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Meron Dejen Asfaha Date

Socio-Contextual Determinants of Community-Level Care Seeking for Neonatal Possible Severe Bacterial Infection (PSBI) in Amhara, Ethiopia

By

Meron D. Asfaha
MPH

Behavioral Sciences and Health Education

Dawn L. Comeau, PhD, MPH
Committee Chair

John N. Cranmer, DNP, MSN, MPH, ANP-BC
Committee Member

Sydney A. Spangler, PhD, MSN, CNM
Committee Member

Colleen McBride, PhD
Department Chair

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By

Meron D. Asfaha

Bachelor of Science in Biology
Virginia Commonwealth University
2015

Thesis Committee Chair: Dawn L. Comeau, PhD, MPH

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

Socio-Contextual Determinants of Community-Level Care Seeking for Neonatal Possible Severe Bacterial Infection (PSBI) in Amhara, Ethiopia
By Meron D. Asfaha

Background: Approximately 25% of neonatal deaths occur globally due to infections. In Ethiopia, neonatal mortality accounts for 42% of under-five deaths with the majority of these deaths driven by infections. Possible Severe Bacterial Infection (PSBI) in neonates is a syndromic diagnosis that non-clinical health providers use to identify newborns with likely sepsis outside of health facilities. In low- and middle–income countries, referral to a hospital may not be feasible due to transportation, distance or finances. Growing evidence suggests health extension workers (HEWs) can identify and manage PSBI at the community level when referral to a hospital is not possible. However, community-based PSBI care strategies have not been widely scaled-up.

Methods: We conducted eleven focus group discussions (FGDs) and six in-depth interviews (IDIs) to analyze illness recognition and care seeking intentions from four rural kebeles in Amhara, Ethiopia. FGDs were conducted among mothers, fathers and households with recruitment stratified among households that have had a newborn with at least one symptom of PSBI (Symptomatic Group), and households that have had a newborn regardless of the child's health status (Community Group). IDIs were further conducted among peripheral family members. Data were then thematically analyzed using MAXQDA software.

Results: Mothers were described as primary caretakers of the newborn and were often appreciated for making decisions for treatment, even when the father was not present. Type of care accessed was often dependent on conceptualization of the illness as simple or complex. When symptoms were not relieved with clinical care, or treatments at facilities were perceived as ineffective, alternative methods were sought. Most participants identified the health center as a reliable facility. While designed to be the first point of access for primary care, health posts were not mentioned as locations where families seek clinical treatment.

Conclusions: This study describes socio-contextual drivers for PSBI treatment at the community level. Future programming should consider the role community members have in planning interventions to increase demand for care at primary facilities. Encouragement of health post utilization could further allow for heightened accessibility-acceptability of a simplified PSBI regimen.

Key words: Ethiopia, Possible Severe Bacterial Infection (PSBI), sepsis, neonatal mortality, care seeking, community-based care

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Abbreviations

AFRINEST	African Neonatal Sepsis Trial
APHI	Amhara Public Health Institute
ARHB	Amhara Regional Health Bureau
CG	Community Group
CSA	Central Statistical Agency
Emory-Ethiopia	Emory in Ethiopia organization
FGD	Focus Group Discussion
GFE	Global Field Experience Award
HDA	Health Development Army
HEP	Health Extension Programme
HEW	Health Extension Worker
IDI	In-depth Interview
IRB	Institutional Review Board
LMIC	Low- and Middle-Income Country
MoH	Ministry of Health
MPH	Master of Public Health
PI	Principal Investigator
PSBI	Possible Severe Bacterial Infection
SG	Symptomatic Group
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Acknowledgements

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"In its own good time, even an egg gets up and walks on its own two legs."
- Old Tigrigna proverb

First and foremost, I would like to thank the mothers, fathers and family members who dedicated their time to participate in this study. In several instances, community members rescheduled their commitments (i.e. heading to town on "market days") and were so kind as to welcome the research team to their communities. It was an honor to hear your stories and I hope we've captured your experiences.

My utmost gratitude goes to my thesis chair Dr. Dawn Comeau – your support and mentorship throughout our weekly meetings has been a source of light and has pushed me to transform thoughts into actionable steps. To my advisor Dr. John Cranmer, I thank you deeply. Your commitment to the development and synthesis of this study from idea generation to analysis has opened my eyes to the indelible work and value of a thought leader. I would also like to thank Dr. Sydney Spangler for your consistent feedback and timely advice. Your devotion to the advancement of thoughtful qualitative global work is greatly appreciated.

My sincerest gratitude goes to the Emory-Ethiopia team including Dr. Abebe, Lamesgin, Mulusew and Tadesse for your full support. My thanks also goes to Brandon who has welcomed this collaboration; this work is unimaginable without you all. Additional thanks to the Center for Excellence in Maternal and Child Health Education, Science and Practice, the Emory Global Field Experience and the Faculty Development Award (through Dr. John Cranmer) for funding these efforts.

Finally, I'd like to thank my incredible support system for being a constant reminder that gratitude can persist in any moment. To my Mom and Dad, thank you for your love. To my *hafteys* Lewam, Blein, Banna, Fiyori and Hiyab, thank you for being true sisters to me. And my sincerest thanks to my colleagues and chosen family Bethlehem, Tsedenia and Wintana who have encouraged me endlessly.

I hope I have made you all proud.

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CHAPTER 1: INTRODUCTION

In 2016, 15,000 under-five children died per day amounting to roughly 5.6 million total deaths globally (United Nations International Children's Emergency Fund, 2017a). In the same year, under-five mortality ratios were substantially higher in low-income countries (73.1 deaths per 1000 live births) in comparison to high-income countries (5.3 deaths per 1000 live births) (World Health Organization, 2016). Although notable progress has been made in reducing under-five mortality, neonatal mortality ratios have decreased at a much slower rate (UNICEF, 2017a). Mortality ratios for children 1-59 months were reduced by 62% from 1990 to 2016, while the neonatal mortality ratio (death from 0-28 days of life) lessened at a rate of 49% in the same time period (UNICEF, 2017a). Further, newborn deaths have constituted an increasing amount of under-five deaths with newborns contributing to 46% of all under-five deaths in 2016. Most newborn deaths occur in the first week of life (WHO & UNICEF, 2014). The primary causes of newborn death include prematurity and low birthweight, infections, asphyxia and birth trauma (WHO, 2018a) of which prematurity, intrapartum-related events and neonatal sepsis account for about 75% of neonatal deaths (WHO, 2018c).

All United Nations member states pledged to support the Millennium Development Goals, a declaration for improving global health in eight specific domains by 2015. The fourth Millennium Development Goal (MDG) aimed to reduce child mortality by two thirds from 1990 to 2015 (WHO & UNICEF, 2014). In Ethiopia, MDG 4 was achieved three years ahead of the 2015 deadline with 205 under-five deaths per 1000 live births reported in 1990 to 64 under-five deaths per 1000 live births in 2013 (Ruducha et al., 2017). However, the global rate of reduction for neonatal deaths did not decrease as rapidly as under-five deaths (UNICEF, 2017a). As such, strategic initiatives such as the "Every Newborn: An Action Plan to End Preventable Deaths" have been developed by global agencies to reduce neonatal mortality

rates (WHO & UNICEF, 2014). In transitioning from the MDGs to the global Sustainable Development Goals (SDGs), SDG 3 aims to decrease the neonatal mortality ratio to 12 deaths per 1000 live births by 2030 (WHO, 2018b). However, significant progress must be made to achieve this SDG 3 benchmark.

