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**Results of the Community Demand Study
for the Essential Services for Health
in Ethiopia Project (ESHE)**

*BASICS is a USAID-Financed Project Administered by
The Partnership for Child Health Care, Inc.*

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**Analysis of Data from the
Community Demand Study
For the Essential Services
for Health in Ethiopia (ESHE) Project**

Final Report

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LIST OF ACRONYMS

ARI	Acute respiratory infections
BASICS	Basic Support for Institutionalizing Child Survival, a USAID-financed project
CHA	Community health agent
EPI	Expanded program of immunization
ESHE	Essential Services for Health in Ethiopia
HC	Health center
HIV	Human Immunodeficiency Virus
HS	Health station
KAT	Kambata, Alaba and Tembarro zone
MCH	Maternal and child health
NGO	Non-governmental organization
ORS	Oral rehydration solution
PA	Peasant Association
SEPR	Southern Ethiopian People's Region
STD	Sexually transmitted disease
TB	Tuberculosis
TBA	Traditional birth assistant
USAID	United States Agency for International Development
WVI	World Vision International

EXECUTIVE SUMMARY AND IMPLICATIONS FOR THE ESHE PROJECT

Now we sow seeds. We wish to see the seeds germinate, grow, and be harvested. Similarly, we are eager to see the thing that comes from all this discussion.
—Women in Borbosa

We hope that you did not come to our village only to discuss our problems. We expect something to be done in alleviating our water, health, and food shortage problems. —Men in Oge

Introduction

The Essential Services for Health in Ethiopia (ESHE) Project is a bilateral agreement between USAID/Ethiopia and the Government of Ethiopia. The purpose of ESHE is to improve the health status of the population through increased utilization of essential primary and preventive health services such as family planning, peri-natal care, management of the sick child, immunizations, and STD/HIV prevention and control. The ESHE project will be implemented in the Southern Ethiopian People's Region (SEPR).

The design of specific strategies and interventions of the ESHE project must take into account preferences and priorities of local communities in order to be effective and sustainable. For this reason, USAID/Ethiopia and the BASICS project conducted a community demand study to identify important operational issues related to the demand for and perceptions of services, local priorities, and experience with family planning and primary health care activities.

Methodology

The community demand study sought to build local capacity for assessing community demand of health services using appropriate and participatory data collection methods. The methodology was participatory in that local people analyzed their own problems and identified potential solutions with the help of a moderator. The study used a combination of eight qualitative and participatory research methods.

The community demand study was conducted in nine villages in four zones (North Omo, KAT, Hadiya, Sidama) of the Southern Ethiopian People's Region. Two teams of four data collectors each spent four days in each village over five weeks during June and July 1995.

Study Findings

Health as a Priority

Overall, water, health, and food scarcity were the most important problems mentioned (see Table 1). Water was ranked the most important problem in six of 18 ranking exercises. Food was ranked most important in four exercises. Health came between food and water with five groups of people ranking health their most important problem. Only one group (women in Olola) did not mention health among their top six problems. It should be noted that when respondents discussed health, sometimes they talked about their health problems being most important while other times they discussed the need for a health center or hospital in their village.

Zone	Village	Problem Ranked Most Important by Men's Groups	Problem Ranked Most Important by Women's Groups	Priority of Health (1=most important, 6=least important)*
Sidama	Olola	Water	Relief grain	M-2, W->6
	Wessa	Health	Health center	M-1, W-1
Hadiya	Borbosa	Water	Water	M-2, W-2
	Sagada Bekera	Water	Health	M-3, W-1
KAT	Chaffa	Health	Water	M-1, W-3
	Hansawa	Unemployment	Food shortage	M-3, W-2
North Omo	Oge	Oxen, farm tools	Malnutrition	M-4, W-2
	Demeba	Health problems	Water	M-1, W-3
	Boyne	Grain mill	Food shortage	M-4, W-4

*The numbers indicate what priority health was given by men and women. For example, in Olola, men ranked health as their second most important problem while women did not list health among their top six problems.

Perceived Health Problems and Demand for Services

Table 2 shows the illnesses that villagers would most like to be free of. When asked which illness they would like to be free of, men in all villages reported that they would like to be free of either diarrhea or malaria. Women's responses were more varied. They reported that they would like to be free of kidney pain (which they associated with hard work), incomplete miscarriages, malaria, and diarrhea. When women were asked which illness they would like their children to be free of, women in most villages said diarrhea and vomiting. In Wessa, they said measles and in Demeba, women said they would like their children to be free of diphtheria (it is unlikely that this is actually diphtheria, but may refer to respiratory infections in general).

Table 2: Perceived Health Problems of Men, Women and Children: If we could be free of 1 illness?				
Zone	Village	Men's Illnesses	Women's Illnesses	Children's Illnesses
Sidama	Olola	Diarrhea	TB	Tonsillitis
	Wessa	Diarrhea	Incomplete miscarriage	Measles
Hadiya	Borbosa	Dysentery	Kidney pain	Fever
	Sagada Bekera	Diarrhea	Diarrhea	Diarrhea & Vomiting
KAT	Chaffa	Malaria	Malaria	Diarrhea & Vomiting
	Hansawa	Malaria	Yellow fever	Worms
North Omo	Oge	All 6 illnesses	Fever & Headache	Diarrhea & Vomiting
	Demeba	Malaria	Diarrhea & Vomiting	Diphtheria
	Boyne	Vomiting & diarrhea	Vomiting & diarrhea	Diarrhea & Vomiting

Men were asked about men's illnesses, women were asked about both women's illnesses and children's illnesses.

During focus group discussions, men and women were asked which health services they needed. The most frequently mentioned response was curative services. However, after curative services, people mentioned immunization, health education, and family planning as important services. Five of the nine men's groups mentioned family planning despite anecdotal evidence that men are opposed to family planning. However, one respondent said that they want family planning, but not oral contraceptives since women become sick from the pills.

Care-Seeking Behavior

When ranking health care providers, men and women were asked which provider they would want if they could have only one provider. As Table 3 shows, traditional healers, TBAs, or CHAs were not mentioned by any of the respondents as the one provider they would prefer. Both health centers and health stations were mentioned as the one provider they would prefer to have in 13 of the 18 groups. In five (three women's groups and two men's groups) of the 18 groups held, respondents listed a drug vendor as the one provider they would prefer. In only three of the sites did men and women agree on which provider they would prefer. In the other six sites, women preferred one provider while men preferred another.

Table 3: Ranking Health Care Providers: If you could have only one provider?			
Zone	Village	Men's Group	Women's Group
Sidama	Olola*	Govt. HS	Drug vendor
	Wessa	Bushulo HC	Bushulo HC
Hadiya	Borbosa	Hossana Hospital	Drug vendor
	Sagada Bekera*	Hossana Hospital	Govt. HS
KAT	Chaffa	Drug vendor	Govt. HS
	Hansawa	Mission HS	Mission HS
North Omo	Oge	Sodo Hospital	Drug vendor
	Demeba	Drug vendor	Sodo HC
	Boyne*	Govt. HS	Govt. HS

*The government health station is inside the village.

During focus group discussions, men and women were asked to specify the criteria by which CHAs should be selected. The results are shown in Table 4. The most important criterion was that CHAs should be selected by the community with 12 of the 18 groups mentioning this. Respondents also said that CHAs should be committed to serving the community, have no addictions to alcohol or *chat* (an herbal stimulant), and have some education (though respondents differed on what level of education). Some health knowledge and experience was also mentioned as important. Some respondents said that CHAs should be married, but not have a large family. Only one women's group said the CHA should be a woman and they emphasized that with a woman they would be able to discuss their problems freely. When asked if they would be willing to contribute in cash or in-kind for the CHAs, eight out of nine women's groups said that they would be willing to contribute, but only four of nine men's groups were willing to contribute.

Selection Criteria	Men's Groups (n=9)	Women's Groups (n=9)	Total (n=18)
Selected by the community	6	6	12
Committed to serve community	4	5	9
No addictions	4	4	8
Above 12th grade	4	3	7
Can read and write	2	4	6
Basic education	2	3	5
Some health knowledge and experience	2	3	5
Must be trusted	2	1	3
Respect and love villagers	2	1	3
Have patience		2	2
Must have free time		2	2
Must be respected	2		2
Must be healthy		2	2
Should be married	2		2
Not have large family		1	1
Male	1		1
Female		1	1

Willingness and Ability to Pay for Health Services

While preventive services were usually provided free of charge, respondents reported paying large sums for curative services. The average cost of medicine alone ranged from 13 Birr to 745 Birr. Transportation costs were often significant, reaching 70 to 80 Birr in some cases.

Across the nine villages, the percentage of people who reported borrowing money for health care ranged from 18 percent to 65 percent and the amount borrowed ranged from 3 to 1000 Birr. In focus group discussions, participants from all sites reported paying for health services by selling grain, milk cows, ploughing oxen, and pawning land, oxen, and cows. They said that providers rarely accept in-kind payments or extend credit. When people do not have anything to pawn, they sometimes can get a certificate from the Peasant Association (PA) which entitles them to receive free treatment. However some respondents reported that the providers either do not accept the certificate or that they force patients to wait a long time to receive treatment.

Community-Based Health Care Providers

As a CHA, my primary responsibility is to give health education about child spacing, how to clean water, and environmental sanitation. This is not the same

*as other providers. It differs because I am not paid and other providers are paid.
- I give health education and preventive services when other providers cure patients
using drugs and injections. —A CHA in Boyne (trained by World Vision)*

Only one of the nine study villages had an active CHA, six villages had inactive CHAs. The CHAs saw their role as primarily providing preventive services including health education and promoting environmental sanitation. However, both CHAs and TBAs reported the need for additional training and better supplies of medicine and equipment. CHAs also reported that they needed better supervision from health center and health station staff.

None of the CHAs or TBAs had experienced any financing mechanisms other than fee-for-service, and none had worked closely with health committees or other community groups.

Recommendations

Revise the CHA Selection Process and Criteria

Currently the only criterion for the selection of CHAs is that the person be able to read and write. Local communities have recommended a number of additional criteria, including that the CHA should not be addicted to anything. The results from this study show that local communities think it is essential that they be involved in selecting the CHAs who should be from their own villages. Most respondents said that they would not be willing to contribute in cash or in-kind unless they selected the CHA and the CHA came from their own village. Respondents also said that the CHAs should be held accountable to the Peasant Association and should be supervised by the health centers and stations. Unless local communities are involved in the selection and supervision of CHAs, the project runs the risk that CHAs will be under-utilized and unsustainable over time. The Ministry of Health needs to review the roles of CHAs and provide clear guidelines, including the distribution of contraceptives, tuberculosis drugs, and the policy on giving injections. There should also be written job descriptions for CHAs and policy on incentives. Training needs to be strengthened for both CHAs and TBAs.

Work with Traditional Community Groups

Although only one of the villages had a health committee, traditional groups that provide assistance during a death or serious illness exist in all villages. Often these groups involve households contributing money on a regular basis. The ESHE project should explore opportunities to link CHAs with these traditional groups. This could involve a financial mechanism where part of the funds are used to support the CHA or provide money to transport seriously ill people based on the CHA's referral. These traditional groups could also be trained to supervise and support CHAs to promote better health.

Integrate Programs Whenever Possible

Although health is a high priority in all the villages studied, it is not always the top priority. Food and water are sometimes considered more important problems and are often viewed as a root cause of ill-health. Health programs are likely to be better received and have greater impact when integrated with nutritional and environmental interventions.

Consider Potential Roles of Drug Vendors

In all of the study villages, drug vendors were a very important source of health care. Even when government health stations were nearby, drug vendors were often preferred as a source of health care. Hence, drug vendors should not be ignored although they are not part of the formal health care system. The ESHE project should explore opportunities to involve drug vendors, possibly by training them to refer serious cases, using them to supply drugs to CHAs, or teaching them safer, more affordable and effective ways to manage child illness.

Recognize Importance of Medicines and Curative Care

When asked what services they want, respondents mentioned curative services most frequently. Like nearly every community in the world, curative services and medicines are perceived to be more important than preventive services. CHAs who provide curative services and some medicine are likely to have higher utilization, as well as higher status in the communities than if they were to provide only preventive services. Respondents perceive equipment and medicine to be an indicator of the quality of care they are receiving. Again, there is a need for clear guidelines from the Ministry of Health on the roles and responsibilities of CHAs.

Recognize Seasonal Patterns

With the exception of Hadiya Zone, the lack of food, most illness, most work, and least access to health facilities tended to coincide during a few months, though not always during the rainy season. During some months, access to health facilities is limited not only by impassable roads but also by food scarcity when “men do not have the strength to carry patients to health facilities.” Health planners should find out which months are the most difficult months (it varies somewhat among villages) in order to provide increased outreach or credit services during those times.

Recognize Variation Between and Within Communities

Although all nine villages studied were in the Southern Ethiopian People’s Region, there was considerable variation among them due to the geographic and cultural heterogeneity of the region. Attempts must be made by health planners to understand the differences in perceived problems, seasonal patterns, previous experience with development projects, and available resources in order to plan appropriate health interventions. Similarly within each community, some households are at greater risk of health problems than others. These households are often known in the

community (female-headed households, households with small land plots, etc.) and may be targeted for special attention (though this must be done with caution).

Continue the Dialogue with Local Communities through Rapid Assessment Methods

Local health officials and ESHE project staff should use rapid assessment methods such as those employed in this study. Regular use of these methods will permit decision makers to stay in touch with and learn more about the communities they seek to assist—their preferences, concerns, knowledge, attitudes, and practices. We are outsiders to these communities and special efforts and methods are needed to aid our understanding in a timely manner.

Topics for Further Research

Traditional Beliefs and Practices

This study only touched on some of the traditional practices used to cure health problems. There were cases of uvulectomy, use of hot irons to relieve pain, and use of local herbs. Additional research will be needed to identify the beneficial practices which should be promoted and the harmful practices which should be discouraged for specific health problems such as pneumonia, diarrhea, delivery practices, etc.

Management and Supervision of CHAs

Review of previous experience and operations research on the best ways to manage and supervise CHAs would provide valuable insight into the best role of CHAs and how to improve their utilization and sustainability.

Communication Channels

Before any health communication intervention could be designed, additional information is needed on the sources of information on health. It was beyond the scope of this study to identify the prevalence of radios, availability of newspapers, or potential for the use of the marketplace as an intervention.

Traditional Healers and Drug Vendors

Additional research should be conducted to assess the potential to involve traditional healers and drug vendors in the formal health care systems. Specifically, information on the different types of drug vendors about their experience and motives would assist in making decisions for their potential roles.

INTRODUCTION

Objectives of the Community Demand Study

The Essential Services for Health in Ethiopia (ESHE) Project is a bilateral agreement between USAID/Ethiopia and the Government of Ethiopia. The purpose of ESHE is to improve the health status of the population through increased utilization of essential primary and preventive health services such as family planning, peri-natal care, management of the sick child, immunizations, and STD/HIV prevention and control. The ESHE project will be implemented in the Southern Ethiopian People's Region (SEPR).

The design of specific strategies and interventions of the ESHE project must take into account preferences and priorities of local communities in order to be effective and sustainable. For this reason, USAID/Ethiopia and the BASICS project conducted a community demand study to identify important operational issues related to the demand for and perceptions of services, local priorities and experience with family planning and primary health care activities.

The ESHE project recognizes the importance of setting priorities based on understanding local communities' perceptions of their own needs and demand for services. Need is a variable concept with a variety of meanings including, 'ought to have,' 'must have,' 'would like,' or 'demand.' While there will be areas of agreement between health professionals and the community in their judgment of need, there will also be differences. The goal of the community demand study was to understand the perceived needs of local communities so that the ESHE project could be appropriately implemented.

The objectives of the community demand study were as follows:

1. Understand what priority local communities place on health.
2. Understand the perceived health problems of local communities and households and the demand for health services.
3. Understand the patterns of provider preference and care-seeking behavior.
4. Understand the willingness and ability of people to pay for health services.
5. Understand the potential and existing role of community-based health care providers.

Methodology

The community demand study sought to build local capacity to for assessing community demand for health services using some appropriate and participatory data collection methods. With this in mind, the methodology that is being used does not require expensive resources

such as computers nor does it require advanced knowledge of statistics. The methodology is participatory in that local people analyze their own problems and identify potential solutions with the help of a moderator.

Each of the main objectives listed above was further broken into specific research questions. This final report is organized as answers to these research questions. The research questions were investigated using a combination of eight qualitative and participatory research methods. Appendix C presents a matrix showing which data collection procedures were used to answer which specific research question. Every attempt was made to answer each question using several procedures to ensure the validity of the data. A brief description of each of the methods is presented below and all the data collection instruments are provided in Appendix C.

- **Procedure A: Ranking the Priority of Health**—Separate groups of men and women list their most important problems and then rank them by drawing a diagram.
- **Procedure B: Social Mapping**—Separate groups of men and women draw a picture of their village and show all the places that they go for health care and the distances they must travel. Poor households are also identified.
- **Procedure C: Seasonal Diagraming**—Separate groups of men and women show through diagrams the seasonal variations of work in the fields, work at home, availability of food, times of income, times of expenditure, times of debt, times of illness, access to health facilities, and migration.
- **Procedure D: Ranking Health Problems**—Separate groups of men and women were asked to list all their health problems (men listed men's health problems, women listed women's and children's health problems). They were then asked to rank the six most important health problems according to those which were most common and those which were most severe.
- **Procedure E: Ranking Providers**—Separate groups of men and women were asked to list all the providers that they go to for health care. They then ranked the top six providers according to those which were most frequently visited, most expensive, and provide the best quality service.
- **Procedure F: Provider Interviews**—In each study site, face-to-face interviews were done with four to six health care providers. These included health station staff, traditional healers, and drug vendors.
- **Procedure G: Illness, Death and Delivery Narratives**—In each study site, households which had experienced a death, serious illness, or delivery during the past three months were identified through the social mapping and in discussions with the PA. Face-to-face

interviews were conducted with members of these households to understand the patterns of care-seeking and expenditures for health care.

- Procedure H: Focus Group Discussion—Focus group discussions were held with separate groups of men and women in each village. The topics of the discussion included their previous experience with CHAs, their recommendations for how CHAs should be selected, and their willingness to contribute to support CHAs. In addition, in two villages focus group discussions were held with village elders to discuss how CHAs should be managed and held accountable.

Draft versions of the data collection procedures were developed by the BASICS project based on similar studies in other countries. The data collection procedures were then modified by the local research team based on their experience with the local conditions and cultural context. The health problem ranking, seasonal diagraming, and narratives of illness episodes (Procedures C, D, G) were pilot-tested in a village which was not part of the study sample.

The data were collected by two teams of four people each (five men and three women) who had experience in rural development work and interviewing. The data collection process was coordinated by a BASICS resident advisor. All eight team members were trained in the data collection procedures during one week which included practice sessions and a field visit. The study was conducted in nine villages in four zones in the SEPR over a period of five weeks in June and July 1995. The two data collection teams worked in separate villages (except for the last village) and each team spent four days in each village to complete the data collection.

