable to malaria"* (female participant rural Arsi Negele). *"I don't think there is a link between malaria and HIV; malaria is transmitted by the mosquito, the mosquito doesn't suck our white blood cells and that's it doesn't transmit HIV/AIDS"*. *"I have learned the fact that HIV/AIDS is not transmitted by bugs or insects. So, AIDS and malaria are not related"* (Male participant, Siraro, urban).

Some have said that there is a link between the two illnesses. *“If a person has HIV virus in his blood, he will easily acquire malaria; he is more vulnerable to malaria”* (Male interviewee, urban Merti). Another woman from the same area has said *“Yes, if he has HIV, he can’t resist malaria and will become weak unless treated early”*. When explaining why a person living with HIV virus is more vulnerable, a rural male from Azezo *“A person living with HIV is more vulnerable than a healthy person, as he lacks a strong body defense”* (Male interviewee, Siraro, urban). *“Because the HIV patient is easily affected, he can early develop malaria”*.

Others think when both diseases occur together, it results in a significantly more severe illness and weakening of the affected person. *“This one (HIV) is fire and that one (malaria) is too. Therefore, if both fires are together, how can the person get better?”* (Male FGD participant, Merti) *“If he has both, he might not be able to resist it. He will be hurt more; I would think... If both of them affect a single person at the same time, it can cause more illness”* (Male participant Siraro, rural).

Respondents did not mention any taboo with regard to having malaria. Unlike HIV, disclosing malaria is not a problem. *“We prefer to have malaria than AIDS ...AIDS is transmitted through sexual intercourse, delivery and blood transfusion”*. Other males participating in Merti, Arsi have put it like this *“A person who has it knows it, we don’t know. We only hear about the name HIV. If we are good mannered, we won’t have HIV”*... *“We don’t know about them (HIV and malaria)...we only know about the link between TB and HIV”*. A man from urban Siraro who was interviewed has said that he does not know the link as HIV is a disease from God.

The absence of taboo about malaria encourages people affected to talk openly about malaria which opens room for instituting appropriate treatments early unlike other disease such HIV/AIDS.

5.3.8 Barriers Associated with Acceptance and Uptake of ANC and PMTCT Service

Knowledge about ANC / PMTCT Services Availability

Most informants know about the care given to pregnant women in their areas, *“When a pregnant woman first goes to the health post, they will give her card. She will go monthly, have follow up and they will tell her when to come as she approaches delivery....”* as stated by a rural male interviewee from Zeway Dugda. Another man who participated in a rural FGD in Azezo puts it like this *“For pregnant women: the government, the community and HEWs: all together take good care of them. After becoming pregnant, HEWs send them to clinic (HP) for follow up.... She will be examined, if the fetus and woman are healthy, she will be appointed to come back and will have the information of what to do in case she gets sick. And if she has anemia or*

lacks balanced food, she will be given nutritional advice as well as medicine....They (HEWs) treat them well”.

Few respondents have mentioned they are unaware of available services for pregnant women. A rural man interviewed from Limu Seka “... *I do not know any service available to pregnant women to prevent MTCT”.* Similarly a male interviewee from Bosset has said that he is not aware of the availability of services.

Practice Regarding ANC/PMTCT

The majority of the community members agree that pregnant women use ANC. “*There is no pregnant woman in this area who doesn’t visit health facility. Some people even go to far away health centers for better services”* (Female FGD participant rural Azezo). Another woman from the same group said, “*I don’t think there are any that do not use services at this time, as the health care service is nearby, all pregnant women are using it”* An urban male FGD discussant from Shebe has also confirmed that women follow ANC very much in his locality.

Time of first visit varies from women to women, some saying pregnant women should go around 3 months, and others say they should go earlier. “*A pregnant woman should visit health care from 3 months...”* (Female participant Bossete rural) pregnant woman attending ANC FGD at Lumame have agreed that follow up should start earlier. “*When the menstruation stops, she needs to attend the health care service.... Forty days after menstruation stops, she has to start ANC follow up”.*

On the other hand, some rural women have said that pregnant women in their area attend health services late in pregnancy as they are shy or self conscious about their pregnancy early on. Female participants from rural Azezo FGD, “*We go after the six month, when everyone knows we are pregnant, but going before that makes us shy”.* Other rural female FGD participants from Siraro have also said “*Our women are illiterate, do not have confidence and do not go to health facility till their abdomen is big and can be seen”.*

Frequency of ANC visits also varies from individual to individual. Generally, it’s assumed that healthy women will have fewer follow ups than those that have different illnesses. “*It depends upon her condition. Those who have anemia and malaria will go many times, every fortnight and every week”* (Female participant Lumame rural).

Preference of Health Facility

Government health facilities are preferred over private clinics by most people in the community for ANC follow up. Availability of different quality services and drugs as well as free provision, were given as reasons for preference. *“Because there are different drugs in health centers, private clinics give drugs for pregnant women without any investigation and these can bring problems”* (Woman Arsi Negele rural).

On the other hand, health centers are preferred by most informants over health posts as it's assumed that more comprehensive services are available...*“They give medications if there is heart burn or anemia. At the health post, they have only given me vaccination”* (Female participant Arsi Negel urban). Another rural female FGD participant from Azezo has mentioned it this way.... *“But if we need to measure our blood pressure or know about the status of the fetus, we will go to health center...here (health post); they give us only vaccines, painkillers and advice”*.

Perceived Benefit of ANC/PMTCT

Most people in the community have positive attitude towards ANC and PMTCT; they understand the benefits to the health of mother and child. TT vaccination is the most commonly mentioned benefit, a healthy baby and safe delivery has also been mentioned. Few respondents mentioned about advice being given on ITN use during ANC. *“We get vaccine every third month and the position of the baby is known, then we will have an easy delivery”*. (Female FGD participant Azezo rural) A male FGD participant from Merti, has mentioned *“...I think in this area, there is no one who doesn't like his child and doesn't want to prevent HIV transmission to his baby, if they are educated that there is medicine that prevents HIV”*. ANC attendant from Liben Chekuala has mentioned that she is given advice including ITN use during follow up.

Although there is no uniformity on the timing of the first antenatal care visit and the frequency of subsequent visits, many have mentioned that ANC is beneficial for the mother and the baby. For some informants, TT vaccination seems to be the main benefits of ANC follow up. Thus, it is important to prepare clear message about the full benefits of ANC for mothers to encourage consistent use.

Knowledge about MTCT and PMTCT

The knowledge about MTCT and PMTCT is good in the community. Majority of respondents are aware that HIV can be transmitted during breast feeding. Most are also aware that it can transmit during pregnancy and through the process of delivery. Some have mentioned that the use of blades and other materials increases the risk of transmission; a rural FGD

participant from Siraro has put it like this “*When she uses the same blade for herself and her child, HIV will be transmitted*”. Many respondents have also mentioned the services to prevent the transmission of HIV from mother to child. On the other hand, there is confusion in some respondents about the transmission and prevention methods some of which are summarized in the Table 3.

The most frequently mentioned method of PMTCT is avoiding breast feeding, the next being delivering in health facility. Others have also added that precautions when handling a baby, preventing contact with parents blood, helps in preventing transmission. “*HIV doesn’t transmit if mother doesn’t breast feed her child and if mother and father handle child with caution, without contaminating him with their blood from cuts*”. “*It’s possible to prevent, if I don’t breast feed handle my child and prepare appropriate food*” (Liben Chukala ANC attendant).

Despite the fact that most of the informants believe HIV can be transmitted from mother to child, there is no clarity on means of transmission and the possibility of being prevented. Thus, these perceptions might affect their utilization of PMTCT services. Therefore, there is a need to clear these misconceptions when addressing behavior change.

Table 2. Misconceptions about MTCT/PMTCT in Oromia and Amhara Regions, Ethiopia, June 2009

Region/Residence	Misconceptions about MTCT/PMTCT	Quotations
Amhara/ Urban	All children born to HIV positive mother and father will be HIV positive	<p>“<i>The community do not believe that their child would be safe if they (parents) have HIV</i>”</p> <p>“<i>...If a husband and a wife have the virus, how is it possible for their child not to have the virus? Because, both the mother and the father have it and the baby takes food from his mother</i>” Urban females FGD Azezo</p>
Oromia/ ANC attendants		<p>“<i>...Their one child has HIV but not the second child. The positive child, has it through his mother’s blood that food was being given to him... but the child who is negative, I don’t understand how he didn’t get it from his mother</i>” (ANC attendant Liben Chukala)</p>

Oromia/ Rural	No transmission during pregnancy	<i>“HIV/AIDS is not transmitted from mother to child until women give birth and contact is made”</i> Rural pregnant IDI Bosset
Amhara/ Azezo	MTCT prevented by vaccination during pregnancy	<i>“I know that vaccination is given during pregnancy to prevent transmission”</i> Rural female IDI Azezo
Oromia/ Rural	MTCT prevented by Immediately picking up baby after delivery	<i>“Because the baby’s & our blood flow have connection, we need to pick up the child immediately.”</i> Rural Female Liben Chukala
Oromia/ Urban	No transmission through breast feeding	<i>“I doubt that HIV is transmitted through Breast feeding”</i> Urban Male Limu Seka
Oromia / Urban	Prevention not possible	<i>“It is impossible to prevent transmission in the uterus.”</i> Urban Female IDIBosset
Oromia/ ANC Attendants		<i>“I do not think it is preventable because when I deliver, the child will get contaminated with blood”</i> ANC attendant Liben Chukala

Willingness to Use PMTCT Service

Many have said women in their community are not willing to use PMTCT services while some are willing. The reasons for not being willing are; lack of awareness and understanding about the services, fear of stigma and discrimination if found to be positive, and husband’s disapproval. A female rural participants, in Liben Chikuala FGD mentioned, *“Our people are in rural area and do not have the habit of health service utilization and also as husbands does not like it, they are not willing to use services”*. A male interviewed from urban Bosset has explained it as *“The reason the community are not willing is due to lack of awareness. They think that it (prevention mechanism) causes harm and that the society might discriminate them if they start attending PMTCT services”* (Urban male Bosset)

Educating the public and raising awareness about the benefits of PMTCT, is regarded as the most important motivating factor for utilization of PMTCT. *“Giving education (awareness) on its advantage and importance as this is not known by our women.”* (Limu Seka, female participant urban). Some also mentioned that family members, particularly husbands, are influential and have cited them; others are source of motivation for using services ...*“My husband initiates me to go to health facility in addition to my mother”* (Liben Chukala ANC attendants). While another women who participated in the same discussion have said that neighbors and HEW motivate her to use services.

Willingness to use services is largely influenced by awareness about services and perceived benefit. Close family members may also encourage or discourage use of services and thus affect willingness. In addition, fear of stigma and discrimination on being HIV positive is an important factor. Thus, interventions to increase willingness for PMTCT services need to target not only pregnant women but the larger community as well with particular emphasis to the most influential people including partners and parents.

Barriers Associated with Acceptance and Uptake of ANC/PMTCT

The reasons stated by the study participants as major barriers for not attending health services when pregnant are; lack of awareness about services and their benefits. Fear of stigma and discrimination by the community are also mentioned by many respondents. It's assumed that fear of being stigmatized and not being willing to use services are related to the low level of knowledge in the community regarding PMTCT and ANC services. Distance from health facility and the subsequently incurred costs have been mentioned to have inhibited use of services by many respondents from rural areas.

Other factors are husband's disapproval about use of services and previous bad experience in health facilities, "*Husbands are not willing to send them*" a health worker from Limu Seka mentioned. "*Some health workers are angry with the patient and insult them*" (Male participant Liben Chukala urban). "*They gave me injectable contraceptive and told me to come back after three months, when I came back, some tests were done and I was told that I was pregnant. Since then, I am not using any of the services given in that health facility*" (FGD discussant Arsi Negele). Another reason though not very common given for not attending ANC and PMTCT services is pregnancy out of wedlock and incest. A male FGD participant from Azezo said that, "*there may be some who are afraid of coming to the health care services. If they are pregnant from a relative partner "ke-zemed", if they are student*".

Table 3: Commonly Mentioned Barriers to ANC/PMTCT in Oromia and Amhara Regions Ethiopia, June 2009

Region/Residence	Barrier to ANC/PMTCT	Quotations
Oromia/ Urban	Lack of awareness	"... <i>They do not have enough education and they can't realize whether services are useful or not.</i> " Urban Male FGD Merti
Oromia/ Urban		" <i>It is because of lack of knowledge and not knowing the benefit</i> " Urban female Arsi Negele,
Oromia/ Rural		" <i>We do not go because of our ignorance</i> " Rural female

		FGD Bosset
Oromia/ Rural	Fear of Stigma and discrimination	<i>“In our community those who say prevention of HIV is impossible are popular”</i> Rural female FGD Liben Chikuala
Oromia/ Urban		<i>“I think in our community there is a problem if a person has HIV, it’s a big issue and he/she will perceive that they miss out on every thing, as they get discriminated...this makes people fear HIV testing”</i> Urban male IDI Limu Seka
Oromia/ Urban		<i>“They fear that people talk about them”</i> Urban female FGD, Zeway Dugda
Oromia/ Rural	Distance and transportation cost	<i>“There is no convenient road to the health station and it is far away”</i> Rural male Liben Chekuala
Oromia/ Rurla		<i>“Accessibility of ANC and PMTCT services are major problems in my locality as we have to travel a long distance to health center.”</i> Rural female IDI Bosset.
Oromia/ Rural		<i>“Transportation is not available for those people who can’t walk to health facilities”</i> Rural male IDI Limu Seka
Oromia	Lack of availability of comprehensive services	<i>“There are no available material at site, health education is given house to house”</i> Siraro HEW
		<i>“First we have no material, and as government or NGO’s didn’t train us, we don’t know deeply about PMTCT”</i> HW, PC Arsi Negele
		<i>“We have no material. If we were equipped with the appropriate maternal in our clinic, women are willing to come to us”</i> Bosset HEW

Most HEWs’ in rural kebeles have also put lack of awareness and long distances to health facilities as barriers. In addition, the absence of materials needed for follow up, like examination beds, weighing scale and different drugs further aggravates the situation. The fact that they are not trained on PMTCT and have to refer clients to health centers where trained personnel are available has also been suggested to decrease utilization. Private clinics’ health workers have mentioned cost of prices as a barrier. In addition clients are lost when they are referred to Health centers for PMTCT services.

Decision Making on Service Utilization

Most of the informants believe that, the decision to use ANC and PMTCT service is made by their husbands. While some said that they decide by themselves and others together with their husbands. As a rural male interviewee from Liben Chekuala explained it as, *“When women go to health station the decision maker is the husband”*. A female participant from Bosset, puts it as, *“Husbands have to think it over first, and then take us to the health facilities. It is the mandate of the husbands rather than women to decide and go for health center. But for us (women) it’s not our culture and may lead to the conflict, even to the extent of divorce .We can not just go to health center”*.

Some participants acknowledge a change in this regard, *“In the past, there was men’s domination. But now there is a better understanding and the women is the one who decides to visit the health cares. The men are even encouraging their wives (pregnant wives) to have medical examinations”* (Azezo rural female FGD participant). *“She will go by herself. Our husbands do not tell us to go because they have no education. He doesn’t prevent me from going, neither tells me to go; that is it”* (Female participant Arsi Negele urban). There are also some husbands who are supportive of their wives and motivate them to use services, *“On my side for example, my husband initiates me to attend the services; during my pregnancy, he treats me more than other times. Therefore, he has supportive role.”* (Female participant Bosset urban)

Perceived benefit to mother and baby was the most commonly mentioned factor for utilization of services. Health education has been widely recommended by most respondents to motivate use of services. Close family members, husbands, parents and neighbors have also been sited as motivators. In rural area, many respondents agree that HEW through house-to-house visits as well as community gatherings encourage women to attend services.

Different factors overlap together in creating obstacles for service utilization. Absence of comprehensive services at health post and private clinic makes women go long distances and incur transportation costs for attending services. Fear of stigma and discrimination, and lack of awareness about benefit of services as well as husbands disapproval leads women to be unwilling to use services. Husbands’ positive involvement in their partners’ health should be encouraged and women should understand that they need to take more responsibility for their own health.

5.3.9. Institutional Delivery

Almost all women said that women in their community prefer to give birth at home and it is only when they face difficulty of labor that they visit health center. Some of the reasons mentioned can be classified broadly as health facility related such as health worker’s attitude,

personal attitude towards home as well as institutional delivery related to cultural or religious beliefs, and decision making and social support during delivery.

Delivery service is not available in the health post which is the primary contact with the health system for most rural communities. When a woman is in labor she has to look for transportation means to go to the nearby health center where she can get the services. Thus, a woman needs money not only for the service but also for the transportation, which may be expensive especially if she is unable to take public transport or if she is considered ill. Some also mentioned that the cost of service in government health facility is expensive and no one will help a laboring mother unless she paid first. *“I know a woman who died after she reached hospital because they did not give her the service immediately even if she brought support letter from kebele to get free service”* (FGD discussant Liben Chukala Urban)

In addition, when a woman reaches a health facility to a particular service, health workers' attitude is another factor which discourages woman not to come back again. One of the informants put it as follows, *“The health workers always get angry with us, during labor we want to sit and deliver however, they order us to sleep with our back and deliver”* (in-depth interview with pregnant woman Lumame, urban) *“When I was pregnant with my first child, I went to Tahisas Hospital; after the health worker examined me, he told me not to try to deliver at home and gave me phone number to call ambulance when the labor starts. I did not because when you go to health facility, they take your cloth off and put your leg up; besides I heard that they leave a laboring mother alone in a room. So, I delivered at home... thank God”* (FGD discussant Arsi Negele, Urban). *“Women feel safe and confident when they deliver in the hands of their family”* (Male informant Limu Seka urban). *“There are also who insult and hit a laboring mother... We say why we lose our dignity we better give birth at home”* (FGD discussant Arsi Negele, Urban).

Fear of clinical procedures during delivery is also another reason women mentioned for not using health facility for delivery. As mentioned before, a laboring mother does not seek for medical care unless she faces difficult labor or complication. Therefore, by the time this woman arrives at the health facility, it may be too late for spontaneous vaginal delivery and she may undergo some procedure which create discomfort on the woman. One informant expresses her disappointment like this: *“When a laboring mother comes to health facility, the health workers hurry to do operation and start telling you about it rather than helping you to deliver normally”* (ANC attendant, Liben Chukala). More over, they do not want to be left alone in the delivery room and expose their body to a stranger in the health facility.

Some pregnant women do not go to health facility during labor because they do not want to face problem in between their home and the health facility. There are cultural and religious beliefs attached to it. Some put it as *“Pregnant women at labor shouldn't be taken out of her*

home because it is not good not only for the mother but also for the child; cold might harm the new born as well as the mother”(ANC attendants, Liben Chukuala). Some also mentioned that its shame for a woman to seek for medical care for normal delivery. A woman who delivers at home safely earns her neighbors respect. One FGD discussant woman stated this as follows... *“A woman who delivers outside her home is like a cow giving birth in the field every body looking at her”* (pregnant woman from Arsi Negelle, urban)

There are religious and traditional rituals where by women get together and pray to the “Atete”, a spirit believed to be helpful in such situations. *“Atete will not expose me to give birth outside my home”*(FGD discussants). Some also put it like this, *“St. Mary will be with the delivering mother and would not let any harm happen both to the mother and the baby”* (FGD discussants). Some said that when a woman wants to deliver in the health facility, her husband will not be supportive because there is always cost associated to it. One informant said that, *“... Her husband wants her to deliver at home because he thinks that if she dies in the health facility while giving birth, he will not have money to transport her body home”* (Limu Seka, rural male).

There is also especial preference by many women to deliver at home assisted by TBAs. As they say that the TBAs have many years of experience and have good reputation in the community. One woman put it as follows, *“... If it is the will of God, there is this woman in the village who is very skillful and helps us during delivery. There is also another woman named... when she approached you, you can easily deliver; no one can be compared with her except a Doctor”*.