Disparities in proportionate and absolute mortality exist across global regions and countries. For instance, the majority of global newborn deaths are known to occur in South Asia and Sub-Saharan Africa (39% and 38%, respectively) (UNICEF, 2017a). Further, five countries account for nearly 50% of all global neonatal deaths: India (24%), Pakistan (10%), Nigeria (9%), the Democratic Republic of the Congo (4%) and Ethiopia (3%) (UNICEF, 2017a). In Ethiopia, the setting for this formative qualitative study, neonatal mortality remains a public health burden with nearly 40% of all under-five deaths attributed to neonates (Liu et al., 2016). Within Ethiopia, the burden of absolute and proportionate neonatal mortality in rural, agrarian regions remains elevated due to factors such as limited availability and accessibility of clinical services due to geographic or financial constraints. As stated in WHO's "A Conceptual Framework for Action on the Social Determinants of Health," health inequities due to social positioning have implications on freedom and may be reflective of the ability to access basic material resources (Solar & Irwin, 2010). These structural barriers are often coupled with clinical risk factors for neonatal mortality such as maternal death and disability (from conditions such as hemorrhage or sepsis) or neonatal asphyxia, prematurity or sepsis. Baseline regional disparities in mortality within countries are further exacerbated by household-level poverty or rural residence (UNICEF, 2017a).

Approximately 25% of global neonatal deaths are driven by infections such as sepsis (WHO, 2015). In communities and primary care clinics, neonatal infection is usually syndromically defined using Possible Severe Bacterial Infection (PSBI) criteria. Clinical signs

of PSBI include fast breathing (≥ 60 breaths per minute), severe chest-in drawing, fever (≥ 38 °C), hypothermia (< 35.5 °C), no movement or movement upon stimulation only, poor/no feeding and convulsions (WHO, 2015). First-line facility-based treatment for PSBI is a 7-day course of injectable antibiotics (either procaine penicillin plus gentamicin or ampicillin plus gentamicin) (WHO, 2015). However, access to facility-level care is not always feasible or possible in low and middle-income contexts. Consequently, the WHO revised PSBI guidelines in 2015 to include a simplified but equally effective short-course regimen of combination antibiotics (such as 2-days of injectable gentamicin plus 7 days of oral amoxicillin) for use at non-hospital or peripheral health facilities. These peripheral health facilities are more readily accessible to communities compared to hospitals in rural contexts where transportation, household finances, or sociocultural factors limit the accessibility or desirability of hospital-based or biomedical care. When curative treatment at the hospital is not possible, Health Extension Workers (HEWs) have the ability to accurately identify and treat PSBI symptoms using a simplified antibiotic treatment (Degefie et al., 2017). This simplified antibiotic treatment can be given by HEWs and for infants 0-59 days old, includes injectable gentamicin for 2 days and oral amoxicillin for seven days (Degefie et al., 2017; WHO, 2015). Families adhered well to this simplified regimen, although penetration to all PSBI households in the study setting remained around 50% (Degefie et al., 2017).

In Ethiopia, the decision to seek treatment at the peripheral level (health posts) and at higher-level facilities (health centers, hospitals) is influenced by many social and environmental factors (Federal Democratic Republic of Ethiopia Ministry of Health, 2010). Documented determinants to accessing facility-based care for newborns include distance to health facility, cost of transportation, and common cultural practices. In Ethiopia, some perceptions and practices which may affect the access of treatment for newborn infections may include fear of

newborn exposure to environmental factors (i.e. sunlight) and newborn isolation from strangers until the newborn has been religiously blessed (Degefie et al., 2017). Current literature suggests that important challenges to care seeking at health facilities include decision-making dynamics at the household level (resulting in delays), limited accesses to resources, geographic distance to facilities, and perceptions of the quality of care (Z. S. Lassi, Middleton, Bhutta, & Crowther, 2016). Although studies cite factors that may impact care seeking among sick newborns (Geldsetzer et al., 2014; Tefera et al., 2014), there is a paucity of information available on care seeking among families whose neonates have PSBI symptoms.

Problem Statement

Recognizing the need for services, particularly in rural areas, the Ethiopian Federal Ministry of Health (MoH) launched the Health Extension Programme (HEP) (Federal Ministry of Health, 2007). Health Extension Workers (HEWs) are community health workers who are trained and recruited from their respective communities to deliver healthcare services at the community (*kebele*) level. HEWs have the ability to accurately identify and treat PSBI symptoms using syndromic diagnostic criteria (Khanal et al., 2011). For example, in the AFRINEST 2015 study, 97% of families adhered to the simplified regimen (injectable gentamicin for 2 days and oral amoxicillin for 7 days) (African Neonatal Sepsis Trial (AFRINEST) group et al., 2015). However, PSBI treatment coverage at rural health posts in Ethiopia remains low (Degefie et al., 2017). Decision-making for sick newborns may be constrained by financial limitations, in which families delay actions to secure care due to costs of healthcare services and treatments as well as low illness recognition and low maternal knowledge of neonatal danger signs (Gebre et al., 2018; Onarheim, Sisay, Gizaw, Marie Moland, & Miljeteig, 2017). Additional barriers to accessing PSBI treatment at health posts that appear in the literature include: knowledge (limited knowledge of PSBI), societal norms

(fear of evil eye, social stigma, advice from elders, beliefs about recovery without medicine), household-level dynamics (financial limitations, distance to facilities, husband care refusal) and health-related beliefs (perceived infant fragility or fear of injections) (Tefera et al., 2014). However, there is an absence of detailed analyses of the impact of socio-contextual factors that may limit or promote the uptake of simplified PSBI treatment regimen for outpatient settings.

Theoretical Framework

The Health Belief Model, in synergy with the Three Delays Model, were the guiding frameworks used to guide the scope of this project as well as the development of data collection tools (interview guides). The Health Belief Model was originally designed to summarize factors that limit the uptake of preventive screening services and to drive the design of targeted interventions (Glanz, Rimer, & Viswanath, 2015). At the center of this framework is the self-efficacy construct, or the assurance that an individual can successfully engage in a health behavior. Other constructs include perceived illness severity (how the individual views the seriousness of a condition), perceived susceptibility to illness (one's perception on the likelihood of obtaining the illness), perceived barriers to care (challenges to taking health action) and cues to taking health actions (internal or external factors that may encourage one to take action). This model suggests factors that support or constrain individual behaviors for preventing or treat illnesses.

The Three Delays Model was originally developed by Thaddeus and Maine to explain how three delays contribute to maternal death during pregnancy which occur when seeking care, accessing facilities for care and obtaining quality care at the facility (Thaddeus & Maine, 1994). Although the Three Delays Model is conventionally used to explain maternal deaths, we used this model to understand potential drivers of neonatal death because the timing of

care is a key driver of neonatal deaths as well (Prakash Upadhyay, K. Rai, & Krishnan, 2013). We used the primary concepts presented in this module to further guide the development of our research methods and specific tools.

Purpose Statement

The Ethiopian Ministry of Health (MoH) supports implementation of simplified antibiotic regimen at health posts when referral to a hospital is not feasible or possible. In maximizing uptake and access to this intervention (a 2-day injectable treatment of gentamicin followed by 7 days of oral amoxicillin), this study aims to collect information on socio-contextual factors driving PSBI care seeking in Amhara. More specifically, this research explores 1) how families decide to seek treatment for PSBI neonates and 2) sociocultural household-level facilitators and barriers that may influence short-course PSBI treatment uptake.

Research Question(s)

This study aims to answer the following research question and sub-questions:

How do households make the decision to seek care for newborns with PSBI at the community level in Amhara, Ethiopia?

- What are influential factors for households with neonates to engage in treatment-seeking behavior?
- How is illness identified and subsequent methods of care sought for newborns with PSBI?

Significance Statement

These data are synergistically designed to complement a contemporary study on health system determinants of PSBI care. Collectively, these formative data will be used in

partnership with the Amhara Regional Health Bureau (ARHB) to create a home-to-hospital continuum of PSBI identification and management that is simplified (compared to standard facility-based care) and decentralized (using syndromic sepsis diagnosis by the Health Development Army volunteers). In doing so, this study aims to inform future implementation strategies for simplified PSBI treatment.