All the procedures were completed in all the villages. The ranking of priority of health (procedure A), social mapping (procedure B), seasonal diagraming (procedure C), ranking of health problems (procedure D), ranking of providers (procedure E), and focus group discussion (procedure H) were completed by one group of men and one group of women in each village (different people were selected to participate in each of the procedures so that the same group of women or men were not asked to complete several procedures). The number of narratives and provider interviews completed differed among the villages and are shown in Tables 5 and 6.

Zone	Village	Illness				Death				Delivery	Total
		Adult		Children		Adult		Children			
		M	F	M	F	M	F	M	F		
Sidama	Olola	3	4	4	6	3					20
	Wessa	4	5	3	4		1	1	1	1	20
Hadiya	Borbosa	4	1	2	2	1		1		1	12
	Sagada Bekera	1	3	1	2			1		2	10
KAT	Chaffa	5	3	2	6					1	17
	Hansawa	4	3	7	3						17
North Omo	Oge	3	2	6	2				1		14
	Demeba	3	4	5	3				1	1	17
	Boyne	3	3	7	5	3	2		1	2	26
Total		30	27	37	33	7	3	3	4	8	152

Zone	Village	Traditional Healer	Bone Setter	CHA	TBA	Drug Vendor	Health Station	Total
Sidama	Olola	1		1	2	1	1	6
	Wessa		1		1	1		3
Hadiya	Borbosa		1	2	1			4
	Sagada Bekera			1	1	1	1	4
KAT	Chaffa	1		1	2	1		5
	Hansawa	1	1	2			1	5
North Omo	Oge			1	2	1		4
	Demeba		3		1	1	1	6
	Boyne	1		2	1	1	1	6
Total		4	6	10	11	7	5	43

The analysis of the data was completed approximately two weeks after the data collection by the data collection team with assistance from BASICS staff. All the final field notes were written in English. All of the data was reviewed to identify the main themes, important quotations, and variation in responses for each of the specific research questions. A number of dummy tables had been prepared which were completed through hand-tabulation of responses.

Selection of Sites and Respondents

The community demand study was conducted in nine villages in four zones in the Southern Ethiopian People's Region. Two villages were selected in Sidama, KAT, Hadiya Zones, and three villages were selected in the North Omo Zone. In each zone, zonal and woreda authorities were contacted and villages were selected with their assistance. The main objective of the sampling design was to identify the range of beliefs, practices, and experiences with community-based health care delivery in SEPR, and not to select a statistically representative sample generalizable to the whole region.

Every attempt was made to select one village in each zone with an active CHA, but due to the dearth of active CHAs, this was not possible. Instead, villages were selected so that one village in each zone had easier access to a health station and the other village had less access.

The PA was enlisted to help identify and recruit people to participate in the various group sessions and the narratives. In a few villages, people expected that treatment would be provided. When the first participants found no treatment, it became more difficult to recruit others.

In order to ensure that the poorest people in the village were represented in the study, poor households were identified during the social mapping procedure. First, respondents were asked to list criteria by which they know a person or a household is poor and then asked to identify households which met these criteria. Table B1 in Appendix B shows the criteria people use to assess the level of poverty. Overall, the lack of land or cattle was seen as the main sign of poverty. Households without food, clothing, or shelter were also considered poor. In Hansawa and Oge, female-headed households were considered poor.

Profiles of the Study Sites

Table 7 presents the main characteristics of the study villages. Pseudonyms have been used for the village names to protect the confidentiality of respondents. As the table shows, the community demand study covered the Sidama, Hadiya, Kambata, and Walayta ethnic groups. A brief description of each of the villages is given below.

Zone	Village	Approximate Population	Ethnic Groups	Religions	Distance from HS	CHA?
Sidama	Olola	16,000	Sidama Oromo(Guji)	Protestant & Orthodox	Inside village	Inactive
	Wessa	4,800	Sidama	Protestant Catholic	8 km	None
Hadiya	Borbosa	3,000	Hadiya	Protestant	None	Inactive
	Sagada Bekera	10,500	Hadiya Gurage	Protestant Muslims (few)	Inside village	None
KAT	Chaffa	9,000	Kambata	Protestant	4 km	Inactive
	Hansawa	12,000	Kambata	Protestant	8 km	Inactive
North Omo	Oge	5,000	Walayta Amhara (few)	Orthodox Protestant (few)	None	Inactive
	Demeba	5,000	Wolayta	Protestant Catholic	None	Inactive
	Boyne	5,130	Wolayta	Protestant Catholic	Inside village	Active

Olola (Sidama)

Olola village is found in Awassa Zuria Woreda. It is 27 kilometers away from Awassa town. The approximate population of the village is 16,000. There are two main ethnic groups: the Sidama and Oromo, the dominant being Sidama. The major languages spoken in the village are Sidamigna and Oromigna, and Amharic is spoken by the two groups. The main occupations of the villagers are farming and minor trade activities. Some members of the village work in a meat factory. Olola village is a cash crop-growing area where coffee, *chat* (an herbal stimulant), sugar cane, tomato, potato, banana, and various vegetables are grown.

Although a road was under construction at the time of this study, Olola does not have an all-weather road. However, since Olola village is near a meat factory, it has a partial electric light for 24 hours. In addition, there are horse-driven carts that give services inside and outside of the village.

Although there are four modern water wells, none of them were functioning which forced the villagers to use river or unprotected spring water for drinking.

Within the village, there are four grinding mills, a government health station, private drug vendors, TBAs, and traditional healers. In the semi-urbanized part of the village is a market place. There is also an NGO health center (HC) in an adjacent village, which is not far from Olola. It is mostly here

that the Olola villagers go for treatment if referrals are not made to Loke HC, Yirgalem, or Kuyerra hospitals.

There are no formal village groups except the peasant association. The PA seemed cooperative and active in mobilizing the “village groups” for the study.

Wessa (Sidama)

Wessa is located in Sidama Zone in the woreda called Awassa Zuria. The village is situated about eleven kilometers away from Awassa, which is the administrative town of the Southern Ethiopia Region. The village is about 6 kilometers from the main road that passes to other Southern regional towns.

The village has an approximate population of 1500 people. Excluding youths in school, the villagers estimated that 20 percent of the men and about 7 percent of the women were literate. The main occupation of the village is farming and related activities such as trading, black smithing, and tanning.

The majority of the people are from the Sidama ethnic group speaking Sidamigna. There are also traditional groups called *edir* (local language) for helping each other during times of sorrow and happiness, and *debo* or *dea* (a sort of mutual assistance) by which they help each other during preparation of land, farming, weeding, sowing, and construction of their houses. Most villagers are Christian followers of different churches, some are Catholic or Protestant, but none of them are of the Coptic or Muslim faith.

The nearest health station is about 10 kilometers from the village. There is a primary school (grades 1 through 6). Except for the local markets, there are no developed service centers with shops in this area. In Wessa, there is no source of clean water and the only drinking water villagers have access to is from the nearby river.

At first, the chairman of the PA of Wessa was not willing to talk to the team. He explained that a year or two earlier, promises had been made by the Regional Health Bureau to construct a health station in the village, but for some reason the promise was not kept. Meanwhile the villagers had collected a huge amount of gravel and sand for the construction. After some discussion, the PA executive members, that is the local community leaders, were cooperative in calling the required group of people to carry out the daily work activities.

Borbosa (Hadiya)

Borbosa is a village found in Limu Woreda, Hadiya Zone. The approximate population of the village is 9,000 and it is densely populated. The major ethnic group is Hadiya with very few Amhara and Kembatta; Hadiyigna is the language spoken here. The religion of the people, by and large, is Protestant.

The main occupations of the villagers are farming and small trade activities despite the acute shortage of farm land. There is no cash-crop, but wheat, barley, beans, and other cereals are grown. The staple food is *kocho* prepared from a false banana called *enset*. Borbosa village does not have any water sources except polluted river water. It has an elementary school and a grinding mill. In addition, villagers have access to a dry-weather road that runs from Hossanna town to Borbosa.

In the village, there are no private or government clinics. It was only recently that EPI outreach services were started. There are trained CHAs and TBAs—TBAs being active and CHAs being inactive. There are also traditional healers. Because there are no modern health units inside the village, residents are forced to go to Hossana hospital or to other providers in Hossanna.

There are no formal village organizations other than peasant associations. The PA leaders of Borbosa were very cooperative and active in assisting the accomplishment of this study.

Sagada Bekera (Hadiya)

Sagada Bekera is situated in Hadiya Zone about 10 kilometers away from the main zonal town called Hosanna. The village is located under Lemo Woreda. This village is on the main road to Addis Ababa and other towns. It has a population of about 10,500. In this village the people said that they have many literate people. They estimate the literacy in the local language to be about 38 percent for men and 24 percent for women.

The main occupation of this village is farming and a few people are engaged in trading. The peasant association provides local leadership in assisting the people with security and the settlement of disputes. There are also traditional groupings which they call *edir* for marriage and burial ceremonies, and *debo* for mutual assistance. They help each other in farming, sowing, weeding, and in general when they require more labor service.

This village was heterogenous to some extent, with both Hadiya and Guragie ethnic groups. The Guragies are known to be traders and speak both Guragigna and Hadiyigna. The religion of this village is mixed; we found Muslims, Protestants, and Coptic believers. Throughout the village in different locations there are Orthodox churches, mosques, and prayer houses.

There is a health station which was previously established by the Sudan Interior Mission. The campus of the health station is well-situated and is large enough to upgrade into a health center if additional health staff were provided. As compared to the other villages of Sidama, this village has consumer services such as shops and a grinding mill. However, scarcity of water is a crucial problem in this village.

In general, the PA was not very cooperative in this village which may be due to the peri-urban setting. The PA sent out incorrect information for the recruitment and as a result, many poor and ill people came expecting relief and treatment. The team observed that the village seemed more dependent on NGO support as compared to other villages.

Chaffa (KAT)

Chaffa village is found in Kedida Gamella Woreda, Kembatta, Alaba, and Tembarro Zone. It is only five kilometers from Duramie town, the capital of KAT. It has dry-weather roads in two directions that lead to Duramie, but there is no all-weather road leading to the village.

The approximate population is 9,000. The main occupations of the villagers are farming and minor trade activities. Coffee and banana are the cash-crops. The staple food is *kocho*, made from *enset*. There is a junior secondary school, grinding mills, and one non-functional water well in the village. The main religion is Protestant and there are many churches.

Villagers of Chaffa have different sources of health care even though there is no government clinic inside the village. The sources are the Duramie government clinic, a private drug vendor inside the village, TBAs, and traditional healers. Other than these sources, they go to the Wotta Catholic clinic, and the malaria center. Malaria is widespread in the village because of swampy areas near the Belle River.

Hansawa (KAT)

Hansawa is located in KAT Zone in the Kedida Gamella Woreda. It is about eight kilometers away from the main administrative town of the zone called Duramie. The village is on the side of the main road leading to other zonal towns. It has a population of about 12,000, and the population density is high in the villages of this zone. In KAT Zone, the literacy rate is about 42 percent for males and 17 percent for women.

The main occupation of this village is farming, with very few traders. When compared to other villages, water was more scarce in Hansawa. As in other villages of Hadiya and Sidama, this village also has traditional groupings like *edir* and *debo* with similar functions. The health station is about four kilometers away from the village. Sick people mostly go to this health station called Abonsa which was built by the Adventist mission. There are churches of Adventists and Protestants, and the majority of people are Protestant with very few Coptic and Muslims believers.

Hansawa seemed very dependent on relief aid. One agricultural extension worker complained that she had tried for two days unsuccessfully to set up a meeting in the village.

Oge (North Omo)

Oge is a village found in Sodo Zuria Woreda, North Omo Zone. Its population is about 5,000. Oge village is 12 kilometers away from Sodo town. There is a well-constructed dry weather road that crosses the village. Oge is semi-urban, although there is no school or electricity. There is a grinding mill (only for maize), one water well, and a water spring. There is a big market place in the center of the village. On the market day, the villagers complain that theft and robbery are rampant.

The main ethnic group is Wolita, and the language is Wolitigna. There are a few Amhara. The main religion of the village is Coptic, but there are also followers of the Protestant faith.

There are no government or NGO clinics in Oge, however, there are private drug vendors, TBAs, and traditional healers. People in need of health care go to these providers; for higher level care they go to Sodo Ottona hospital, Sodo health center or to different private drug vendors found in Sodo town. Although there is a health post in the village, the CHA is inactive, but the TBAs are active.

Unlike other villages, the expectations of the villagers for relief-aid was very high. There are no formal village organizations except the PA.

Demeba (North Omo)

This village is located in North Omo Zone in the Sido Zuria Woreda. It is situated 20 kilometers away from the administrative town of Sodo. There is a main road which passes to Gofa Woreda. The village has an estimated total population of 5300. The literacy rate, excluding the youths who attend schools, is about 14 percent for men and 6 percent for women.

The main occupation of the people is farming and a few of them are engaged in trading, weaving, black smithing and pottery making. The village groups in this area are the Peasant Association and the traditional working groups locally called *debo* and *edir*. These groups exist in almost all rural villages of the zone. It is through this organized group that the villagers help each other.

Inside this village there is no health station established by the government, but there is a very small private clinic that provides services. Previously they had a piped water supply at the central location of the village, but at present the water pipe motor is not functioning due to unknown reasons. There is a primary school in the village.

The people living in this village are mostly the Wolyita ethnic group, speaking the local language called Wolitigna. Most of the people are Protestant with very few Muslims. The people reported that there is scarcity of land due to the dense population.

Boyne (North Omo)

This village is located in the North Omo Zone in the Sido Zuria Woreda. It is about 20 kilometers away from the administrative town of Sodo. There is a very rough road that leads to the village. The village is typical of remote villages where there are no services such as shops or grain mills.

The approximate population is 5130. The main occupation of the people is farming, very few of them are engaged in black smithing, weaving, and pottery-making. Like many of the other villages, there is a scarcity of water and land.

The groups that exist in this village are the Peasant Association and the traditional ceremonial groups, *edir* and *debo*. In every village you find these groups and all individuals in the village are members of them as a person who is not a member will not get assistance at all so therefore, it is obligatory to be a member. The population is mostly from the Wolayita ethnic group speaking Wolaytigna. Their main religion is Protestant.

World Vision International (WVI) is currently working in Boyne in North Omo to promote rural development through health, education, agriculture, and road construction projects. WVI's health activities include supporting the existing health station by providing medicine and equipment, training health station staff, training of CHAs and TBAs and providing incentives, and establishing health posts. In this village there are trained TBAs and CHAs which are actively assisting the people by teaching about health education. There is a health station in the village that sometimes gets medicine from World Vision International. Generally speaking, the level of cooperation from the village PA members was very high.

HEALTH AS A PRIORITY

1. *How high a priority do local communities place on health compared with other problems they face (especially food and water)?*

A problem is important when it affects our overall progress or development, because it threatens our survival, especially food shortage. When we are hungry we are humiliated, have no dignity and hunger leads us to desperation.

It is important to deal with the oxen problem (cattle disease) and need for farm tools because they are very essential for us as farmers to produce sufficient food.

Shortage of water is our most serious problem. We walk two hours or more to the river. But the water is dirty, especially during rains, which results in amoeba and other diseases. --A respondent from Borbosa

As the quotations above illustrate, villagers see their problems as inter-related. The lack of food threatens not only their physical survival, but also their dignity. Cattle diseases impact on the availability of food, and the lack of clean water causes all sorts of diseases.

Overall, water, health, and food scarcity were the most important problems mentioned, as shown in Table 8. Water was ranked the most important problem in six of eighteen ranking exercises. Food was ranked most important in four exercises. Health came between them with five groups of people ranking health their most important problem. Both men and women in Wessa ranked health as the most important problem. Women in Sagada Bekera and men in Chaffa and Demeba ranked health as the number one problem. Five groups ranked health as the second most important problem, four groups ranked health third, three ranked health fourth, and women in Olola did not even mention health as one of their most important problems. It should be noted however, that when respondents

discussed health, sometimes they talked about their health problems being most important while other times they discussed the need for a health center or hospital in their village.

Respondents in all villages recognized the linkages among all their problems. The lack of clean water and food was closely related to poor health. As elders in Boyne said, "The first and foremost cause of any type of disease is starvation. If one does not get the needed amount of food, one becomes weak and cannot resist even minor illnesses. There is a saying 'yetegebe aytamemim' which means that a person who eats well resists all diseases."

Other respondents in Boyne related their problems to the population density. "High population growth is the cause of many of the problems we face (land shortage, cutting too many trees, etc.)." They also related high population density to unemployment: "Youth unemployment is our most serious problem because youngsters are dependent on their families and create economic crisis in the village (the population is too dense)."

In Borbosa, education was given a high priority. As one woman said

We don't want to see our children facing the suffering we have at present and in the past. This can be solved by educating our children. The need for upgrading our school is very crucial; we lost our chance, but our children should not.

Other important problems included cattle and coffee disease, lack of schools, and the high cost of fertilizer and irrigation.

Table 8: Ranking the Priority of Health (Problems listed in order of importance)			
Zone	Village	Men	Women
Sidama	Olola	Water Upgrade HS to HC Lack of high school Transportation problem Cattle disease Fertilizer and seed	Relief grain Water Electric light Garbage disposal
	Wessa	Health Water School Irrigation Fertilizer Grain mill	Health center Water Fertilizer School Ploughing land Grain mill
Hadiya	Borbosa	Water Health School Road Improved seed and fertilizer Cattle disease	Water Health problem Unemployment Bridge problem Unequal distribution of land
	Sagada Bekera	Water Shortage of food Health Unemployment High school Electricity	Health Water Fertilizer Draft oxen Latrine Grain mill
KAT	Chaffa	Health Unemployment Coffee disease Road and bridge High cost fertilizer Lack of clean water	Water Coffee disease Lack of clinic Drought
	Hansawa	Unemployment Water Health Fertilizer Animal disease Bridge problem	Shortage of food Health Draft oxen Fertilizer Seed Water
North Omo	Oge	Oxen and farm tools Fertilizer and seed Robbery and theft Health Cattle disease Water	Malnutrition Health Lack of clean water Ploughing oxen
	Demeba	Health problem Cattle disease Water Fertilizer Shortage of food School	Water Poverty Health Orphans Unemployment Small bridges
	Boyne	Grain mill Secondary school Shortage of food Health Water Fertilizer	Shortage of food Draft oxen Grain mill Health Plowing of land Water

PERCEIVED HEALTH PROBLEMS AND DEMAND FOR SERVICES

2. *What are the five most important health problems of men, women, and children in the village?*

The results of the ranking of men's, women's, and children's illnesses are presented in Tables 8 through 10. Men were asked to rank men's health problems while women were asked to rank women's and children's health problems. Note that the tables present the data using the approximate English terms, but should be interpreted cautiously as the terms may not correspond to the biomedical definition. For example, when malaria is listed it may refer to fevers more broadly. Appendix A provides the local terms for the listed health problems in the four languages that were used.

When asked which illness they would like to be free of, men in all villages reported that they would like to be free of either diarrhea or malaria. Women's responses were more varied. They reported that they would like to be free of kidney pain (which they associated with hard work), incomplete miscarriages, malaria, and diarrhea. When women were asked which illness they would like their children to be free of, women in most villages said diarrhea and vomiting. In Wessa, they said measles and in Demeba, women said they would like their children to be free of diphtheria.