For those who use health facility during delivery, economic problem and skill of health workers are issues for preferring public health facility over private health facility.

Although their preference in most cases is to deliver at home, they all know the benefit of giving birth at health facility. They also believe that a woman who give birth at home may suffer from prolonged labor, excessive bleeding, placenta retention and her new born may also suffer from problems which cannot be handled at home. *“Many of them need to give birth at home; however, giving birth at home is not right. It is only those who are blessed by God can give birth at home; delivering at health facility is safe and avoids suffering such as excessive bleeding”* (Female informant Bossete rural).

Educating women is the most frequently forwarded solution that all informants agreed up on, to motivate women’s use of health facility for delivery. Teaching their husbands has also been raised by some of the respondents. In addition they also point out that it will be motivating if ambulance is available whenever woman is in labor. *“...it will be motivating if gave away materials such as, soup, baby and mother clothing are given as a present when ever a pregnant woman come to health facility and deliver”*(rural male informant Arsi Negele).

VI. DISCUSSION

This report tries to summarize some of the most important information regarding malaria prevention and control in Ethiopia. Based on that, this research attempted to broaden our understanding of the community's knowledge, perception and behaviors about causes of malaria and its transmission; ITN utilization patterns and barriers to effective utilization; IRS practices and barriers to widespread application; treatment seeking behaviors and barriers to early treatment seeking; and sources of information about malaria. In addition, attempt was made to gather relevant information about ANC and PMTCT service utilization. These findings can help develop effective communication messages and strategies to support implementation of effective malaria and HIV prevention and control activities.

Although every effort was made to obtain a widely accepted views and opinions, the nature of the qualitative study would not allow strict generalization of the study findings. Even though it was not the intention of the study, the sites selected for the study were not very far from roads indicating their closeness to urban sites. The selection of the sites was made in consultation with the woreda (district) health office representative, in most cases the representative was a focal person for malaria control in the district. The main site selection criterion was relative endemicity of malaria as recognized by the district office. Such proximity to the urban centers could mean more easy access to information and thus, some of the misconceptions hold by remote communities and barriers to utilization of malaria interventions might not have been captured fully in this study.

The selection of study participants was done based on the known characteristics of potential respondents which include mainly being knowledgeable about malaria, ability to effectively communicate and willingness to participate. This kind of selection procedure is largely used for qualitative studies in order to obtain rich information. However, it is important to recognize that such respondents are better informed and probably with less misconceptions. Thus, this study should be regarded as a spring board for crafting initial communication messages but not as a sole source of information for developing relevant messages. Efforts must continue to gather relevant information as the communication interventions unfold; for example appropriate piloting of communication strategies and messages need to be done.

Triangulation of information sources and data is one way of increasing the trustworthiness of information gathered through qualitative methods. The study tried to obtain information from urban and rural residents; used in-depth interview and focused group discussion; and involved different kinds of informants including community members (male and female) and health workers. This is supposed to help us get as diverse opinion as possible. Those procedures would allow us to ensure trustworthiness of the information provided in the report.

Hopefully, the quantitative study that is conducted at about the same time of this study would provide how wide spreads are some of the opinions and views expressed in the qualitative study.

The value of this research is dependent on how it is actually used in developing clear communication messages by concerned agencies. Some important considerations for that effort are described here. Messages should be designed based on norms and values (regardless of their scientific merit) expressed by the community. Messages should be simple, easily understandable and easy to remember by the community in specific context; messages should be based on specific realities. Segmentation of audience for different messages should be considered; create messages and materials differently for different distinct groups in the community. Using local language and terminologies as medium of communication is obviously an advantage. The selection of channels of communication should take into consideration the trust that the medium has already received in the community. The issue of print media deserves special consideration during developing communication strategies. This study could not get sufficient evidence regarding print media; this could be related to the quantity produced, distribution and quality of print media in the study areas. It is known that if print media do not contain clear and illustrative messages its value in rural areas is not so much compared to oral communications to which people are used to for generations. Oral/personal communications provide additional insight about the trustworthiness of the source; which most of our respondents emphasized.

The development of communication messages should also consider recognized behavioral change models. Behavioral change is a process by which different actors play roles to influence and demographic and social factors modify actions. The Health Belief Model (HBM) and Theory of Planned Behavior (TPB) are among the various behavioral models designed to explain the process of behavior change and the interaction among these factors. The use of such models is useful to ensure completeness of messages and the possible outcomes. In the following section, we tried to discuss the core behaviors which are expected to be changed or adopted after implementation of successful communication strategy.

As shown in Figure 3 & 4; high perceived seriousness of malaria and perceived susceptibility to malaria are important factors in adopting the desired behavior having direct link to perceived threat. This study showed that, although people perceive malaria as a serious problem some do not consider themselves susceptible, as they are living in high land. This influences utilization of preventive tools such as IRS and ITN. The external factors which affect utilization of preventive methods in this model are unavailability of IRS on a regular basis, inadequate distribution of ITN and unavailability of the preferred ITN brand. These appropriate evidences need to be communicated to implementers and policy makers as intervention should be carried out beyond community level. Otherwise, communication strategies that do not address

these issues may not be effective as most of the time IRS and ITN are provided by Government and partners.

General knowledge about causes of malaria and means of transmission are also important factors for utilization of both IRS and ITN. These may in turn influence the perception of the community on the usefulness of adopting specific behavior. In this study, some informants have described lack of environmental and personal hygiene as causes of malaria; these misconceptions may devalue the importance of vector control through utilization of IRS and ITN. Besides these have direct link with perceived threat which again influences use. On the other hand, lack of skill in hanging ITN appropriately is an important factor which influence perceived benefit of ITN. In this study, the perceived benefit of IRS and ITN outweigh the perceived barriers. Thus, the likelihood of IRS and ITN utilization is higher for most informants. However, as some perceived barriers still remain in the community, utilization of both methods by all community members can not be guaranteed.

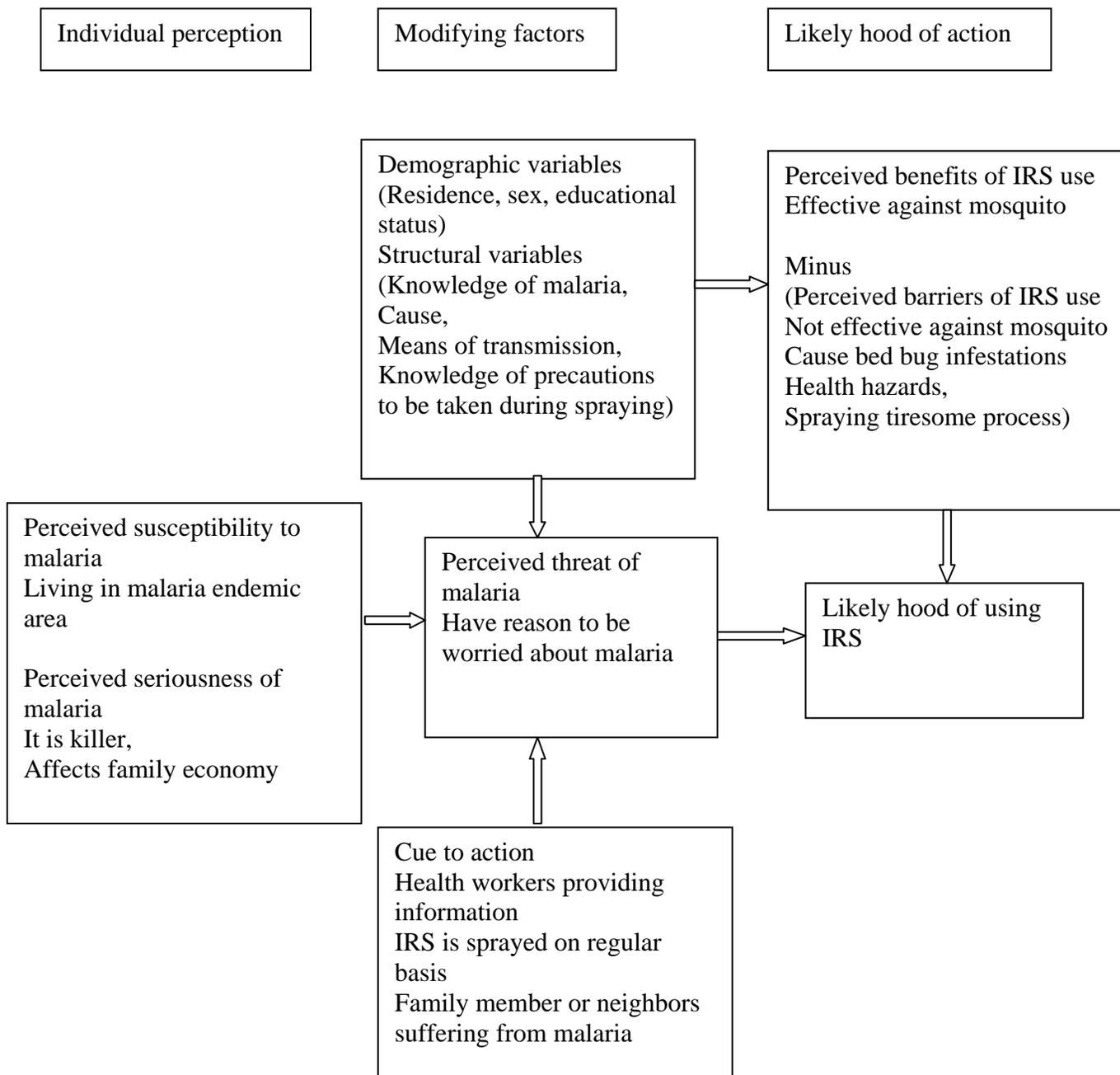


Figure 3: Schematic Presentation of Barriers to IRS Utilization Using Health Belief Model

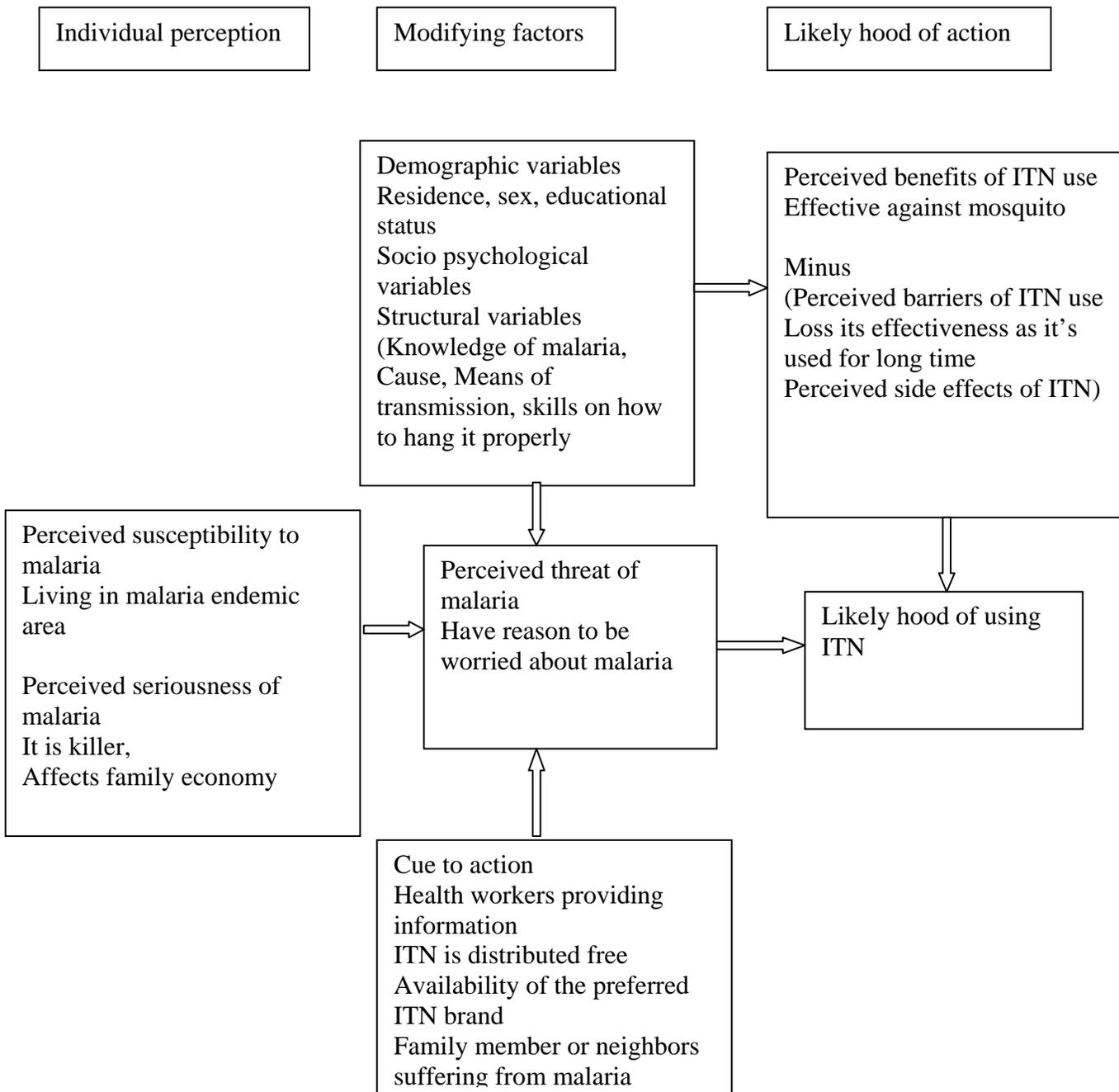


Figure 4: Schematic Presentation of ITN Utilization and Contributing factors using Health Belief Model

ANC/PMTCT Service Utilization as a Behavior to be Adopted

There are two ways of interaction among behavioral belief, normative belief and control belief. All three have direct influence on willingness of a pregnant woman to use ANC/PMTCT service. As it is evident in this study most have positive attitude towards ANC services, partners and parents also encourage use. However, this was not the case for PMTCT service. Perception of the informants about the benefit of PMTCT is low and women are more worried about what significant others would say if they turn out to be HIV positive. In addition, perceived behavioral control influences ANC/PMTCT use, by shaping the normative belief, willingness to use the services and the likely hood of use of services.

Besides this perceived behavioral controls are directly influenced by actual behavioral control; this has little importance in utilization of ANC service as the service is given not only in the health center but also in the health posts. However, PMTCT service is available only in health centers and they are not accessible for rural community. Figure 5 shows the interactions between behavior and the factors.

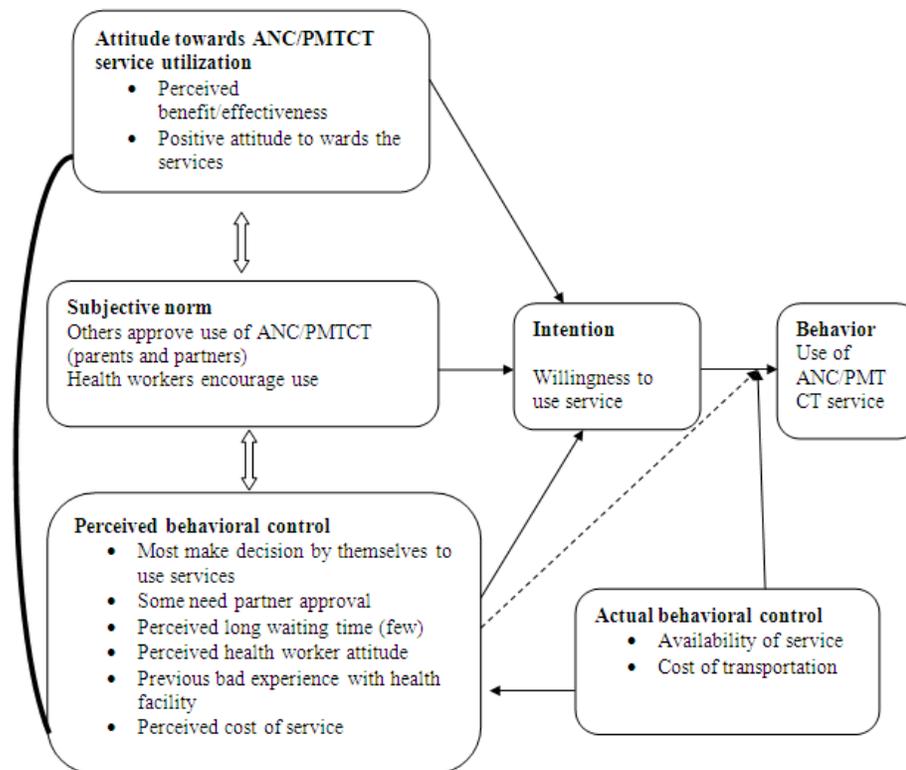


Figure 5: Schematic Presentation of Utilization of ANC/PMTCT and the contributing Factors Using Theory of planned Behavior

VII. CONCLUSIONS and RECOMMENDATIONS

Community members know about causes, symptoms, mode of transmission and prevention methods of malaria. Most of them know that malaria is transmitted by mosquito bite, however, there are also a lot of misconceptions about its cause, transmission and treatment; there are some who believe malaria is transmitted via cooking utensils, breathing and there are also beliefs that eating certain food staffs can cause and aggravate malaria. These misconceptions might modify the way people respond to malaria prevention and control. Thus, there is need to clear these misconceptions by giving clear and repeated messages.

People also believe that there are two kinds of malaria; ‘red’ and ‘yellow’. They also believe that the “Yellow” one is not curable. Therefore, when they think that a person has acquired the yellow malaria, they assume that his or her chance of survival is low and are reluctant to take the patient to health facility. Malaria related messages should focus on its causes, means of transmission and the possibility of cure.

Community members have different knowledge and practices in relation to malaria prevention. Use of ITN, IRS and early treatment were mentioned as prevention measures. However, the majority believe that environmental management is the most important preventive measure for prevention of malaria while it is the least effective method of prevention. Therefore, in addition to distribution of ITN and IRS it is important to tailor clear information on the relative effectiveness of the preventive methods for the community. On top of this, as health workers are the sources of this information they should be targeted with appropriate and updated information on malaria prevention in general.

Almost all informants know what ITN is and hold positive attitude towards its benefit and utilization. Although most said that they are using it, not all members of the household that are sleeping under it; this is mainly due to the inadequacy of the ITN. Some also use it inappropriately as a bed sheet or scarf. Thus, there should be adequate education on how to use ITN. Distribution of ITN should also consider the size of family. The community should also know when to wash and how long the ITN is effective since many stop using it assuming that it has lost its effectiveness. Proper utilization of ITN can be ensured through availing ITN which is adequate for all members of the family, providing adequate information during distribution preferably by health workers on how to use it, possible side effect and benefit. One major reason for improper use of ITN is doubt about its effectiveness especially after they use it for some time. So people should know for how long ITN will stay effective once it is distributed and the things which should be done while using it, such as re-socking. People also believe that whenever distribution is done by health workers they get the necessary information on the use,

benefit and they can ask questions and get answer. Therefore, distributing ITN through the health workers might increase its utilization.

Preference for shape and color of ITN is also another reason for non use of ITN. “Green and conical shape” was the most preferred type of ITN. Either these people should be provided with the type of ITN they want to have or should get proper information on how to properly make use of it with out the inconveniences they mentioned. Lack of knowledge on how to hang a bed net was also mentioned as main reason for not using ITN properly even to the extent of using it as a bed sheet instead of hanging it. Thus, focus on the procedure should be considered.

Most also believe on the effectiveness of IRS but the urban respondents complained that spraying is not done in the urban areas. They agreed not only making it available but also believe it has to be sprayed on regular bases. Nevertheless, the community did not deny that there are people who fear its side effects and trying to avoid IRS and re-plaster their house after the spray. Therefore, it is necessary to consider spraying in the urban areas and spraying should be accompanied by proper message on its effect, how it should be sprayed, and the disadvantage of re-plastering.