CHAPTER 2: LITERATURE REVIEW

The neonatal period (0-28 days of life), in which the immune system of newborns is particularly fragile, is a sensitive time in the newborn's life. In 2016, the neonatal period drove 46% of all under-five deaths globally. One million of these under-five deaths occurred during the first day of life (WHO, 2016). Primary causes of neonatal deaths include infections, prematurity and asphyxia, with 36% of neonatal deaths specifically attributed to the onset of infections (including sepsis-pneumonia, tetanus and diarrhea) (WHO, 2011). Ninety-nine percent of all neonatal deaths occur in low- and middle-income countries (WHO, 2011). Ethiopia is in the top five countries for the absolute burden of total neonatal deaths which reached approximately 90,000 deaths in 2016 (UNICEF, 2017a). The under-five mortality ratio was 59 deaths per 1,000 live births and 49% of these under-five deaths occur in the neonatal period (UNICEF, 2017b). Although neonatal mortality is the most severe sequala from infections, other adverse outcomes include neurodevelopmental impairment (NDI) and disability (Seale et al., 2013).

Neonatal Mortality in Ethiopia

Ethiopia is a landlocked country in the Horn of Africa and home to about 102 million residents (The World Bank, 2016). As of 2018 in the Amhara region of Ethiopia, where this study is conducted, there are 21.7 million residents (Central Statistical Agency, 2018). More than 80% of inhabitants reside in rural areas. Further, the majority of Amhara residents are children 0-9 years of age (4,650,000) (Central Statistical Agency, 2018).

Amhara also has the highest neonatal mortality ratio compared to all other regions of the country (47 deaths per 1000 live births) while the capital city, Addis Ababa, had the lowest (18 per 1000 live births) (Central Statistical Agency & ICF, 2016). Neonates in Amhara,

Beninshangul-Gomez and Tigray have a higher risk of dying compared to neonates in Addis Ababa (Mekonnen, Tensou, Telake, Degefie, & Bekele, 2013). However, there is limited data available on the determinants of neonatal death in this region.

Possible Severe Bacterial Infection

Neonatal infections are a substantive public health burden and a significant driver of neonatal mortality and all under-five mortality. Incidence of Possible Severe Bacterial Infection (PSBI) are markedly elevated in low-income countries. In 2012, 6.9 million cases of PSBI occurred globally. Of these, 2.6 million were in Sub-Saharan Africa. 3.6 and 0.8 million were in South Asia, and Latin America respectively (Seale et al., 2014). In low- and middle-income countries, severe bacterial infections can be difficult to diagnose due to ambiguity of symptoms and delays in facility-based care seeking (Seale et al., 2014). Consequently, the symptom-based syndromic diagnosis of Possible Severe Bacterial Infection (PSBI) was developed as a proxy for clinical sepsis as diagnosed by skilled clinicians.

Possible Severe Bacterial Infection (PSBI) is a syndromic approach to detecting potential cases of severe bacterial infection, particularly in low- and -middle income country settings where confirmation of severe infection by a pediatrician or through microbiological screenings is often not possible (Seale et al., 2014). This approach was informed by WHO's formative 1990 study (Weber et al., 2003) and further refined in the 2008 The Young Infants Clinical Signs Study (YICSS) Group study (The Young Infants Clinical Signs Study Group, 2008) that assesses signs of severe bacterial illness in infants 0-2 months old. In syndromically recognizing PSBI, the following seven symptoms are indicators for infants up to 2 months of age: difficulty feeding, convulsions, movement only when stimulated, respiratory rate of 60 breaths per minute or more, severe chest in-drawing, temperature above 37.5° Celsius and temperature below 35.5° Celsius. Incidence of PSBI are markedly high in low- and -middle

income countries. 2012 estimates suggest 6.9 million cases of neonatal PSBI globally (Seale et al., 2014).

Treatment Practices

Preferred PSBI treatment for neonates (0-28 days of life) and young infants (0-50 days of life) remains referral to a hospital for a seven-day course of injectable antibiotics (WHO, 2015). However, hospital care in LMIC settings, it is not always feasible or possible for infants to receive facility-based care due to distance from home to facility, cost of transportation and standard cultural practices. Existing equivalence trials demonstrate that community health workers (CHWs) may deliver simple, short course antibiotic treatment in outpatient and community settings while achieving similar clinical outcomes to facility-based care (Mir et al., 2017; Tshefu et al., 2015). In LMICs, frontline health workers are able to identify cases of severe bacterial infection using a clinical algorithm with relatively high specificity (82%) and high sensitivity (69%) (Lee et al., 2014). In Ethiopia, HEWs are able to identify PSBI and achieve high adherence to treatment regimens. However, at the population level, only half of PSBI newborns access treatment at the health post (Degefie et al., 2017). Existing barriers to PSBI treatment uptake within the closest health service point to communities requires further investigation so challenges to PSBI uptake can be reduced.

Determinants of Neonatal Mortality

Most newborn deaths are from preventable illnesses (Akseer et al., 2015). Delays to care seeking may lead to the exacerbation of neonatal illnesses and death. Multiple studies have utilized the three-delay model for maternal mortality to describe neonatal mortality (Bogale, Worku, Bikis, & Kebede, 2017; Prakash Upadhyay et al., 2013; Waiswa, Kallander, Peterson, Tomson, & Pariyo, 2010). In Bogale et al.'s 2017 study on the three-delays in northwest Ethiopia, most (81%) of neonatal deaths were associated with a delay in accessing treatment

outside of the home (Bogale et al., 2017). Additionally, in a review of all neonatal deaths, sepsis was the most common disorder. Similarly, other studies in LMICs have found that delays within the household decisions to seek care are a major driver of all neonatal deaths (Prakash Upadhyay et al., 2013).

Care Seeking Behaviors

Multiple studies identify factors that influence care seeking behaviors. In Northwest Ethiopia, community members' treatment practices and preferences for specific neonatal danger signs was assessed (including married men, married women, HEWs and religious leaders) (Bogale, Gebeyehu Worku, Worku Yalew, Andargie Biks, & Tigabu Kebede, 2018). Using focus group discussions (FGDs) and in-depth interviews (IDIs), they discovered treatment-seeking behaviors depended on illness causal beliefs, perceived severity, perceived treatment effectiveness, limited knowledge of biomedical illness causes and fear of malevolent spirits. Similar work in Southern Ethiopia among household heads identified five primary factors limiting facility-based care. These included perceived low illness severity (symptom not severe enough; 7.8%), perceived inadequate treatment availability at facilities (24.7%), high cost of clinical care (42.9%) and distance to facilities (5.9%) (Bojola, Dessu, Dawit, Alemseged, & Tessema, 2018). In the Southern Nation's, Nationalities, and People's Region (SNNPR), perceived financial costs of care influenced household decision makers' perceptions about if and when newborn treatment is needed (Onarheim et al., 2017). In conducting 41 semi-structured interviews and seven focus groups on mothers and/or caretakers of sick newborns, mothers and/or caretakers who experienced newborn death, health workers and community members, Onarheim et al. also found that confusion over an ill newborn's condition may delay care seeking (Onarheim et al., 2017).

Factors leading to treatment-seeking vary widely. Barriers to accessing treatment for

households in rural, low-income settings may include confusion about the newborn's illness, lack of knowledge of illness, low perceived illness severity and fear of malevolent spirits. In many cases, financial limitations and logistical barriers (such as distance and accessibility) may mediate the decision to seek care for the newborn. Often, delays in care seeking occur and when deciding to seek treatment for the newborn, these may persist when families are thinking about whether to seek care outside of the home.

Current literature suggests HEWs have the ability to accurately identify PSBI symptoms; however, PSBI treatment coverage at rural health posts in Ethiopia remains low (Degefie et al., 2017). There is a paucity of information available on treatment-seeking practices of households with PSBI neonates—particularly in Amhara, Ethiopia which bears the highest burden of national neonatal deaths. Additionally, limited information on household perceptions limits opportunities to create locally relevant interventions for increasing PSBI care. Consequently, this study explores household-level socio-contextual facilitators and barriers to PSBI treatment-seeking in Amhara, Ethiopia. Findings from this study will be used to create a locally relevant, simplified PSBI service delivery model in collaboration with the Ministry of Health.