The children's illnesses most frequently mentioned by women (shown in Table 9) were diarrhea and vomiting, worms, tonsillitis, skin diseases, measles, fever, and eye disease. When asked which illness they would like to be free of, four groups said diarrhea and vomiting and one group each said tonsillitis, measles, fever, worms, and diphtheria. Measles was mentioned in Wessa and Bobosa only. Diphtheria was the most common and severe problem in Demeba, though this term may refer to ARI.

Table 9: Women's Perceptions of Children's Health Problems (frequency problem was mentioned)		
Health Problem	Six most common (n=9)	Six most severe (n=9)
Worms*	7	7
Vomiting and Diarrhea**	6	6
Fever*	4	4
Diarrhea	3	3
Eye disease	3	3
Measles*	3	3
Scabies	3	3
Skin disease	3	3
Tonsillitis*	3	3
Cold	2	2
Typhoid fever*	2	2
Ear aches	2	2
Headache and Fever	2	2
Malaria	2	2

* Mentioned by one group as the illness they would like to be free of.

**Mentioned by four groups as the illness they would like to be free of.

Other children's health problems that were mentioned by one group only include anemia, coughing, ear infections, kwashiorkor, malnutrition, marasmus, pneumonia and coughing, stomach ache, and vomiting.

The most frequently mentioned health problems of women include gastritis, cold, and kidney pain. Women associated kidney pain with hard work especially when they have to carry water from long distances. Men in Wessa said, "Our women have to travel long distances to fetch water from a river which is not clean. Due to this, pregnant women suffer a lot." Delivery problems and miscarriages were also frequently mentioned by women as shown in Table 10.

Table 10: Women's Perceptions of Their Health Problems (frequency problem was mentioned)		
Health Problem	Six most common (n=9)	Six most severe (n=9)
Gastritis	5	5
Cold	4	4
Kidney pain*	4	4
Fever and Headache*	3	3
Headache	3	3
Incomplete miscarriage*	3	3
Malaria*	3	3
TB*	3	3
Vomiting and Diarrhea**	3	3
Womb infection	2	2
Worms	2	2
Diarrhea*	1	1
Yellow Fever*	1	1

*Mentioned by one group as the health problem that they would like to be free of.

**Mentioned by two groups as the health problem they would like to be free of.

Other health problems which were mentioned by one group of women included asthma, backache, boils, coughing, delivery problems, dental problems, fever, hemorrhoids, liver, malnutrition, miscarriage, pneumonia, rheumatism, scabies, skin disease, and typhoid

Men's perceptions of their health problems (Table 11) were less varied than women's perceived health problems. Malaria was more frequently mentioned by men than by women. Eye disease was not mentioned by women at all, while five men's groups ranked eye disease as among the top six most common and most severe health problems.

Table 11: Men's Perceptions of Their Health Problems (frequency problem was mentioned)		
Health Problem	Six most common (n=9)	Six most severe (n=9)
Malaria**	6	6
TB	6	6
Eye disease	5	5
Typhoid	4	4
Diarrhea**	4	3
Cold	3	3
Kidney pain	3	3
Vomiting and Diarrhea	3	3
Cancer	2	2
Worms	2	2
Dysentery*	1	1

*Mentioned by one group as the health problem they would like to be free of.

**Mentioned by three groups as the health problem they would like to be free of.

Other health problems mentioned by only one group of men included amoeba, black leg, epilepsy, headache, heart disease, skin disease, STDs, stomach ache, swelling of the body, urinary tract infection, and yellow fever.

Detailed tables which show the results of the ranking of health problems in each village are provided in Appendix B.

Respondents perceive illness to be severe when it causes death quickly, when it spreads to many people and when there is no medicine. Respondents also noted that diseases which are debilitating and makes a person weak and unable to work are severe illnesses.

3. *What are the five most important health services that people want provided to them?*

Table 12 shows the perceptions of the root causes of ill health. In all of the 18 focus group discussions, the lack of clean water was mentioned as a root cause of ill health. The lack of health education, health services, and shortage of food were also seen as important causes of ill health. In four of the nine women's groups, women mentioned their heavy workload as a cause of ill health. Workload was not mentioned by any of the men's groups as a cause of ill health. As women in Boyne said, "We travel from market to market to sell or exchange things to make up for shortages in the house. As a result, we are exposed to many kinds of diseases like kidney problems and tiredness."

Table 12: Root Causes of Ill-Health (frequency mentioning in focus group discussions)			
Root Cause of Ill-Health	Number of Men's Groups (n=9)	Number of Women's Groups (n=9)	Total (n=18)
No clean water	9	9	18
No health education	6	6	12
Shortage of food	5	6	11
No health facilities/services	6	4	10
No malaria control	5	2	7
Poverty	3	2	5
Workload	---	4	4
Ineffective health services	1	2	3
Marshy areas	1	1	2

Table 13 shows the changes needed to improve health recommended by focus group participants. Clean water was recommended by all except one of the focus groups. Other recommended changes included health education, the establishment of a health center or a health station, and increasing the amount of food that is available.

Table 13: Recommended Changes to Improve Health (frequency of mentioning in focus group discussions)			
Recommended Change	Number of Men's Groups (n=9)	Number of Women's Groups (n=9)	Total (n=9)
Clean water	8	9	17
Health education	3	7	10
Establish HS or HC	5	5	10
Provide health services nearby	3	4	7
Increase food availability	4	3	7
Malaria control	3		3

During focus group discussions, men and women were asked which specific health services they needed. As shown in Table 14, the most frequently mentioned response was curative services which probably includes malaria treatment. However, after curative services, people mentioned immunization, health education, and family planning as important services. Five of the nine men's groups mentioned family planning despite anecdotal evidence that men are opposed to family planning. However, one respondent said that they want family planning, but not oral

contraceptives since women become sick from the pills. Some respondents were opposed to family planning as a woman from Borbosa noted “Our husbands prohibit us from getting family planning because they want to have many children.”

Table 14: Frequency of Mentioning of Health Services (all villages)

Service	Number of Men's Groups (n=9)	Number of Women's Groups (n=9)	Total (n=18)
Curative services	8	5	13
Health education	7	6	13
Immunization	7	5	12
Family Planning	5	6	11
Delivery services	5	3	8
Antenatal services	3	4	7
Postnatal services	1	3	4
Preventive services	1	2	3
Malaria	2	0	2
Trained CHA, TBA	0	1	1

Elders in Boyne listed as the most essential “services” (things that should be done to improve health): clean drinking water; food; improvement of existing clinic by providing medicine, equipment, and more staff; health education; and medicine for cattle disease. Specifically, the elders said that they need education on family planning (especially alternatives to oral contraceptives), environmental sanitation, and immunization. One man said, “The place where the injection is given makes a scar and people consider this an illness.”

During the interviews with health care providers, they were asked which health services they perceive as the most essential for the people they serve. These data are shown in Table 15. Immunization and health education were the most frequently mentioned responses. CHAs were more likely than other providers to see family planning, environmental sanitation, and clean water as essential services.

Table 15: Providers' Perceptions of the Most Essential Health Services

Services	Government (n=5)	Traditional Healers (n=10)	CHAs (n=10)	TBA's (n=11)	Drug Vendors (n=7)	Total (n=43)
Immunization	60%	30%	60%	18%	57%	42%
Health education	40%		70%	27%	57%	37%
Family planning	20%	10%	40%		43%	21%
Environment sanitation	40%		60%			19%
Establishment of HS		20%	40%		14%	16%
Antenatal	20%	10%	30%		9%	14%
Malaria treatment	20%	10%	30%		9%	14%
Treatment for various diseases	20%	50%				14%
Clean water	20%		40%		9%	14%
Delivery		10%	30%		9%	12%
MCH		20%			18%	9%

4. *What are the seasonal variations in time availability, cash availability, food availability, illness, access to clinics/medicine, and migration?*

Men and women in all villages were asked to diagram the seasonal variations in their workload, income and expenses, availability of food, illness, and access to health facilities. These data are presented in seasonal charts showing the parts of the year when times are good, that is when there is some income, not much work in the fields, and food is available. Another chart shows the times of the year when the villagers face difficulties, that is, when there is not much food, a lot of work in the fields, high debt, a lot of illness, and little access to health facilities. An example of these charts for the village of Wessa is shown below. In the Wessa charts, the data show that the villagers are better off from November to February and also in August. The villagers of Wessa face more difficulties during the months of May to July as there is little food, a lot of work and debt, illness, and little access to health facilities. This coincides with the rainy season. Similar charts were completed for each village and are included in Appendix B.

When Times are Good -Wessa

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Most Income			▲▲	▲	▲							●
Least Work in Fields			▲	▲	●▲	●▲	▲				●▲	▲
Most Food	●▲	●▲										●▲

● = Reported by men
▲ = Reported by women

When Times are Difficult - Wessa

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Least Access to Health Facilities											●▲	●▲
Most Illness										●▲	●	
Most Debt									●	●▲	●▲	
Most Work in Fields	▲							●▲	●▲			
Least Food										●▲	●▲	

● = Reported by men
▲ = Reported by women

Table 16 below summarizes some of the seasonal patterns of all the study villages. With the exception of Hadiya Zone, the lack of food, most illness, most work, and least access to health facilities tended to coincide during a period of a few months. The most difficult months in Sidaina and KAT Zones are May to July, while in North Omo the difficult times are earlier from March to May. In Hadiya, responses varied with some months being difficult due to food shortages while other months were difficult due to debt and work in the fields. In all villages, food shortages were associated with illness. September was the month of the highest expenditures for the Meskel festival and school fees. Women had more work at home during this month to prepare food for the festival. In Chaffa, men reported that during food shortages, they do not have the strength to carry patients to health facilities creating difficult access although the roads may be passable.

Table 16: Seasonal Patterns of Well-Being (summary of all villages)

Zone	Village	Most Difficult Months	Comments by Respondents
Sidama	Olola	May-August	<u>May-June</u> : malaria and children's illness due to lack of food <u>Aug.-Sept.</u> : migration to eastern side of village due to flooded homes
	Wessa	May-July	<u>July</u> : "there is no food at all"; "a time of starvation" <u>July-Aug.</u> : muddy roads due rains <u>June</u> : more illness because "it's hot and insects which cause illness breed easier"
Hadiya	Borbosa	December, July (mixed responses)	<u>Dec.</u> : "It is harvest time and we are so busy even children do not go to school, and we cannot visit health facilities." Some migration of men in Oct., March, April.
	Sagada Bekera	July-August	<u>Aug.</u> : acute shortage of food and children die <u>Oct.</u> : still food shortage and chickens die <u>Aug., Oct.</u> : men migrate to jobs in sugar factories
KAT	Chaffa	May-June	<u>May</u> : "Due to drought, people will have no food and no strength to carry patients to health facilities" <u>June</u> : "Due to malnutrition, many will be sick," <i>enset</i> decortification, have to buy food to eat <u>May-July</u> : no money for health care <u>Nov.-Jan.</u> : harvest
	Hansawa	June-July	<u>Mar.-May</u> : men migrate as agricultural laborers <u>June-July</u> : asthma and malaria due to cold weather <u>Oct.</u> : men migrate to sugar factories <u>Nov.</u> : harvest
North Omo	Oge	February-May	<u>Feb.-May</u> : shortage of food and money
	Demeba	January-July (mixed responses)	<u>Feb.-Mar.</u> : Women travel long distances to fetch water and grind cereal <u>Feb.-July</u> : Men migrate to towns for work <u>Sept.</u> : no money for transportation
	Boyne	March-May	<u>Feb.-Mar.</u> : men migrate to state farms as laborers <u>Mar.-June</u> : there is illness due to food shortages which causes malaria and swelling of the body <u>April</u> : "there is not enough food, we lose our resistance to illness"

5. ***How do people perceive the health services intended for them in terms of cost, hours, quality of service and care, and staff?***

We would like a big hospital with many beds which could provide in-patient services. Because, in our village, when someone is ill or when pregnant women are in labor, we carry them on our shoulders with a stretcher to health care providers who are far from our village. —Women in Wessa

During the procedure ranking providers, respondents were asked about the perceptions of the quality of providers. Providers are considered high quality when they have “full facilities,” including equipment and medicine, and when patients are cured. The inter-personal behavior of providers was also mentioned as an important indicator of quality: “being helpful and polite,” “has good conduct and behavior,” “good approach.” Other aspects of high quality included the provider knowing the causes of illnesses, referring patients to other facilities, and charging reasonable fees. Men in Chaffa said, “Even though they [TBAs] try to help us, the quality of their service is poor because the question of quality cannot be thought of without the necessary equipment.”

Women in Boyne suggested that the health station should have a kindergarten to take care of children and also a health education unit to teach about the causes of ill health.

When ranking health care providers, men and women were asked which provider they would want if they could have only one provider. Traditional healers, TBAs, and CHAs were not mentioned by any of the respondents as the one provider they would prefer. Both health centers and health stations were mentioned as the one provider they would prefer to have in 13 of the 18 groups. In five (three women’s groups and two men’s groups) of the 18 groups held, respondents listed a drug vendor as the one provider they would prefer. Men and women agreed on which provider they would prefer in only three of the sites. In the other six sites, women preferred one provider while men preferred another.

Table B6 in Appendix B shows the providers ranked most frequently visited, most expensive, and the best quality in each of the nine study villages. There was some disagreement among men and women in their ranking of providers. The criteria for selecting the one provider they would like to have varied among the villages and also between men and women. In a third of the ranking exercises, the providers ranked as being the best quality were also ranked as the most expensive. Only three of the men’s groups and five of the women’s groups chose the provider ranked best quality as the one provider they would like to have.

6. *What are the costs of medicines? How accessible are medicines in terms of distance and time to reach the sources of medicines? How important are commercial medicines in the assessment of the quality of service?*

In our village there is a clinic, but it does not have enough medicine. Because of that most of the villagers die.—A respondent in Boyne

As the quotation above illustrates, villagers perceive medicine to be perhaps the most essential component of quality health care. In general, people feel they are paying for the medicine and not for any special knowledge of providers. Thus when they have the “same” illness, they may just buy the same medicine they used the last time. As one woman put it, “Since my illness was treated by them long ago, I went back there. But this time, I only bought the same medicine without consultation.”

When asked to describe their ideal health station, men in Oge said, “We want a health station to be constructed and be equipped with trained staff, equipment, and medicine.”

Table 17 shows the availability and charges of selected medicine for different types of health care providers. Chloroquine, ORS, antibiotics, and worm medicine were available at all government facilities, NGO facilities, and drug vendors. Oral contraceptives were available at all government facilities, at about half of the traditional healers, and a third of the drug vendors. No traditional healers had antibiotics and only some had chloroquine, ORS, or worm medicine. Government facilities provided some medicine free of charge and the charges of other health care providers ranged from 0.60 Birr for chloroquine to 12 Birr for antibiotics.

	Chloroquine		ORS		Antibiotics		Oral Contraceptives		Worm Medicine	
	% Avail	Charge (in Birr)	% Avail.	Charge (in Birr)	% Avail	Charge (in Birr)	% Avail	Charge (in Birr)	% Avail	Charge (in Birr)
Government Facilities	100	free* .83	100	free* .50	100	1.63	100	0	100	free* 1.10
NGO	100	.60	100	.50	100	12.00	0		100	1-1.5
Traditional Healers	25	1.00	75	.60	0		50	NA	50	1.00
Drug Vendors	100	1.25	100	1.10	100	4.85	33	3.00	100	.96

* Some facilities provided the medicine free of charge

In general, medicines are readily available for purchase by villagers, though the type and quality of the medicines could not be assessed. Table 22 below that villagers often spend exorbitant

amounts on medicines, in one case reaching 980 Birr which reflects the priority given to medicines as an important aspect of quality medical care.

CARE-SEEKING BEHAVIOR

7. *Where do people go for health care - government, traditional, informal? How has this changed over the past five to ten years?*

There is a wide range of health care providers in all of the villages, as shown in Table 18. All the study villages had traditional healers, including bonesetters and traditional birth attendants. Five of the nine villages have trained TBAs. Only Boyne had an active CHA who was trained by World Vision International. Two villages had no CHAs at all and the rest of the villages had only inactive CHAs. The distance from health centers ranged from five to twenty-five kilometers away from the villages. Health stations were located inside three of the villages. All of the villages had access to at least two drug vendors and some had as many as seven drug vendors that they use.

Zone	Village	Health Center		Health Station		Traditional Healer	CHA	TBA	Drug Vendor
		Govt.	NGO	Govt.	NGO				
Sidama	Olola	None	5-25 km outside	Inside	None	Bonesetter	Inactive	2 Trained	1 inside 3 outside
	Wessa	11 km outside	2 hrs on foot	8km outside	None	Bonesetter	None	1 Untrained	3 outside
Hadiya	Borbosa	None	None	None	None	Bonesetter	Inactive	1 Trained	6 outside
	Sagada Bekera	None	None	Inside	None	Bonesetter	None	1 Trained	1 inside 1 outside
KAT	Chaffa	None	None	4km away	10 km away	Bonesetter	Inactive	1 Untrained 1 Trained	1 inside 4 outside
	Hansawa	None	None	8km away	2 km away	Bonesetter (3)	Inactive	1 TBA	3 outside
North Omo	Oge	12 km away	None	None	None	Bonesetter	Inactive	2 Trained	1 inside 6 outside
	Demeba	20 km away	None	None	11 km away	Bonesetter (4)	Inactive	5 Untrained	1 inside 3 outside
	Boyne	15 km away	None	Inside	None	Bonesetter	Active	2 Untrained	5 outside

When asked how their sources of health care had changed over the past five to ten years, respondents mentioned that there had been little change with the exception that some CHAs and

TBAs had been trained and there were new drug vendors. Respondents in seven of the nine villages mentioned that TBAs and/or CHAs had been trained in the past five to ten years. In Borbosa, outreach immunization services had been started recently.

8. *Where do people go for deliveries, immunizations, and other preventive services?*

TBAs perform most deliveries. In six villages, immunization is provided through monthly outreach services. Other preventive services such as family planning are received from the government health units. Growth monitoring was not being conducted in any of the study sites, though a few of the sites were receiving relief food grain from various NGOs.

9. *Where do people go for curative care?*

When his uvula becomes inflamed we get rid of it. After that he vomited for two weeks. I took him to the drug vendor who gave him injection, but he is not cured up to now. --A mother of a sick child in Oge

As described in question 7 and shown in Table 18, people have a wide range of health care providers to choose from. Respondents reported seeking care from a variety of providers, including traditional healers, drug vendors, and government health facilities. Table 19 shows which providers were chosen when only one provider was visited (data are from the narratives of illnesses, deaths and deliveries). There is significant variation among the nine study villages. In Borbosa, 100 percent of the respondents visited a government provider, while in Oge 100 percent of the respondents visited a drug vendor. [Note that due to small sample sizes, only broad patterns can be observed.] In general, it is important to note the relatively high utilization of drug vendors and low utilization of traditional healers.

Table 19: Source of Health Care for Those Who Went to Only One Provider (from narratives)

Zone	Village	Government Provider (%)	Drug Vendor (%)	NGO (%)	Traditional Healer (%)
Sidama	Olola (n=6)	33	33	33	
	Wessa (n=9)	44	44		11
Hadiya	Borbosa (n=5)	100			
	Sagada Bekera (n=8)	62	37		
KAT	Chaffa (n=7)	14	43	43	
	Hansawa (n=7)	14	14	71	
North Omo	Oge (n=6)		100		
	Demeba (n=15)	33	53		7
	Boyne (n=16)	75	25		

10. What are the most important criteria that people use to decide where to go for treatment (e.g., type of illness, geographic accessibility, availability of medicine, perceived quality, etc.)?