The tiresome process during spraying and IRS effect on the appearance of their house were also mentioned as reason for refusal of IRS and re-plastering of walls. Thus, appropriate message should be designed addressing the benefit as well as the risk with out IRS. The messages should emphasis the need to prevent unnecessary suffering and death of children and family members- give value to life.

Health workers are the most commonly mentioned and trusted sources of information followed by community meetings. The Health Extension workers are preferred and trusted by the rural community. Therefore, education would be more effective if it is given at health facilities and during community meeting by the health workers. As to the mass media, radios are the most accessible and preferable means of media compared to others. Early in the morning and at the evening when most family members are at home is the preferable time for passing messages. Some also suggested if there are radio programs every morning and evenings. Sunday after church is the day most listen radio for a longer period compared to other days. There are also community members that suggested education through their children and recommended to have regular education program in schools.

Most said that they go to health facility early when they recognize symptoms of malaria while some delay. One of the commonest causes of delay is traditional remedies like using different roots and plant, going to holy water or going to some traditional healers. During this time the diseases progress and gets complicated and by the time they reach health facility the condition may not be curable. This in turn leads to lack of confidence in health facilities. What

community members meant, when referring to “yellow malaria” seems to be cerebral malaria, which often results from delaying treatment of malaria. Thus, people should be aware that the appropriate solution when they suspect malaria is to go to the nearest health facility as fast as possible.

Cost of service and transportation are repeatedly discussed reasons for not seeking medical care early despite the service is given free of charge both in the health post and health center. Thus, people need to be aware that this service is available freely at the local public health facilities; adequate emphasis needs to be given to inform the public about where and when exactly these services are available.

Most comply with the prescription that the health workers give them when they have malaria but some do not. The reasons for not complying most of the times are feeling better and some also stop taking full dose of anti-malaria drug because of its side effect. Thus, emphasis should be given to educate people that they must take drug full dose appropriately and providing proper counseling while prescribing drug would help them to cope with side effects.

The community’s knowledge about the relationship between malaria and HIV is negligible. Although they have made some tangible guesses about the relationship, they have never heard or learned from any source in the past. Education in the future should also incorporate the linkage between HIV and malaria and what measure they should take.

The knowledge about the time of initiating ANC, the perception and practice differs between the urban and the rural and the educated and the uneducated. The urban and the educated have better knowledge, perception and use the ANC than the rural.

Though there is high perceived ANC service utilization, and high perceived benefit by the informants, there is no clear understanding about the timing and frequency of ANC. In rural communities, Non-attending ANC is also related to traditional beliefs and practices which hamper its use. Such practices may not be prevented by educating mothers only but the whole community members, including the traditional healers. These healers are very influential in their community and discussing with them and convincing them to participate in educating the community is very important. Inaccessibility due to distance and previous dissatisfaction in the health care giving institutions are also important causes of non-attendance. Stigma and discrimination, fear of being HIV positive, and fear of notifying status to the spouse are barriers to use of PMTCT services. Thus, this requires more communication not only with women but with spouse, close family members and the community members.

Although ANC is perceived to be associated with positive birth outcome both to the mother and the baby, the utilization of component services such as PMTCT was low. As

Knowledge about MTCT and PMTCT is low misconceptions about MTCT and PMTCT are yet exist. Fear of being positive and difficulty to announce that to their husbands are the barriers for service utilization. Therefore, it requires much work in the community especially through community meetings where both mothers and husbands attend.

Although many believe it is beneficial to deliver in health institutions, there are reasons given by the community members for low utilization of health facilities; traditional beliefs, distance of health facilities, especial preference to the local traditional birth attendants who are renowned in the community, the thought of exposing her body to a stranger, previous unsuitable experience in health facilities are among those mentioned.

The traditional beliefs and using the TBAs have been there for a long time and appears to take long time to change. With continuous education of the community through community forums and HEWs, it is important to work with the traditional birth attendants and traditional healers in the community.

VIII. ANNEXES

ANNEX 1: List of FGDs and IDIs by selected woredas' for the qualitative study in Oromia and Amhara regions, Ethiopia, June 2009

No	Name of Zones	Name of woredas	FGDs per woreda			Individual in-depth interviews with community members by sex		Key informant in-depth interviews health workers, HEWs		
			Women	Men	ANC attendants	Female	Male	Gov. HC	Private clinic	HEW
1	Arsi	Merti	2	2	1	3	3	2	2	2
		Zeway Dugda	2	2	1					
2	West Arsi	Siraro	2	2	1	3	3	2	2	2
		Arsi Negele	2	2	1					
3	Jimma	Shebe	2	2	1	3	3	2	2	2
		Limu Seka	2	2	1					
4	East Shewa	Bosset	2	2	1	3	3	2	2	2
		Liben Chekuala	2	2	1					
5	East Gojam	Lumame	2	2	1	3	3	2	2	2
6	North Gonder	Azezo	2	2	1	3	3	2	2	2
Total			20	20	10	30	30	20	20	20

ANNEX 2: FGD guide for community

Consent Form

Hello my name is _____ and I work for an organization named Addis Continental Institute of Public Health found in Addis Ababa. I'm here to collect information for the research conducted on malaria prevention and control by the institution and AED (Academy for Educational Development). The purpose of the study is to understand the community's awareness, perception and practice to wards malaria prevention and control and establish evidence and support the activities carried out to prevent and control malaria in the country.

Participation is based on your willingness besides; you can withdraw from the study anytime. However your kin participation would mean. In addition, no personal identification will be written and we assure you that what ever information you are providing will only be used for the research purpose and the data will be handled only by the research team.

While we are collecting the data it is difficult to jot down everything thus we will tape record our discussion. If you need any further information about the study please contact the following person

Dr. Meaza Demissie
Addis Continental Institute of Public Health
Tel. 0114 16 82 26

Are you willing to participate in the study?

Agreed _____

Not Agreed _____

Thank you

Name Data collector _____ signature _____

Date of data collection _____

Part I: General information about participants

Participants	Age (year)	Sex	Marital status	Occupation	Educational status	Religion
P1						
P2						
P3						
P4						
P5						
P6						
P7						
P8						

Part II: FGD guide

No.	Objectives/questions
	Objective: Identify the KAP of community regarding causes of malaria and its transmission
	<p>Q1 what does the community know/say about malaria? Probe:</p> <ul style="list-style-type: none"> A. What is the cause of malaria? B. How does a person get malaria? Probe for person to person transmission, other ways of transmission C. How does the community know when a person has malaria? Probe for symptoms that identify presence of malaria, which symptom is common? D. Who is vulnerable to malaria? Probe for children and pregnant women E. Does the community think malaria as serious problem in your locality? How serious? Why? Probe if it is not considered as serious and why? F. What is a local name for malaria?
	Objective: Identify behavioral determinants and perception of community regarding malaria prevention practice
	<p>Q1 Can you tell us if there are any perceptions and practices in relation to malaria prevention in your community? Probe for:</p> <ul style="list-style-type: none"> A. Any traditional/cultural methods for prevention or B. Treatments for malaria C. What does the community do to make sure that their children or pregnant women in their household won't get malaria?
	Objective: Identify key behavioral barriers for use of ITNs and promotion of net culture
	<p>Q1. What practices exist in your community which prevent or promote the use of ITN? Probe :</p> <ul style="list-style-type: none"> A. Does the community use ITN? Why? probe for any beliefs which prevent use of ITN B. Why do people in your community do not use ITN? Explain C. How can we make sure that these people use ITN? Probe what motivate utilization D. Do you think a person who doesn't use bed net at risk of getting malaria? Why? Why not? E. How do people use ITN commonly? Probe for what purpose, any other practices related to ITN

	<p>F. What is the commonly used ITN brand in the community? List, do you know any other brands? Which brand do people prefer to use? why?</p> <p>G. Are there any preference for the shape and color of ITN? Probe which one is the most preferred, and why?</p>
	<p>Objective: Understand the perceptions of the community about IRS and explore existing practices</p>
	<p>Q1. How do you see the perception and practice of the community to wards IRS? Probe :</p> <p>A. Has any one sprayed the interior wall of your house with IRS?</p> <p>B. Who sprayed the interior wall of your house? If not why? How do people see its use?</p> <p>C. Are there people who refuse to spray their house? If yes why?</p> <p>D. How often does your house sprayed with IRS? Why?</p> <p>E. Have you heard of any health hazards which are believed to be caused by IRS? probe for these side effects</p> <p>F. Do people re-plaster their house after the interior walls of the house being sprayed against mosquito? If yes why? Do you think it is appropriate to do so? What is the problem doing so?</p>
	<p>Objective: Identify and prioritize appropriate communication channels/media for malaria prevention and control messages</p>
	<p>Q1. Where does the community get information about malaria? Probe :</p> <p>A. Who provide the information? Probe for health workers, HEWs or other</p> <p>B. Which one is the most preferred source of information about malaria? Why? Probe for different media, radio, TV, Posters, Billboards, road show, community meetings, etc...</p> <p>C. Any special program that a community preferred to attend or listen?</p> <p>D. The most trusted source of information, why?</p> <p>E. When is the appropriate time for the community to receive information about malaria? Probe for time of a day and specific days in a week</p>
	<p>Objective: Explore barriers to early treatment seeking behavior and sources of treatment for malaria</p>
	<p>Q1. What are the barriers or promoting factors for early treatment seeking? Probe:</p> <p>A. How does a community know when a child has malaria? Probe for symptoms</p> <p>B. How does the community identify presence of fever?</p> <p>C. What does the community use to cure malaria? List for treatment options used by the community, Probe for self medication before going to health facility, preference</p>

	<p>D. How soon a child is taken to health facility when malaria is suspected? Probe for immediately, within 24 hours, when it gets serious</p> <p>E. Why do people delay to seek for medical care after they suspect malaria?</p> <p>F. Are there any reasons for not seeking for medical care in the community? Probe for cost, preference, attitude of health worker, poor health service, waiting time</p> <p>G. Where do people get malaria drugs? How do they use it? Probe for drug compliance</p>
	Objective: Understand community perception about the linkages of malaria with HIV/AIDS
	<p>Q1. How do people perceive the link between malaria and HIV/AIDS? Probe :</p> <p>A. Do you think of any link between malaria and HIV/AIDS?</p> <p>B. Can you explain the link?</p> <p>C. Do you think HIV positive people are vulnerable to malaria?</p>

❖ **Now I am going to ask you about services provided for women during pregnancy**

No.	Objective : Explore barriers associated with acceptance and uptake of ANC and PMTCT service
	<p>Q1. Can you tell us what you know about ANC and PMTCT? Probe:</p> <p>A. When do you think a pregnant woman should visit health care (ANC)?</p> <p>B. How many times does a pregnant woman should visit ANC?</p> <p>C. Is HIV transmitted from mother to child? If they say yes Probe for how they think it is transmitted?</p> <p>D. Is mother to child transmission of HIV preventable? How?</p> <p>E. Do you know any service available to pregnant women to prevent MTCT? Describe?</p> <p>Q2. Can you tell us the community's perception and practice regarding ANC and PMTCT in your locality? Probe:</p> <p>A. Do people in your community think ANC beneficial? Probe: If so how? What benefits do you know?</p> <p>B. In your community, do women attend ANC during pregnancy? If not why?</p> <p>C. Are women willing to use ANC service? If not why? Probe what motivate them to use ANC?</p> <p>D. Where do pregnant women get ANC service in your community? Probe for any preference like private, public or NGO or other. Probe: why do they prefer specific</p>

	<p>health facility? Probe for cost of service, waiting time, geographical accessibility, health workers attitude etc...</p> <p>E. When do pregnant women in your community go to ANC clinic? Probe: when do you think the right time for first visit?</p> <p>F. How is the decision making process going on for a woman to seek for ANC and PMTCT?</p> <p>G. Is there any stigma associated with ANC use? If so please explain.</p> <p>H. Do you think pregnant women are willing to use PMTCT?</p>
	<p>Q 3. Can you tell us your opinion about the ANC and PMTCT service given in your locality? Probe:</p> <ul style="list-style-type: none"> A. Accessibility in terms of cost, time and geography B. Waiting time (time spent for full service) C. Health workers attitude <p>Q4. Where do pregnant women prefer to go for delivery? Probe:</p> <ul style="list-style-type: none"> A. For public health facility, private health facility, NGO, home B. Why do woman prefer to give birth at home? C. Do you think giving birth at home safe? Why? If not why? D. What motivate pregnant women to use deliver in health facilities?

ANNEX 3: FGD Guide for Pregnant Women

Consent Form

Hello my name is _____. I work for an organization named Addis Continental Institute of Public Health found in Addis Ababa. I'm here to collect information for the research conducted on malaria prevention and control by the institution. As part of this research, we want to see health seeking behavior of women especially pregnant women and factors which affect the uptake of ANC and PMTCT.

Participation is based on your willingness besides; you can withdraw from the study anytime. However your kin participation would contribute a lot for our study. In addition the confidentiality of the information you gave us will be kept. No personal identification will be written and we assure you that what ever information you are providing will only be used for the research purpose and the data will be handled only by the research team.

While we are collecting the data since it is difficult to jot down everything we will tape record our discussion. If you need any further information about the study please contact the following person

Dr. Meaza Demissie
Addis Continental Institute of Public Health
Tel. 0114 16 82 26

Are you willing to participate in the study?

Agreed _____

Not Agreed _____

Thank you

Name Data collector _____ signature _____

Date of data collection _____

Part I: General information about participants

Participants	Age (year)	Marital status	Occupation	Educational status	Currently pregnant
P1					
P2					
P3					
P4					
P5					
P6					
P7					
P8					

Part II: ANC FGD guide

Objective : Explore barriers associated with acceptance and uptake of ANC and PMTCT service

Q1. Can you tell us what you know about ANC?

Probe:

- F. When do you think a pregnant woman should visit health care (ANC)?
- G. How many times should a pregnant woman visit ANC?
- H. Is HIV transmitted from mother to child? If so Probe for how she thinks it is transmitted?
- I. Is mother to child transmission of HIV preventable? How?
- J. Do you know any service available to pregnant women to prevent MTCT? Describe?

Q2. Can you tell us the community's perception and practice regarding ANC and PMTCT in your locality?

Probe:

- I. Do you think ANC beneficial? Probe: If so how? What benefits do you know?
- J. In your community, do women attend ANC during pregnancy? If not why?
- K. Are women willing to use ANC service? If not why? Probe what will motivate them to use ANC?
- L. Where do pregnant women get ANC service in your community? Probe for any preference like private, public or NGO or other. Probe: why do they prefer specific health facility? Probe for cost of service, waiting time, geographical accessibility, health workers attitude etc...
- M. When do pregnant women in your community go to ANC clinic? Probe: when do you think the right time for first visit?
- N. How is the decision making process going on for a woman to seek for ANC and PMTCT?
- O. Is there any stigma associated with ANC use? If so please explain.
- P. Do you think pregnant women are willing to use PMTCT? If not why?

Q 3. Can you tell us your opinion about the ANC and PMTCT service given in your locality?

Probe: Accessibility in terms of cost, and geography

- D. Waiting time (till they get what they came for)
- E. Attitude of health worker and confidentiality

Q4. Where do pregnant women prefer to go for delivery?

Probe: For public health facility, private health facility, NGO, home

- E. Why do woman prefer to give birth at home?
- F. Do you think giving birth at home safe? Why? If not why?
- G. What will motivate pregnant women to deliver in health facilities?

ANNEX 4: In-depth Interview Guide for Community

Consent Form

Hello my name is _____ and I work for an organization named Addis Continental Institute of Public Health found in Addis Ababa. I'm here to collect information for the research conducted on malaria prevention and control by the institution and AED (Academy for Educational Development). The purpose of this study is to understand the community's awareness, perception and practice to wards malaria prevention and control and establish evidence, and support the activities carried out to prevent and control malaria in the country.

Participation is based on your willingness besides; you can withdraw from the study anytime. However your kin participation would mean a lot. In addition, no personal identification will be written and we assure you that whatever information you are providing will only be used for the research purpose and the data will be handled only by the research team.

While we are collecting the data, it is difficult to jot down everything thus we will tape record our discussion. If you need any further information about the study please contact the following person

Dr. Meaza Demissie
Addis Continental Institute of Public Health
Tel. 0114 16 82 26

Are you willing to participate in the study?

Agreed _____

Not Agreed _____

Thank you

Name Data collector _____ signature _____

Date of data collection _____

Part I: General information about participants

No	Background information	
1	Age of participant	____
2	Sex	Male 1 Female 2
3	Marital status	Single 1 Married 2 Widowed 3 Separated 4
4	Educational status	-----
5	Religion	Orthodox 1 Muslim 2 Protestant 3 Catholic 4 Others _____
6	Occupation?	_____
7	Number of less than 5 years children the participant has	_____
8	Age of the youngest child	_____

Part II: FGD guide

No	Study objectives /Questions
	Objective: Identify the KAP of community regarding causes of malaria and its transmission
	<p>Q1. What do you know about causes of malaria and its transmission?</p> <p>Probe :</p> <ul style="list-style-type: none"> A. What is the cause of malaria? B. How does a person get malaria? C. How do you know if a person has malaria? List the symptoms D. Who are the most affected groups of community by malaria? probe for pregnant women, children E. Do you think malaria as a serious problem in your locality? How serious? Why?
	Objective: Identify behavioral determinants and perception of community regarding malaria prevention practice
	<p>Q1. What measures do you take to protect yourself from malaria?</p> <p>Probe :</p> <ul style="list-style-type: none"> A. Is malaria preventable? How? list the possible methods B. What do you know about insecticidal treated nets? Benefits, side effects C. What do you know about insecticidal residual spray? Benefits, side effects D. What do you know about malaria treatment? Benefits, side effects
	Objective: Identify key behavioral barriers for use of ITNs and promotion of net culture
	<p>Q1. Are there any practices which prevent or promote the use of ITN?</p> <p>Probe :</p> <ul style="list-style-type: none"> A. Do you have ITN in your house? If not why? B. Does every member of your household sleep under the ITN? If not why? C. Who gets the priority to sleep under the ITN in your house? Why? D. When do you use ITN? Why? E. Do you use ITN regularly? If not why? Probe for consistent use: every night through out the year F. From where do you often get ITN? How much does it cost? How do you see the cost? G. Is your ITN soaked in a liquid to kill mosquito?? H. Do you have any suggestion that promote the use of ITN? What will motivate those who do not use ITN to start using?
	Objective: Understand the perceptions of the community about IRS and explore existing practices
	<p>Q1. What do you know about IRS?</p> <p>Probe :</p> <ul style="list-style-type: none"> A. How do you see its use in malaria prevention?