CHAPTER 3: STUDENT CONTRIBUTION

Fundamental study proceedings, such as project administration as well as data collection activities, were undertaken by the MPH student and Principal Investigator (PI) of this study (Meron Asfaha) and committee members (Dr. John Cranmer, Dr. Dawn Comeau and Dr. Sydney Spangler). This study was initially formulated through collaborative discussions with Dr. Cranmer (Assistant Clinical Professor, Emory University's Nell Hodgson Woodruff School of Nursing) in developing a research question of interest as well as Brandon Spratt, a Doctor of Nursing Practice student, who is currently conducting a systems-level study to analyze PSBI supply logistics in the Amhara region. Data collection tools, such as discussion guides, were developed by Meron with edits and feedback provided by Dr. John Cranmer, Dr. Sydney Spangler and Dr. Dawn Comeau. Brandon Spratt and Lamesgin Alamineh, an Emory-Ethiopia staff member, assisted in study site selection and provided feedback during data collection instrument development. Study site selection was determined by the PI. Data collection tools were translated with the assistance of Emory-Ethiopia staff members, Lamesgin Alamineh and Tadesse Biru.

Funding

Meron received funding through Emory University's Global Field Experience (GFE) Award with additional funding provided through a fellowship with the Centers of Excellence in Maternal and Child Health Education. Further funding was provided by Dr. John Cranmer through the Faculty Development Award. Emory ethical review was applied for by Meron, with feedback given from Dr. John Cranmer and Dr. Sydney Spangler. An exemption from the full Institutional Review Board (IRB) human subjects review was provided after completing the full online Emory IRB application. This exemption was provided because no identifiable information was analyzed for this study. Local ethical review was also received

from the Amhara Public Health Institute (APHI) to which Meron developed, submitted and made edits to all application materials.

Data Collection

Meron developed the data collection schedule and training materials for the data collectors (moderator and notetaker). Further, Meron hired study personnel (moderator, notetaker, driver and transcriber) and developed administrative forms (contracts). Meron accompanied the study team to all study sites, noting contextual observations for data analysis. Additionally, Meron ensured recruitment criteria were being met for the inclusion of study participants through communication with the study personnel. The moderator assisted in translating recruitment criteria to the *kebele* health center HEWs and center staff. Meron facilitated further discussions with the study team after discussions to provide feedback in informing tool refinement. Throughout the conclusion of the data collection period, Meron was responsible for payment of the data collectors and driver as well as communicating with the Emory-Ethiopia office to ensure that all requirements were being met with regards to the collection of receipts and completion of required forms.

Analysis

Meron wrote memos and created an initial codebook derived inductively from the data. Inter-coder agreement and reliability were sought from a fellow colleague in the Behavioral Sciences and Health Education (BSHE) program at the Rollins School of Public Health, Bethlehem Besrat, who is experienced in coding health systems data. Thematic analysis was conducted by Meron with feedback from Dr. John Cranmer, Dr. Sydney Spangler and Dr. Dawn Comeau. Weekly meetings with Dr. Dawn Comeau facilitated significant write-up proceedings, as well as bi-weekly meetings with Dr. John Cranmer. Descriptive analysis was performed by Meron from participants' demographic information. Meron was responsible for

write-up of thesis chapters and manuscript(s), including the development of figures and tables. Substantive feedback and edits were provided by Dr. John Cranmer and Dr. Dawn Comeau. Advisement regarding qualitative analytic procedures was provided by Dr. Sydney Spangler. Journals for submission were decided amongst all committee members.

The journal for first manuscript submission is *BMC Health Services Research*.

CHAPTER 4: MANUSCRIPT SUBMISSION

Socio-Contextual Determinants of Community-Level Care Seeking for Neonatal Possible Severe Bacterial Infection (PSBI) in Amhara, Ethiopia

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AUTHORS

Meron D. Asfaha, Emory University, Atlanta, Georgia, USA, masfaha@emory.edu

Dawn L. Comeau, Emory University, Atlanta, Georgia, USA, dcomeau@emory.edu

Sydney A. Spangler, Emory University, Atlanta, Georgia, USA, s.spangler@emory.edu

Brandon L. Spratt, Emory University, Atlanta, Georgia, USA, brandon.spratt@emory.edu

Lamesgin Alamineh, Emory-Ethiopia, Bahir Dar, Amhara, Ethiopia, lamesgin2012@gmail.com

John N. Cranmer, Emory University, Atlanta, Georgia, USA, john.cranmer@emory.edu

ABSTRACT

Background: Approximately 25% of neonatal deaths occur globally due to infections. In Ethiopia, neonatal mortality accounts for 42% of under-five deaths with the majority of these deaths driven by infections. Possible Severe Bacterial Infection (PSBI) in neonates is a syndromic diagnosis that non-clinical health providers use to identify newborns with likely sepsis outside of health facilities. In low- and middle–income countries, referral to a hospital may not be feasible due to transportation, distance or finances. Growing evidence suggests health extension workers (HEWs) can identify and manage PSBI at the community level when referral to a hospital is not possible. However, community-based PSBI care strategies have not been widely scaled-up.
Methods: We conducted eleven focus group discussions (FGDs) and six in-depth interviews (IDIs) to analyze illness recognition and care seeking intentions from four rural kebeles in Amhara, Ethiopia. FGDs were conducted among mothers, fathers and households with recruitment stratified among households that have had a newborn with at least one symptom of PSBI (Symptomatic Group), and households that have had a newborn regardless of the child's health status (Community Group). IDIs were further conducted among peripheral family members. Data were then thematically analyzed using MAXQDA software.
Results: Mothers were described as primary caretakers of the newborn and were often appreciated for making decisions for treatment, even when the father was not present. Type of care accessed was often dependent on conceptualization of the illness as simple or complex. When symptoms were not relieved with clinical care, or treatments at facilities were perceived as ineffective, alternative methods were sought. Most participants identified the health center as a reliable facility. While designed to be the first point of access for primary care, health posts were not mentioned as locations where families seek clinical treatment.
Conclusions: This study describes socio-contextual drivers for PSBI treatment at the community level. Future programming should consider the role community members have in planning interventions to increase demand for care at primary facilities. Encouragement of health post utilization could further allow for heightened accessibility-acceptability of a simplified PSBI regimen.

KEYWORDS
Ethiopia, Possible Severe Bacterial Infection (PSBI), sepsis, neonatal mortality, care seeking, community-based care

BACKGROUND

In 2016, 15,000 under-five children died per day comprising 5.6 million total deaths globally [1]. Although notable progress has been made in reducing under-five mortality, neonatal mortality ratios have decreased at a much slower rate [1]. Further, about 75% of neonatal deaths are due to prematurity, intrapartum related events and neonatal sepsis [2] with one out of four neonatal deaths driven by sepsis. In Ethiopia specifically, neonatal mortality is a public health concern as 40% of all under-five deaths are driven by deaths in the neonatal period [3]. Nationally, the burden of absolute and proportionate neonatal mortality in rural, agrarian regions remains elevated. In large part this persistent mortality burden is driven by limited availability and accessibility of clinical services due to geographic distance between households and facilities or financial costs of transportation [4-7]. Regionally, neonates in Amhara, Beninshangul-Gomez and Tigray have a higher risk of mortality compared to their peers in Addis Ababa [8]. However, there remains limited region-specific data on the precise determinants of neonatal death in Amhara.