The most frequently mentioned criteria for choosing a health care provider were the distance of the provider, the expense, and the quality of the provider. As a woman in Olola said, “I go to the drug vendor because he is near and I do not have money to go to other providers.” Other respondents reported that they were referred to providers, but did not have the money to go. Other important criteria for selecting providers and perception of quality include the availability of medicine, and laboratory and x-ray equipment. A number of respondents mentioned the importance of good inter-personal skills while other respondents mentioned that some providers were known to them. A man in Wessa explained why he took his wife to Bushulo HC: “I decided to take her to Bushulo HC because from my own experience, I knew that if there is not anybody whom you know in the health unit, you do not get a turn for treatment. Since I know someone at Bushulo, I took her there.”

It is important to recognize the dynamics within households which occur when treatment decisions are being made. The patient is often only one of several people involved in the decision to seek treatment. Older relatives and neighbors often advise the use of specific providers or treatments. A woman in Chaffa said, “When I got seriously sick my neighbors insisted I use herbal medicine at home, otherwise it will become complicated and cause me to die.” When

money must be borrowed or assets sold to pay for treatment, other people become involved and make recommendations. This is especially true for decisions regarding treatment for women and children who often have less authority and access to cash as the following quotation illustrates:

Even though my sickness is severe, I did not have money for treatment. Besides, when I became weak and sick, my husband left me and married another woman. --A pregnant woman in Chaffa abandoned by her husband when she became sick

Women in Wessa said that when a child gets sick, they simply inform their husbands. According to them, the amount of money to be paid for health care is decided by their husbands. Sidama women have no right to any property when they are married and live with their husbands. If the husband does not think the child needs treatment, he may not give the money required, as this case illustrates:

My child has a stomach ache and a strong appetite, but then he vomits whatever I feed him. I told my husband, but since he has another wife and many children from her, he paid no attention. He told me not to worry, that the child's problem was the lack of a balanced diet. He ordered me to give my child milk everyday.

11. ***What is the pattern of utilization of government, NGO, and traditional health services (especially TBAs, CHAs)? In other words, do people seek care of several providers simultaneously or do they see providers sequentially? Who do they visit first, second, third?***

In general, people go from one provider to another until they are “cured” (of course the local perception of a “cure” may differ from the biomedical concept). For example, in Chaffa, a child with a toothache and malaria was taken to a clinic for medicine, but when that did not cure her, she was taken to a traditional healer who massaged her for 22 days.

Table 20 shows the sequence of provider utilization among respondents using more than one provider. In general, traditional healers were rarely utilized (with exception of Wessa) even when three or four providers were utilized. Government providers (primarily health stations) were used as much as drug vendors as the first provider visited. The table illustrates that there is no fixed sequence of provider utilization. Sometimes government providers are chosen, sometimes NGO or drug vendors, and there is a certain amount of shifting back and forth for the same illness episode. It is very likely that the type of health problem influences the sequence and type of providers visited. However, this study was unable to investigate how utilization patterns differ for different health problems.

Table 20: Pattern of Utilization for Those Using More Than One Provider (from narratives)

Zone	Village	Number of Places Visited	1st Place Visited	2nd Place Visited	3rd Place Visited	4th Place Visited	
Sidama	Olola	2	Drug vendor	Govt.			
		2	Govt.	NGO			
		2	Govt.	NGO			
		3	Govt.	Drug Vendor	NGO		
		3	Govt.	NGO	NGO		
		3	Govt.	NGO	Drug vendor		
		3	Govt.	Drug vendor	NGO		
		3	Govt.	Drug vendor	Drug vendor		
		3	NGO	NGO	Govt.		
		4	Drug vendor	Drug vendor	NGO	NGO	
		4	Drug vendor	Drug vendor	NGO		
		4	NGO	Drug vendor	Govt.	Drug vendor	
		4	Govt.	NGO	NGO	Drug vendor	
	4	Drug vendor	Drug vendor	NGO			
	Wessa		2	Trad. Healer	NGO		
			2	Drug vendor	NGO		
			2	Govt.	NGO		
			2	NGO	Drug vendor		
			2	NGO	Govt.		
3			Drug vendor	NGO	Govt.		
Hadiya	Borbosa	2	Govt.	Drug vendor			
		2	Govt.	Drug vendor			
		2	Govt.	Drug vendor			
		2	Drug vendor	Govt.			
		2	Drug vendor	Drug vendor			
3	NGO	Govt.					
	Sagada Bekera	2	Govt.	Trad.Healer			

Table 20 (continued): Pattern of Utilization for those Using More than One Provider (from narrative)						
Zone	Village	Number of Places Visited	1st Place Visited	2nd Place Visited	3rd Place Visited	4th Place Visited
KAT	Chaffa	2	NGO	Govt.		
		2	Drug vendor	Drug vendor		
		2	NGO	Govt.		
		2	Drug vendor	Drug vendor		
		3	Drug vendor	Drug vendor	NGO	
		3	Drug vendor	Drug vendor	NGO	
		4	NGO	NGO	Drug vendor	Drug vendor
	Hansawa	2	NGO	NGO		
		2	NGO	Govt.		
		2	NGO	Govt.		
		2	Govt.	Govt.		
		3	NGO	NGO	Govt.	
		3	NGO	NGO	NGO	
		4	Drug vendor	NGO	Drug vendor	NGO
North Omo	Oge	2	Drug vendor	Govt.		
		2	Drug vendor	Drug vendor		
		2	Govt.	Govt.		
		3	Trad. healer	Govt.	Drug vendor	
	Demeba	2	Drug vendor	Govt.		
		2	NGO	Trad. Healer		
		2	Drug vendor	Govt.		
		2	Govt.	NGO		
	Boyne	2	Drug vendor	Govt.		
		2	Drug vendor	Govt.		
		3	Govt.	Govt.	Drug vendor	
		3	Drug vendor	Drug vendor	Govt.	
		3	Govt.	Drug vendor	Govt.	
		3	Govt.	Drug vendor	Govt.	
5		Govt.	Govt.	Govt.	Govt.	

12. *What is the role of CHAs, TBAs, and other extension agents as perceived by the community?*

Overall, there was very little previous experience with CHAs and where there was experience, it had not been good. Previously, they had a CHA in Demeba, but they did not know what he did. Women said, "He either hid or sold the medicine for his own benefit. The health post which had been constructed was destroyed four years ago." In North Omo, a health post was constructed and a CHA trained. The health post was destroyed when the EPRDF took power, and the CHA became a local injector.

In a separate discussion, the men agreed saying, "Previously some people came and gave false promises. The people who come from outside the village are not trustworthy." Men in Chaffa

said that “even if we select and train someone from our village, we don’t think it will improve our health because the type of person you are talking about is hardly better than an ordinary farmer and will not be able to assist us. We would not trust such a person.”

In Oge, elders said that the CHAs had been selected by a few people. “In the past, the CHA was given a supply of medicine, but no one knows where the stock of medicine is now. There was no supervision, and we do not know who supplied this medicine.” They said the PA should assign a competent person to supervise the CHA. The elders of Oge said that they have managed other development programs, including distribution of fertilizer on credit, installation of a grinding mill, and the sale of some staple foods (sugar, salt, etc.) for a profit.

Women in Demeba claimed that the TBAs in their village were untrained and provided poor quality services. Men in Oge said, “We have delivery problems because the TBAs do not refer patients to the hospital on time. They only refer when the situation becomes hopeless and as a result, some women die on the way to the hospital. Therefore, TBAs need additional training.”

During focus group discussions, men and women were asked to specify the criteria by which CHAs should be selected. The results are shown in Table 21. The most important criterion was that CHAs should be selected by the community with 12 of the 18 groups mentioning this. Men in Sagada Bekera said that “the CHA should be selected by the villagers. If a CHA is assigned by someone else, it would be futile.” Women in Chaffa said that the health agents “used to be selected by leaders without any participation of the community and this brought about the lack of services.” They also said that the CHA should be supported by a responsible person to implement the program. Elders in Boyne said that CHAs should be selected by the villagers. The CHA should be supervised by the *kebele*. In all the focus group discussions, participants said they preferred a CHA to be selected from their own village. They reported that they would not trust someone from another village and that person would not be available for emergencies.

Respondents also said that CHAs should be committed to serve the community, have no addictions to alcohol or *chat* (an herbal stimulant), and have some education (though respondents differed on what level of education). Some health knowledge and experience was also mentioned as important.

Some respondents said that CHAs should be married, but not have a large family. The CHA should be a married man. “If he is married, his destination will be known. And, he has to be a man to bring information from a far distance.” The TBA should be a woman since that is for women. Only one women’s group (in Borbosa) said the CHA should be a woman: “If possible, we prefer a female. We highly prefer a female because we could discuss our problems with her freely.” The elders in Oge said the CHA should be male due to the hardship of the work.

When asked if they would be willing to contribute in cash or in-kind for the CHAs, eight out of nine women’s groups said that they would be willing to contribute, but only four of nine men’s groups were willing to contribute for the CHA.

Selection Criteria	Men's Groups (n=9)	Women's Groups (n=9)	Total (n=18)
Selected by the community	6	6	12
Committed to serve community	4	5	9
No addictions	4	4	8
Above 12th grade	4	3	7
Can read and write	2	4	6
Basic education	2	3	5
Some health knowledge and experience	2	3	5
Must be trusted	2	1	3
Respect and love villagers	2	1	3
Have patience		2	2
Must have free time		2	2
Must be respected	2		2
Must be healthy		2	2
Should be married	2		2
Not have large family		1	1
Male	1		1
Female		1	1

WILLINGNESS AND ABILITY TO PAY

13. *What do people currently pay for preventive health services?*

Respondents in all the study villages repeated that immunizations were provided free. Table 17 above shows that oral contraceptives are provided free of charge from most providers though drug vendors reported charging 3.00 Birr. Table 22 shows some of the costs for deliveries, ranging from 29 Birr in Sagada Bekera to 405 Birr in Boyne.

14. *What do people currently pay for curative health services?*

I have paid out everything for treatment. I have nothing left. I have no hope anymore. –Woman with cancer "Mujia" in Olola

Table 22 below presents the range and average costs of consultation, medicine and transportation for illnesses, deaths, and deliveries. Illnesses and causes of deaths varied among men, women, and children. Since the sample size is very small and the health problems varied, these numbers must not be interpreted as expenditure estimates for the general population. However, some patterns can be observed about the range of expenditures and the relative costs of consultation,

medicine, and transportation. The most expensive part of treatment is the medicine, while the consultation fee is relatively less expensive and often simply included in the charge for medicine. The average cost for medicine ranged from 13 Birr in Demeba to 745 Birr in Olola. Not surprisingly, respondents reported spending more on people who subsequently died. Transportation costs were often significant, in some cases reaching 70 to 80 Birr.

Table 22: Costs of Consultation, Medicine and Transport in Birr (from narratives)

Zone	Village	Type of Narrative	Registration and Consultation	Medicine	Transportation
Sidama	Olola	Illness (n=17)	Range 7-33 Average 17	Range 3-150 Average 52	Range 4-28 Average 13
		Death (n=3)	NA	Range 510-980 Average 745	- -
	Wessa	Illness (n=16)	Range 1-25 Average 8	Range 5-301 Average 98	Range 4-26 Average 52
		Death (n=3)	NA	Range 5-10 Average 74	NA
		Delivery (n=1)	1	15	4
Hadiya	Borbosa	Illness (n=9)	Range 2-3 Average 10	Range 12-144 Average 86	Range 1-52 Average 21
		Death (n=2)	- Average 2	Range 30-128 Average 77	NA
		Delivery (n=1)	10	23	80
	Sagada Bekera	Illness (n=7)	- Average 8	Range 5-30 Average 16	- Average 8
		Death (n=1)	NA	1	NA
		Delivery (n=2)	- Average 5	- Average 29	- Average 18
KAT	Chaffa	Illness (n=16)	Range 1-5 Average 4	Range 1-520 Average 58	Range 2-10 Average 6
		Delivery (n=1)	NA	9	NA
	Hansawa	Illness (n=17)	Range 7-78 Average 20	Range 1-109 Average 31	Range 7-78 Average 44

Table 22: Costs of Consultation, Medicine and Transport in Birr (from narratives)					
Zone	Village	Type of Narrative	Registration and Consultation	Medicine	Transportation
North Omo	Oge	Illness (n=13)	Average 2	Range 4-205 Average 76	Range 19-52 Average 35
		Death (n=1)	NA -	- Average 34	NA -
	Demeba	Illness (n=15)	Range 1-3 Average 2	Range 4-20 Average 13	Range 8-30 Average 22
		Death (n=1)		5	NA
		Delivery (n=1)	32	50	12
	Boyne	Illness (n=18)	Range 1-3.50 Average 2	Range 5-227 Average 39	NA
		Death (n=6)	Range 1-3 Average 2	Range 11-115 Average 65	- Average 20
		Delivery (n=2)	NA	Range 10-800 Average 405	NA

Table 23 shows the average cost of treatment and medicine (excluding transportation costs) by type of provider. In general, traditional healers were the least expensive provider in all the study villages. Drug vendors were often less expensive than NGO or government facilities. In Sidama Zone, costs at NGO facilities were higher than in government facilities, while in other zones NGO facilities cost less than government facilities.

Table 23: Average Cost of Treatment and Medicine by Type of Facility in Birr (from narratives)					
Zone	Village	Government HS and HC	NGO	Drug Vendors	Traditional Healers
Sidama	Olola	45	88	18	NA
	Wessa	49	96	47	37
Hadiya	Borbosa	60	NA	62	NA
	Sagada Bekera	72	NA	15	1
KAT	Chaffa	128	34	10	NA
	Hansawa	73	12	10	NA
North Omo	Oge	207	NA	47	10
	Demeba	42	13	11	6
	Boyne	31	NA	23	NA

15. *What do people consider a reasonable or affordable amount of money to pay for preventive health services?*

Participants in all of the 18 focus groups agreed that they should not have to pay for preventive health services since it always has been provided free. Respondents said that preventive services are the responsibility of the government. Two of the women's groups said that although they thought the services should be free, they would be willing to pay a couple Birr.

Women in Wessa said that they were not in a position to say how much should be charged for services. They said that the price is fixed by the providers, and their husbands would have to be consulted for how much should be paid.

Men in Demeba also felt that immunization and other preventive services should be free. However, they also said that they would be willing to pay four to five birr if the services were provided right in the village.

16. *What do people consider a reasonable or affordable amount of money to pay for curative health services?*

We are supposed to pay whatever they say for the treatment of our illness. We go there to be cured. Sometimes they even ask how much money we have before examining us. Therefore we do not say anything about the payment. —Men in Bobbosa

- *We do not have the right or experience to decide how much to pay for curative health services. If we want to get treatment, we have to pay whatever price they asked. If we refuse to pay or if we have no money, the only alternative is to return home without getting treatment. —Women in Oge*

Table 24 shows the recommendations made by focus group participants for the amount to pay for curative health services. Many groups felt that they could not make any recommendations because the decision rests completely with the providers. Women were often reluctant to mention specific recommendations saying that they had to consult their husbands first. Four of the men's groups specified what should be paid for minor illnesses, severe illnesses, and hospitalizations. For minor illnesses, the recommended amount to pay ranged from two to ten Birr, and three to fifty Birr for severe illnesses. Respondents in Chaffa thought the government should pay for charges over 50 Birr.

Zone	Village	Men	Women
Sidama	Olola	5-8 Birr for minor illness 10-20 Birr for severe illness 50 Birr for admission including medicine and food	Providers decide charges
	Wessa	Willing to pay according to the service provided	Willing to be decided by the government
Hadiya	Borbosa	Providers decide charges	50% of the amount charged by providers
	Sagada Bekera	According to the affordability of each person	50% of the amount charged by providers
KAT	Chaffa	5-10 Birr for minor illness 10-50 Birr for severe illness If more than 50 Birr, government should pay	Providers decide charges
	Hansawa	25% of the amount charged by providers	5-10 Birr for getting good treatment
North Omo	Oge	3-5 Birr for minor illness 5-10 for severe illness Birr More than 10 Birr for hospitalization	Providers decide charges
	Demeba	Providers decide charges	Not more than 5 Birr for all curative treatments
	Boyne	2-3 Birr for minor illness 3-5 Birr for less severe 15-30 Birr for severe illness	Depends on the type of illness and treatment provided

17. *What are the patterns of borrowing and pawning assets for health care? Who is asked for money (e.g., is there a "money lender" or through relatives)? How much is borrowed for health care? How is it repaid (e.g., interest rates, labor)?*

I sold grain and a goat to pay for the boy's illness treatment. This has caused difficulties in our family living conditions. --Man in Bobbosa

I sold my land for 200 Birr to pay for treatment costs and my only son died after severe diarrhea. I now have no land, no money, and no source of support. --Widow in Boyne

We sold our only donkey to pay for treatment at the hospital. We are now very poor. I don't know how we will survive. --Woman in Boyne

In focus group discussions, participants from all sites reported paying for health services by selling grain, milk cows, ploughing oxen, and pawning land, oxen, and cows. They said that providers rarely accept in-kind payments or extend credit. When people do not have anything to pawn, they sometimes can get a certificate from the PA which entitles them to receive free treatment. However, some respondents reported that the providers either do not accept the certificate or that they force patients to wait a long time to receive treatment.

In Oge, men said that they usually pay for health care by borrowing from the *edir* or using a free certificate from the PA, but “although it is legally accepted, the health people don’t consider it important. They don’t give an appointment. In the meantime, the patient may die before getting treatment. As a result, now we don’t ask for the certificate.” Men in Sagada Bekera also said that the PA certificate is not accepted for medical treatment and that “we usually pay for health care by selling our property, by destroying what we have.”

Almost all health care is paid for by borrowing or selling some assets. There were some examples of people going into tremendous debt to pay for health care. One man in Wessa said, “The treatment was not worth the money because I lost all my wealth by selling to pay for treatment and I still have not recovered.” Table 25 shows the patterns of borrowing, selling, and pawning in the nine study villages. The last column of Table 25 shows the types of items sold and pawned to pay for health care. The percentage of people who had to borrow money for health care ranged from 18 percent to 65 percent and the amounts borrowed ranged from three Birr to 1000 Birr.

Table 25: Borrowing to Pay for Health Services (from narratives)				
Zone	Village	% Who Borrowed or Pawned	Range of Amount Borrowed in Birr	Items Sold or Pawned
Sidama	Olola	65	3 - 330	Oxen, cow, calf, heifer, sheep, chicken, food grain, <i>chat</i> , local drink
	Wessa	25	50 - 200	Food grains, <i>chat</i> , injera local drink, cow, sheep, rented farm land
Hadiya	Borbosa	50	100 - 900	Cow, goat, food grains, and potato
	Sagada Bekera	30	5 - 1000	
KAT	Chaffa	35	4 - 125	Oxen, calf, goat, chicken, coffee, butter and cheese
	Hansawa	41	6 - 300	Chicken, calf, and food grains
North Omo	Oge	23	4 - 20	Sheep, food grains, pawn half of the farm land, got from <i>ikub</i>
	Demeba	18	20 - 30	Potato, eucalyptus tree, and coffee
	Boyne	65	7 - 300	Food grains, coffee, sheep, oxen, donkey, and chicken.