	<p>B. What is your opinion towards the use of IRS? Probe for effectiveness against malaria, C. any fear associated with use of ITN</p> <p>Q2. Have you allowed your house to be sprayed with IRS? Probe: A. If not why? B. Who spray the house? How often? Do you think it is frequent? C. What precautions one should do after his/her home sprayed with IRS? Probe for re-plastering of the walls, waiting outside of the house for some time after IRS, etc D. What is your role when your house sprayed with IRS? E. What would you recommend to make other people allow spraying their house? Motivating factors</p> <p>Q3. Are there any perceived health hazards associated with IRS use? Probe A. If yes please explain</p>
	<p>Objective: Identify and prioritize appropriate communication channels/media for malaria prevention and control messages</p>
	<p>Q1. Where do you often get information about malaria? Probe : A. Who provide the information? Probe for HEWs, B. Which source do you prefer? Why? Probe for radio (which radio), TV, posters, billboards, road show, community meetings etc... C. Is there any special program that you preferred to attend or listen? List? D. Which sources of information about malaria do you trust most? Why E. How often do you get the information? Probe weekly, F. When is the appropriate time for you to receive information about malaria? Probe for time of a day and specific days in a week</p>
	<p>Objective: Explore barriers to early treatment seeking behavior and sources of treatment for malaria</p>
	<p>What are the barriers or promoting factors for early treatment seeking for malaria? Probe: A. How do you know when your child has malaria? Probe for symptoms B. How do you know whether your child has fever? C. Where do you go when you first suspect malaria? Why? D. Are there any home remedies for malaria treatment? List for treatment options E. What do you do when you suspect malaria? Probe for self medication before going to health facility F. When do you seek for medical care for malaria? Probe after self treatment, if it gets worse, after visiting traditional healer... why is the delay? G. Do you have special reasons for not seeking for medical care? Probe for cost, preference,</p>

	attitude to health worker, poor health service, waiting time H. Where do people get malaria drugs? How do they use it? Probe for drug compliance
	Objective: Identify community perceptions regarding population groups at risk (malaria during pregnancy)
	Q1. Is there any specific group who are vulnerable for malaria in the community? Probe : A. Who are they? List, do you think you are at risk of malaria? B. Why are they vulnerable?
	Objective: Understand community perception about the linkages of malaria with HIV/AIDS
	Q1. Do you think of any link between malaria and HIV/AIDS? Probe: A. If yes, can you explain the link? B. Do you think HIV positive people are vulnerable to malaria?

❖ Now I am going to ask you about services provided for women during pregnancy

Objective : Explore barriers associated with acceptance and uptake of ANC and PMTCT service
Q1. Can you tell us what you know about ANC and PMTCT? Probe: K. When do you think a pregnant woman should visit health care (ANC)? L. How many times does a pregnant woman should visit ANC? M. Is HIV transmitted from mother to child? If so Probe for how he/she thinks it is transmitted? N. Is mother to child transmission of HIV preventable? How? O. Do you know any service available to pregnant women to prevent MTCT? Describe?
Q2. Can you tell us the community's perception and practice regarding ANC and PMTCT in your locality? Probe: Q. Do you think ANC beneficial? Probe: If so how? What benefits do you know? R. In your community, do women attend ANC during pregnancy? If not why? S. Have you (women) or your wife (for men) used ANC? if not why T. Are women willing to use ANC service? If not why? Probe what motivate them to use ANC? U. Where do pregnant women get ANC service in your community? Probe for any preference like private, public or NGO or other. Probe: why do they prefer specific health facility? Probe for cost of service, waiting time, geographical accessibility, health workers attitude

etc...

V. When do pregnant women in your community go to ANC clinic? Probe: when do you think the right time for first visit?

W. How is the decision making process going on for a woman to seek for ANC and PMTCT?

X. Is there any stigma associated with ANC use? If so please explain.

Y. Do you think pregnant women are willing to use PMTCT? If not why?

Q 3. Can you tell us your opinion about the ANC and PMTCT service given in your locality?

Probe:

F. Accessibility in terms of cost is it costly, and geography

G. Waiting time (till they get what they came for)

H. Attitude of health worker

Q4. Where do pregnant women prefer to go for delivery?

Probe:

H. For public health facility, private health facility, NGO, home

I. Why do woman prefer to give birth at home?

J. Do you think giving birth at home safe? Why? If not why?

K. What motivate pregnant women to deliver in health facilities?

ANNEX 5: In-depth Interview guide for Health personnel

Consent Form

Hello my name is _____. I work for an organization named Addis Continental Institute of Public Health found in Addis Ababa. I'm here to collect information for the research conducted on malaria prevention and control by the institution and AED (Academy for Educational Development). Thus we would like to hear your opinion on community's health seeking behavior and possible contributing factors associated with health seeking behavior for malaria in your locality.

Participation is based on your willingness besides; you can withdraw from the study anytime. However your kin participation would mean a lot. In addition, no personal identification will be written and we assure you that what ever information you are providing will only be used for the research purpose and the data will be handled only by the research team.

While we are collecting the data, it is difficult to jot down everything thus we will tape record our discussion. If you need any further information about the study please contact the following person

Dr. Meaza Demissie
Addis Continental Institute of Public Health
Tel. 0114 16 82 26

Are you willing to participate in the study?

Agreed _____

Not Agreed _____

Thank you

Name Data collector _____ signature _____

Date of data collection _____

Part I: General information

No	Background information	
1	Age of participant	____ ____
2	Sex	Male 1 Female 2
3	Marital status	Single 1 Married 2 Widowed 3 Separated 4
4	Profession	HEW 1 Nurse 2 Physician 3 Other _____
5	How long did you work as health professional	_____ (years)
6	Type of health facility you are currently working in	Private 1 Government 2 NGO 3 other _____

Part II : Interview guide

No.	Objective: To explore barriers to early treatment seeking behavior and sources of treatment for malaria
	<p>Q1. How do you see health seeking behavior of your community?</p> <p>Probe :</p> <ul style="list-style-type: none"> A. In your opinion where do people prefer to go when they have any health problem? B. Where do people prefer to go when they suspect malaria? Why? Probe for: what people commonly do when they have malaria, self treatment, traditional, health care, drug vender, hone remedies C. How long it take for a person to seek for medical care after having malaria symptoms? If there is a delay, why delay? D. Who gets to health facility immediately after malaria symptoms? Why? (Women, pregnant, children etc...) E. In your opinion do people use malaria treatment properly? Full dose if not why? F. Is malaria drug available all the time? If not why? G. How much does a person cost him/her to get service for malaria in your facility? In your opinion is it expensive for the community to use medical service for malaria? H. What do you think of your contribution in malaria prevention? Is there any thing you are doing to motivate people to seek medical care early for malaria?
	Objective: Explore barriers associated with acceptance and uptake of ANC and PMTCT
	<p>Q1. Are there any barriers or promoting factors for ANC (health post) and PMTCT (health centers) service utilization?</p> <p>Probe:</p> <ul style="list-style-type: none"> A. Is ANC service available in your health facility? If not why? B. When do pregnant women seek for ANC care? C. How do you see the uptake of ANC in the community? Why? D. Are there other health facilities which provide ANC service in your locality?

	<p>Probe: for other public facility, private, NGO etc</p> <p>E. From your observation where do pregnant women prefer to attend ANC? Why?</p> <p>F. Is PMTCT service available in your health facility? If not why?</p> <p>G. How do you see uptake of PMTCT in the community? Why?</p> <p>H. Is there any cost incurred to get ANC or PMTCT service in your facility? How much?</p> <p>I. How do you rate or see the level of partner involvement in PMTCT utilization?</p> <p>J. In general what is your contribution to increase uptake of ANC and PMTCT among pregnant women? What did you do so far?</p> <p>K. What do you recommend in the future to increase acceptance and uptake of both ANC and PMTCT service by pregnant women?</p>
	<p>2. Where do pregnant woman prefer to deliver?</p> <p>Probe:</p> <p>L. For public health facility, private health facility, NGO, home</p> <p>M. Why do woman prefer to give birth at home?</p> <p>N. In your opinion what do you think will motivate pregnant women to deliver in health facilities?</p>

ANNEX 6: FGD Guide for Community members (Amharic version)

ጤና ይስጥልኝ ስሜ ----- ይባላል፡ አዲስ አበባ ውስጥ ለሚገኝ አዲስ ኮንትራክታል ለተባለ የህብረተሰብ ጤና አጠባበቅ ተቋም የምሰራ ስሆን እዚህ የመጣሁት ኤ.ኤ.ዲ(AED). ከሚባል ድረጅት እንዲሁም ከኦሮሚያ እና አማሃራ ክልል ጤና ቢሮ ጋር በመተባበር ለሚሰራ ጥናት መረጃ ለመስበሰብ ነው። ጥናቱ የሚሰራው ስለወጣ መከላከል እና መቆጣጠር ህብረተሰቡ ያለውን ግንዛቤ እንዲሁም በመከላከል ላይ የህብረተሰቡን ደርሻ ለመረዳት ነው። የዚህም ጥናት ውጤት በሀገሪቱ ለሚደረገው የወጣን በሽታ መከላከል እናመቆጣጠር ስራ በማገዝ ትልቅ አስተዋጾ ያደርጋል ተብሎ የታመናል። ይህ መጠይቅ በአማካይ 45 ደቂቃ የሚፈጅ ነው።

እዚህ ጥናት ውስጥ ሲሳተፉ በፈቃደኝነት ሲሆን በማንኛውም ሰአት ከጥናቱ አቋቋሙ መውጣት ይችላሉ። ነገርግን በጥናቱ ቢሳተፉ ለምንሰራው ስራ ትልቅ እገዛ እንደሚሆን ልገልፅሎት እወዳለሁ። የሚሰጡን ማንኛውም መረጃ ከዚህ ጥናት አላማ ውጪ ለሌላ የማይውል ሲሆን የእርሶን ማንነት ሊገልፁ የሚችሉ መረጃዎችን አንመዘግብም። በተጨማሪም ይህን መረጃ ስለሰበሰብ ሁሉንም ውይይታችንን በፅሁፍ መያዝ ስለሚከብድ ውይይታችንን በቴፕ እቀዳለሁ። ቃለመጠይቁን በተመለከተ ተጨማሪ ማወቅ የሚፈልጉት ካለ በሚከተለው አድራሻ የተቀሰትን በለሙያ ማነጋገር ይችላሉ።

ዶር. መአዛ ደምሴ
አዲስ ኮንትራክታል ህብረተሰብ ጤና ኢንስቲትዩት ፡
ስልክ 011 4168207/0114168265
ኢሜል: aciph@ethionet.et

ከመጠይቁ በፊት የተጠየቀውን ስምምነት ማረጋገጫ

ከላይ የተሰጠኝን ማብራሪያ ተረድቻለሁ። በዚህ መሰረት ከእኔ የሚጠበቅብኝን ድርሻ በሚገባ አውቄአለሁ። በጥናቱ ላይ ለመሳተፍ ሊከሰቱ የሚችሉትን ሁኔታዎች ተገንዝቶ ቤአለሁ። በዚህ ቃለመጠይቅ በማንኛውም ጊዜ ያለምንም ቅድመ ሁኔታ ማቋረጥ እንደምንችልና ይህን ውሳኔ ተከትሎ በእኔም ሆነ በሌሎች ላይ ምንም አይነት በደል እንደማይደርስብን ተረድቻለሁ።

መጠይቁን እንዲቀጥል ፈቃደኛ ነዎት?

- 1. አዎ ፈቃደኛ ናቸው ----- ቃለመጠይቁን ይቀጥሉ
- 2. አይ ፈቃደኛ አይደሉም ----- አመስግነው ይሰናበቱ።

የቃለመጠይቁ አቅራቢ

በቃለመጠይቁ ተሳታፊ ለሆኑት ከላይ የተመለከተውን በትክክል ስለማንበቤ ወይም ስለመግለጻ ፣ ለተነሱት ጥያቄዎች ተጨማሪ ማብራሪያ ስለመስጠቴ በቃለ መጠይቁ ተሳታፊ ለመሆን መቻል ወይም አለመቻልዎ ማስረዳቱን በፊርማዎ አረጋግጣለሁ።

ቃለመጠይቁን አድራጊ ሙሉ ስም -----

ቀን -----

ፊርማ -----

አመሰግናለሁ።

ክፍል 1 : ስለጥናቱ ተሳታፊ አጠቃላይ መረጃ

ቁ	ጥያቄ	
1	የተሳታፊው መለያ ኮድ	
2	የተሳታፊው እድሜ	-----
3	ፆታ	ወንድ 1 ሴት 2
4	የጋብቻ ሁኔታ	ያላገባች 1 ያገባች 2 የሞተባት 3 የተለያዩች 4 የፈታች 5
5	የትምህርት ደረጃ	ያጠናቀቁት ክፍል----- ማነበብ እና መፃፍ ብቻ 09 ትምህርት ቤት ገብቼ አላውቅም 88 ሌላ ካለ ይግለፁ-----
6	ሀይማኖት	ኦርቶዶክስ 1 ሙስሊም 2 ፕሮቴስታንት 3 ካቶሊክ 4 ሌላ -----
7	ዋና የሚሰሩት ስራ አይነት	-----
8	እድሜያቸው ከ5 አመት በታች የሆኑ ልጆች ብዛት በቤተሰብ ውስጥ	-----
9	የመጨረሻ ልጅ እድሜ	-----
10	የሚኖሩበት ቦታ ቅርብ ካለው ጤና ጣቢያ ምን ያህል ሰአት ያስሄዳል	በሰአት ----- በደቂቃ -----
10	የመኖሪያ ቦታ	ከተማ 1 ገጠር 2
12	የወረዳው ስም	-----
13	ክልል	አሮሚያ 1 አማራ 2

ክፍል 2 : መወያያ ጥያቄዎች

1. ስለ ወባ በሽታ መንስኤ እና መተላለፊያ መነገዶቹ የሚያውቁትን ቢነግሩኝ?

- 1.1. ስለ ወባ በሽታ ሰምተዋል?
- 1.2. አንድ ሰው በወባ በሽታ እንዴት ሊያዝ ይችላል? መንስኤው?
- 1.3. አንድ ሰው በወባ በሽታ እንደተያዘ እንዴት ይታወቃል? የሚያውቁትን ምልክቶች ይዘርዘሩ
- 1.4. የወባ በሽታ በህብረተሰቡ ውስጥ እንዴት ይሰራጫል?

2. ከወባ በሽታ እራሶን ለመጠበቅ ምን ያደርጋሉ?

- 2.1. የወባ በሽታ በአካባቢያችሁ ከባድ ችግር ነው? ምን ያህል? ለምን?
- 2.2. የወባ በሽታን ሲያስቡ በጣም የሚያሳስቦት ነገር ምንድነው?
- 2.3. የወባ በሽታን መከላከል ይቻላል ብለው ያስባሉ? እንዴት? መከላከያ መነገዶቹን ይዘርዘሩ
- 2.4. በፀረ-ተባይ ኬሚካል ስለተነከረ የአልጋ አጎበር ምን ያውቃሉ? ጥቅሙን፣ ጉዳቱን ይዘርዘሩ
- 2.5. ስለ ፀረ-ወባ በቤት ውስጥ ስለሚረጭ ኬሚካል የሚያውቁትን ቢነግሩኝ? ጥቅሙን፣ ጉዳቱን
- 2.6. ከወባ በሽታ መዳን ይቻላል? እንዴት? የት?
- 2.7. ከወባ በሽታ የመዳን እድልን ለመጨመር ምን መደረግ አለበት?
- 2.8. ለወባ በሽታ ስለሚደረግ ህክምና የሚያውቁትን ቢነግሩኝ? ጥቅሙን፣ ጉዳቱን ይዘርዘሩ

3. በርሶ አመለካከት አንድን ሰው የወባ መከላከያ የአልጋ አጎበርን እንዳይጠቀም ወይም እንዳይጠቀም ሊያደርጉ የሚችሉ ምክንያቶች አሉ?

- 3.1. ስለ አልጋ አጎበር ሰምተዋል?
- 3.2. የአልጋ አጎበር በቤትዎ አለ? ከሌለ ምክንያቱን ቢነግሩኝ፣ ለሁሉም የቤተሰብ አባል ይበቃል?
- 3.3. ሁሉም የቤተሰብ አባል የአልጋ አጎበር ውስጥ ይተኛሉ? ካልሆነ ቅድሚያ የሚሰጠው ለማን ነው? ለምን?
- 3.4. በአመት ውስጥ የአልጋ አጎበርን ሁል ጊዜ ይጠቀማሉ? በየቀኑ ማታ ስለመጠቀማቸው ያረጋግጡ፣ ካልሆነ ምክንያቱ ምንድነው?
- 3.5. ብዙ ጊዜ አጎበር ከየት ነው የሚያገኙት? ምን ያህል ከፈሉ? ዋጋውን እንዴት አዩት?
- 3.6. የአልጋ አጎበር ኬሚካል ውስጥ ተነክሮ ነበር? መቼ? ካልተነከረ ለምን?
- 3.7. በእርሶ አመለካከት ሌሎች ሰዎች አጎበር እንዳይጠቀሙ ለማድረግ ምን መደረግ አለበት?

4. በቤት ውስጥ ስለሚረጭ ፀረ-ወባ ኬሚካል የሚያውቁትን ቢነግሩኝ?

- 4.1. ወባን በመከላከል ረገድ ያለውን ጥቅሙን እንዴት ያዩታል?
- 4.2. ስለ ፀረ-ወባ ኬሚካል አጠቃቀም ያሉት አመለካከት ምን ይመስላል? ወባን ለመከላከል አቅም አለው ብለው ያስባሉ? ካልሆነ ለምን?
- 4.3. ከኬሚካሉ ጋር በተያያዘ በጤና ላይ ለመጣ የሚችል ጉዳት አለ?

5. ቤትዎ በፀረ-ወባ ኬሚካል እንዲረጭ ፈቃደኛ ነበሩ? ካልነበሩ ለምን?

- 5.1. ማን ነበር የእርሶን ቤት በፀረ-ወባ ኬሚካል የረጨው? በየስንት ጊዜ?

- 5.2. በየስንት ጊዜ ቤቶን ይለስናሉ ወይም ይቀባሉ? ቤትዎ በፀረ-ወባ ኬሚካል ቢረጭ የሚልስነብት ጊዜ ይለያል?
- 5.3. ቤትዎ በፀረ-ወባ ኬሚካል ሲረጭ የእርሶ ድርሻ ምን ነበር?
- 5.4. ሌሎች ሰዎች ቤታቸው በፀረ-ወባ ኬሚካል እንዲረጭ ፈቃደኛ ለማድረግ ምን መደረግ አለባቸው ይላሉ?
- 6. ከፀረ-ወባ ኬሚካል ጋር በተገናኘን በጤና ላይ ሊመጡ የሚችሉ ችግሮቻቸው አሉ? ካሉ ይዘርዝሩ?
- 7. የወባን በሽታ በተመለከተ መረጃ የሚያገኙት ከየት ነው?
 - 7.1. ጤናን በተመለከተ መረጃ ከየት ያገኛሉ? የትኛውን የመረጃ ምንጭ የበለጠ ያምናሉ?
 - 7.2. የወባን በሽታ በተመለከተ መረጃ የሚሰጣችሁ ማን ነው? የጤና ኤክስቴንሽን ተጠሪ፣ ጎረቤት፣ ሌላ ይዘርዝሩ
 - 7.3. ስለወባ በሽታ መረጃ ለማግኘት የትኛውን የመረጃ ምንጭ ይመርጣሉ? ለምን? ሬድዮ፣ ቴሌቪዥን፣ በራሪ ፅሁፎች፣ ጋዜጣ የመሳሰሉት
 - 7.4. አዘውትረው መሳተፍ ወይም መከታተል የሚፈልጉት ፕሮግራም አለ? ካለ ይዘርዝሩ?
 - 7.5. የወባ በሽታን በተመለከተ የትኛውን የመረጃ ምንጭ የበለጠ ያምናሉ? ለምን?
 - 7.6. የወባ በሽታን በተመለከተ በየስንት ጊዜ መረጃ ያገኛሉ?
 - 7.7. ስለወባ በሽታ መረጃ ለማግኘት ምቹ ጊዜ የሚሆነው መቼ ነው? በቀን ውስጥ በየትኛው ሰአት፣ በሳምንት ውስጥ በየትኛው ቀን
 - 7.8. ባብዛኛው የሚያዳምጡት የትኛውን የሬድዮ ጣቢያ ነው?
 - 7.9. ምን አይነት የህትመት ውጤቶችን ማንበብ ይመርጣሉ?
 - 7.10. የወባን በሽታ በተመለከተ ምን አይነት መረጃ ቢያገኙ ይመርጣሉ?
- 8. ሰዎች ለወባ በሽታ የህክምና እርዳታ በጊዜ እንዲፈልጉ ወይም እንዳይፈልጉ ሊያደርጉ የሚችሉ ምክንያቶች ምንድናቸው?
 - 8.1. እርሶ ወይም ከቤተሰብ አባል አንዱ የጤና እክል ቢያጋጥም ወይስ ይሄዳሉ?
 - 8.2. በየስንት ጊዜ ወደ ጤና ማእከል ይሄዳሉ?
 - 8.3. በሚታመሙበት ጊዜ ወደ ጤና ማእከል እንዲሄዱ የሚገፋፋዎት ምንድን ነው?
 - 8.4. የወባ በሽታ ምን ያህል ከባድ ይመስሎታል?
 - 8.5. ልጅዎ የወባ በሽታ እንደያዘው በምን ያወቃሉ? ምልክቶቹን ይዘርዝሩ
 - 8.6. ልጅዎ ትኩሳት እንዳለው እንዴት ይለያሉ?
 - 8.7. እርሶ ወይም ከቤተሰብ አባል አንዱ ወባ ሲይዘው መጀመሪያ ምን ያረጋሉ? የት ይሄዳሉ? ለምን? መቼ ወደ ህክምና ቦታ ይሄዳሉ? ምልክቱ በታየ በ24 ሰዓት ውስጥ፣ ሲብስ፣ የባህል ሀኪም ካየው በኋላ፣ ለምን ይዘገያሉ?
 - 8.8. ለወባ በሽታ ተብሎ በቤት ውስጥ የሚዘጋጅ መድሀኒት አለ?
 - 8.9. ለወባ በሽታ በጊዜ የህክምና እርዳታን ላለመፈለግ ዋነኛ ምክንያት ምንድን ነው? የጤና አገልግሎት ዋጋ፣ መስተንግዶ፣ ወረፋ
 - 8.10. ለወባ በሽታ መድሀኒት ከየት ያገኛሉ? የወባ መድሀኒት አጠቃቀም እንዴት ነው? ለምን ያህል ጊዜ ይወስዳሉ?
 - 8.11. ሌሎች ወደ ጤና ማእከል መሄድ ሲያስፈልጋቸው የውሳኔው ሂደት ምን ይመስላል?
- 9. በህበረተሰቡ ውስጥ ለወባ በሽታ በይበልጥ ተጋላጭ የሆኑ ክፍሎች እነማናቸው?