Within communities and primary care clinics, neonatal infection is usually syndromically diagnosed or based upon a set of signs and symptoms that lead the clinician to suspect sepsis. Syndromic diagnosis of sepsis is called Possible Severe Bacterial Infection (PSBI) and has defined clinical criteria per The Young Infants Clinical Signs Study Group algorithm [9]. Clinical signs of PSBI include fast breathing (≥ 60 breaths per minute), severe chest-in drawing, fever (≥ 38 °C), hypothermia (< 35.5 °C), no movement or movement upon stimulation only, poor/no feeding and convulsions [10]. First-line facility-based treatment for PSBI is a 7-day course of injectable antibiotics (either procaine penicillin plus gentamicin or ampicillin plus gentamicin) [10]. However, accessing facility-level care is not always feasible, possible or desirable, particularly in rural low and middle-income country contexts. In rural settings, peripheral health facilities, such as health posts in Ethiopia [11], are more readily accessible to communities when

compared to hospitals . This is often due to limited transportation, low household financial resources, or varied sociocultural factors that limit the accessibility or desirability of hospital-based care that is far from one's home. When curative PSBI treatment at the hospital is not possible, Health Extension Workers (HEWs) have the ability to identify and treat PSBI symptoms using a simplified antibiotic treatment plan [12]. Despite global guidance on PSBI care outside of inpatient health facilities, PSBI treatment coverage at rural health posts and within communities remains low.

Across Ethiopia, documented determinants to accessing facility-based, biomedical care (health centers, hospitals) for newborns include distance to health facility, cost of transportation, and social care seeking norms [11]. At the primary level, the decentralized Ethiopian Health Tier system includes a primary hospital, health centers and rural health posts [11]. Although HEWs may refer those seen during home visits or at health posts to higher facilities for care, significant factors exist that limit community members in accepting these referrals. Sociocultural factors preventing care at health facilities include differences in gender-based priorities and decision-making dynamics at the household level which may delay seeking care for sick neonates [13-15]. Barriers impeding demand of care for newborn treatments include fear of newborn exposure to environmental factors (i.e. sunlight), newborn isolation from strangers until the newborn has been religiously blessed and ambiguous newborn personhood [12, 16]. Although a number of studies cite determinants of care seeking among sick newborns [17, 18], this information is severely lacking for families whose neonates exhibit PSBI symptoms. This study aims to understand household norms, strategies for management and subsequent decision-making for care at the community level among newborns exhibiting PSBI symptoms. Further information on household dynamics is sought to examine low health services utilization at the community level when treatment is available.

METHODS

Study setting

Two *woredas* [districts] within a 300-km radius of Bahir Dar (capital city of Amhara) were selected for inclusion in this study. Both woredas comprise a majority of rural residents and were selected based on data from the 2007 Population and Housing Census of Ethiopia, Statistical Report for Amhara region. Indicators such as population size, number of households and type of settlement (urban versus rural) were considered in site selection (Table 1). Number of households varied between woredas. Woreda A comprised 6,405 households with 767 households in Woreda B. Four rural *kebeles* were then selected with the assistance of the Emory-Ethiopia team with the goals of representing various influencers for PSBI decision makers in rural communities.

Table 1

Characteristics of *woreda* sites

Zone	**Woreda and *kebele***	**Number of households**[a]	**Population size**	**Rural**	**Urban**
West Gojam					
	Woreda A	6,405	292,080	269,403	22,677
	Site 1	*1,348*	*5,764*	--	--
	Site 2	*7,719*	*1,832*	--	--
East Gojam					
	Woreda B	767	132,883	130,299	2,584
	Site 3	*2,332*	*10,183*	--	--
	Site 4	*1,640*	*8,082*	--	--

Source: Central Statistical Agency – Ethiopia. *The 2007 Population and Housing Census of Ethiopia: Statistical Report for Amhara Region.* Addis Ababa, Ethiopia; 2012.

[a] Households refer to housing units, per the Central Statistical Agency – Ethiopia definition

Study design

Qualitative research methods were employed to identify care seeking determinants for neonatal possible severe bacterial infection (PSBI) in rural Amhara. The methodology for this study was informed by existing studies analyzing determinants of health-seeking behavior (such as illness perception and characterization) in low- and middle-income contexts [19]. Data were collected through focus group discussions (FGDs) and in-depth interviews (IDIs). Focus group discussions (FGDs) and in-depth interviews (IDIs) were led by one moderator and one notetaker, with observations documented by the principal investigator (first author) to document setting, behavior and contextual information for analysis. All discussions and interviews were conducted in the Amharic language. FGDs were stratified amongst mothers, fathers and household units while IDIs were carried out with peripheral family members (members residing in the household other than the parents of the newborn). The purpose of collecting information from focus groups of mothers, fathers and household units were to understand household caretaking responsibilities and decision-making within the community.

Mothers in rural Ethiopia are typically primary caretakers of the child, although approval from fathers is often needed to follow-through on decisions requiring financial resources. For this reason, participant groups were separated by parental roles and then among household units. Alternatively, fathers are typically regarded as household decision-makers [16]. Therefore, discussions were also separated per type of participant (mothers, fathers, household units) to investigate how responses of newborn care may differ by typical household role. A thorough understanding of how peripheral family members (such as siblings, aunts/uncles and grandparents) influenced decision-making was also needed to contextualize potential intrahousehold supports and barriers. Thus, IDIs were conducted on peripheral family members to identify care dynamics and familial supports within households.

Recruitment

Prior to accessing *kebele* sites, the research team (one moderator, one notetaker and the investigator) met with nurse managers and health extension workers (HEWs) at *kebele* health centers. HEWs then purposively selected participants from health center records and either called or approached households to schedule FG and IDI discussions. Participants were selected if they had a newborn in the household within the previous two years, were over 18 years of age and either had infants with PSBI symptoms (symptomatic group, SG) or were residents of the target communities (community group, CG). CG data was provided to compare care methods and trajectories among participants that were not recruited based upon a pre-specified ailment or condition.

Participants identified in the SG were chosen if they had a newborn in the household exhibiting one or more PSBI symptoms as defined by the 2015 WHO guidelines. These symptoms included: fast breathing, chest in-drawing, fever, hypothermia, no movement or movement only upon stimulation, poor feeding or no feeding, and/or convulsions [20]. Community group (CG) participants were purposively selected regardless of the newborn's health status based on their residence in the target communities.

All participants must have had a newborn in the household within the previous two years. The sampling frame included ten discussions per woreda (including FGDs and IDIs, Table 2). Final recruitment included 17 discussions with eleven FDGs and six IDIs due to participant unavailability in some woredas.

Table 2
Sampling strategy, per *woreda*

Target Group and Collection Method	**Number by woreda**	**Total Recruitment Goal**	**Total Recruited**
Mothers (FDG)	2 (5-8)	4 (10-16)	4 (29)
Fathers (FDG)	2 (5-8)	4 (10-16)	4 (13)
Household Members (FDGs)	2 (5-8)	4 (10-16)	3 (9)
Peripheral Family Members (IDIs)	4	8	6 (6)
Total	*10 (19-36)*	*20 (38-48)*	*17 (57)*

* Numbers are reported per the number of groups and range of participants in each group

Data collection

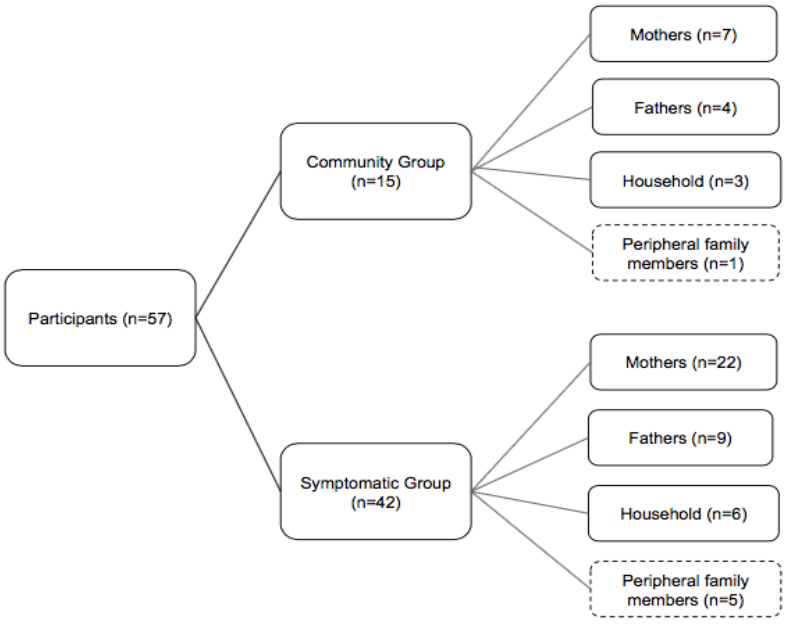
Data from FGDs and IDIs were collected between July and August 2018. The research team was comprised of one moderator and one note-taker, both experienced in qualitative data collection. The moderator, fluent in Amharic and English, was additionally trained as a clinician (nurse). Prior to recruitment efforts, the study team visited woreda health centers to describe the study's purpose to health center administrators and community health workers (HEWs). HEWs assisted in purposively selecting households using the defined inclusion criteria. FGDs lasted 45 - 75 minutes while interviews lasted 20 – 45 minutes. Interview guides included questions on household decision-making, care-taking actions/responsibilities, illness causation and characterization, illness severity, decision-making power and methods/facilities for care (Additional files 1-3). Although questions were pre-empted with specifics on the newborn period, some questions were generalized to extend responses towards infancy.