COMMUNITY BASED HEALTH CARE PROVIDERS

18. *What is the range of provider fees? How do providers determine how much to charge? Do providers charge less to poorer people?*

People most in need of care don't always receive it because most people are poor and cannot afford to pay for treatment. And health care providers do not give free treatment to the poor. -- CHA in Boyne

Table 26 shows the range of fees that providers report charging, though it should be noted that most providers were reluctant to discuss their fees. Drug vendors usually charge only for the medicine, while traditional healers typically charge two to ten Birr.

One TBA in Boyne said that she charges five Birr if it takes her all day, and three Birr if it only takes her half a day. Another TBA said that she charges between five and ten Birr, depending on the family's income. Most TBAs said they accept whatever is given to them.

Table 26: Range of Provider Fees According to Providers

Zone	Village	Government HS	NGO HS	Drug Vendors	Traditional Healers	TBA
Sidama	Olola	Price is fixed by govt.		Charge for medicine	Birr 12	Birr 2
	Wessa	No HS		Charge for medicine	Birr 5-children Birr 10-30 women Birr 10-30 men	Birr 2
Hadiya	Borbosa	No HS		Charge for medicine	Birr 10	Birr 2
	Sagada Bekera	Price is fixed by govt.		Charge for medicine	Birr 5-10	free of charge
KAT	Chaffa	No HS		25% above cost of medicine	Birr 2-3	Birr 5-10
	Hansawa		25% above cost of medicine	Charge for medicine	No charge	NA
North Omo	Oge	No HS		25% above cost of medicine	NA	Birr 2-3
	Demeba	No HS		25% above cost of medicine	Birr 2-10	NA
	Boyne	Fixed by woreda health office		Add some amount on the price of medicine	NA	Birr 2-5

19. *Into which community structures or organizations do the CHAs and TBAs fit? (e.g. health or development committees) How are they selected and held accountable to the community?*

During discussions with village elders in North Omo, the elders said that the CHAs and TBAs fit within the health committees of the Peasant Associations. The elders said that the CHAs have been selected either by the PA executive leader or the PA committee. But the elders also said that the CHAs are not held accountable. In the future, the elders said, the CHAs should be accountable to the PA. The PA should supervise their working hours and distribution of medicine, and the health offices should supervise the technical aspects of their work. The elders in Boyne said that World Vision paid only for the training of the CHAs and then sent them to the village without payment. "Nobody paid them, nobody supervised or provided the necessary materials."

In every village visited, there are traditional groups called *edir* and *ikub*. The purpose of *edir* is to provide overall assistance when a death occurs. The type of assistance includes the provision of

food and drinks during the funeral, preparing temporary shelter, providing a fixed amount of money, and participating in the burial ceremony. *Ikub* is an organization for saving money and providing credit according to the by-laws. Men and women often have separate *edir* and *ikub* groups. There was no evidence that CHAs and TBAs have been financed or supervised through these groups.

Several CHAs recommended forming a health committee so that providers and the community can work together and prepare an action plan.

20. *What types of financing mechanisms have CHAs and TBAs experienced (e.g., revolving drug funds, community funds, etc.)?*

The CHAs and TBAs have been financed through fee for services and medicine. No examples of revolving drug funds or community funds were found. Elders in Oge said that previously the CHA was given a plot of land, but no salary. They said that the government should pay for the CHA "since we are all poor."

21. *What are the perceived needs of CHAs and TBAs?*

Many CHAs and TBAs are not paid anything for their services. One TBA in Olola said, "I am a widow with eight children. Since I am not paid, I have to spend time to earn a living and therefore, I may not be available all the time." TBAs said that they needed gloves, scissors, eye droppers, thread for the newborns, and general support from the HS and HC. They said they need supervision and refresher training. One CHA summed up the problems, "I am not paid for my services. There is no health post in which I am supposed to work. And I am not supplied with essential drugs and equipment."

Many said that they needed better cooperation from the PA and the community in general. One CHA in Sagada Bekera said that his greatest difficulty was the lack of cooperation from the PA. "I had to work day and night to teach people but the PA did not help my family. They did not even pay for my transportation. Due to this, I stopped working as a CHA a year ago." A CHA in Hansawa said, "The PA executive committee is not cooperative and nobody cares about my work. So I didn't do my work with dedication. I don't feel any incentive."

All the CHAs said that the HS should supervise and evaluate their activities, and provide training and essential drugs. A CHA in Boyne said that the HS staff should provide guidelines, drugs, equipment, training, and supervision. A TBA from Oge said that the relationship between the HS and TBAs would be improved by giving reports. "Four years ago I had to report the number of newborns to the HC, but now I have no relationship with them." A CHA in Hansawa said there should be a report of what he does, but no one cares.

A CHA in Chaffa said, "They [HS and HC staff] don't want to have a relationship with us because it reduces their income." A CHA in Olola said, "Better service can be given to the

community when there is a joint meeting with all service providers in the village and when CHAs and TBAs can be given support and medicine.”

Table 27 lists the perceived needs of CHAs and TBAs. Both CHAs and TBAs reported their need for medicine, equipment, and additional training. Many of the CHAs reported that they needed better supervision from the HC and HS staff.

Table 27: Perceived Needs of CHAs and TBAs

Zone	Village	CHAs	TBAs
Sidama	Olola	Health post and medicine Meeting with all service providers Technical support Team work during epidemic occurrence	Community to give an office Support and encouragement HC/HS to give materials for delivery Additional training Inform the community about their role Provision of office
	Wessa		Training
Hadiya	Borbosa	Mobilize the community to work together Community leaders should play a coordinating role Need supervision of their activities Periodic meeting Discussion with the villagers Provision of medicine	Provision of equipment Training
	Sagada Bekera	Cooperation from the PA Providing health education HC or HS to give refresher course and necessary medicine Close interaction and cooperation	Need incentives (payment) HS or HC should observe and help in their activities Give necessary equipment Training
KAT	Chaffa	Necessary medicine Permanent office	Gloves and gown delivery kits Training to additional TBAs. Incentives (payment) Sharing of experience
	Hansawa	Cooperation from the PA leaders Incentives Readiness to help the people First-aid kit HS or HC training Report of the activities Periodical supervision Refresher courses Frequent work relationship	

Table 27: Perceived Needs of CHAs and TBAs

Zone	Village	CHAs	TBAs
North Omo	Oge	Incentives Medicine Joint meeting and discussion HC or HS should support by providing training and periodic supervision	Dedication to their work HC or HS/ to give necessary delivery equipment Establishment of health station Health education HC or HS report about the number of newborns
	Demeba	Community establishment of joint committee to smooth the relationship HC or HS technical assistance Supervision Provision of medicine Close work interaction	Community by giving labor service HS or HC to give training
	Boyne	Incentives (payment) The community has to accept and put into practice the message (health education) HS or HC should support by establishing health post and provide the necessary medicine Report Community formation of health committee Action plan Supervision	Community better services and continuous follow up Selection of more TBAs to be trained HS or HC to give training Providing of first-aid delivery equipment Coordination

22. **What are the perceived roles and responsibilities of TBAs and/or CHAs? Does this include education, prevention, and referral?**

As a CHA, my primary responsibility is to give health education about child spacing, how to clean water, and environmental sanitation. This is not the same as other providers. It differs because I am not paid and other providers are paid. I give health education and preventive services when other providers cure patients using drugs and injections. --A CHA in Boyne (trained by World Vision)

Table 28 presents perceived roles and responsibilities of CHAs and TBAs. While TBAs see their role as giving only delivery services, CHAs saw their role as primarily providing preventive services, including health education and promoting environmental sanitation.

Table 28: Perceived Roles and Responsibilities of CHAs and TBAs			
Zone	Village	CHAs	TBAs
Sidama	Olola	Treatment of minor illness Health education	Delivery services Health education for pregnant women
	Wessa		Helping the women during delivery To refer pregnant women who have difficulties
Hadiya	Borbosa	Health education about environment sanitation & clean water Treatment for minor illness	Give care and advice
	Sagada Bekera	Health education about health & environmental sanitation	Delivery services
KAT	Chaffa	Health education	Delivery services
	Hansawa	Health education about immunization, spread and cause of illness Advise people to boil water before drinking Advise people to dig latrines Provide drugs for minor illnesses	
North Omo	Oge	Health education	Service related to delivery
	Demeba	Preventive service (contraceptive)	Delivery service
	Boyne	Health education about child spacing, clean water & environmental sanitation Report the breakout of epidemics	Delivery service Health education about child care

23. *What referral networks exist currently?*

In general, providers reported that they referred patients to the HS or the HC when an illness became “severe” or when there was excessive bleeding during or after a delivery. A TBA in Oge said that she refers patients “when there is excess bleeding, when the cervix is narrow, and when the fetus is dislocated.” One TBA said that the private drug vendors “are running for the money and not to serve the community.” Some traditional healers referred patients to other healers in the village.

24. *How do health center/station staff see the role of CHAs and what is their capacity to provide support?*

HS staff reported that their greatest difficulties were the shortage of medicine and lack of transportation for outreach services. Some also mentioned that “the community is unwilling to cooperate during outreach sessions.” The lack of incentives and per diem was also reported as a difficulty. Several HS staff also mentioned the need for a health committee.

The health assistant interviewed in Hansawa said that there should be a harmonious work relationship and the CHAs should be supported with supervision. The head of the health station in Sagada Bekera said, “We can work together if support such as supervision, refresher training, and essential drugs are provided to CHAs.” In Olola, the head of the health station said that in order to have a good relationship with the CHA and TBA, reporting mechanisms should be established and evaluation of activities should be conducted. In Boyne, the health station head said that the relationship would be improved if the CHAs were paid by the government.

APPENDICES

APPENDIX A: GLOSSARY OF ILLNESSES AND HEALTH PROBLEMS

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APPENDIX A: GLOSSARY OF ILLNESSES AND HEALTH PROBLEMS

Sidamigna Language

Approximate English Term	Local Term (M=Men, W=Women, C=Children)	Symptoms / Comments
Anaemia	Munde-Ajenno (M,W)	
Ascaris	Hamesho (W,C)	
Asthma	Shinka (M,W)	Severe during rainy season
Back ache	Halotetibe (W)	
Burning during urination	Shuma Girano (M)	Related to STD
Cancer	Balamo (M,W)	Attacks bone
Common cold	Kiddu Tiba (M,W,C)	
Coughing	Busseno (W,C)	
Delivery problem	Elatie-Mitiema (W)	Malposition, labor elongations, the cover of the fetus in wrong directions
Diarrhea and vomiting	Deatuffo (C)	
Diarrhea	Godebo Fushisheno	Bloody diarrhea
Evil eye	Etamie (C)	Scabies/skin disease
Eye illness	Eleti-Tibe (M,W,C)	
Fever	Biso Ebarbiso	
Gonorrhea	Simetto, Shufuro (M,W)	
Headache	Umu-Tibe(M,W) (Umu-Demumei)	
Illness of ear	Mechat malla (C,M)	
Kidney	Mulo Tiba (M)	
Lameness below waist	Natta (W)	There is pus during urination
Liver	Megerto (M)	Occurs at any time
Malaria	Shekere (M,W,C)	
Measles	Hygiene (C,M)	
Miscarriage	Mentu Tiba (W)	Incomplete abortion
Pneumonia	Mulu-mada (C)	
Scabies(skin disease)	Bisohangersiso (M)	
Skin disease(Scabies)	Bijajo (C)	
Stomach-ache(Pair.)	Gedebugemie (M,W)	
Swelling of the skin around the eye	Ele-dershishao	New illness in the village.
Swelling of body	Bisodershisheno (M)	Occurs at any time

Sidamigna Language

Approximate English Term	Local Term (M=Men, W=Women, C=Children)	Symptoms / Comments
TB	Mujee Shombo Tiba (M,W)	
Tonsillitis	Kokebe Derohe (C)	Wound
Toothache	Hinkote Tibe (W)	
Typhoid	Goga (M)	

Kembattigna Language

Approximate English Term	Local Term (M=Men, W=Women, C=Children)	Symptoms / Comments
Abortion	Mecha (W)	
All other worms	Uchimosso (M)	
Amoeba	Wama (M,W) (Mugitta)	
Ascariasis	Hamesso (M,W,C)	
Common cold	Gensho (C,W)	
Dermatitis	Shiya (C)	
Ear disease	Tibito (W) Loka dorshanto	
Elephantiasis	Echakontenn Wolano mosso (W,C)	
Epilepsy	Chatta (M,W)	Also called "Kululena"
Eye disease	Elemosso (M,M,C)	
Fever	Godebe tideta (W,C)	
Gastritis	Kuchame-Mosso (M,W)	
Headache	Folifaama (W)	
Heart disease	Niffazo (M)	Toothache is included in this.
Kidney disease	Muli-Mosso (M,W)	Due to too many pregnancies (women)
Malaria	Shekire (M,W)	There is a marshy area in the village
Malnutrition	Eiba (W,C)	
Measles	Angharru (C,W)	
Pneumonia/cold	Gide-Messo (M,W)	
Polio	Gogi mosso(C)	
Scabies	Mechu-mosso (C,W)	
Skin disease	Ossamu (C) (Shifita)	
Stomach ache	Banichu mosso (M)	
TB	Kedeferi mosa Hamomosso (M)	Mostly poor people are affected
Tetanus	Tutuchamosso (M)	
Tooth ache	Enkomosso (M,W)	
Typhoid	Lukucho (M,W)	Common in Hansawa village
Urinary tract infection	Shumma Mosso (M)	Urination problem
Vomiting and diarrhea	Hoeita Muhita (M,W,C)	
	Damumma (W)	

Wolitigna Language

Approximate English Term	Local Term (M=Men, W=Women, C=Children)	Symptoms / Comments
Abortion	Bosha(W)	Due to work load
AIDS	AIDS (M,W)	Youngsters who often go to towns
Amoeba	Ashogodoti (C)	
Anaemia	Laphese fijigo (C)	
Ascariasis (Worms)	Sheniya (C)	
Asthma	Sheno (M,W)	
Common cold	Meghua Harge (W,M,C)	
Gonorrhoea	Yatta (M)	
Diarrhea	Code Osa (C)	
Diarrhea	Olwakera (W,C,M)	
Diphtheria	Sugeta (C)	
Ear infection	Haitasawa (C,M)	
Elephantiasis	Tewkita (W,M)	
Eye disease	Eyphia Sawa (W,M,C)	
Fever and Headache	Kotwane mishua (W,M,C)	
Gastritis	Wozena mishurs (W,M) Gurgia	
Goiter	Gua (M)	
Headache	Hopesawa (W)	
Hookworm	Kitisiaga (C)	
Infection of womb	Yeloketa	
Kidney disease	Kilewa Sewa (W,M)	
Malaria	Shekeria (W,M,C)	
Malnutrition	Nemsa (C,W)	Also "Bola-kita"
Marasmus	Sahkeries (C)	Lack of balanced diet
Measles	Kufignia (C)	
Pneumonia	Woma (W,C)	
Problem of milk teeth	Bedrech (C)	When milk tooth appears, swelling occurs and illness may follow
Rheumatism	Tosha Hargia (W)	
Scabies	Katcha (C,W)	
Skin disease	Tusa (W,M)	Stays for 3 years
Stomach ache	Aka (C,M)	Also "Kerka"
TB	Ajaje (M,W)	

Wolitigna Language

Approximate English Term	Local Term (M=Men, W=Women, C=Children)	Symptoms / Comments
Tetanus	Tetanus (C)	Due to rusted materials.
Tonsillitis	Seminai (C)	
Toothache	Achasawa (W,M)	
Tumor	Tieya/Tiea) M,W)	
Typhoid	Meshowa(M)	
Vomiting	Chosha (W,M,C)	
Whooping cough	Kufe (C, W)	Also "Keyakufia"
Worms	Oluwa Sawa (C)	

Hadiyigna Language

Approximate English Term	Local Term (M=Men, W=Women, C=Children)	Symptoms / Comments
AIDS	AIDS (M)	
Amoeba	Abogena (M,W)	
Ascariasis/Worms	Henshesha (W,M,C)	Lack of clean water
Asthma	Shinka (M,W)	
Common cold	Gansha (C)	
Coughing	Kuticha (C,W,M)	
Delivery problem (labor, complications of delivery)	Tuchjabbo (W)	The remaining of blood in the womb
Diphtheria	Sorkoba (C)	Epidemic
Dysentery/Diarrhea	Adorra (W,C,M)	Unclean water
Eye disease	Eljabbo (M,W,C)	Cause is unclean water
Fever	Eiba (C)	Due to different illnesses
Gastritis	Satjabbo (W,M)	They call it burning of heart.
Hemorrhoids(W)		Due to pregnancy and child birth, they said
Headache	Horor demuma (M,W)	
Kidney infection	Mur-Jabbo (W)	Due to heavy work
Liver	Afer-Jabbo (W,C)	They also call it backache
Malaria	Hutisha (W,M,C)	Recent phenomenon
Measles	Stekoppa (C)	
Parasites	Godebdekire (M)	
Pneumonia	Kid-Jabbo(W,C)	
Ring worm	Boronsha (C)	Attacks skull
Scabies (like)	Jenjenna(W)	It appears on the leg
Scabies	Kosha (C)	Attacks areas around fingers (hand)
Skin disease	Becherro (W)	Scar like spots over the body (esp. neck)
Stomach ache	Godbe jabbo (C,W.)	
TB	Kedefer-Jabbo(M,W,C)	It is also "Sukoo"
Tonsillitis	Semaga (C)	
Tumor	Mushaa (M)	
Typhoid fever	Lukusho(M)	
Vomiting	Uwisha (C)	

APPENDIX B: ADDITIONAL TABLES

Table B1: Villagers' Criteria for Poverty		
Zone	Village	Who Do You Call Poor?
Sidama	Olola	A person who does not have - enough food, clothing and shelter - enough land - energy to work in the field - helper
	Wessa	Have small plot of land Doesn't have heads of cattle. Doesn't have enough food.
Hadiya	Borbosa	Doesn't have food to eat, clothing to wear and shelter to live. Has small plot of land with large family. Doesn't have draft oxen. Doesn't have cow for milking. Couldn't work due to illness.
	Sagada Bekera	Doesn't have cattle. Doesn't have enough to eat Doesn't have enough land and whose land is infertile. Can't borrow money.
KAT	Chaffa	Doesn't have food to eat and clothing. Doesn't have shelter to live in. Has no land for farming. Has no oxen to plough. Has no milking cows.
	Hansawa	Has no land and cattle. A female-headed household. Can't send their children to school. People who are aged and unhealthy.
North Omo	Oge	Unable to work due to illness. Has no money to support his family. Has no oxen for ploughing or cow for milking. A female-headed household with no money for children. Has small plot of land.
	Demeba	Has no cattle. Doesn't have enough land. Widowed women Children who are orphans.
	Boyne	Doesn't have enough land. Doesn't have anything to eat. Doesn't have cattle and oxen. Female-headed.