- 9.1. በይበልጥ በወባ በሽታ ተጠቂ የሆኑ የህብረተሰብ ክፍሎች የትኞቹ ናቸው? ዘርዘር፣ ለምንድነው በይባልጥ ተጋላጭ የሆኑት?
- 9.2. እርሶ ለወባ ተጋልጫለሁ ብለው ያስባሉ? ለምን?

- 10. በወባ በሽታ እና በኤች. አይ.ቪ./ኤድስ መካከል ምን አይነት ግንኙነት አለ ብለው ያስባሉ? ግለፅ
 - 10.1. የኤች.አይ.ቪ. ቫይረስ በደማቸው ውስጥ ያለ ሰዎች ለወባ በሽታ ተጋላጭ ናቸው ብለው ያስባሉ?

በመጨረሻ በአካባቢዎ ስለወባ በሽታ መከላከያ እና ማዳኛ መንገዶች የሚነግሩኝ ተጨማሪ ነገር አለ?

አሁን ደግሞ በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት እጠይቆታለሁ

- 11. በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት የሚያውቁትን ቢነግሩኝ?
 - 11.1. በእርሶ አመለካከት አንዲት ነፍሰጡር መቼ ወደህክምና ቦታ መሄድ ይኖርባታል? ምን ያህል ጊዜ?
 - 11.2. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ ይተላለፋል ብለው ያስባሉ? እንዴት?
 - 11.3. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ መከላከል ይቻላል? እንዴት?
 - 11.4. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት ያውቃሉ? ያብራሩልኝ
- 12. በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት አንዲሁም የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ስለሚሰጠው የጤና አገልግሎት የህብረተሰቡ አመለካከት እና ድርጊት ምን ይመስላል?
 - 12.1. የቅድመ ወሊድ የህክምና ክትትል ጥቅም አለው ብለው ያስባሉ? እንዴት? የሚያውቁትን ጥቅም ይግለፁ?
 - 12.2. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ ህክምና ክትትል ያደርጋሉ? የት ይከታተላሉ? የትስ ይመርጣሉ? ለምን? የማይከታተሉ አሉ? ለምን?
 - 12.3. ለወንድ:- ባለቤትህ የቅድመ ወሊድ የህክምና ክትትል አድርጋ ታውቃለህ? ለሴት:- የቅድመወሊድ የህክምና ክትትል አድገሽ ታውቂያለሽ? ካላደረጉ ለምን?
 - 12.4. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ የህክምና ክትትል ማድረግ የሚጅምሩት መቼነው? መቼ ማድረግ አለባት ብለው ያስባሉ?
 - 12.5. አንዲት ሴት የቅድመ ወሊድ የህክምና ክትትል ለማድረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚደረገውን የጤና አገልግሎት ተጠቃሚ እንድትሆን የማን ውሳኔ ነው?
 - 12.6. የቅድመ ወሊድ የህክምና ክትትል በተመለከተ በተጠቃሚዎቹ ላይ የሚደርስ አድሎ ወይም መገለል አለ?
 - 12.7. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚደረገውን የጤና አገልግሎት ተጠቃሚ ለመሆን ፈቃደኛ ናቸው ብለው ያስባሉ? ለምን?

13. በዚህ አካባቢ ሰለሚሰጠው የቅድመ ወሊድ የህክምና ክትትል ለማድ
14. ረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ሰለሚሰጠው የጤና አገልግሎት ምን አስተያየት አሉት?
 - 14.1. ከመኖሪያ ቤታቸው ያለው ርቀት፣ ለአገልግሎት የሚከፈለው ክፍያ መጠን፣ ጊዜ ጤና ጣቢያ /ጤና ኬላ ከደረሱ በኋላ አገልግሎት እስኪያገኙ ድረስ ያለው ቆይታ፣ እና በጠቅላላው ያሳለፉት ሰዓት
 - 14.2. የጤና ባለሙያው አመለካከት፣ አቀራረብ፣ ሚስጥር መጠበቅ
15. እዚህ አካባቢ ሴቶች ለመውለድ የት ይመርጣሉ?
 - 15.1. የመንግስት ጤና ጣቢያ/ጤና ኬላ፣ የግለሰብ ክሊኒክ፣ በቤት ውስጥ
 - 15.2. ሴቶች በቤት ውስጥ መውለድን ለምን ይመርጣሉ?
 - 15.3. በቤት ውስጥ መውለድ የሚያስከትለው ጉዳት አለ ብለው ያስባሉ? ለምን?
 - 15.4. ሴቶች የህክምና እርዳታ በሚያገኙበት ቦታ እንዲወልዱ ለማስቻል ወይም ለማበረታታት ምን መደረግ አለበት ብለው ያስባሉ?

ANNEX 7: FGD Guide for Pregnant women (Amharic Version)

ጤና ይስጥልኝ ስሜ ----- ይባላል፡ አዲስ አበባ ውስጥ ለሚገኝ አዲስ ኮንትራክታል ለተባለ የህብረተሰብ ጤና አጠባበቅ ተቋም የምሰራ ስሆን እዚህ የመጣሁት ኤ.ኤ.ዲ(AED). ከሚባል ድረጅት እንዲሁም ከአሮሚያ እና አማሃራ ክልል ጤና ቢሮ ጋር በመተባበር ለሚሰራ ጥናት መረጃ ለመሰበሰብ ነው። ጥናቱ የሚሰራው ስለወጣ መከላከል እና መቆጣጠር ህብረተሰቡ ያለውን ግንዛቤ እንዲሁም በመከላከል ላይ የህብረተሰቡን ደርሻ ለማወቅ በተጨማሪም ሴቶች በተለይም ነፍሰጡር እናቶች በእርግዝና ጊዜ የህክምና አገልግሎት አጠቃቀማቸውን ለመረዳት ነው። የዚህም ጥናት ውጤት በሀገሪቱ ለሚደረገው የወጣን በሽታ መከላከል እናመቆጣጠር ስራ በማገዝ ትልቅ አስተዋጾ ያደርጋል ተብሎ የታመመ። ይህ ቃለመጠይቅ በአማካይ አንድ ሰዓት ይወስዳል።

እዚህ ጥናት ውስጥ ሲሳተፉ በፈቃደኝነት ሲሆን በማንኛውም ሰዓት ከጥናቱ አቋቋሙ መውጣት ይችላሉ። ነገርግን በጥናቱ ቢሳተፉ ለምንሰራው ስራ ትልቅ እገዛ እንደሚሆን ልገልፅሎት እወዳለሁ። የሚሰጡን ማንኛውም መረጃ ከዚህ ጥናት አላማ ውጪ ለሌላ የማይውል ሲሆን የእርሶን ማንነት ሊገልፁ የሚችሉ መረጃዎችን አንመዘግብም። በተጨማሪም ይህን መረጃ ስሰበስብ ሁሉንም ውይይቶችንን በፅሁፍ መያዝ ስለሚከብድ ውይይቶችንን በቴፕ እቀዳለሁ። ቃለመጠይቁን በተመለከተ ተጨማሪ ማወቅ የሚፈልጉት ካለ በሚከተለው አድራሻ የተቀሱትን በለሙያ ማነጋገር ይችላሉ።

ዶር. መአዛ ደምሴ
አዲስ ኮንትራክታል ህብረተሰብ ጤና ኢንስቲትዩት ፡
ስልክ 011 4168207/0114168265
ኢ.ሜል: aciph@ethionet.et

ከመጠይቁ በፊት የተጠየቀውን ስምምነት ማረጋገጫ

ከላይ የተሰጠኝን ማብራሪያ ተረድቻለሁ። በዚህ መሰረት ከእኔ የሚጠበቅብኝን ድርሻ በሚገባ አውቁክለሁ። በጥናቱ ላይ ለመሳተፍ ሊከሰቱ የሚችሉትን ሁኔታዎች ተገንዝቶ ቤክለሁ። በዚህ ቃለመጠይቅ በማንኛውም ጊዜ ያለምንም ቅድመ ሁኔታ ማቋረጥ እንደምንችልና ይህን ውሳኔ ተከትሎ በእኔም ሆነ በሌሎች ላይ ምንም አይነት በደል እንደማይደርስብን ተረድቻለሁ።

መጠይቁን እንዲቀጥል ፈቃደኛ ነዎት?

- 1. አዎ ፈቃደኛ ናቸው ----- ቃለመጠይቁን ይቀጥሉ
- 2. አይ ፈቃደኛ አይደሉም ----- አመስግነው ይሰናበቱ።

የቃለመጠይቁ አቅራቢ

በቃለመጠይቁ ተሳታፊ ለሆኑት ከላይ የተመለከተውን በትክክል ስለማንበቤ ወይም ስለመግለጻ ፣ ለተነሱት ጥያቄዎች ተጨማሪ ማብራሪያ ስለመስጠቴ በቃለ መጠይቁ ተሳታፊ ለመሆን መቻል ወይም አለመቻልዎ ማስረዳቴን በፊርማዬ አረጋግጣለሁ።

ቃለመጠይቁን አድራጊ ሙሉ ስም -----

ቀን -----

ፊርማ -----

አመሰግናለሁ።

ክፍል 1 : ስለጥናቱ ተሳተፊዎች አጠቃላይ መረጃ

ተሳተፊዎች	እድሜ	የትምህርት ደረጃ	የስራ አይነት	የትምህርት ደረጃ	ሀይማኖት
1					
2					
3					
4					
5					
6					
7					
8					
9					

ክፍል 2 : መወያያ ጥያቄዎች

1. በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት የምታውቁትን ብትነግሩኝ?

- 1.1. አንዲት ነፍሰጡሮ መቼ ወደህክምና ቦታ መሄድ ይኖርባታል ብላችሁ ታስባላችሁ? ከወሊድ በፊት ምን ያህል ጊዜ ክትትል ማድረግ አለባት ?
- 1.2. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ ይተላለፋል? እንዴት ይተላለፋል?
- 1.3. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ይቻላል? እንዴት?
- 1.4. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት ታውቃላችሁ? ብታብራሩልኝ

2. በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት እንዲሁም የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ሰለሚሰጠው የጤና አገልግሎት የህብረተሰቡ አመለካከት እና ድርጊት ምን ይመስላል?

- 2.1. እዚህ አካባቢ ህብረተሰቡ የቅድመ ወሊድ የህክምና ክትትል ጥቅም አለው ብሎ ያስባል? እንዴት?
- 2.2. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ ህክምና ይከታተላሉ? የማይከታተሉ አሉ? ለምን?
- 2.3. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ የህክምና ክትትል የሚያደርጉት የት ነው? የት ቢከታተሉ ይመርጣሉ? ለምን?
- 2.4. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ የህክምና ክትትል ማድረግ የሚጅምሩት መቼነው? መቼ ማድረግ አለባት ብለው ያስባሉ?
- 2.5. አንዲት ሴት የቅድመ ወሊድ የህክምና ክትትል ለማድረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚደረገውን የጤና አገልግሎት ተጠቃሚ እንድትሆን የማን ውሳኔ ነው?
- 2.6. የቅድመ ወሊድ የህክምና ክትትል በተመለከተ በተጠቃሚዎቹ ላይ የሚደርስ አድሎ ወይም መገለል አለ?
- 2.7. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚደረገውን የጤና አገልግሎት ተጠቃሚ ለመሆን ፈቃደኛ ናቸው ብለው ያስባሉ?

3. በዚህ አካባቢ ሰለሚሰጠው የቅድመ ወሊድ የህክምና ክትትል ለማድረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ሰለሚሰጠው የጤና አገልግሎት የህብረተሰቡ አስተያየት ምን ይመስላል?

- 3.1. ከመኖሪያ ቤታቸው ያለው ርቀት፣ ለአገልግሎት የሚከፈለው ክፍያ መጠን፣ ጤና ጣቢያ / ጤና ኬላ ከደረሱ በኋላ አገልግሎት እስኪያገኙ ድረስ ያለው ቆይታ፣ እና በጠቅላላው ያሳለፉት ሰዓት
- 3.2. የጤና ባለሙያው አመለካከት፣ አቀራረብ

4. እዚህ አካባቢ ሴቶች ለመውለድ የት ይመርጣሉ?

- 4.1. የመንግስት ጤና ጣቢያ/ጤና ኬላ፤ የግለሰብ ክሊኒክ፤ በቤት ውስጥ
- 4.2. ሴቶች በቤት ውስጥ መውለድን ለምን ይመርጣሉ?
- 4.3. በቤት ውስጥ መውለድ የሚያስከትለው ጉዳት አለ ብለው ያስባሉ? ለምን?
- 4.4. ሴቶች የህክምና እርዳታ በሚያገኙበት ቦታ እንዲወልዱ ለማስቻል ወይም ለማበረታታት ምን መደረግ አለበት ብለው ያስባሉ?

ANNEX 8: In-depth Interview guide for Community (Amharic Version)

ጤና ይስጥልኝ ስሜ ----- ይባላል፡ አዲስ አበባ ውስጥ ለሚገኝ አዲስ ኮንትራንታል ለተባለ የህብረተሰብ ጤና አጠባበቅ ተቋም የምሰራ ስሆን እዚህ የመጣሁት ኤ.ኤ.ዲ(AED). ከሚባል ድረጅት እንዲሁም ከኦሮሚያ እና አማሃራ ክልል ጤና ቢሮ ጋር በመተባበር ለሚሰራ ጥናት መረጃ ለመሰበሰብ ነው። ጥናቱ የሚሰራው ስለወጣ መከላከል እና መቆጣጠር ህብረተሰቡ ያለውን ግንዛቤ እንዲሁም በመከላከል ላይ የህብረተሰቡን ደርሻ ለመረዳት ነው። የዚህም ጥናት ውጤት በሀገሪቱ ለሚደረገው የወጣን በሽታ መከላከል እናመቆጣጠር ስራ በማገዝ ትልቅ አስተዋጾ ያደርጋል ተብሎ የታመናል። ይህ መጠይቅ በአማካይ 45 ደቂቃ የሚፈጅ ነው።

እዚህ ጥናት ውስጥ ሲሳተፉ በፈቃደኝነት ሲሆን በማንኛውም ሰአት ከጥናቱ አቋቋሙ መውጣት ይችላሉ። ነገርግን በጥናቱ ሲሳተፉ ለምንሰራው ስራ ትልቅ እገዛ እንደሚሆን ልገልፅሎት እወዳለሁ። የሚሰጡን ማንኛውም መረጃ ከዚህ ጥናት አላማ ውጪ ለሌላ የማይውል ሲሆን የእርሶን ማንነት ሊገልፁ የሚችሉ መረጃዎችን አንመዘግብም። በተጨማሪም ይህን መረጃ ስለሰበሰብ ሁሉንም ውይይታችንን በፅሁፍ መያዝ ስለሚከብድ ውይይታችንን በቴፕ እቀዳለሁ። ቃለመጠይቁን በተመለከተ ተጨማሪ ማወቅ የሚፈልጉት ካለ በሚከተለው አድራሻ የተቀሱትን በለሙያ ማነጋገር ይችላሉ።

ዶር. መአዛ ደምሴ
አዲስ ኮንትራንታል ህብረተሰብ ጤና ኢንስቲትዩት ፡
ስልክ 011 4168207/0114168265
ኢ.ሜል: aciph@ethionet.et

ከመጠይቁ በፊት የተጠየቀውን ስምምነት ማረጋገጫ

ከላይ የተሰጠኝን ማብራሪያ ተረድቻለሁ። በዚህ መሰረት ከእኔ የሚጠበቅብኝን ድርሻ በሚገባ አውቄአለሁ። በጥናቱ ላይ ለመሳተፍ ሊከሰቱ የሚችሉትን ሁኔታዎች ተገንዝቶ ቤአለሁ። በዚህ ቃለመጠይቅ በማንኛውም ጊዜ ያለምንም ቅድመ ሁኔታ ማቋረጥ እንደምንችልና ይህን ውሳኔ ተከትሎ በእኔም ሆነ በቤተሰቤ ላይ ምንም አይነት በደል እንደማይደርስብን ተረድቻለሁ።

መጠይቁን እንዲቀጥል ፈቃደኛ ነዎት?

- 1. አዎ ፈቃደኛ ናቸው ----- ቃለመጠይቁን ይቀጥሉ
- 2. አይ ፈቃደኛ አይደሉም ----- አመስግነው ይሰናበቱ።

የቃለመጠይቁ አቅራቢ

በቃለመጠይቁ ተሳታፊ ለሆኑት ከላይ የተመለከተውን በትክክል ስለማንበቤ ወይም ስለመግለጻ ፣ ለተነሱት ጥያቄዎች ተጨማሪ ማብራሪያ ስለመስጠቴ በቃለ መጠይቁ ተሳታፊ ለመሆን መቻል ወይም አለመቻልዎ ማስረዳቴን በፊርማዬ አረጋግጣለሁ።

ቃለመጠይቁን አድራጊ ሙሉ ስም -----

ቀን -----

ፊርማ -----

አመሰግናለሁ።

ክፍል 1 : ስለጥናቱ ተሳታፊ አጠቃላይ መረጃ

ቁ	ጥያቄ	
1	የተሳታፊው መለያ ኮድ	
2	የተሳታፊው እድሜ	-----
3	ፆታ	ወንድ 1 ሴት 2
4	የጋብቻ ሁኔታ	ያላገባች 1 ያገባች 2 የሞተባት 3 የተለያዩች 4 የፈታች 5
5	የትምህርት ደረጃ	ያጠናቀቁት ክፍል----- ማነበብ እና መፃፍ ብቻ 09 ትምህርት ቤት ገብቼ አላውቅም 88 ሌላ ካለ ይግለፁ-----
6	ሀይማኖት	ኦርቶዶክስ 1 ሙስሊም 2 ፕሮቴስታንት 3 ካቶሊክ 4 ሌላ -----
7	ዋና የሚሰሩት ስራ አይነት	-----
8	እድሜያቸው ከ5 አመት በታች የሆኑ ልጆች ብዛት በቤተሰብ ውስጥ	-----
9	የመጨረሻ ልጅ እድሜ	-----
10	የሚኖሩበት ቦታ ቅርብ ካለው ጤና ጣቢያ ምን ያህል ሰአት ያስሄዳል	በሰአት ----- በደቂቃ -----
10	የመኖሪያ ቦታ	ከተማ 1 ገጠር 2
12	የወረዳው ስም	-----
13	ክልል	አሮሚያ 1 አማራ 2

ክፍል 2 : መወያያ ጥያቄዎች

1. ስለ ወባ በሽታ መንስኤ እና መተላለፊያ መነገዶቹ የሚያውቁትን ቢነግሩኝ?