Focus group discussions of mothers and fathers were conducted at health posts, within health centers. Focus groups with household members were conducted inside households while in-depth

interviews were conducted in private areas of the house or near the house, out of range from household members and activities. FGDs and IDIs ranged from 30 to 90 minutes. Demographic information was collected after all FGDs and IDIs including age, number of people residing in the household, income, occupation, and education level. For mothers, information on the number of live births and number of children was collected to determine child loss.

We iteratively improved the precision of the qualitative instruments using pre-testing and in-field revision. After reviewing preliminary data from the first three community member focus groups (CG), the research team identified opportunities to increase instrument precision by utilizing additional probes where richness of data could be improved. To ensure a rich understanding of PSBI illness recognition, characterization and care seeking behaviors, the research team decided to focus on recruiting more households with symptomatic infants (SG). As a result, after three CG focus groups, data collection focused on the SG to ensure saturation on the experiences of SG mothers, fathers and households (Figure 1).

Figure 1
Recruitment outcome



--- : in-depth interviews; –– : focus groups

As a result of this recruitment strategy (Table 2), 15 participants met CG recruitment criteria and 42 participants met SG recruitment criteria (Figure 1). Four FGDs with mothers (29 participants), four FGDs with fathers (13 participants) and three FGDs with households (9 participants) were across West and East Gojam zones. Of all FGDs, five were conducted in *Woreda A* and six in *Woreda B.*

All discussions were recorded utilizing audio recorders. After data collection ended, data were transcribed into English by one bilingual Amharic-English transcriber with previous qualitative research and transcription experience. To assure quality of translation, three transcripts were re-transcribed by the same transcriber to check data quality. Further discussions were continued throughout analysis to improve understanding of responses and increase clarity when statements were made within the local context of communities.

Analysis

Data were thematically analyzed utilizing MAXQDA software (version 18.1.1, Berlin, GA, 2018). Thematic analysis is an iterative analytical approach to identifying concepts (themes) in the transcriptions [21]. Analytic memos were first created to contextualize emerging patterns and concepts. Memos addressed four questions: 1) Where did participants go to seek treatment when the newborn was ill? 2) How were methods of care accessed? Initially and as illness progressed? 3) How did diverse family members influence care decisions? and 4) How did service accessibility influence the type of care that was sought and obtained by households? A codebook was then developed inductively using concepts that emerged while reading transcripts.

Three transcripts were coded by the principal investigator and a graduate assistant (qualitative researcher) experienced in analyzing perceptions of healthcare services and quality of care. Codes

were then compared and discussed to reach agreement and increase intercoder reliability. Consequently, a final codebook was created using the input of two investigators. Emerging themes were further identified through iterative analytic memos, transcript summaries of FGDs and IDIs as well as in-depth analysis of key code intersections. Codes were compared and contrasted across sampling methods, sites and type of family member. Iterative frameworks were created and revised throughout analysis to conceptualize study findings. Coding, memos and interim analyses were discussed across the team—including the lead investigator, senior authors, faculty and data collectors.

Ethics

During the consent process, participants were informed of the study's purpose, procedure and implications. Verbal consent was obtained since most respondents did not read or write in Amharic. The Emory University Institutional Review Board (IRB) determined these data were exempt from full human subjects research review (July 3, 2018). Activities were additionally approved by the Amhara Public Health Institute (APHI) ethical review board (July 18, 2018). Letters of support were provided to West and East Gojam zonal health departments.

RESULTS

Participant characteristics

Fifty-seven participants took part in FGDs and IDIs. 42 respondents had symptomatic newborns (SG) while 15 were community members without symptomatic newborns (CG). Rural kebeles were selected in both woredas; 24 respondents came from Woreda A and 23 respondents came from Gozamen. 29 FG participants were 29 mothers and 13 fathers (Table 2). Further, 6 peripheral family members were IDI respondents (3 brothers, 2 sisters and 1 grandmother of the infant).

All participants were Christian Orthodox and of Amhara ethnicity. The median respondent age was 28 years and median household size was 4 (including the participant). Participants primarily reported working in agriculture or as merchants (61.4%) with a median annual household income of 13,700 birr (approximately 476 USD). However, there were substantive variations in obstetric history with 20.7% of mothers experiencing a child loss and mothers having between 1-9 live births.

Key themes

Emergent themes largely involved intrahousehold identification of illness, subsequent decision-making for treatment methods and the specific sites visited per types of illness. We summarized community level experiences related to newborn care in general, gender and relationship-based roles within the household, illness identification strategies and preferred treatment approaches based on illness type. Consequently, five key themes emerged: maternal responsibility for the newborn, familial deference to maternal decision-making, hygiene and nutrition practices that were considered beneficial or harmful, how illness is conceptualized based on based on perceived illness complexity and common care seeking strategies that differed according to perceived illness type and severity.

Maternal responsibility for the newborn

Mothers reported primary responsibility for providing overall care for newborns. While participants from FGDs and IDIs regarded both parents as instrumental for newborn and infant care, mothers were consistently identified as the primary caretakers across respondent groups—particularly in the first two weeks of life. Most participants indicated the mother's primary role was to breastfeed and/or provide breastmilk. Some participants indicated maternal breastfeeding was one of the few actions households could take to protect the newborns health during the first

two weeks of life. Additionally, respondents indicated mothers were responsible to maintaining the child's hygiene using practices such as washing the newborns' clothes, cleaning the newborn's body (through bathing) and preventing the child from being exposed to dirty objects or environments (such as contaminated water or placement of miscellaneous items into the mouth) in the infant period. Other maternal caretaking roles during the newborn period included preparation of newborn sleep space (preparing the "mat"), relaxing or playing with the child and protecting them from harm or diseases. This was accomplished through protecting the newborn from the cold, avoiding sunlight and utilizing mosquito nets while sleeping.

Maternal responsibility for the newborn was often described with regards to the provision of nutritional nourishment and dietary care, as described by a dialogue in a focus group of fathers:

> *F3: From my knowledge the mother should eat different types of balanced foods such as energy-giving foods. Up until six months the infant should feed from the mother's breastmilk only.*
>
> *I: What about others? As a father what do you do to make your child healthy?*
>
> *F1: There is nothing more than this. It is the same as he explained. Before we gave [food] for the infant to make his body grow faster but it became harmful so, we don't give other foods up to six months of age. Because of this until the child grows bigger we don't do anything but the mother performs most of the care. The infant doesn't take the other foods we feed for the mother.*
>
> *(FGD, Fathers, PSBI, Woreda A)*

Often, participants remarked that there is "nothing more" than the mother with regards to newborn care provision. However, fathers and peripheral family members (such as siblings and

grandparents of the newborn) indirectly cared for the child. Paternal actions for newborn care primarily included securing materials, such as buying soap and food, for the child as well as transporting the newborn to health facilities for care during times of illness or for receiving vaccinations (namely, the health center). For instance, several fathers mentioned assuring medications were given to the child as prescribed by health workers, although further details on specific medications were not mentioned. While peripheral family members were generally believed to provide very limited newborn care compared to parents, some siblings reported providing ancillary family care to support parents and newborns such as preparing food and coffee for the mother while she was away to the health center or washing the child's clothing for the parents.