Table B2: Women's Perceptions of Children's Health Problems

Zone	Village	Most Common Illness (From most to least common)	Most Severe Illness (From most to least severe)	If we could be free of one illness?
Sidama	Olola	Worms Tonsillitis Diarrhea Ear disease Coughing Skin disease	Worms Tonsillitis Diarrhea Skin disease Coughing Ear disease	Tonsillitis
	Wessa	Worms Kwashiorkor Eye disease Fever Diarrhea Measles	Measles Kwashiorkor Fever Diarrhea Worms Eye disease	Measles
Hadiya	Borbosa	Fever Tonsillitis Vomiting Diarrhea Worms Measles	Tonsillitis Measles Fever Diarrhea Vomiting Worms	Fever
	Sagada Bekera	Vomiting and Diarrhea Worms Pneumonia and Coughing Headache and Fever Malaria Scabies	Vomiting and Diarrhea Pneumonia and Coughing Worms Headache and Fever Malaria Scabies	Vomiting and Diarrhea
KAT	Chaffa	Diarrhea and Vomiting Measles Skin disease Cold Fever Worms	Diarrhea and Vomiting Worms Measles Fever Cold Skin disease	Diarrhea and Vomiting
	Hansawa	Worms Vomiting and Diarrhea Malnutrition Stomach ache Ear disease Eye disease	Vomiting and Diarrhea Malnutrition Worms Stomach ache Ear disease Eye disease	Worms

Table B2: Women's Perceptions of Children's Health Problems

Zone	Village	Most Common Illness (From most to least common)	Most Severe Illness (From most to least sever)	If we could be free of one illness?
North Omo	Oge	Diarrhea and Vomiting Tonsillitis Scabies Eye disease Ear infection Marasmus	Diarrhea and Vomiting Tonsillitis Scabies Ear infection Eye disease Marasmus	Diarrhea and Vomiting
	Demeba	Diphtheria Skin disease Vomiting and Diarrhea Malaria Fever Anemia	Diphtheria Vomiting and Diarrhea Skin disease Fever Malaria Anemia	Diphtheria
	Boyne	Diarrhea and Vomiting Fever and Headache Diphtheria Cold Scabies Hookworm	Vomiting and Diarrhea Fever and Headache Diphtheria Cold Scabies Hookworm	Diarrhea and Vomiting

Table B3: Perceived Health Problems of Women

Zone	Village	Most Common Illness (From most to least common)	Most Severe Illness (From most to least severe)	If we could be free of one illness?
Sidama	Olola	Headache Womb infection Gastritis Rheumatism Asthma TB	TB Headache Womb infection Gastritis Rheumatism Asthma	TB
	Wessa	Malaria Cold Backache Boil Incomplete miscarriage Headache	Malaria Incomplete miscarriage Headache Boil Cold Backache	Incomplete miscarriage
Hadiya	Borbosa	Gastritis Delivery problem Kidney pain TB Worms Liver	Delivery problem Liver Kidney pain Worms TB Gastritis	Kidney pain
	Sagada Bekera	Diarrhea Malaria Cold Hemorrhoid Headache TB	Diarrhea Cold Malaria Headache Hemorrhoid TB	Diarrhea
KAT	Chaffa	Malaria Cold Kidney pain Skin disease Gastritis Worms	Malaria Cold Skin disease Gastritis Kidney pain Worms	Malaria
	Hansawa	Yellow Fever Incomplete miscarriage Kidney pain Typhoid Vomiting and Diarrhea Fever	Yellow Fever Incomplete miscarriage Vomiting and Diarrhea Typhoid Fever Kidney pain	Yellow Fever

Table B3: Perceived Health Problems of Women

Zone	Village	Most Common Illness (From most to least common)	Most Severe Illness (From most to least severe)	If we could be free of one illness?
North Omo	Oge	Gastritis Fever and Headache Miscarriage Kidney pain Pneumonia Malaria	Fever and Headache Miscarriage Pneumonia Gastritis Kidney pain Malaria	Fever and Headache
	Demeba	Vomiting and Diarrhea Womb infection Malnutrition Fever and Headache Gastritis Coughing	Vomiting and Diarrhea Fever and Headache Gastritis Coughing Malnutrition Womb infection	Vomiting and Diarrhea
	Boyne	Vomiting and Diarrhea Incomplete miscarriage Fever and Headache Scabies Dental problem Cold	Vomiting and Diarrhea Incomplete miscarriage Fever and Headache Cold Dental problem Scabies	Vomiting and Diarrhea

Table B4: Perceived Health Problems of Men

Zone	Village	Most Common Illness	Most Severe Illness	If we could be free of one illness?
Sidama	Olola	Diarrhea Malaria Typhoid TB Swelling of the body Cancer	Diarrhea Malaria Typhoid TB Swelling of the body Cancer	Diarrhea
	Wessa	Typhoid Yellow Fever STD Cancer Diarrhea Black leg	Yellow Fever Diarrhea Typhoid STD Black leg Cancer	Diarrhea
Hadiya	Borbosa	Dysentery Worms Malaria Worms Eye disease Kidney pain	Dysentery Malaria Worms Kidney pain Eye disease	Dysentery
	Sagada Bekera	Eye disease Cold Kidney pain Worms TB Diarrhea	Eye disease TB Cold Kidney pain Diarrhea Worms	Diarrhea
KAT	Chaffa	Malaria Typhoid Amoeba TB Diarrhea Heart disease	Malaria Typhoid Amoeba TB Heart disease Kidney	Malaria
	Hansawa	TB Vomiting and Diarrhea Typhoid Malaria Urinary tract infection Epilepsy	Malaria Vomiting and Diarrhea Typhoid Urinary tract infection TB Epilepsy	Malaria

Table B4: Perceived Health Problems of Men

Zone	Village	Most Common Illness	Most Severe Illness	If we could be free of one illness?
North Omo	Oge	Headache Stomach ache TB Skin disease Eye disease Gastritis	Stomach ache Headache TB Skin disease Eye disease Gastritis	All 6 diseases
	Demeba	Malaria Cold Vomiting and Diarrhea TB Dental problem Eye disease	Vomiting and Diarrhea Malaria TB Cold Dental problem Eye disease	Malaria
	Boyne	Vomiting and Diarrhea Kidney pain Cold Malaria Toothache Eye disease	Vomiting and Diarrhea Kidney pain Malaria Cold Eye disease Toothache	Vomiting and Diarrhea

Table B5: Perceived Need for Health Services

Zone	Village	Men	Women
Sidama	Olola	Antenatal and postnatal services Immunization services Health education promotion Malaria control services Family planning services Complete curative services	Training of CHAs and TBAs Promotion of health education Preventive services such as immunizations Curative services Family planning service
	Wessa	Delivery service Health Education Immunization service Family planning Curative services	Antenatal and postnatal service Family planning service Health education Preventive services
Hadiya	Borbosa	Curative services Preventive services Health education Family planning	Antenatal and postnatal services Immunization services Health education Family planning Curative services
	Sagada Bekera	Immunization services Curative services Delivery service	Curative services Immunization services Delivery services
KAT	Chaffa	Immunization services Family planning Curative services Health education Eradication of malaria Antenatal care	Preventive services Promotion of health education Curative services Family planning
	Hansawa	Curative service Delivery service Immunization service Antenatal care Promotion of health education	Promotion of health education Promotion of free curative services for the poor Immunization services Antenatal care Delivery services
North Omo	Oge	Delivery service EPI service Curative services Health education	Family planning Health education
	Demeba	Immunization services Delivery services Health education Curative services Family planning	Family planning Delivery service Immunization services Antenatal and postnatal care
	Boyne	EPI service Family planning Delivery service Curative services Eradication and control of malaria Promotion of health education	Immunization services Family planning Delivery service Antenatal care Curative services

Figure B1: Seasonal Patterns of Well-Being - Olola

When Times are Good												
Most Income			▲	▲	●▲	●▲	●	●	●			
Least Work in Fields	●	●●				●▲				●	▲	▲
Most Food		●	●▲	●▲	▲	▲						
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
 ▲ = Reported by women

When Times are Difficult												
Least Access to Health Facilities	●▲	▲								●	●▲	●▲
Most Illness	●				▲	▲			●	●	▲	▲
Most Debt	●							●	●▲	●▲	▲	▲
Most Work in Fields				▲			●▲	●▲			●	
Least Food									●▲	●▲	●▲	▲
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
 ▲ = Reported by women

Figure B2: Seasonal Patterns of Well-Being - Wessa

When Times are Good												
Most Income			▲▲	▲	▲							●
Least Work in Fields			▲	▲	●▲	●▲	▲				●▲	▲
Most Food	●▲	●▲										●▲
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
 ▲ = Reported by women

When Times are Difficult												
Least Access to Health Facilities											●▲	●▲
Most Illness										●▲	●	
Most Debt									●	●▲	●▲	
Most Work in Fields	▲							●▲	●▲			
Least Food										●▲	●▲	
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
 ▲ = Reported by women

Figure B3: Seasonal Patterns of Well-Being - Barbosa

When Times are Good												
Most Income				▲	●▲	●						▲
Least Work in Fields	●	●										
Most Food	▲			●▲	●▲					●	●▲	
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

When Times are Difficult												
Least Access to Health Facilities	●			●▲							●▲	●▲
Most Illness		▲				●	●▲	●	▲			
Most Debt	●▲			●▲							●▲	
Most Work in Fields			▲	●▲						●	●▲	
Least Food								▲	●▲			●
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

Figure B4: Seasonal Patterns of Well-Being - Sagada Bekera

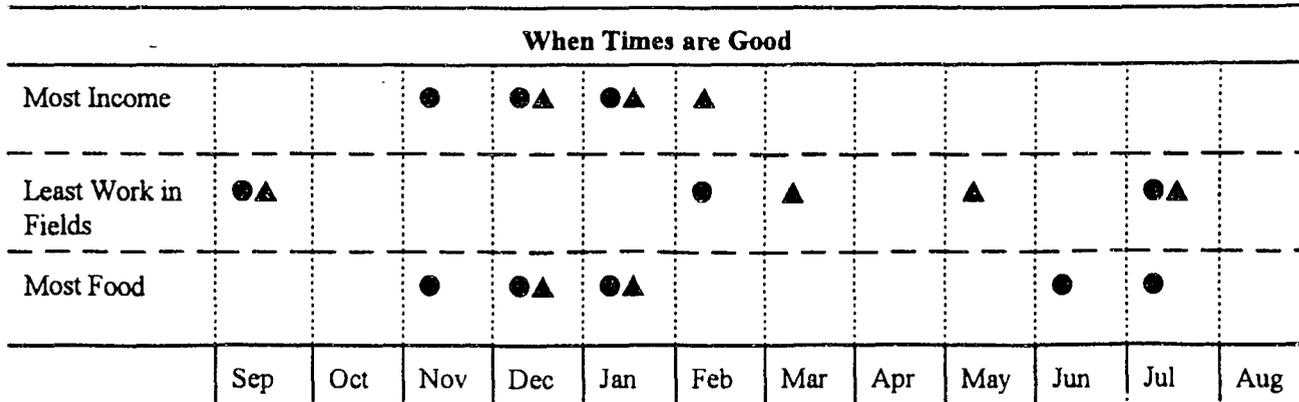
When Times are Good												
Most Income				●▲	●	●	●					
Least Work in Fields	●▲	●▲										●
Most Food				●▲	●▲	●	●●					
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

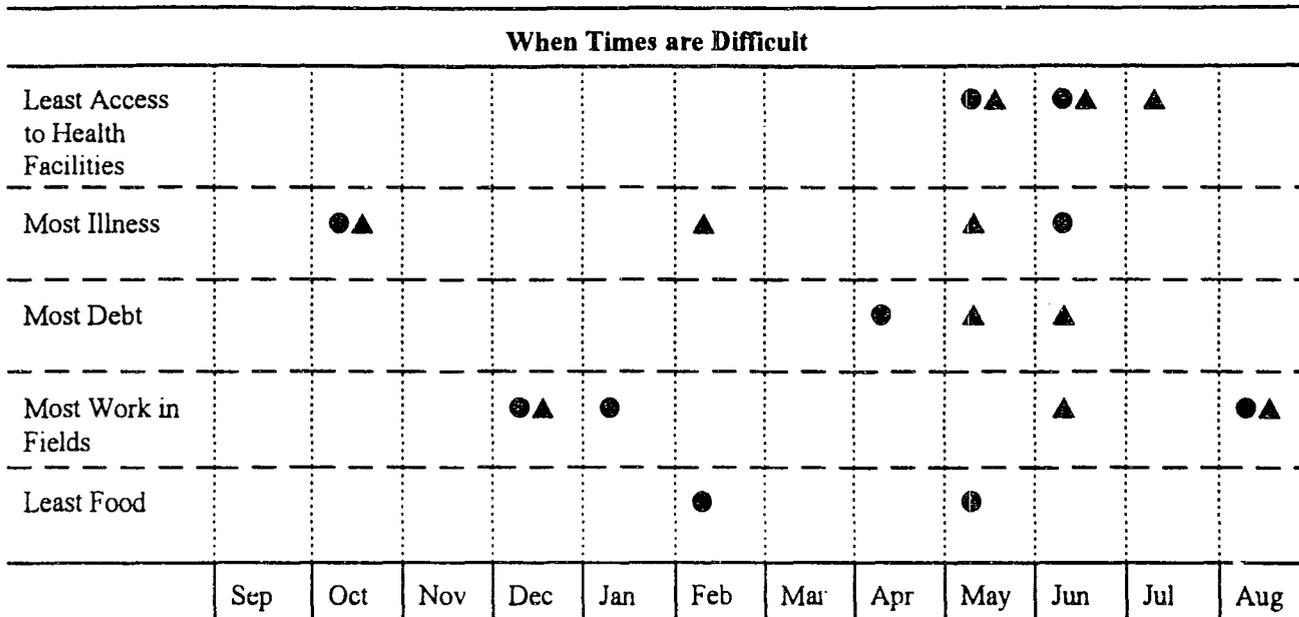
When Times are Difficult												
Least Access to Health Facilities	●	●								●	●▲	●▲
Most Illness					●	●▲	●▲					▲
Most Debt	●▲									●	●▲	●▲
Most Work in Fields				●▲	●▲	●	●				▲	
Least Food	●▲	▲								●	●	●▲
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

Figure B5: Seasonal Patterns of Well-Being - Chaffa



● = Reported by men
▲ = Reported by women



● = Reported by men
▲ = Reported by women

Figure B6: Seasonal Patterns of Well-Being - Hansawa

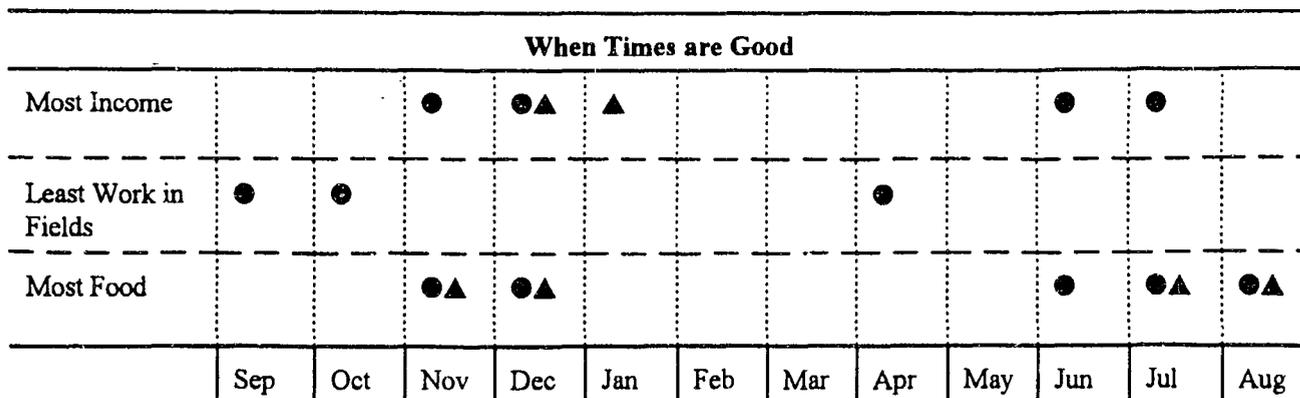
When Times are Good												
Most Income			▲	●▲								
Least Work in Fields	●▲		●▲	▲		▲		●▲	●▲	●		●▲
Most Food	●		●●	●▲							●	●
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

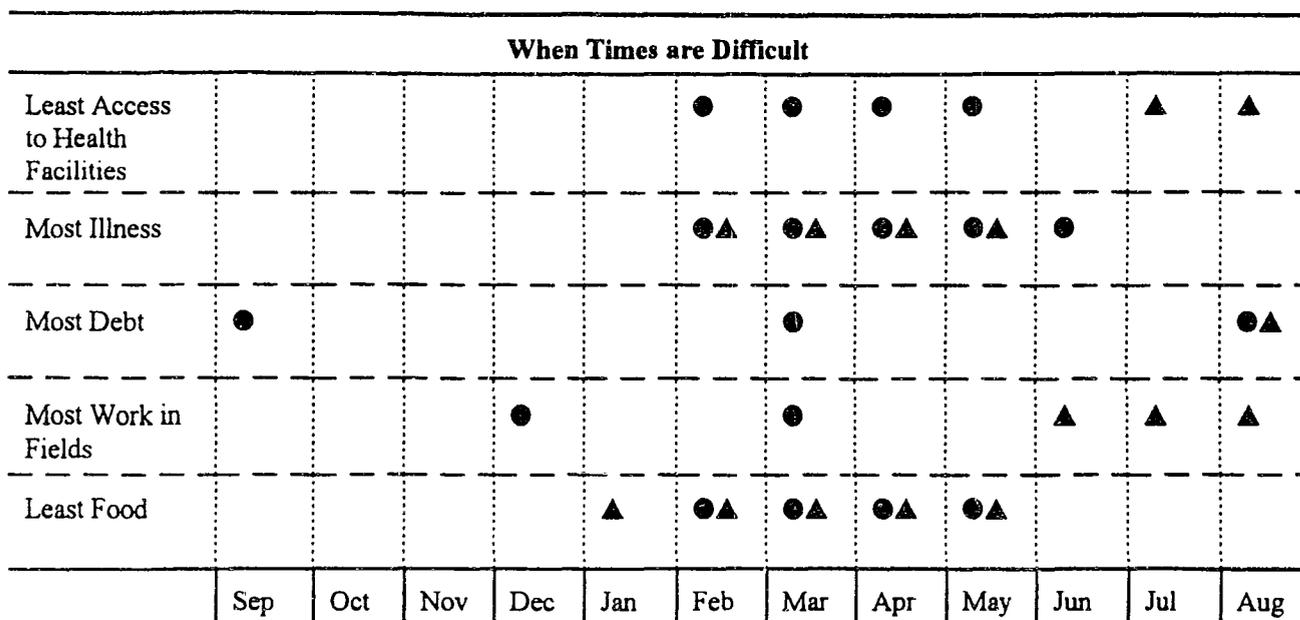
When Times are Difficult												
Least Access to Health Facilities										●	●▲	●
Most Illness		▲				●	●			●▲	●	
Most Debt	●▲				●			▲				
Most Work in Fields		●			●		▲				●▲	
Least Food								▲	▲	▲		
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