- 1.5. ስለ ወባ በሽታ ሰምተዋል?
- 1.6. አንድ ሰው በወባ በሽታ እንዴት ሊያዝ ይችላል? መንስኤው?
- 1.7. አንድ ሰው በወባ በሽታ እንደተያዘ እንዴት ይታወቃል? የሚያውቁትን ምልክቶች ይዘርዘሩ
- 1.8. የወባ በሽታ በህብረተሰቡ ውስጥ እንዴት ይሰራጫል?

2. ከወባ በሽታ እራሶን ለመጠበቅ ምን ያደርጋሉ?

- 2.9. የወባ በሽታ በአካባቢያችሁ ከባድ ችግር ነው? ምን ያህል? ለምን?
- 2.10. የወባ በሽታን ሲያስቡ በጣም የሚያሳስቦት ነገር ምንድነው?
- 2.11. የወባ በሽታን መከላከል ይቻላል ብለው ያስባሉ? እንዴት? መከላከያ መነገዶቹን ይዘርዘሩ
- 2.12. በፀረ-ተባይ ኬሚካል ስለተነከረ የአልጋ አጎበር ምን ያውቃሉ? ጥቅሙን፣ ጉዳቱን ይዘርዘሩ
- 2.13. ስለ ፀረ-ወባ በቤት ውስጥ ስለሚረጭ ኬሚካል የሚያውቁትን ቢነግሩኝ? ጥቅሙን፣ ጉዳቱን
- 2.14. ከወባ በሽታ መዳን ይቻላል? እንዴት? የት?
- 2.15. ከወባ በሽታ የመዳን እድልን ለመጨመር ምን መደረግ አለበት?
- 2.16. ለወባ በሽታ ስለሚደረግ ህክምና የሚያውቁትን ቢነግሩኝ? ጥቅሙን፣ ጉዳቱን ይዘርዘሩ

4. በርሶ አመለካከት አንድን ሰው የወባ መከላከያ የአልጋ አጎበርን እንዳይጠቀም ወይም እንዳይጠቀም ሊያደርጉ የሚችሉ ምክንያቶች አሉ?

- 4.1. ስለ አልጋ አጎበር ሰምተዋል?
- 4.2. የአልጋ አጎበር በቤትዎ አለ? ከሌለ ምክንያቱን ቢነግሩኝ፣ ለሁሉም የቤተሰብ አባል ይበቃል?
- 4.3. ሁሉም የቤተሰብ አባል የአልጋ አጎበር ውስጥ ይተኛሉ? ካልሆነ ቅድሚያ የሚሰጠው ለማን ነው? ለምን?
- 4.4. በአመት ውስጥ የአልጋ አጎበርን ሁል ጊዜ ይጠቀማሉ? በየቀኑ ማታ ስለመጠቀማቸው ያረጋግጡ፣ ካልሆነ ምክንያቱ ምንድነው?
- 4.5. ብዙ ጊዜ አጎበር ከየት ነው የሚያገኙት? ምን ያህል ከፈሉ? ዋጋውን እንዴት አዩት?
- 4.6. የአልጋ አጎበር ኬሚካል ውስጥ ተነከር ነበር? መቼ? ካልተነከረ ለምን?
- 4.7. በእርሶ አመለካከት ሌሎች ሰዎች አጎበር እንዳይጠቀሙ ለማድረግ ምን መደረግ አለበት?

16. በቤት ውስጥ ስለሚረጭ ፀረ-ወባ ኬሚካል የሚያውቁትን ቢነግሩኝ?

- 16.1. ወባን በመከላከል ረገድ ያለውን ጥቅሙን እንዴት ያዩታል?
- 16.2. ስለ ፀረ-ወባ ኬሚካል አጠቃቀም ያሉት አመለካከት ምን ይመስላል? ወባን ለመከላከል አቅም አለው ብለው ያስባሉ? ካልሆነ ለምን?
- 16.3. ከኬሚካሉ ጋር በተያያዘ በጤና ላይ ለመጣ የሚችል ጉዳት አለ?

17. ቤትዎ በፀረ-ወባ ኬሚካል እንዲረጭ ፈቃደኛ ነበር? ካልነበር ለምን?

- 17.1. ማን ነበር የእርሶን ቤት በፀረ-ወባ ኬሚካል የረጨው? በየስንት ጊዜ?

- 17.2. በየስንት ጊዜ ቤቶን ይለስናሉ ወይም ይቀባሉ? ቤትዎ በፀረ-ወባ ኬሚካል ቢረጭ የሚልስነብት ጊዜ ይለያል?
 - 17.3. ቤትዎ በፀረ-ወባ ኬሚካል ሲረጭ የእርሶ ድርሻ ምን ነበር?
 - 17.4. ሌሎች ሰዎች ቤታቸው በፀረ-ወባ ኬሚካል እንዲረጭ ፈቃደኛ ለማድረግ ምን መደረግ አለባቸው ይላሉ?
18. ከፀረ-ወባ ኬሚካል ጋር በተገናኘ በጤና ላይ ሊመጡ የሚችሉ ችግሮቻቸው አሉ? ካሉ ይዘርዝሩ?
19. የወባን በሽታ በተመለከተ መረጃ የሚያገኙት ከየት ነው?
- 19.1. ጤናን በተመለከተ መረጃ ከየት ያገኛሉ? የትኛውን የመረጃ ምንጭ የበለጠ ያምናሉ?
 - 19.2. የወባን በሽታ በተመለከተ መረጃ የሚሰጣችሁ ማን ነው? የጤና ኤክስቴንሽን ተጠሪ፣ ጎረቤት፣ ሌላ ይዘርዝሩ
 - 19.3. ስለወባ በሽታ መረጃ ለማግኘት የትኛውን የመረጃ ምንጭ ይመርጣሉ? ለምን? ሬድዮ፣ ቴሌቪዥን፣ በራሪ ፅሁፎች፣ ጋዜጣ የመሳሰሉት
 - 19.4. አዘውትረው መሳተፍ ወይም መከታተል የሚፈልጉት ፕሮግራም አለ? ካለ ይዘርዝሩ?
 - 19.5. የወባ በሽታን በተመለከተ የትኛውን የመረጃ ምንጭ የበለጠ ያምናሉ? ለምን?
 - 19.6. የወባ በሽታን በተመለከተ በየስንት ጊዜ መረጃ ያገኛሉ?
 - 19.7. ስለወባ በሽታ መረጃ ለማግኘት ምቹ ጊዜ የሚሆነው መቼ ነው? በቀን ውስጥ በየትኛው ሰአት፣ በሳምንት ውስጥ በየትኛው ቀን
 - 19.8. ባብዛኛው የሚያዳምጡት የትኛውን የሬድዮ ጣቢያ ነው?
 - 19.9. ምን አይነት የህትመት ውጤቶችን ማንበብ ይመርጣሉ?
 - 19.10. የወባን በሽታ በተመለከተ ምን አይነት መረጃ ቢያገኙ ይመርጣሉ?
20. ሰዎች ለወባ በሽታ የህክምና እርዳታ በጊዜ እንዲፈልጉ ወይም እንዳይፈልጉ ሊያደርጉ የሚችሉ ምክንያቶች ምንድናቸው?
- 20.1. እርሶ ወይም ከቤተሰብ አባል አንዱ የጤና እክል ቢያጋጥም ወይስ ይሄዳሉ?
 - 20.2. በየስንት ጊዜ ወደ ጤና ማእከል ይሄዳሉ?
 - 20.3. በሚታመሙበት ጊዜ ወደ ጤና ማእከል እንዲሄዱ የሚገፋፋዎት ምንድን ነው?
 - 20.4. የወባ በሽታ ምን ያህል ከባድ ይመስሎታል?
 - 20.5. ልጅዎ የወባ በሽታ እንደያዘው በምን ያወቃሉ? ምልክቶቹን ይዘርዝሩ
 - 20.6. ልጅዎ ትኩሳት እንዳለው እንዴት ይለያሉ?
 - 20.7. እርሶ ወይም ከቤተሰብ አባል አንዱ ወባ ሲይዘው መጀመሪያ ምን ያረጋሉ? የት ይሄዳሉ? ለምን? መቼ ወደ ህክምና ቦታ ይሄዳሉ? ምልክቱ በታየ በ24 ሰዓት ውስጥ፣ ሲብስ፣ የባህል ሀኪም ካየው በኋላ፣ ለምን ይዘገያሉ?
 - 20.8. ለወባ በሽታ ተብሎ በቤት ውስጥ የሚዘጋጅ መድሀኒት አለ?
 - 20.9. ለወባ በሽታ በጊዜ የህክምና እርዳታን ላለመፈለግ ዋነኛ ምክንያት ምንድን ነው? የጤና አገልግሎት ዋጋ፣ መስተንግዶ፣ ወረፋ
 - 20.10. ለወባ በሽታ መድሀኒት ከየት ያገኛሉ? የወባ መድሀኒት አጠቃቀም እንዴት ነው? ለምን ያህል ጊዜ ይወስዳሉ?
 - 20.11. ሌሎች ወደ ጤና ማእከል መሄድ ሲያስፈልጋቸው የውሳኔው ሂደት ምን ይመስላል?

21. በህብረተሰቡ ውስጥ ለወባ በሽታ በይበልጥ ተጋላጭ የሆኑ ክፍሎች እነማናቸው?

- 21.1. በይበልጥ በወባ በሽታ ተጠቂ የሆኑ የህብረተሰብ ክፍሎች የትኞቹ ናቸው? ዘርዘር፣ ለምንድነው በይባልጥ ተጋላጭ የሆኑት?
- 21.2. እርሶ ለወባ ተጋልጫለሁ ብለው ያስባሉ? ለምን?

22. በወባ በሽታ እና በኤች.አይ.ቪ./ኤድስ መካከል ምን አይነት ግንኙነት አለ ብለው ያስባሉ? ግለፁ

- 22.1. የኤች.አይ.ቪ. ቫይረስ በደማቸው ውስጥ ያለ ሰዎች ለወባ በሽታ ተጋላጭ ናቸው ብለው ያስባሉ?

በመጨረሻ በአካባቢዎ ስለወባ በሽታ መከላከያ እና ማዳኛ መንገዶች የሚነግሩኝ ተጨማሪ ነገር አለ?

አሁን ደግሞ በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት እጠይቃለሁ

23. በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት የሚያውቁትን ቢነግሩኝ?

- 23.1. በእርሶ አመለካከት አንዲት ነፍሰጡር መቼ ወደህክምና ቦታ መሄድ ይኖርባታል? ምን ያህል ጊዜ?
- 23.2. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ ይተላለፋል ብለው ያስባሉ? እንዴት?
- 23.3. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ መከላከል ይቻላል? እንዴት?
- 23.4. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት ያውቃሉ? ያብራሩልኝ

24. በእርግዝና ጊዜ ለነፍሰጡሮች ሰለሚደረግ የጤና አገልግሎት እንዲሁም የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ስለሚሰጠው የጤና አገልግሎት የህብረተሰቡ አመለካከት እና ድርጊት ምን ይመስላል?

- 24.1. የቅድመ ወሊድ የህክምና ክትትል ጥቅም አለው ብለው ያስባሉ? እንዴት? የሚያውቁትን ጥቅም ይግለፁ?
- 24.2. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ ህክምና ክትትል ያደርጋሉ? የት ይከታተላሉ? የትስ ይመርጣሉ? ለምን? የማይከታተሉ አሉ? ለምን?
- 24.3. ለወንድ:- ባለቤትህ የቅድመ ወሊድ የህክምና ክትትል አድርጋ ታውቃለሽ?
ለሴት:- የቅድመወሊድ የህክምና ክትትል አድገሽ ታውቂያለሽ? ካላደረጉ ለምን?
- 24.4. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የቅድመ ወሊድ የህክምና ክትትል ማድረግ የሚጅምሩት መቼነው? መቼ ማድረግ አለባት ብለው ያስባሉ?
- 24.5. አንዲት ሴት የቅድመ ወሊድ የህክምና ክትትል ለማድረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚደረገውን የጤና አገልግሎት ተጠቃሚ እንድትሆን የማን ውሳኔ ነው?
- 24.6. የቅድመ ወሊድ የህክምና ክትትል በተመለከተ በተጠቃሚዎቹ ላይ የሚደርስ አድሎ ወይም መገለል አለ?
- 24.7. በዚህ አካባቢ ሴቶች በእርግዝና ጊዜ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚደረገውን የጤና አገልግሎት ተጠቃሚ ለመሆን ፈቃደኛ ናቸው ብለው ያስባሉ? ለምን?

25. በዚህ አካባቢ ሰለሚሰጠው የቅድመ ወሊድ የህክምና ክትትል ለማድረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ሰለሚሰጠው የጤና አገልግሎት ምን አስተያየት አሎት?

25.1. ከመኖሪያ ቤታቸው ያለው ርቀት፤ ለአገልግሎት የሚከፈለው ክፍያ መጠን፤ ጊዜ ጤና ጣቢያ /ጤና ኬላ ከደረሱ በኋላ አገልግሎት እስኪያገኙ ድረስ ያለው ቆይታ፤ እና በጠቅላላው ያሳለፉት ሰዓት

25.2. የጤና ባለሙያው አመለካከት፤ አቀራረብ፤ ሚስጥር መጠበቅ

26. እዚህ አካባቢ ሴቶች ለመውለድ የት ይመርጣሉ?

26.1. የመንግስት ጤና ጣቢያ/ጤና ኬላ፤ የግለሰብ ክሊኒክ፤ በቤት ውስጥ

26.2. ሴቶች በቤት ውስጥ መውለድን ለምን ይመርጣሉ?

26.3. በቤት ውስጥ መውለድ የሚያስከትለው ጉዳት አለ ብለው ያስባሉ? ለምን?

26.4. ሴቶች የህክምና እርዳታ በሚያገኙበት ቦታ እንዲወልዱ ለማስቻል ወይም ለማበረታታት ምን መደረግ አለበት ብለው ያስባሉ?

ANNEX 9: In-depth Interview guide for Health Personnel

ጤና ይስጥልኝ ስሜ ----- ይባላል፡ አዲስ አበባ ውስጥ ለሚገኝ አዲስ ኮንትራት ቤት ለተባለ የህብረተሰብ ጤና አጠባበቅ ተቋም የምሰራ ስሆን እዚህ የመጣሁት ኤ.ኤ.ዲ(AED). ከሚባል ድረጅት እንዲሁም ከኦሮሚያ እና አማራ ክልል ጤና ቢሮ ጋር በመተባበር ለሚሰራ ጥናት መረጃ ለመሰበሰብ ነው። ጥናቱ የሚሰራው ስለወጣ መከላከል እና መቆጣጠር ህብረተሰቡ ያለውን ግንዛቤ እንዲሁም በመከላከል ላይ የህብረተሰቡን ደርሻ ለመረዳት ነው። የዚህም ጥናት ውጤት በሀገሪቱ ለሚደረገው የወጣን በሽታ መከላከል እና መቆጣጠር ስራ በማገዝ ትልቅ አስተዋጾ ያደርጋል ተብሎ የታመናል። ይህ ቃለመጠይቅ 30 ደቂቃ ይወስዳል።

እዚህ ጥናት ውስጥ ሲሳተፉ በፈቃደኝነት ሲሆን በማንኛውም ሰአት ከጥናቱ አቋቋሙ መውጣት ይችላሉ። ነገርግን በጥናቱ ቢሳተፉ ለምንሰራው ስራ ትልቅ እገዛ እንደሚሆን ልገልፅሎት እወዳለሁ። የሚሰጡን ማንኛውም መረጃ ከዚህ ጥናት አላማ ውጪ ለሌላ የማይውል ሲሆን የእርሶን ማንነት ሊገልፁ የሚችሉ መረጃዎችን አንመዘግብም። በተጨማሪም ይህን መረጃ ስለሰበሰብ ሁሉንም ውይይታችንን በፅሁፍ መያዝ ስለሚከብድ ውይይታችንን በቴፕ እቀዳለሁ። ቃለመጠይቁን በተመለከተ ተጨማሪ ማወቅ የሚፈልጉት ካለ በሚከተለው አድራሻ የተቀሱትን በለሙያ ማነጋገር ይችላሉ።

ዶር. መአዛ ደምሴ
አዲስ ኮንትራት ቤት ህብረተሰብ ጤና ኢንስቲትዩት ፡
ስልክ 011 4168207/0114168265
ኢ.ሜል: aciph@ethionet.et

ከመጠይቁ በፊት የተጠየቀውን ስምምነት ማረጋገጫ

ከላይ የተሰጠኝን ማብራሪያ ተረድቻለሁ። በዚህ መሰረት ከእኔ የሚጠበቅብኝን ድርሻ በሚገባ አውቄአለሁ። በጥናቱ ላይ ለመሳተፍ ሊከሰቱ የሚችሉትን ሁኔታዎች ተገንዝቶ ቤአለሁ። በዚህ ቃለመጠይቅ በማንኛውም ጊዜ ያለምንም ቅድመ ሁኔታ ማቋረጥ እንደምንችልና ይህን ውሳኔ ተከትሎ በእኔም ሆነ በሌሎች ላይ ምንም አይነት በደል እንደማይደርስብን ተረድቻለሁ።

መጠይቁን እንዲቀጥል ፈቃደኛ ነዎት?