Later, after the newborn period, respondents identified various nutritional practices. For instance, participants in FGDs with mothers and FGDs with fathers self-identified that when the infant becomes six months of age, the child's diet is expanded with complementary foods. However, participants report that newborns solely received breastmilk. One participant described an instance in which newborns receive raw butter (*kibeh*), only when referring to a traditional dietary practice that is now considered harmful and does not occur. Food items provided after six months of age that were mentioned include cow milk, bread, eggs and roasted barley flour (*besso*).

Maternal decision-making

Mothers were often identified as the primary decision-makers for newborn healthcare—this included seeking care for sick infants at health facilities or using informal methods. Mothers reported they had primary responsibility for deciding how and where the newborn received care for illness. However, fathers reported that both fathers and mothers were responsible for making health care decisions. Fathers often mentioned the type of facility or treatment provider visited to

care for ill children was only selected after both parents discussed the child's state of health. In some cases, fathers mentioned mothers as primary decision-makers for care, although this was reported less often in focus groups with fathers. Fathers indicated child health decisions were only made by fathers alone if the mother was unable or not present.

Beyond the primary caretaking role of mothers, fathers explicitly appreciated mothers taking initiative to choose how to care for infants when infants were sick. One father remarks:

> *F: We simply accept her decision. For example, when she makes decisions about family situations, maybe for health conditions, we accept and help her to be effective in her decisions.*
>
> *(FGD, Household, CG, Woreda B)*

Most members of the household, in fact, valued maternal decision-making. Types of care decisions that were appreciated included initiative taken on securing vaccinations for the newborn (preventative) or active follow-through on visiting formal/informal care (curative), especially when the father was not present often due to work outside of the home. Fathers generally expressed agreeance to maternal decisions, at times explicitly expressing appreciation (as seen above). Some household members explained that this appreciation was due to the amount of time fathers usually spent outside of the house. As such, fathers were not always present when newborn illnesses were recognized and decisions were made for care.

Environment and hygiene-nutrition practices as drivers of illness

Participants across stakeholder groups and locations reported newborn illnesses were primarily caused by gaps in hygiene practices or unmet maternal nutritional needs. There were three

hygiene-drivers of newborn illness identified. These included an unclean home environment such as exposure of the newborn to polluted water which could thus introduce bacteria and cause illness. One daughter in the household (sibling of the newborn) noted utilizing a soap only intended to wash the newborn so as not to cause infection. Two other drivers of newborn illness were related to maternal nutrition drivers. Improper nutrition for the mother included high consumption of alcohol or having an imbalanced diet, such as consumption of diverse foods that may not be agreeable to the mother, or foods the mother ate which are not "energy giving." One mother remarks on the causes of newborn illnesses:

> *M: When we feed them contaminated foods, when we do not keep the children clean, exposing the newborn baby with cold air and when we do not put them to sleep properly.*
>
> *(FGD, Mothers, PSBI, Woreda B)*

External environmental and spiritual causes of illness were less commonly identified. Exposure to cold weather and wind were generally identified as factors contributing to illness as well as specific sleeping habits, such as sleeping without a mosquito net. Finally, evil eye could also cause infant illness although respondents indicated visits to traditional healers and herbal remedies could avert the effects of evil eye for infants.

Most participants reported failing to access the health center for ill infants could cause severe consequences. For example, without biomedical care at health centers or hospitals, some infants could die or have their illness progress further. However, in the case of severe adverse outcomes such as death, participants saw this as a spiritually-driven outcome. In some cases, participants referred to these serious consequences as fate or "God's will." For example, one mother who recently lost a daughter indicated,

I: Maybe if your child got better medical treatment do you believe she may have been cured?

M3: No, I do not think so. It was fatal. She couldn't reach the next referral. God didn't allow her to grow up and be mine.

(FGD, Mothers, PSBI, Woreda A)

Although maternal responsibility in nurturing the child was duly noted, blame was not placed on household members; instead, unsuitable outcomes were either reported as being caused by the environmental/social factors (nutrition, hygiene and evil eye) and lack of preventative car. Limited treatment services at the health center were mentioned as factors contributing to illness exacerbation. For example, one father noted the lack of suitable supplies (medication) at the health center that are appropriate in treating a variety of illnesses. Another stated that going to the health center could "waste time", particularly when the child is sick and needs immediate attention. However, these causes of further illness severity were less frequently mentioned.

Illness conceptualization based on complexity

Approaches to identifying child illness were similar among household respondents (mothers, fathers, family members) and between households across regions. Families primarily identified symptoms of concern as fever (high body temperature), abnormal breathing and lack of feeding or no feeding. Families also noted non-PSBI symptoms including abnormal or frequent crying, vomiting, diarrhea. Perceptions of causes of illness were most often lack of protective hygiene measures (keeping child away from dirty environments, bathing regularly), lack of appropriate nutrition (irregular feeding) and weather (cold temperatures, wind).

Conceptualization led to varying methods for care, according to what treatment method was deemed appropriate for the particular illness. Some participants described illnesses as "simple" or "complex" based on the severity of the illness and made their treatment decisions based upon how the illness was characterized. "Simple" cases were referred to as instances the disease was easily understood (causation, conceptualization) whereas "complex" cases were regarded as instances where the disease could not be explained and were thus too severe for biomedical treatment. These perceptions of the illness as either simple or complex informed decisions for where families sought care. For common symptoms in the community, participants primarily sought care at health centers. However, if the illness involved a sudden onset of symptoms that could not be explained by participants or were considered "emergency" cases, other methods such as holy water and traditional medicines were obtained first.

> *I: Do you use traditional medicine to treat child sickness?*
>
> *F: Yes, we do.*
>
> *I: What kinds of medicine do you use?*
>
> *F: When there are sudden diseases that the health workers cannot understand, at that time we use traditional medicines. The children suddenly cry or become silent and their temperatures drop, at that time we use traditional medicine in emergency cases to help sick infants.*
>
> *(FGD, Fathers, PSBI, Woreda A)*

However, traditional medications were not often the first choice for care. Further, receiving holy water at the Orthodox Church was viewed primarily as a preventative strategy and only used curatively if symptoms were unresolved at the health center.

Care seeking trajectory

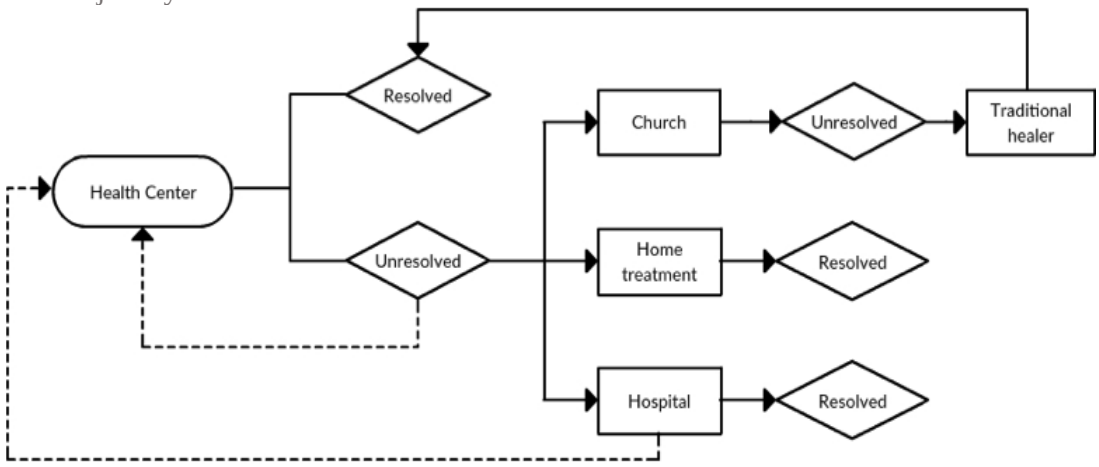
All participants, in both FGDs and IDIs, mentioned the access of healthcare facilities as a primary method for treating sick infants. Specifically, health centers were referred to as the fundamental source of curative care for childhood illnesses. However, health posts were not mentioned by any participants as a location to seek care for sick newborns. All participants, with the exception of one, mentioned accessing the health center when noticing that the newborn was sick. Although participants mentioned that they did not seek care at the health post if the child was perceived to be healthy, they often reported visiting the health posts to receive preventative care such as newborn vaccinations.