Figure B7: Seasonal Patterns of Well-Being - Oge



● = Reported by men
▲ = Reported by women



● = Reported by men
▲ = Reported by women

Figure B8: Seasonal Patterns of Well-Being - Demeba

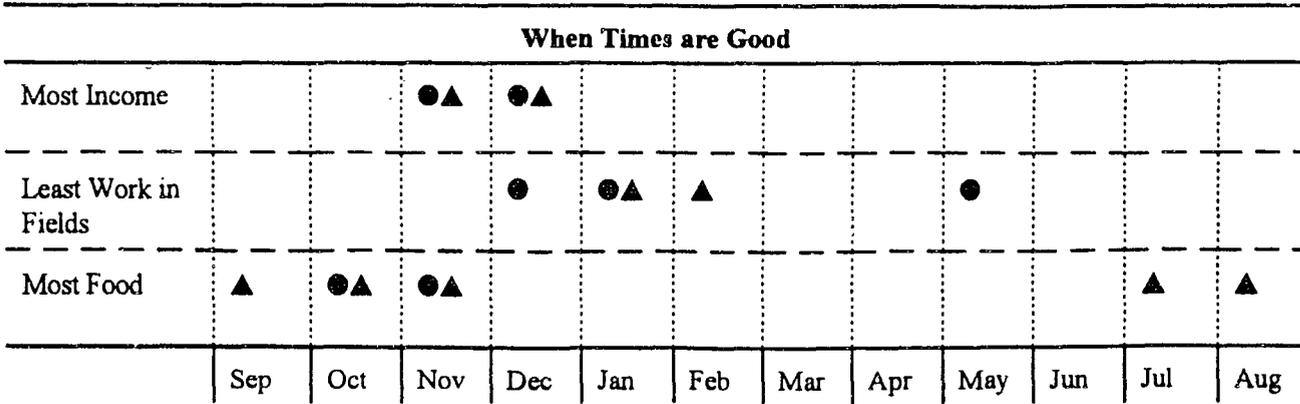
When Times are Good												
Most Income		▲	●▲	●▲								
Least Work in Fields	●▲	▲		●	▲					●▲		●
Most Food	●	●▲	●▲	▲							●	●
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

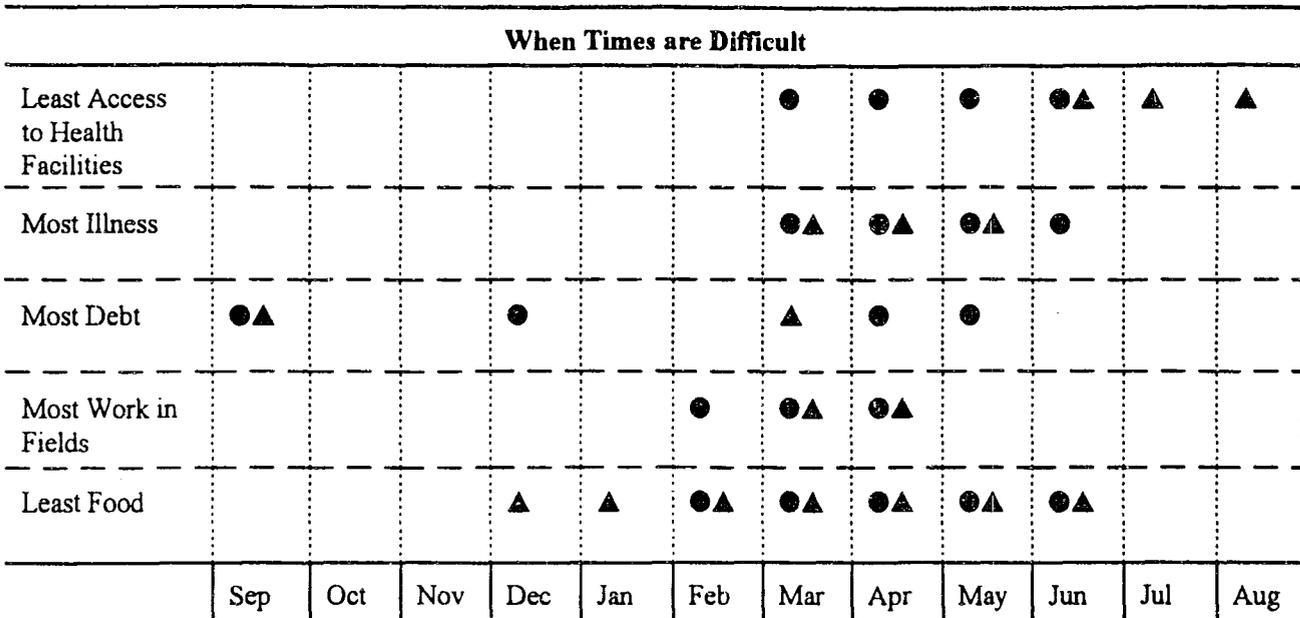
When Times are Difficult												
Least Access to Health Facilities	●				●▲	●▲	●	●	●	●	●▲	▲
Most Illness	▲	●▲		●	●	●		●	●	●	▲	▲
Most Debt	●				▲	▲	●▲	●▲	●▲	●▲		
Most Work in Fields		●				●	●▲				●▲	▲
Least Food				●	●	●	●	●	●	●		
	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

● = Reported by men
▲ = Reported by women

Figure B9: Seasonal Patterns of Well-Being - Boyne



● = Reported by men
▲ = Reported by women



● = Reported by men
▲ = Reported by women

Table B6: Ranking of Health Care Providers

Zone	Village	Most Frequently Visited		Most Expensive		Best Quality		If we could have only 1 provider?	
		Men	Women	Men	Women	Men	Women	Men	Women
Sidama	Olola	Govt. HS Kella HC Drug vendor 1 Awassa HC Loke HC Traditional healer	Drug vendor 1 Govt. H.S. Drug vendor 2 Drug vendor 3 Kella HC Loke HC	Drug vendor 1 Loke HC Kella HC Awassa HC Govt. HS Traditional healer	Drug vendor 1 Drug vendor 3 Kella HC Loke HC Drug vendor 2 Govt HS	Loke HC Govt HS Kella HC Drug vendor 1 Awassa HC Traditional healer	Drug vendor 1 Drug vendor 3 Govt HS Drug vendor 2 Kella HC Loke HC	Govt HS	Drug vendor 1
	Wessa	Bushulo HC Awassa HC Drug vendor 1 Govt HS Drug vendor 2 Traditional healer	Bushulo HC Awassa HC Private clinic Govt HS Traditional healer Yirgalem Hospital	Drug vendor Drug vendor Bushulo HC Govt. HS Awassa HC Traditional healer	Private clinic Govt. HS Yirgalem Hospital Awassa HC Bushulo HC Traditional healer	Drug vendor 2 Bushulo HC Drug vendor 1 Awassa HC Govt HS Traditional healer	Govt. HS Awassa HC Bushulo HC Private clinic Yirgalem Hospital Traditional healer	Bushulo HC	Bushulo HC

Table B6: Ranking of Health Care Providers

Zone	Village	Most Frequently Visited		Most Expensive		Best Quality		If we could have only 1 provider?	
		Men	Women	Men	Women	Men	Women	Men	Women
Hadiya	Borbosa	Hossana Hospital Drug vendor 1 Malaria center Mission HS 1 Drug vendor 2 Mission HS 2	Hossana Hospital Hossana HC Drug vendor 3 Drug vendor 2 Drug vendor 4 Drug vendor 1	Drug vendor 1 Drug vendor 2 Hossana Hospital Mission HS 1 Mission HS 2 Malaria center	Drug vendor 2 Drug vendor 4 Drug vendor 1 Drug vendor 3 Hossana HC Hossana Hospital	Drug vendor 1 Hossana Hospital Drug vendor 2 Malaria center Mission HS 1 Mission HS 2	Drug vendor 3 Drug vendor 4 Hossana Hospital Drug vendor 1 Drug vendor 2 Hossana HC	Hossana Hospital	Drug vendor 3
	Sagada Bekera	Govt HS 1 Hossana Hospital Traditional healer Traditional healer Red Cross Pharmacy Drug vendor 1	Govt HS 2 Drug vendor 2 Hossana Hospital TBA Drug vendor 3 TBA	Drug vendor 1 Hossana Hospital Red Cross Pharmacy Govt. HS 1 Traditional healer Traditional healer	Drug vendor 2 Hossana Hospital Govt HS 2 Drug vendor 3	Hossana Hospital Govt HS 1 Drug vendor 1 Red Cross Pharmacy Traditional healer Traditional healer	Govt HS 2 Drug vendor 2 Drug vendor 3 Hossana Hospital TBA TBA	Hossana Hospital	Govt HS
KAT	Chaffa	Mission HS 1 Govt HS Yirgalem Hospital Drug vendor 1 Drug vendor 2 Mission HS 2	Mission HS 1 Govt HS Drug vendor 2 Drug vendor 1 Drug vendor 3 Drug vendor 4	Drug vendor 1 Govt HS Drug vendor 2 Mission HS 2 Mission HS 1 Yirgalem Hospital	Drug vendor 3 Drug vendor 1 Drug vendor 4 Drug vendor 2 Govt. HS Mission HS 1	Drug vendor 1 Mission HS 1 Yirgalem Hospital Mission HS 2 Drug vendor 2 Govt. HS	Mission HS 1 Drug vendor 3 Drug vendor 1 Drug vendor 2 Govt. HS Drug vendor 4	Drug vendor 2	Govt. HS
	Hansawa	Mission HS 1 Mission HS 2 Drug vendor 1 Drug vendor 2 Ottana Hospital Yirgalem Hospital	Mission HS 2 Mission HS 1 Drug vendor 3 TBA Durame HC Traditional healer	Drug vendor 1 Drug vendor 2 Mission HS 2 Yirgalem Hospital Ottana Hospital Mission HS 1	Drug vendor 3 Mission HS 2 Durame HC Mission HS 1 TBA Traditional healer	Mission HS 2 Mission HS 1 Ottana Hospital Drug vendor 1 Drug vendor 2 Yirgalem Hospital	Mission HS 2 Durame HC Mission HS 1 TBA Traditional healer Drug vendor 3	Mission HS 2	Mission HS 2

Table B6: Ranking of Health Care Providers

Zone	Village	Most Frequently Visited		Most Expensive		Best Quality		If we could have only 1 provider	
		Men	Women	Men	Women	Men	Women	Men	Women
North Omo	Oge	Drug vendor 1 Sodo Hospital TBA/Bone setter Drug vendor 2 Drug vendor 3 Drug vendor 4	Drug vendor 1 Sodo Hospital Sodo HC Drug vendor 5 Drug vendor 2 Drug vendor 6	Ottana Hospital Drug vendor 2 Drug vendor 1 TBA/Bone setter	Drug vendor 1 Drug vendor 6 Drug vendor 5 Drug vendor 2 Sodo Hospital Sodo HC	Sodo Hospital Sodo HC Drug vendor 5 Drug vendor 2 Drug vendor 1 Drug vendor 6	Sodo Hospital Sodo HC Drug vendor 5 Drug vendor 2 Drug vendor 1 Drug vendor 6	Sodo Hospital	Drug vendor
	Demeba	Drug vendor 1 NGO HS Ottana Hospital Govt. HS 1 Govt HS 2 Drug vendor 2	Drug vendor 3 Sodo HC Govt. HS 3 Drug vendor 1 TBA Traditional healer	Ottana Hospital Drug vendor 2 Drug vendor 1 Govt. HS 2 Govt. HS 1 NGO HS	Drug vendor 3 Govt. HS 3 Drug vendor 1 Sodo HC Traditional healer TBA	Ottana Hospital NGO HS Drug vendor 2 Govt. HS 1 Govt. HS 2 Drug vendor 1	Sodo HC Drug vendor 3 Drug vendor 1 Govt. HS 3 TBA Traditional healer	Drug vendor 1	Sodo HC
	Boyne	Govt. HS 1 Drug vendor 1 Drug vendor 2 Ottana Hospital Govt. HS 2 Drug vendor 3	Govt. HS 1 TBA Traditional healer Drug vendor 1 Drug vendor 4 Sodo Hospital	Ottana Hospital Drug vendor 2 Drug vendor 1 Govt. HS 1 Drug vendor 3	Sodo Hospital Drug vendor 4 Govt. HS 1 Traditional healer TBA Drug vendor 1	Ottana Hospital Govt. HS 1 Drug vendor 2 Drug vendor 1 Drug vendor 3 Govt. HS 2	Sodo Hospital Govt. HS 1 TBA Traditional healer Drug vendor 4 Drug vendor 1	Govt. HS 1	Govt. HS 1

Table B7: Recommended Criteria for CHA Selection and Contribution

Zone	Village	Criteria for CHA Selection		Willing to Contribute for CHA?	
		Men	Women	Men	Women
Sidama	Olola	Educated above 8th grade Free from any addictions Committed to service to villagers with distinction	Have basic education Committed and dedicated to serve the community Not having large family	Willing not to pay because the group suggested costs to be covered by the government since they are poor	Willing to pay according to the services by CHAs and affordability of the community in kind or in cash
	Wessa	Ability to read & write Basic knowledge of health	Must be selected by community 12 grade completed Basic health experience Respects the community Not addicted	Willing to pay according to the service provided	Willing to pay in cash according to the community capability
Hadiya	Borbosa	Has to be educated Willingness to serve villagers Must be selected by community Committed to provide service	Ability to read and write Basic education and able to take training Must be patient No addictions Above 20 yrs old Must be female Selected by community	Willing to contribute as what is needed	Willing to pay bill 100 per month
	Sagada Bekera	Must complete 12 grade Must have basic health experience Committed and dedicated	Must read and write Have patience Loyal and dedicated	Willing to be covered by the government	Willing to pay in cash or in kind according to the CHAs services
KAT	Chaffa	Must be selected by the community Must complete 12th grade Must be trusted by villagers Not addicted Must be respected by his family and community	Ability to read and write Committed and dedicated to provide health service Have free time and willingness Have no family problems Selected by community	Willing the payment to be covered by the government	Willing to contribute in cash or in kind according to the service provided

Table B7: Recommended Criteria for CHA Selection and Contribution

Zone	Village	Criteria for CHA Selection		Willing to Contribute for CHA?	
		Men	Women	Men	Women
	Hansawa	Must have better communication with the villagers Have basic education Not addicted Selected by community	Healthy person Complete 12th gr Genuine and dedicated willingness to serve day and night Not addicted Basic health education	Willing to pay in labor	Willing to contribute in cash or in-kind according to their affordability
North Omo	Oge	Must be selected by the community Completed 12th grade Must be respected and accepted by community 25-30 yrs old and married Willing to service the community	Selected by community Basic education Free time to serve Loyal and willingness	The payment must be decided by the all villages	Willing to contribute according to their affordability
	Demeba	Must read and write Loyal and close to the villagers Good character and not addicted Should respect and love the villagers Selected by community	Must be selected by the community Must complete 12th gr Must be trusted by villagers Basic health experience	Willing to be covered by the government since they are poor	Willing to contribute Birr 0.30 (family) month
	Boyne	Must be selected by community Complete 12th gr Loyal to villagers Must be married Must be male	Selected by community Read and write Understand problems of community Not addicted Love of community Health person	Willing to be covered by NGOs	Not willing to contribute in cash, in-kind, or even in labor.

APPENDIX C: DATA COLLECTION PROCEDURES

**Ethiopia Community Demand Study
Research Questions to Methods Matrix**

Research Question	A: Ranking the Priority of Health (M/W)	B: Social Mapping (M/W)	C: Seasonal Diagraming (M/W)	D: Ranking Health Problems (M/W)	E: Ranking Providers (M/W)	F: Provider Interviews	G: Illness or Death Narratives	H: Focus Group Discussion (M/W)
Health as a Priority								
1. How high a priority do local communities place on health compared with other problems they face (especially food and water)?	X							
Perceived Health Problems and Demand for Services								
2. What are the 5 most important health problems of <u>men, women, and children</u> in the village?				X				
3. What are the 5 most important health services that people want provided to them?				X				X
4. What are the seasonal variations in time availability, cash availability, food availability, illness, access to clinics/medicine, and migration?			X					
5. How do people perceive the health services intended for them in terms of cost, hours, quality of service and care, and staff?					X		X	
6. What are the costs of medicine? What is the time and geographic access to medicine? How important are commercial medicine in the assessment of the quality of service?					X		X	X
Care-Seeking Behavior								
7. Where do people go for health care - government, traditional, informal? How has this changed over the past 5-10 years?		X					X	

Research Question	A: Ranking the Priority of Health (M/W)	B: Social Mapping (M/W)	C: Seasonal Diagraming (M/W)	D: Ranking Health Problems (M/W)	E: Ranking Providers (M/W)	F: Provider Interviews	G: Illness or Death Narratives	H: Focus Group Discussion (M/W)
8. Where do people go for deliveries, immunizations, and other preventive services?		X			X			
9. Where do people go for curative care?		X			X		X	
10. What are the most important criteria that people use to decide <u>where</u> to go for treatment (e.g., type of illness, geographic accessibility, availability of medicine, perceived quality, etc.)?					X		X	
11. What is the pattern of utilization of government, NGO, and traditional health services (especially TBAs, CHAs)? In other words, do people seek care from several providers simultaneously or do they see providers sequentially? Who do they visit first, second, third?					X		X	
12. What is the role of CHAs, TBAs, and other extension agents as perceived by the community?					X		X	X
Willingness and Ability to Pay								
13. What do people currently pay for <u>preventive health services</u> ?							X	X
14. What do people currently pay for <u>curative health services</u> ?							X	X
15. What do people consider a reasonable or affordable amount of money to pay for <u>preventive health services</u> ?			X					X
16. What do people consider a reasonable or affordable amount of money to pay for <u>curative health services</u> ?			X					X

Research Question	A: Ranking the Priority of Health (M/W)	B: Social Mapping (M/W)	C: Seasonal Diagraming (M/W)	D: Ranking Health Problems (M/W)	E: Ranking Providers (M/W)	F: Provider Interviews	G: Illness or Death Narratives	H: Focus Group Discussion (M/W)
17. What are the patterns of borrowing and pawning assets for health care? Who is asked for money (e.g., Is there a "money lender" or through relatives)? How much is borrowed for health care? How is it repaid (e.g., interest rates, labor)?			X				X	X
Community Based Health Care Providers								
18. What is the range of provider fees? How do providers determine how much to charge? Do providers charge less to poorer people?						X		
19. Into which community structures or organizations fit CHAs and TBAs (e.g., health or development committees)? How are they selected and held accountable to the community?						X		
20. What types of financing mechanisms have CHAs and TBAs experienced (e.g., revolving drug funds, community funds, etc.)?						X		
21. What are the perceived needs of CHAs? TBAs?						X		
22. What are the perceived roles and responsibilities of TBAs and CHAs? Does this include education, prevention, and referral?						X		
23. What referral networks exist currently?						X		
24. How do health center/station staff see the role of CHAs, and what is their capacity to provide support?						X		

Procedure A: Free Listing and Ranking of Problems

Purpose: To understand the problems that people face and what priority is given to health.