- 1. አዎ ፈቃደኛ ናቸው ----- ቃለመጠይቁን ይቀጥሉ
- 2. አይ ፈቃደኛ አይደሉም ----- አመስግነው ይሰናበቱ።

የቃለመጠይቁ አቅራቢ

በቃለመጠይቁ ተሳታፊ ለሆኑት ከላይ የተመለከተውን በትክክል ስለማንበቤ ወይም ስለመግለጻ ፣ ለተነሱት ጥያቄዎች ተጨማሪ ማብራሪያ ስለመስጠቴ በቃለ መጠይቁ ተሳታፊ ለመሆን መቻል ወይም አለመቻልዎ ማስረዳቴን በፊርማዬ አረጋግጣለሁ።

ቃለመጠይቁን አድራጊ ሙሉ ስም -----

ቀን -----

ፊርማ -----

አመሰግናለሁ።

ክፍል 1 : ስለጥናቱ ተሳታፊ አጠቃላይ መረጃ

ቁ	ጥያቄ	
1	የተሳታፊው መለያ ኮድ	-----
2	ፆታ	ወንድ 1 ሴት 2
3	የጋብቻ ሁኔታ	ያላገባች 1 ያገባች 2 የመተባት 3 የተለያዩ/ች 4 የፈታ/ች 5
4	ሞያ	የጤና ኤክስቴንሽን ተጠሪ 1 ነርስ 2 ሀኪም 3 ሌላ-----
5	በዚህ ሞያ ለምን ያህል ጊዜ ሰሩ	-----
6	የሚሰሩበት የጤና ድርጅት አይነት	የግል ክሊኒክ 1 የመንግስት የጤና ድርጅት 2 መንግስታዊ ያልሆነ የጤና ድርጅት 3 ሌላ -----
7	ክልል	አሮሚያ 1 አማሃራ 2
8	የወረዳው ስም	-----

ክፍል 2 : መወያያ ጥያቄዎች

1. በዚህ አካባቢ ስለሚኖረው ህብረተሰብ የጤና አገልግሎት አጠቃቀም ልምዱን ቢነግሩኝ?
 - 1.1. በዚህ አካባቢ ሰዎች ማንኛውንም አይነት የጤና ችግር ሲያጋጥማቸው ወደ የት መሄድ ይመርጣሉ?
 - 1.2. የወባ በሽታ እንደያዛቸው ሲጠረጥሩስ? ለምን? ተዘውትረው ስለሚደረጉ ነገሮች ይጠይቁ፤ ራስን ማከም፤ የባህል ህክምና ቦታ መሄድ፤ መደሀኒት ቤት
 - 1.3. ለወባ በሽታ ተብሎ በቤት ውስጥ የሚሰራ መድሀኒት አለ?
 - 1.4. አንድ ሰው በወባ በሽታ መያዙን ከተጠራጠረ በምን ያህል ጊዜ ወስጥ ወደ ህክምና ቦታ ይመጣል? ለምን ይዘገያሉ?
 - 1.5. የወባ በሽታ ምልክት ሲታይበት በአፋጣኝ ወደህክምና ቦታ የሚመጣው የህብረተሰቡ ክፍል የትኛው ነው? ለምን? (እርጉዞች፤ ህፃናት)
 - 1.6. በእርሶ አመለካከት ሰዎች የወባ መድሀኒት በትክክል ይወሰዳሉ ብለው ያስባሉ? የተሰጣቸውን ጨርሰው ይወስዳሉ? ካልሆነ ለምን?
 - 1.7. በሚሰሩበት የጤና ድርጅት የወባ መድሀኒት አቅርቦቱ ምን ይመስላል?
 - 1.8. አንድ ሰው ለወባ በሽታ ህክምና ለማግኘት አርሶ በሚሰሩበት የጤና ድርጅት ምን ያህል ያወጣል? በእርሶ አመለካከት ውድ ነው ብለው ያስባሉ?
 - 1.9. ወባን ለመከላከል እና ለመቆጣጠር በሚደረገው ሂደት ውስጥ የእርሶን አስተዋፆ እንዴት ያዩታል?
 - 1.10. ህብረተሰቡ በጊዜ ወደህክምና ቦታ እንዲመጣ እና አገልግሎት እንደያገኝ የእርሶ አስተዋፆ ምን ይመስላል?

2. በእርሶ አመለካከት ነፍሰጡር ሴቶች የቅድመ ወሊድም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚሰጠውን የጤና አገልግሎት እንዲገለገሉ ወይም እንዳይገለገሉ ሲያደርጉ የሚችሉ የሚሉትን ነገሮች ቢገልፁልን?
 - 2.1. ለነፍሰጡር ሴቶች የሚደረግ የቅድመ ወሊድ ህክምና ክትትል እርሶ በሚሰሩበት የጤና ድርጅት ውስጥ ይሰጣል? የማይሰጥ ከሆነ ምክንያቱን ቢገልፁልን?
 - 2.2. ነፍሰጡር ሴቶች የህክምና እርዳታ ለማግኘት ወደ ጤና ድርጅት የሚመጡት መቻ ነው?
 - 2.3. በእርሶ አካባቢ የነፍሰጡር ሴቶች የቅድመ ወሊድ ህክምና አገልግሎት የመጠቀም ፍላጎታቸው እና አጠቃቀማቸው ምን ይመስላል? የማይጠቀሙ ከሆነ ለምን?
 - 2.4. እርሶ ከሚሰሩበት የጤና ድርጅት ውጪ የቅድመ ወሊድ ህክምና አገልግሎት የሚሰጥ ሌላ የጤና ድርጅት ካለ ይጥቀሱ? ሌላ የጤና ድርጅት ካለ
 - 2.5. በእርሶ አመለካከት ነፍሰጡር ሴቶች ለቅድመ ወሊድ ህክምና ክትትል የት መሄድ ይመርጣሉ?
 - 2.6. የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚሰጠውን የጤና አገልግሎት እርሶ በሚሰሩበት የጤና ድርጅት ይሰጣል? ከሌለ ለምን? አገልግሎቱን አጠቃቀማቸው ምን ይመስላል? ዝቅተኛ ከሆነ ለምን? ከፍተኛ ከሆነ እንዲጠቀሙ ያደረጉአቸው ነገሮች ምን ነበሩ?

- 2.7. የቅድመ ወሊድም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚሰጠውን የጤና አገልግሎት ለማግኘት የሚደረግ ክፍያ አለ? ምን ያህል?
 - 2.8. ነፍሰጡር ሴቶች የቅድመ ወሊድም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚሰጠውን የጤና አገልግሎት እንዲጠቀሙ በትዳር አጋሮቻቸው በኩል ምን አይነት ድጋፍ ያገኛሉሁ?
 - 2.9. ነፍሰጡር ሴቶች የቅድመ ወሊድም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል የሚሰጠውን የጤና አገልግሎት እንዲገለገሉ ለማድረግ እንደባለሞያ የእርሶ አሰተዋፆ ምን ይመስላል? ከዚህ በፊት የተሰሩ ስረዎችን ቢገልፁልኝ?
 - 2.10. ወደፊት በይበልጥ ሴቶች እነዚህን አገልግሎቶች እንደጠቀሙ ምን መደረግ አለበት ይላሉ
3. በዚህ አካባቢ ሰለሚሰጠው የቅድመ ወሊድ የህክምና ክትትል ለማድረግም ሆነ የኤች.አይ.ቪ. ቫይረስ ከእናት ወደ ልጅ እንዳይተላለፍ ለመከላከል ሰለሚሰጠው የጤና አገልግሎት የህብረተሰቡ አስተያየት ምን ይመስላል?
- 3.1. ከመኖሪያ ቤታቸው ያለው ርቀት፣ ለአገልግሎት የሚከፈለው ክፍያ መጠን፣ ጤና ጣቢያ /ጤና ኬላ ከደረሱ በኋላ አገልግሎት እስኪያገኙ ድረስ ያለው ቆይታ፣ እና በጠቅላላው ያሳለፉት ሰዓት
 - 3.2. የጤና ባለሞያው አመለካከት፣ አቀራረብ

ANNEX 10: FGD Guide for Community (Oromifa Version)

Akkam jirtu. Maqaan Kiyaa_____jedhama. Finfinnee keessatti dhaabbata ‘Addis Koontineental’ egumsa fayyaa hawaasummaa irratti hojjatu keessa hojjadha. As kan dhufeefis dhaabbanni kun, dhaabbatu guddina barnootaa (A.E.D.) majjiin ta’udhaan qo’annoo adeemsisuuf odeeffannoo funaanuufi. Qo’annoon kan adeemsifamu tamsa’inna busee ittisuu fi too’achuu irratti hubannoo hawaasni keenya qabu beekuu fi dhukkuba busee ofirraa ittisuu irratti gaheen hawaasaa maal akka fakkaatu hubachuufi. Bu’aan (firiin) qo’annoo kanaas ittisaa fi to’annaa dhukkuba busee sadarkaa biyyoo lessatti geggeefamuuf gahee ol’aanaa taphata jedhame amanama.

Qo’anna kanati kan hirmaattan fedhiidhaani. Yeroo dhimmi addaa nama mudate addaan kutanii bahuun homa jiru. Garuu, hirmaannaan keessan qo’annaa adeemsifamuuf milkaa’ inna ol’annaa akka qabu ibsuun barbada. odeeffannoon isin nuuf kennita kaayyoo qo’annoo asiin olitti ibsameen alatti kan birootiif akka hin olle maqaa dhaabbatichaatiin waadaa isiniif gala, dhimma waa’ee nama tokkoo ifatti ibsuun ragaa hin galmeessinu.

Dhuma irratti odeeffannoo funaanamu kana hunda haala barreeffamaatiin galmeeffachuun waan ulfaatuuf marii amma adeemsifnu teephiidhaan waraabbana. Egaa qo’annoo adeemsifamu kanatti hirmachuuf feedhii qabdan maaliin nuuf ibsitu_____.

Eeyyeen/lakki.

Gala toomaa!

Kutaa 1. Odeeffannoo Waligalaa waa'ee Hirmaattotaa

Hirmataa	Umuri (Waggaa)	Haala Gaa'elaa	Hojii	Sad. Barnootaa	Amantii
P1					
P2					
P3					
P4					
P5					
P6					
P7					
P8					

Gaafilee marii

1. **Yeroo ulfaa , dubartoota ulfaaf gargaarsa fayyaa godhamuuf kan beektan osoo natti himtanii?**
 - 1.1 Dubartiin ulfaa yoom gara mana yaalaa deemuu qabdi jettanii yaaddu?
 - 1.2 Dubartiin ulfaa yeroo meeqa gara mana yaalaa deemtee ilaalamu qabdi?
 - 1.3 Dhuukkubi HIV haadhaairaa gara mucaatti ni darbaa? akkamiin darba?
 - 1.4 Dhukkubni HIV haadhaa gara mucaatti akka hin darbine gochuun ni danda'amaa? akkamiin?
 - 1.5 Dhukkubni HIV haadharraa gara mucaatti akka hin darbine dubartoota ulfaaf wallaansa fayyaa taasifamu beektuu? Osoo naatti ibsitan?
2. **Yeroo ulfaa, dubartoota ulfaa, tajaajila wallaansa fayyaa akkasumas vaayireesiin HIV haadha irraa gara mucaatti akka hindarbine gochuuf gargaarsa fayyaa kennamu irratti ilaalichiifi gochi hawaasaa maal fakkaata?**
 - 2.1 Hawaasni naannoo kanaa wallansaafi hordofiin da'umsaan duraa faayida illaalchafi jadhee yaadaa? akkamiin?
 - 2.2 Naannoo kanatti dubartooni Yero ulfaa mana yaala hordofuun (ANC) faaydaa qabaa? Kan hinhordofne jiruu? Maaliif?
 - 2.3 Naannoo kanatti dubartoonni wallaansa da'umsaan duraa eessatti hordofu? eessatti osoo hordofanii filatu? maaliif?
 - 2.4 Naannoo kanatti dubartoonni wallaansa da'umsaan duraa hordofuu yoom jalqabu? yoom jalqabuu qabu jettanii yaaddu?
 - 2.5 Dubartiin tokko hodoffii wallaansaa fayyaa da'umsaan duraas ta'e vaayireesiin HIV haadha irraa gara mucaatti akka hindarbine gochuuf tajaajilli fayyaa akka argatuuf murtoo ken kennu eenyuu?
 - 2.6 Wallaansa da'umsa duraa ilaalchisee tajaajilamtoota irratti loogiin godhamu jiraa?
 - 2.7 Naannoo kanatti dubartoonni yeroo ulfaa vaayireesiin HIV haadha irraa gara mucaatti akka hindarbine gochuuf tajaajilli fayyaa kennamufiti fayyadamuuf fedha qabu jettanii yaadduu?
3. **Naannoo kanatti tajaajila wallaansa fayyaa da'umsaan duras ta'e akkasumas vaayireesiin HIV haadha irraa gara mucaatti akka hindarbine gochuuf tajaajila fayyaa kennamu irratti ilaalchisee yaadni hawaasa maal fakkata?**
 - 3.1 Mana jireenya isaanii irraa fageenya jiru tajaajilaaf kan kaffalamu, kellaa fayyaa/buufataa fayaa erga ga'anii booda tajaajila amma argatanitti ammam turu, akkasumas akka waliigalattiyeeroo itti fudhate
 - 3.2 Ilaalicha ogeessa fayyaaf haala namatti dhiyeenya isaa ilaalchisee?
4. **Naannoo kanatti dubartoon yeroo da'umsaa eessa demu filatu?**

- 4.1 Kellaa fayyaa /buufataa fayaa mootummaa, kilinika dhuunfaa, mana isaanii?
- 4.2 Dubartoonni manatti da'uu maaliif filatu?
- 4.3 Manatti da'uuummiidha ni qaba jettanii yaaddu? maaliif?
- 4.4 Dubartoonni gargaarsa fayyaa bakka argatanitti akka da'an gochuufi yookiin jajjabeessuuf maaltu godhamuu qaba jettanii yaaddu?

ANNEX 11: In-depth Interview Guide for community (Oromifa Version)

Akkam jirtu. Maqaan Kiyaa_____jedhama. Finfinnee keessatti dhaabbata ‘Addis Koontineental’ egumsa fayyaa hawaasummaa irratti hojjatu keessa hojjadha. As kan dhufeefis dhaabbanni kun, dhaabbatu guddina barnootaa (A.E.D.) majjiin ta’udhaan qo’annoo adeemsisuuf odeeffannoo funaanuufi. Qo’annoon kan adeemsifamu tamsa’inna busee ittisuu fi too’achuu irratti hubannoo hawaasni keenya qabu beekuu fi dhukkuba busee ofirraa ittisuu irratti gaheen hawaasaa maal akka fakkaatu hubachuufi. Bu’aan (firiin) qo’annoo kanaas ittisaa fi to’annaa dhukkuba busee sadarkaa biyyoo lessatti geggeefamuuf gahee ol’aanaa taphata jedhame amanama.

Qo’anna kanati kan hirmaattan fedhiidhaani. Yeroo dhimmi addaa nama mudate addaan kutanii bahuun homa jiru. Garuu, hirmaannaan keessan qo’annaa adeemsifamuuf milkaa’ inna ol’annaa akka qabu ibsuun barbada. odeeffannoon isin nuuf kennita kaayyoo qo’annoo asiin olitti ibsameen alatti kan birootiif akka hin olle maqaa dhaabbatichaatiin waadaa isiniif gala, dhimma waa’ee nama tokkoo ifatti ibsuun ragaa hin galmeessinu.

Dhuma irratti odeeffannoo funaanamu kana hunda haala barreeffamaatiin galmeeffachuun waan ulfaatuuf marii amma adeemsifnu teephiidhaan waraabbana. Egaa qo’annoo adeemsifamu kanatti hirmachuuf feedhii qabdan maaliin nuuf ibsitu_____.

Eeyyeen/lakki.

Gala toomaa!

Oddeeffannoo waligalaa Hirmaattotaa

T.L	Odeeffannoo ijoo	
1	Umrii hirmaattotaa	
2	saala	Dhi - 1 Dub - 2
3	Haala gaa'ilaa	Kan hinfune/tanhin heerumne 1 Kan fuudhe/tan heerumte 2 Kan haatimanaairraa dute/ tan abbaan manaa irraa du'e 3 Kan addaa jiratan 4 Kan hiike/hiikte 5
4	Sadarkaa barnootaa	Waggaa barnootaa kan xumurame)____ Gonkumaa mana barnoota kan hin galin 88
5	Amantaa	Ortoodoksii 1 Muslima 2 Proteestaantii 3 Kaatolikii 4 Kan bira _____
6	Hojii	_____
7	Daa'imma waggaa shanii gadii meeqa qabdu?	_____
8	Umriin daa'ima keessanii isa quxusuu ykn ishee quxusuu meeqa?	_____Ji'a, guyyaa
9	Buufata fayyaa irraa hangam fagaatanii jiraatu?	Fageerya deemsaatiin _____ Sa'atiin____ dagiiqaan____ Meeqa isinitti fudhata

Kayyoo; waa'ee beeknmsaafi hnbnoo ummata busaa akkamitti akka dhufu

Q1. Waa'ee sababa ka'umsa busee fi haala ifti daddabritu maal beektuu ?

- A. Waa'ee busee dhageessanii beektuu/ taa?
- B. Namni akkamitti buseen qabamaa?
- C. Dhukkuba busee maaltu fidaa? Dhukkubni busee kun hawaasa naannoo kanaa keessa jira?
- D. Mallatooleen dhukkuba buusee maal maal fa'a? Namni tokko dhukkuba kannan qabamuu isaa maaliin beektuu?
- E. Namoota akkamittu irra caalaa dhukka busee kanaan qabamaa? Hawaasa naannawaa keessatti garee kamtuu irra caalaaa dhukkubaan hubamaa? namoota kamtuu dhukkuba buseetti baay'ee saaxilama? (probe pregnant women, children)
- F. Dhukkubni busee kun haala akkamiitiin hawaasa naannoo kessatti tamsa'aa?

Objective-2. Identify behavioral determinants and perception of community responding malaria prevention practice.

Q1. Dhukkuba busee of iraa ittisuuf tarkaanfii maal fudhattuu / ttaa?

- A. Dhukkubni busee naannoo keessanitti rakkoo guddaa akka ta'e ni yaadduu / ddaa?
- B. Maaltu isin dhiphisa waa'ee dhukkuba busee innaa yaaddan / yaaddu?
- C. Namni dhukkuba kannan qabamee of iraa ittisuu danda'aa? Mee maaliin ofirraa ittisuun danada'amaa? Tarreessaa?
- D. Akka dhukkubni busee isin / si hin qabnee ofiin maal hojjechaa jirtu?
- E. Waa'ee Agoobarii maal beektuu / taa?
Faayida agoobarii _____
Miidhaa _____
- F. Waa'ee (IRS) DDT spray maal beektuu / taa?

Faayiddaa _____

Miidhaa _____

- G. Dhukkuba busee qorichaan ni fayanii?
- H. Namni Dhukkuba buseen qabamee carraa dhibee kana irra fayyuu attamiin dabaluu danda'aa?
- I. Dhukkuba busee eessatti fayyani?
- J. Kan dhukkuba buseen qabamee carraa dhibee kana irraa fayyuu attamiin dabaluu danda'aa?
- K. Waa'ee yaalii dhukkuba busee godhamuu maal beektuu?

Objective Identify key behavioral barriers for use of ITNs and promotion of net culture

Q1. Gochaaleen agoobara akka itti fayyadamanii fi hin fayyadamne nama dhorkan jiru?

- A. waa'ee agoobaraa dhageessanii beektuu / beektaa?
- B. Mana keesanii agobara qabdu?

Yoo hin qabaanne maaliif?

- C. Maatiin keessan hundinuu agoobaratti fayyadamanii rafuu?
- D. Eenyutu Agoobaratti carraa fayyadamuu manatti maatii keessa argata? maaliif?
- E. Yeroo hundumaa agoobaratti fayyadamtu / fayyadamta?
- F. Agoobara yeroo hundaa itti fufiinsaan fayyadamtu? Yoo hin fayyadamne ta'e maaliif ?
probe for consistent use: Halkan hundaa waggaa gutuu keessa
- G. Agoobara (ITN) essaa argatuu? Bittaaadhaan gatiin isaa meeqa? Gatii Agoobarri
ittin bitamu akkamitti ilaaltu?
- H. Busee agoobaraa qoriichaanni cuuphxuu?
- I. Ittifayyadamiinsa agoobaraa akka ol guddatu yaadni qabdan jiraa?
Warra Agoobaratti fayyadammaa hin jireef akka itti fayyadamaa ergaa maal
dabarsitu?

Q1. Waa'ee ISR maal beektuu ?

Probe:

- A. IRS (DDT) spray dhukkuba busee ittisuuf faadaa qabu akkamitti ilaaltuu ?
- B. IRS (DDT) spray irratti yaadni isin qabdan maali? Probe for effectiveness
- C. Agoobara illalchisee sodaan isin qabdan jiraa?

Q 2. IRS (DDT) mana keessanitti akka afuufamu ni hayyamtu?

Prob:

- A. Yoo hin hayyamin maaliif?
- B. Eenyuu mana keessa DDT afuufaa? Yeroo meeqa?Irra deebi'amee moo?
- C. Manna keessan halluus ta'ee waragaa adda addaa itti maxxansituu? (ji'aan, waggan)
- D. Gahen keessan maali yeroo IRS (DDT) afuufamu?
- E. Namoota birro akka IRS (DDT) mana isaanitti afuufan maal gorsitu?