Who: The ranking will be done with two groups, one of men and one of women, of 6-8 people by 2 interviewers. The participants should not be too old (who might have very traditional ideas) or too young (who might not have enough experience). A good estimate might be people who have children who are 10-15 years old.

Materials: A clear space to draw the matrix. Different leaves or grains to show different problems.

Procedure: Have the group sit in a circle near an open area. Try to keep the number of spectators to a minimum. The moderator will facilitate the group and the note-taker will fill out the forms. The moderator explains the purpose of the activity and asks each person in turn to list the problems they face. One by one, everyone lists a problem until no one can think of any more. These are written onto form A.1 by the note-taker.

If there are more than 6 problems you will have to read out the problems and ask the participants which are the most important problems. Eliminate the least important problems until you have 6 problems.

Next, the 6 problems are ranked according to importance. Have the group draw a symbol or place a leaf to show each of the six problems in a row. Then ask them to place grain or stones under each problem to show which is a more important problem. The more stones or grain, the more important that problem is. When they have finished, say

"This shows that the most important problem is ____ and the least important is _____. Is this correct?"

Record the ranking on Form A.2.

Discuss the criteria that they used to determine the importance of problems. Keep notes of the discussion that takes place.

Ask them "If you could have only one of these problems solved, which would it be?" Does this match the problem that was ranked as most important?

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form A.2: Ranking of Problems

What are the most important problems in your village?

	Problem A:	Problem B:	Problem C:	Problem D:	Problem E:	Problem F:
Most Important						

[Write the numbers 1 through 6 in the appropriate boxes. 1 is the most important and 6 is the least important.]

How do you know which problems are the most important? What makes some problems important and others not so important?

If you could solve only 1 of these problems, which would you choose and why?

Other Comments

Moderator: _____

Note-Taker: _____

Procedure B: Social Mapping

Purpose: To establish rapport with the villagers. To identify households which had experienced a serious illness, delivery or death in the past 3 months, the sources of health care, and changes in the past 10 years.

Who: This will be done by 1 moderator and 1 note-taker per group. The mapping will be done with two groups, one of men and one of women, of 6-8 people. The participants should not be too old (who might have very traditional ideas) or too young (who might not have enough experience). A good estimate might be people who have children who are 10-15 years old.

Materials: A clear space to draw the maps. Different leaves or grains to show health facilities and poor households.

Procedure: Have the group sit or stand near an open area. Try to keep the number of spectators to a minimum. The moderator will facilitate the group and the note-taker will draw the map and take notes. The moderator explains the purpose of the activity.

Ask the participants to draw a map of their village using sticks or chalk to draw the outline and leaves, corn cobs etc. to show important landmarks.

Once the outline of the village is drawn (there is no need to show each individual house), ask the following questions and ask them to show them on the map using leaves, pebbles, etc.

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form B.1: Mapping

Draw Map Here:

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

1. Ask about the general background on the village:

a. Total number of households and approximate population: _____

b. Percent who can read and write in the local language:

Men _____ Women _____

c. Main occupations of villagers: _____

What kinds of village groups exist? (including women's organizations, health or development committees, etc.)

2. Where are all the places you go for health care and deliveries? (this should include clinics, drug peddlers, traditional healers and birth attendants and any other source). [NOTE: If the source is outside the village, have them show the direction and ask how long it takes to reach the provider.]

3. How have the sources of health care changed over the past 10 years?

4. Where are all the places that you get medicines? (if different from sources of health care)

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

5. Which households have experienced a deaths, delivery or serious illness in the past 3 months? (Ask for the approximate age and cause of death for each. Get the names so that these people can be contacted later.)

6. According to your perception, who do you call poor?

7. Where are the poorest households in the village? (Which households are unable to borrow money? Which are female-headed households?)

Moderator: _____

Note-Taker: _____

Procedure C: Seasonal Diagramming

Purpose: To understand the seasonal variations in illnesses, time, cash and access to health care facilities.

Who: The diagramming will be done with two groups, one of men and one of women, of 6-8 people. The participants should not be too old (who might have very traditional ideas) or too young (who might not have enough experience). A good estimate might be people who have children who are 10-15 years old.

Materials: A clear space to draw the diagrams. Different leaves or grains to show different time, food, illness, income, access to facilities.

Procedure: Have the group sit in a circle near an open area. Try to keep the number of spectators to a minimum. The moderator will facilitate the group and the note-taker will fill out the forms. The moderator explains the purpose of the activity.

Begin with a discussion of the local names of the months or seasons - however they divide up their year. Draw boxes in a clear area and explain that each box represents a month (or whatever their division of the year is) of the year. Then ask the participants to fill the boxes with pebbles, leaves, or anything else available to show the amount of work in the fields during each month.

Draw another line of boxes and ask participants to fill the boxes to show the heaviest work in the home. Continue in this way to show the 1) food availability, 2) times of income, 3) times of expenditure, 4) times of debt, 5) times of illnesses, 6) difficult access to health care facilities and 7) times of migration.

[NOTE: If you need more room to draw boxes, you can wipe off some of the earlier ones but always leave the boxes showing work in the fields at the top.]

One interviewer should fill in Form C.1, write down the names of the months and take notes of the discussions which take place.

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Work in the Fields

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Work in the Home

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Availability of Food

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Times of Income

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Times of Expenditure

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men ____

Zone: _____

Women ____

Form C.1

Times of Debt

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Times of Illness

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Difficult Access to Health Facilities

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbut		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form C.1

Times of Migration

Month	Diagram	Comments
Meskerem		
Tikemt		
Hidar		
Thaisas		
Tir		
Yekatit		
Megabit		
Miaza		
Ginbot		
Sene		
Hamele		
Nehase		

Moderator: _____

Note-Taker: _____

Procedure D: Free Listing and Ranking of Health Problems

Purpose: To understand what the most important health problems are for men, women, and children.

Who: The ranking will be done with two groups, one of men and one of women, of 6-8 people by 2 interviewers. The participants should not be too old (who might have very traditional ideas) or too young (who might not have enough experience). A good estimate might be people who have children who are 10-15 years old.

The men should rank men's illnesses.
The women should rank women's illnesses
The women should also rank children's illnesses on a separate form.

Materials: A clear space to draw the matrix. Different leaves or grains to show different health problems.

Procedure: Have the group sit in a circle near an open area. Try to keep the number of spectators to a minimum. The moderator will facilitate the group and the note-taker will fill out the forms. The moderator explains the purpose of the activity and asks each person in turn to list the most important health problems that they face. One by one, everyone gives the name of a common illness until no one can think of any more. These are written onto form D.1 by the note-taker.

[NOTE: If people have difficulty thinking of health problems, help them by asking what problems they have in the rainy season, the dry season, etc.]

If there are more than 6 illnesses, you will have to read out the illnesses and ask the participants which are the least common illnesses. Eliminate the least common illnesses until you have 6 illnesses.

Next, the 6 illnesses are ranked according to importance, common, and severity. Have the group draw a symbol or place a leaf to show each of the six illnesses in a row. Then ask them to place grain or stones under each illness to show which is more common. The more stones or grain, the more common that illness is. When they have finished, say

"This shows that the most common illness is ___ and the least common is ___. Is this correct?"

Record the ranking on Form D.2.

Next, clear the stones or grain and ask them to place them under the illnesses according to severity. The more grain or stones, the more severe the illness. Follow the same procedure as above.

Explain the final ranking to the participants and ask if this makes sense to them. Would they agree with the ranking they produced?

Discuss the criteria that they used to determine the importance health problems. Keep notes of the discussion that takes place.

Ask them "If you could be free of any 1 health problem in the village, what would it be?" Does this match the health problems that were ranked most common or severe?

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form D.2: Ranking of Health Problems for Men __, Women __, Children __

What are the most common health problems of _____ (Men, women, children) in your village?

	Illness A:	Illness B:	Illness C:	Illness D:	Illness E:	Illness F:
Common						
Severe						

[Write the numbers 1 through 6 in the appropriate boxes. 1 is the most common or most severe and 6 in the least common or least severe illness.]

How do you know when an illness is severe:

If you could be free of one illness, what would it be and why?

Other Comments

Moderator: _____

Note-Taker: _____

Procedure E: Free Listing and Ranking of Providers

Purpose: To understand how people categorize providers and where people go for curative and preventive care. To rank health care providers based on cost, quality of service and frequency of visits.

Who: The ranking will be done with two groups, one of men and one of women, of 6-8 people by 2 interviewers. The participants should not be too old (who might have very traditional ideas) or too young (who might not have enough experience). A good estimate might be people who have children who are 10-15 years old.

Materials: A clear space to draw the matrix. Different leaves or grains to show different providers.

Procedure: Have the group sit in a circle near an open area. Try to keep the number of spectators to a minimum. The moderator will facilitate the group and the note-taker will fill out the forms. The moderator explains the purpose of the activity and asks each person in turn to list the health providers they visit. One by one, everyone gives the name of a provider until no one can think of any more. These are written onto form E.1 by the note-taker.

If there are more than 6 providers, you will have to read out the providers and ask the participants which are the least visited providers. Eliminate the least visited providers until you have 6 providers.

Next, the 6 providers are ranked according to frequency of visits, quality and expense. Have the group draw a symbol or place a leaf to show each of the six providers in a row. Then ask them to place grain or stones under each provider to show which is more frequently visited. The more stones or grain, the more frequently that provider is visited. When they have finished, say

"This shows that the most frequently visited provider is ____ and the least frequently visited is _____. Is this correct?"

Record the ranking on Form E.2.

Next, clear the stones or grain and ask them to place them under the providers according to the quality. The more grain or stones, the better quality that provider is. Follow the same procedure as above.

Then follow the same procedure to rank providers according to expense.

Discuss the criteria that they used to determine the best quality of providers. Keep notes of the discussion that takes place.

Ask them "If you could have only one of these providers, which would it be?" Does this match the providers that were ranked as most frequently visited or best quality?

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Form E.2: Ranking of Health Care Providers

Who are the most frequently visited providers in your village?

	Provider A:	Provider B:	Provider C:	Provider D:	Provider E:	Provider F:
Most Frequently Visited						
Best Quality						
Most Expensive						

[Write the numbers 1 through 6 in the appropriate boxes. 1 is the most frequently visited, best quality, or most expensive and 6 is the least frequently visited, worst quality and least expensive.]

How do you know when provider is high quality? What do you look for in a health care provider?

If you could have only 1 of these providers, who would you choose and why?

Other Comments

Moderator: _____

Note-taker: _____

Procedure F: Interviews with Health Care Providers

Purpose: To understand the role and needs of community based health care providers, including Community Health Agents and traditional healers.

Who: This will be done by one interviewer with each health care provider for a total of 6-10 interviews per study site.

Selection of Health Care Providers: Interviews should be conducted with the health care providers used most often by people in the study village(s). This should include:

- Traditional healers,
- Traditional birth attendants,
- Private practitioners (qualified and unqualified),
- Pharmacists / Drug vendors
- Community Health Agents
- Health Station staff
- Health Center Staff

Explain to them the purpose of the demand study and assure them that their answers will be completely confidential.

Form F.1
Interviews with Health Care Providers

1. Date of Interview _____
2. Interviewer: _____
3. Village _____
4. Zone _____
5. Type of Provider:
 - ___ CHA
 - ___ Pharmacist / Drug Vendor
 - ___ Traditional healer
 - ___ Traditional birth attendant
 - ___ Health Center Staff, Position: _____
 - ___ Health Station Staff, Position: _____
 - ___ Other SPECIFY _____
6. How far is the provider from the village?
 - ___ Inside the village
 - ___ Outside the village >> How many hours to reach provider? _____

General Information

7. How many years have you been practicing? in this area?
Total years _____ In this Area _____
8. How did you learn your skills as a health care provider?
9. Approximately, how many people do you treat each week?
Men _____ Women _____ Children _____

10. What are the most common illnesses that you see among men, women, and children?

Men:

Women:

Children:

Services Provided

11. What are your hours of service? Are you available if there is an emergency?

12. Do you provide any services which prevent illnesses? If yes, what? (e.g. immunizations, vitamins, amulets, etc.)

13. Do you ever refer your patients to other providers?

Yes No

If yes, under what circumstances would you refer patients and who would you refer them to?

14. Do other providers ever refer patients to you?

Yes No

If yes, who refers patients to you and under what circumstances would they be referred to you?

15. How often do you provide outreach services? That is, services in people's homes or in central locations in the village? What type of services do you provide through outreach (e.g. health education, immunization, antenatal care, etc.)

16. What do you think are the most essential or important health services for the people you serve?

17. Do you have medicines here? Are they always available? Specifically, do you have the following medicines?

ORS:	Yes	No	Charge	_____
Chloroquine:	Yes	No	Charge	_____
Antibiotics:	Yes	No	Charge	_____
Oral Contraceptives:	Yes	No	Charge	_____
Worm medicine:	Yes	No	Charge	_____

Fees and Charges

18. How much do you charge for your services? How do you decide what to charge?

19. Do you ever extend credit to people? Do you accept in-kind payments? (e.g. food, labor, etc.)

20. Do the people most in need of health care always receive it? If no, why not?

Roles and Responsibilities

21. As a provider, what are your primary roles and responsibilities (e.g. preventive services, health education)? How is this the same or different from other providers?

22. What can local communities do to improve their health?

23. What are the greatest difficulties you face in providing health care?

24. Do you interact with local community organizations, such as a health committee?

Yes No

If yes, what types of community groups do you work with and how do you work with them?

25. How could the relationship between the community and providers be improved?
26. How do you think the staff in Health Centers and Stations should support and work with other providers, especially Community Health Agents (CHAs) or Traditional Birth Attendants (TBAs)?
27. How could the relationship between the Health Center / Health Station and providers be improved?

Thank You!

Procedure G: Narratives of Illnesses, Deaths, and Deliveries

Purpose: To understand the patterns of treatment seeking behavior. To document the costs of health care.

Who: There will be one on one interviews with each respondent for a total of 20-25 interviews per study site.

10 narratives about children under 5 years old

5-7 narratives about women age 15-45, including some deliveries

5-7 narratives about men age 15-45

Selection of Respondents: Interviews should be conducted with the people or households identified during the social mapping who had experienced a death, serious illness, or delivery in the past 3 months.

Households should be selected to include the following characteristics:

- Main ethnic groups
- Poor and non-poor households, such as female headed households

EXCLUDE people who died from "old age".

Form G.1
Narratives of Illnesses, Deaths and Deliveries

1. Date of Interview _____

2. Interviewer _____

3. Village _____

4. Zone _____

5. Type of Narrative:

Illness

Death

Delivery

Other SPECIFY _____

6. Respondent's relationship to the person who was ill, died or delivered:

Self

Mother

Father

Grandmother

Other SPECIFY _____

7. Age and sex of person who was ill, died or delivered:

Age: _____ years

Male

Female

8. The Story of the Illness, Death or Delivery

Could you tell me what happened from the beginning?

9. What was the problem? When did you first realize the person was sick or needed care?

10. What did you do at home for the person who died, was ill or delivered? How did that help?

Decision to Seek Care

11. How did you first decide to seek treatment outside the home? Who did you discuss it with? Who disagreed with the decision?

12. How did you decide to visit those specific providers instead of other providers?

13. Who paid for the treatment? [Note if a different person paid for different providers.]

Time and Money

14. How much did you pay for the treatment? medicines? transportation?
How long did it take you to reach each place from your home?

How many places did you visit for treatment or medicines for this problem?

[Fill in table - from first place of treatment to the last]

Place	Costs			Time it took to reach
	Registration and Consultation	Transport	Medicines	
1.				
2.				
3.				
4.				
5.				

15. Did any of the people or places that you visited extend credit to you?

Yes HOW MUCH? _____
 No

16. How much money did you have to borrow to come to each of those places?
Did you give something in exchange (e.g. grain)?

How long did it take for you to arrange the money?

[Fill in table]

Place	Amount Borrowed	Source of money	Repayment Terms	Time it took to arrange the money
1.				
2.				
3.				
4.				
5.				

17. Did you have to sell or pawn anything to pay for treatment? If yes, what?

18. Do you think the treatment you got was "worth the money"? Why or why not?

19. Comments on Family Background

Procedure H: Focus Group Discussion

Purpose: To have the local community discuss the role of CHAs and TBAs and their willingness and ability to pay for health services.

Who: This will be done by 2-4 interviewers with 2 groups (1 with men and 1 with women) of 6-8 people. Try not to include 2 people from the same family as one person might be reluctant to speak in front of the other. The participants should not be too old (who might have very traditional ideas) or too young (who might not have enough experience). A good estimate might be people who have children who are 10-15 years old.

Materials: A quiet place to hold the discussion where there are not too many spectators or other distractions.

Procedure: One interviewer will serve as the moderator and the other will take notes during the session. Use the following topic guide for the discussion. The discussion should follow the guide loosely. The purpose of the focus group is to generate ideas from the participants. The moderator should not provide information or contradict anything which has been said. The moderator is NOT an interviewer but should stimulate the conversation. Ideally, the focus group will need little intervention.

Some Tips

- Ensure as much as possible the equal participation of everyone, don't let one person dominate or other remain quiet
- Use open-ended questions (which cannot be answered yes or no) to minimize the moderator's influence on the discussion.
- Use previous comments in forming the next questions.
- Help keep the discussion from going too far away from the topics but DO NOT allow it to become a question and answer session.
- Probe for details and explanations of statements: For example, a poor woman says "All the decisions are made by the elders, so we can do nothing." The moderator should probe as to which decisions specifically are made by the elders.
- Point out contradictions in statements (e.g. you just said doctor x is better but now you say you always go to doctor y)

The note-taker should:

- Write down all the main points in the words of the participants as much as possible
- Write down disagreements that occur
- Keep track of any major interruptions or disturbances
- Write down how the questions are asked by the moderators

Focus Group Discussion Guide

Introduction: "We are working in SEPR for community development. We are here to learn about your problems so that we can improve the delivery of social services. We would like this to be a group discussion so there are no right or wrong answers and everyone should participate."

1. What are the root causes of ill health? What changes are necessary to improve health of people in this village?
2. If you could design a health system for your P.A., what would it look like? What are the most important health services that people in your village need (e.g. immunization, family planning, antenatal care, post-natal, growth monitoring, etc.)?
3. What has been your experience with Community Health Agents or trained Traditional Birth Attendants? What services do they provide? What is the quality of their services?
4. What do you think about having someone from a nearby village visiting periodically to teach you about health and treat minor illnesses? Do you think this would improve your health? Would you trust such a person with your health problems?
5. How should such a person be selected? What criteria should be used?
6. How much would you be willing to contribute, in cash or in kind, to have such a community health agent?
7. How much did you spend (cash or kind) on health care during the past 3 months for your household? What do you currently pay for deliveries on average? For children's illnesses? For adult illnesses? For medicines?
8. How do you usually pay for health care? Mention the sources of payment (e.g. P.A. certificate, borrowing, credit, in-kind payments).
9. What do you consider a reasonable or affordable amount of money to pay for preventive health services like deliveries and immunizations?
10. What do you consider a reasonable or affordable amount of money to pay for curative health services?

Village: _____

Number of Participants: Men _____

Zone: _____

Women _____

Page ____ of ____

Form H.1: Field Notes

Actual Statements

Comments/Observations

Moderator: _____

Note-Taker: _____