Q3. Dhiibeen miidhaa geessuu kan IRS (DDT) spray walqabatee akka jiru hubannoo qabduu (qabda)?

A. Eeyyeen yoo ta'e ibsaa (ibis)

Objective:

Identify prioritize appropriate communication channels (media for malaria preventions and control message)

Q1. Yeroo baay'ee odeeffannoo waa'ee dhukkuba busee eessaa argattu (argatta)?

Prob:

- A. Dimshaashumatti odeeffannoo waa'ee fayyaa eessaa argatu (argatta)?
- B. Odeeffannoo kam yeroo baay'ee amantuu (amantaa)?
- C. Odeeffannoo dhukkuba busee ilaalchisee eessaa argatuu (Argattaa)?
- D. Madda odeeffannoo kam irra caalaa feetan? Maaliif? Prove for radio ,TV, Posters, bill
boards, walgahii ummataa.....)
- E. Sagantaa addaa dhukkuba busee ilaalchisee isin fedhiin hordofuu baraaaddan jira?
Tarreessaa (tarreessi)
- F. Odeeffannoo isa kam dhukkuba busee ilaalchisee caalatti amantuu (amantaa)? Maliif?
- G. Yeroo hangam hangamiin odeeffannoo argatuu (argattaa)?

Prob: torbeen, Ji'aan.....

H. Odeeffannoo argachuuf yeroon isiniif (siif yoom) tola?

Prob: guyyaa torbee keessa_____

Yeroo (sa'aatii)_____

I. Tamsasa Raadiyoo yeroo baay'ee caaftan (dhageefattu kami)?

J. Barrulee kan yeroo baay'ee dubbisuu jallattuu (jaalataa)?

K. Odeeffannoo dhukkuba busee ilaalchisee isa kam caalatti dhageeffachuu jaalattuu /jaalattaa?

Objective:

to explain barriers to early treatment seeking behavior and sources of treatment for malaria

1. Wantoonni battaluma dhukkubni busee nama qabetti yaala akka hin barbannee guffuu ta'an fi akka yaalaman godhu maal fa'a?

Probe:

A. Yoo isin (ati ykn maatiin keessan) maatiin kee dhukkuba feedhe haatu'uu dhukkubsate eessa deemtuu (deemtaa)?

B. Fayyaa keessan (kee eegachuuf hangaama eddo tajaajila fayyaa deemtuu deemtaa?

C. Yeroo dhukkubsattan (tte eenyutu tajaajila fayyaa akka argattan deegarsa godha?

D. Akka yaada keessanitti (keetitti dhikkabni busee hangam tokko miidhaa fida?

E. Dhukkubani busee miidhaa hawaasa irraa gahe jettanii (jettee yaadduu) yaaddaa?

F. Yoo daa'imni keessan (kee dhukkuba buseen qabame attamitti beektu (beekta)?

G. Daa'imni oo'a (qaxaxxee) qabaaachuu isa/ ishee maaliin beektu (beekta)?

H. Maatii keessa namni tokkoo yoo dhukkuba buseen qabamee wanti isin jalqaba gootan (gootu maali)?

I. Jalqabuma yoo dhukkuba busee shakkitan (shakkite eessa deemtu)deemta? Maaliif?

J. Dhukkuba busaan nama qabame yaaluuf battalumatti yaalii isin manatti gootan jira? Yaalii manaa tti godhamu kun maal fa'a?

K. Yeroo dhukkuba kana shakkitan (shakkite jalqaba eessa deemtu) deenta?

L. Dhukkuba busaan qabamtee yoom mana yaalaa deemtu / demta?

Probe:

- Ofumma eegun of yaaluu, eega isinitti (cime)?
- Eega gorichaa aadaa fudhatanii?
- Maaliif yaalamuu irratti turtan (turte)?

M . Yeroon mana yaalaa deemtanii (deemtee) wanti hin yaalamneef sababni addaa jiraa ?

Probe:

- Kafaltii qorichaa
- Fedhii
- Ilaalcha ogeessa fayyaa irraa qabdan
- Tajaaiilli Fayyaa laafaa waan ta'eef
- Dabareen yeroo dheera waan fudhatuuf

N. Qoricha dhukkuba busaa namoonni naannoo keessanii/ eessaa argatu?

O. Yaalamuuf (tajaajila fayyaa) argachuuf yeroo baay'ee dubariin kophaa isaanii deemuu?

Objective: Identify community perceptions regarding population group at risk(malaria during pregnancy)

Q1. Hawaasa keessa irra caalaa eeynuttu yeroo baay'ee dhukkuba buseen qabamaa?

Probe:

- A. Eeynuun fa'a? Eeynuu fa'a akka dhukkuba kanatti saaxilamaan nuuf tarreessaa/tarreessi?
- B. Isaannan kuneen maaliif dhukkuba busaatti saaxilamu?

Objective! Understand community perception about the linkages of malaria with HIV/AIDS

Q1. Dhukkubni busee fi HIV/AIDS walitti dhufeenya qabuu jettanii/jettee yaadduu/yaaddaa? Probe!

- A. Eeyyeen yoo ta'e haala walitti dhufeenya nuuf ibsaa/ ibis?
- B. Namooni HIV/eedisiin qabaman dhukkuba buseetti ni saaxilamuu jettanii/jettee yaadduu/yaaddaa?

Amma egale gaafiia isin gaffdhuu tajajelaa duhartoota ulfaaf gootahin nidha

<p>Kayyaa: Gufuuwaan tajajilaa malootaa Ittissa Dadarbiinsaa Hadharaa gara Ilmootti (MIDHGI) fi egannoo Dhalootan Dura Tasiifamuu (EDDT) ilalchisee jiruu baruuf.</p>
<p>Gaf 1. Wa'ee MIDHGI fi EDDT waan beektuu qabdaa?</p> <ul style="list-style-type: none"> A. Akka Yadaa keetii, dubartiin ulfii yoomii kan EDDT in ishee barba chiisue? Yeroo meqaaf? B. Dhukubni HIV hadha irraa ilmoti darbaa? Yoo eyyee jette akamiin? Ittifamuu danda'a akkamiti? C. Tajajilaa dubartii ulfaaf kenamuu kan akka MIDHGI fayaa duu beekta?
<p>Gaf 2. Ilalchaa nanoo kee wa'ee iffifayadamaa MIDHGI fi EDDT ilalchisee qabuu himii?</p> <ul style="list-style-type: none"> A. Ummani nanno ketii EDDTin fayidaa qabeesaa jedhee yadaa? Akkamiti fi malfaaf fayadaa jetta? B. Nannoo keeti dubartoonii ulfaa EDDTin fayadamu? Mitti yoota'e maliif? Maaltuu akka fayaadamaniif issaan kakasuu danda'a? C. Nanno keettii dubarttonii tajajilla EDDT esaa argatuu? Dhunfaa, mottumaa, dhabata miti-motumaa, kanbiraa) ? yoo filatuu ta'e maliif filatuu? D. Dubartin ulfaa nanoo kee jirtuu tokko isuum kan isheen kilinikaa EDDT deemtuu? Tajajilaa isaa jalqabaatif yeroon siriin yoom sitti fakkata? E. Akka dubartoonii ulfaa tajajilaa EDDT fi MIDHET akka fudhatuu enyuu murteesaa? F. Qoqabaau tajajilaa MIDHI fi EDDT argachuu ilaalchisee Yoo jiraatee Ibsii G. Akka yaadaa keetti dubarttonii ulfii MIDHGI fudhachaaf feedhii qabuu?
<p>Gaf 3. Waa'ee tajajilaa MIDHGI fi EDDT naannoo keettii kenanaa jiruu ilalchiisee yaadaa mataa Keetii naafkennuu dandeesaa?</p> <ul style="list-style-type: none"> A. Dabareen, yerroo fi fageenyaa ilaalchisuu B. Yerro ittifudhauu, tajajilaa guutuu argachuuf C. Ilalchaa fi hicitii hojeetooni fayaa qaban ilalchiisee
<p>Gaf 4. Dubarttonii ulfii Dawuudhaaf/dhaluudhaaf essaa filatu?</p> <ul style="list-style-type: none"> A. Mana yalaa motummaa, Dhunfaa, Miti-Motummaa, mana offiisanii B. Yoo manati dahan, maalif? Manati dawun siriidha? Maalif? Miti yoo jete maaliif?

C. Dubartiin akka mana yalatti deesuuf maaltuu leakassoo?

ANNEX 12: FGD Guide for Pregnant women (Oromifa Version)

Akkam jirtu. Maqaan Kiyaa_____jedhama. Finfinnee keessatti dhaabbata ‘Addis Koontineental’ egumsa fayyaa hawaasummaa irratti hojjatu keessa hojjadha. As kan dhufeefis dhaabbanni kun, dhaabbatu guddina barnootaa (A.E.D.) majjiin ta’udhaan qo’annoo adeemsisuuf odeeffannoo funaanuufi. Qo’annoon kan adeemsifamu tamsa’inna busee ittisuu fi too’achuu irratti hubannoo hawaasni keenya qabu beekuu fi dhukkuba busee ofirraa ittisuu irratti gaheen hawaasaa maal akka fakkaatu hubachuufi. Bu’aan (firiin) qo’annoo kanaas ittisaa fi to’annaa dhukkuba busee sadarkaa biyyoo lessatti geggeefamuuf gahee ol’aanaa taphata jedhame amanama.

Qo’anna kanati kan hirmaattan fedhiidhaani. Yeroo dhimmi addaa nama mudate addaan kutanii bahuun homa jiru. Garuu, hirmaannaan keessan qo’annaa adeemsifamuuf milkaa’ inna ol’annaa akka qabu ibsuun barbada. odeeffannoon isin nuuf kennita kaayyoo qo’annoo asiin olitti ibsameen alatti kan birootiif akka hin olle maqaa dhaabbatichaatiin waadaa isiniif gala, dhimma waa’ee nama tokkoo ifatti ibsuun ragaa hin galmeessinu.

Dhuma irratti odeeffannoo funaanamu kana hunda haala barreeffamaatiin galmeeffachuun waan ulfaatuuf marii amma adeemsifnu teephiidhaan waraabana. Egaa qo’annoo adeemsifamu kanatti hirmachuuf feedhii qabdan maaliin nuuf ibsitu_____.

Eeyyeen/lakki.

Gala toomaa!

Odeffannoo waligalaa hirmaatootaf

Hirmaattota	Umuuri (waggaa)	Halaa fudhaaf heruumaa	Hojjii	Sadarka barnotaa	Amantaa
H1					
H2					
H3					
H4					
H5					
H6					
H7					
H8					

Kutaa III Qajeelcha hirmattota mariattotaaf

Lakk	Kayyoo/Gaffiilee
	Kayyo: sababa fi haalaa dadarbinsaa dhukuba busaa ilalchiisee beekumsa, ilachaa fi barmatilee ummaani qabu adda basuuf.
	<p>Gaf: 1 Dhukubaa busaa ilalchiisee ummani maal beekaa?</p> <p>A. Sababni dhukuba buusaa maali?</p> <p>B. Akkamitti dhukubni buusaa namaa qaba? Akkamitti namanamaatii darbaa? karaan biraa itti dadarbuu yoo jiratees.</p> <p>C. Enyuu bayinaan kan dhibee bussaaatiif saxilamu? gaffii daimaniif dubhartoota ulfaa.</p> <p>D. Naannoo keetti umannii dhibee busaa akka rakkina cimatti fudhatuu? Yoo eyyee jettee hagaam fi maaliif cimaa dha? Yoo miti jettee maaliif?</p> <p>E. Maqaan nanoo keetti dhukubni busaa ittin beekammu mayiini?</p>
	Kayyoo: Goochoota dhibee buusaa ittisuu ilalchiisee amalaa fi ilachaa ummannii nanoo qabuu addabaasuuf
	<p>Gaf. 1. Malootaa garagaraa ummanni naannoo kanaa dhibee busaa ofiraa ittisuf fayadamu himaa?</p> <p>A. Agobara / DiiDiitii fayadamun</p> <p>B. Malootaa adaa garagaraa fayadamun</p> <p>C. Wal’ansa dafaani fudhachuun</p>
	<p>Gaf. 2 Itti fayadaminsaa agoobaraa kan ciimsuus ta’e kan lafiisuu, nanoo kee jiraa?</p> <p>A. Barmatilee garagaraa kan ittifayaadaminsa agoobaraa dhorkan jiruu ? kan ittifayaadaminsaa isaa cimsaa noo? maalfa’i?</p> <p>B. Ittifayaadaminsaa agoobaraa cimsuuf ummanni nanoo maal gochuu danda’a?</p> <p>C. Namni agoobaraa baka cisiichaa isaatti hin toolfanee dhukuuba buusaatin nimidhama jettee yaaddaa? Maliif? Miti yoo jettee woomaaliif?</p> <p>D. Bay inaan ummani akkamitti agobara fayadamu karooca maaliif, gochoota kammiyuu kan ittifayadannaa agobaraa caala fayadamu yoo jiratee.</p> <p>E. Ummani nanoo kanaa agoobaraa akkamiiti fayadama? Biraandii/gosaa agoobaraa isaa kam filataa? Maaliif? (bocaa fi bifa)</p>
	Gaf. 3. Barmatilee Ittifayaadaminsaa fi ilaalchaa ummanni Diidiitii ilalchiisee qabuu akkamitti ilalta?
	<p>A. Ummani itti fayadamuu Diiditti akkamitti ilalaa? Barmatilee itti fayadaminsaa Diidiitii dhorkuu jiraa? Akka fudhatamaa argatuwoo kan tasiisuu?</p> <p>B. Keenyaan kessa mana ketti Diiditiin bifameeraa? Enyuun? Yeeroo ammamammamitin bifama?</p> <p>C. Namoonii manni isaanii akka hin bifamun hin barbadnee jiruu? Yoo eyyee jettee maaliif?</p> <p>D. Erga keenyaan keessaa mana isaanii Diiditfin bookee busaa bifaanii boodaa, namoonii laastiikii (qoolaan) uffisuu? Eyyee yoo jette maaliif? Akkas gochuin sirriidha jeta? Rakkin kana rawachuu woomaaliif?</p>

	E. Miidhaa Diiditiiti fayaadamuun dhufuu woo dhogeesee beektaa? Gamaa midhaa isaa.
	Gaf. 4. Waantoonii dhibein busaa? A. Mallatton daimni dhiibee buusaan qabomtee agarsiistuu maaliini? Dabaaluu boinsaa qamon akkamii unnanni beekoo B. Ummani akkammin dhibee buusaa irra fayaa? Gosoota wal'ansaa tareesii, Mallootaa osoomana yalaa hin dhaqiin dura ittin of yaalaan, filanoon biras yoo jiratee? C. Yeroo haangamitti daimmii dhukuba busaa irraa shakanitee mana yalaatti fudhatami? (attataman, satii 24 kessatti, akka maalee yoo dhukubee)? Egaa dhukubaa buesaa qabamuu saanii shakaaniin boodaa namoonii maaliif mana yalaa dadafiin hin deemnee? D. Nanaa kanaatti sababnii hmanii akka mana yalaa hin dhaqnee godhuu jiraa? (baasii filanno, ilalchaa hojjetootaa fayyaam hirinaa tajajiilaa fayaa, yeeroo itti egaan E. Qurichaa dhukuba buesaa ummoni essaa argata? Akkammitti itti fayaadamuu?
	Kayyoo: Dhukuubaa Busaa ittissuu fi to' achuuf ,odouaa wal-qunamtii hawassa adda baasun irratti xiyeefachuu.
	Gaf 1. Ummanii odeefanoo wa'ee dhukubaa busaa essaa argata? A. Bu'uroota odeefannoo wa'ee dhukuba busaa tarelsilo? Midyaa goragora, Radiyoo, TV, Poosterii, Bill Boordii, agarsiisaa daniirraa, waalgaii ummataa, KK.F, buraa filatoomaa, maalif? Bu'uroa amanamoo, maadiif? Odeefanoo kama enyuulataa? (hojjetoota fayaa , kanbiraa) B. Sagantaa odeefanoon irratti kenamuuf filatamuu jiraa? Guyaa fi yeroo sirriin odeefanoon waa'ee dhukubaa busaaitti kenamuu?
	Kayyo: Ilalchaa ummannii walitti dhufenyaa dhibee buusaa fi HIV/AIDSn qaban hubachuuf
	Gaf.1. Ummani walitti dhufenyaa dhiibee busaa fi HIV/AIDS akkamitti hubata? A. Walqunamtiin dhibeen buusaa fi HIV/AIDSn qaban jira? Maalini walitti dufeenyii isanii? B. Namnii HIVn qabamee tookoo dhukubaa busaaf saxilamaa?

Amma egale gaafiia isin gaffdhuu tajajilaa duhartoota ulfaaf gootahin nidha

No 1	Kayyao: Gufuuwaan tajajilaa malootaa Ittissa Dadarbiinsaa Hadharaa gara Ilmootti (MIDHGI) fi egannoo Dhalootan Dura Tasiifamuu (EDDT) ilalchisee jiruu baruuf.
	<p>Gaf 1. Wa'ee MIDHGI fi EDDT waan beektuu qabdaa?</p> <p>D. Akka Yadaa keetitii, dubartiin ulfii yoomii kan EDDT in ishee barba chiisue? Yeroo meqaaf?</p> <p>E. Dhukubni HIV hadha irraa ilmoti darbaa? Yoo eyyee jette akamiin? Ittifamuu danda'a akkamiti?</p> <p>F. Tajajilaa dubartii ulfaaf kenamuu kan akka MIDHGI fayaaduu beekta?</p>
	<p>Gaf 2. Ilalchaa nanon kee wa'ee iffifayadamaa MIDHGI fi EDDT ilalchisee qabuu himii?</p> <p>H. Ummani nanno ketii EDDTin fayidaa qabeesaa jedhee yadaa? Akkamiti fi malfaaf fayadaa jetta?</p> <p>I. Nannoo keeti dubartoonii ulfaa EDDTin fayadamu? Mitti yoota'e maliif? Maaltuu akka fayadamaniif issaan kakasuu danda'a?</p> <p>J. Nanno keettii dubarttonii tajajilla EDDT esaa argatuu? Dhunfaa, mottumaa, dhabata miti-motumaa, kanbiraa) ? yoo filatuu ta'e maliif filatuu?</p> <p>K. Dubartin ulfaa nanoo kee jirtuu tokko isuum kan isheen kilinikaa EDDT deemtuu? Tajajilaa isaa jalqabaatif yeroon siriin yoom sitti fakkata?</p> <p>L. Akka dubartoonii ulfaa tajajilaa EDDT fi MIDHET akka fudhatuu enyuu murteesaa?</p> <p>M. Qoqabaau tajajilaa MIDHI fi EDDT argachuu ilaalchisee Yoo jiraatee Ibsii</p> <p>N. Akka yaadaa keetti dubarttonii ulfii MIDHGI fudhachaaf feedhii qabuu?</p>
	<p>Gaf 3. Waa'ee tajajilaa MIDHGI fi EDDT naannoo keettii kenanaa jiruu ilalchiisee yaadaa mataa</p> <p>Keetii naafkennuu dandeesaa?</p> <p>D. Dabareen, yerroo fi fageenyaa ilaalchisuu</p> <p>E. Yerro ittifudhauu, tajajilaa guutuu argachuuf</p> <p>F. Ilalchaa fi hicitii hojeetooni fayaa qaban ilalchiisee</p>
	<p>Gaf 4. Dubarttonii ulfii Dawuudhaaf/dhaluudhaaf essaa filatu?</p> <p>D. Mana yalaa motummaa, Dhunfaa, Miti-Motummaa, mana offiisanii</p> <p>E. Yoo manati dahan, maalif? Manati dawun siriidha? Maalif? Miti yoo jete maaliif?</p> <p>F. Dubartiin akka mana yalatti deesuuf maaltuu leakassoo?</p>