If families first sought biomedical treatment for sick infants, but it wasn't effective, families sought alternative care including holy water and traditional medications. Holy water (*kurban*) was sought at churches and most participants viewed holy water as a strategy to prevent illnesses for newborns and parents. Medicinal herbal treatments were obtained through traditional healers and used to prevent or cure evil eye. In addition, traditional therapies and healers were the primary resource for treating complex illnesses or used when the illness cause was not well understood. This care seeking pathway is described by one father during a CG focus group in Woreda B:

> *F: Most of the time the community goes to the health center when the child becomes sick. After the health center, if not cured, we go to other places to treat our sick child. First we use medical treatment and then holy water treatment...if they're not cured we use traditional medicine... If they're not cured we come back to the health center and get medical treatment but we complain about why they don't refer us to the hospital because there we have medical insurance. After that the community makes their own choices, either they go for holy water treatment or they use traditional medicine.*

The health center was the facility that participants most often went to when recognizing that the child was ill. Multiple participants mentioned that due to their health insurance coverage, there was no reason not to visit health centers. However, if all participants did not report having universal health care coverage. When illnesses were unresolved, alternative methods such as home treatments and the hospital were subsequently sought (Table 3).

Figure 2
Care trajectory



Failure to visit biomedical facilities for care was at times due to observed ineffectiveness of medical treatments. In one focus group, CG fathers mentioned forgoing the HEW's advice of avoiding removal of the tonsil in their sick child. This was due repeated occurrences of child deaths from tonsillitis within the community. Upon noticing these child deaths and recurring infections in their own children, they opted to either visit the traditional doctor or self-perform removal of tonsils. However, forgoing medical advice was not common and never occurred without first visiting a biomedical facility. Further, all participants recommended the health center for treatment when recognizing symptoms indicating illness in the newborn.

DISCUSSION

The objective of this qualitative study is to identify the socio-contextual determinants for newborn possible severe bacterial infection (PSBI) care in the rural Amhara region of Ethiopia. Although there are several existing studies on treatment seeking for newborns with illnesses in low and middle-income contexts [7, 17, 22, 23], this study is the first to assess the determinants of securing treatment at the community-level for newborns with possible severe bacterial infection (PSBI). In designing this study, the intention was to assess how intrahousehold decisions to secure care, whether at biomedical facilities or at informal settings, for newborns with PSBI were made and how these decisions informed subsequent treatment methods. The aims of this study are to describe household roles and assess intrahousehold decision-making when visiting biomedical (health post, health center, hospital) or informal (traditional healer, church) facilities for treatment. Through analysis, findings suggest that there are five key themes describing care seeking determinants; maternal responsibility of the newborn, maternal decision-making, environmental and hygiene-nutrition practices as drivers of illness, illness conceptualization based on complexity and care seeking trajectory. The conclusions drawn from this study thus implicate public health programming efforts, policy and potential avenues for future research.

The aforementioned themes largely address household roles (maternal role and decision-making appreciation), conceptualization of illness (severity and perceived causes) and systems of support (household resources, community structures and social networks) that affect care trajectory. Maternal roles were acknowledged most as helpful throughout newborn care and care seeking, often due to the nutrient demands (breastfeeding) of the newborn during this time period. Community-based interventions could employ health campaigns for promoting or influencing

intrahousehold care seeking for mothers during the newborn period, as this is known to create a sense of the individual's autonomy in their own care provision [24].

Symptoms identified by parental figures most often included fever; lack of, or poor, breastfeeding; and excessive or abnormal crying, all of which have been identified in a similar study on care seeking practices in Central and Southern Ethiopia [25]. Further, mothers were identified as being primarily responsible in ensuring adequate care for the newborn, similar to another study in rural Oromia finding mothers often actively sought permission to seek care outside of the home [26]. However, contrary to findings in the rural Oromia region, family members were adamant in the mothers' autonomy in making care decisions. For example, father and family members report "accepting" the mother's decision about the most appropriate treatment for ill newborns. Some mothers and fathers acknowledge that both parents typically discuss care methods for sick newborns, but none of our Amhara respondents indicated mothers must obtain permission from the father prior to securing care.

Like other studies, we identified that care seeking trajectories were based on how parents and households characterized a child's illness [7, 26]. However, unlike one study in Southwest Ethiopia, participants did not mention the health post as a viable facility for care of sick newborns [27]. This may be an artifact of the HEW-based purposive sampling from health center records since participants may have been chosen if they lived closer to the health center and were more accessible for HEWs to recruit. Additionally, some discussions occurred within health posts where the health post was actually one room nested within a health center. Therefore, some participants may not have differentiated between services offered at health posts compared to health centers since health centers and posts shared a common location for some of our respondents.

Participants frequently and strongly indicated sick newborns should be cared for at health centers and financial barriers to obtaining care were not identified. Other logistical barriers (distance to facilities, facility accessibility and family time to seek care) were rarely mentioned. Further, several participants mentioned how health insurance was readily available and provided financial support to care for sick newborns. Some participants referred to their health insurance as justification for liberally visiting health centers if their child became ill ("there is no reason not to visit the health center"). Therefore, most potential constraints on accessing care for sick newborns were related to the perceived nature or severity of illness. This is a key finding in support of community/government partnerships and provisions for healthcare, most notably with the scale-up of the community-based health insurance in 2015 and the implementation of the social health insurance scheme in 2016 [28]. Although rarely mentioned, there were reported barriers to receiving biomedical care at facilities which coincides with resource mobilization gaps reported in the Maternal, Newborn, and Child Health Logistics System Assessment, Ethiopia report findings [29].

Implementation strategies should further focus towards expanding proven approaches in low-income country contexts. In order to do this action should be taken to incorporate community mobilization, expand community health worker strategies (HEWs and HDAs) and enhance community-based interventions, of which community members are involved in the development and implementation of programming efforts, to amplify acceptability of care seeking learned approaches [30].

LIMITATIONS

Although this study originally aimed to sample households with symptomatic children (SG) and community members in general (CG), this sampling frame did not yield divergent responses to

care seeking strategies for sick newborns between community and symptomatic households. Since many childhood illnesses share symptoms (fever, diarrhea, decreased feeding), the similarity in findings across CG and SG groups may represent commonly shared approaches to childhood illness at the community level.

In addition, to obtain an adequate sample for analysis we included any households that had a sick infant in the previous two years. This long timeframe may contribute to recall bias and diminish respondents specificity about PSBI-specific care seeking behaviors. Future studies may compare response from families with sepsis-confirmed newborns versus community members in general to gain additional understanding of PSBI-Sepsis-specific care in this setting or limit the sample to respondents whose infants were more recently ill—perhaps in the previous one to two months.

CONCLUSIONS

This study contributes to knowledge on newborn illness conceptualization and community-level care in rural Amhara, Ethiopia. It suggests community norms around care seeking strategies and trajectories in this context may be widely shared at the community level. Consequently, strategies to engage community members in defining and creating decentralized approaches to PSBI care are indicated to maximize their relevance, accessibility and desirability. In the Ethiopian health system context, engaging peripheral health workers (HEWs) and volunteers (HDAs) may be a salient strategy for creating a decentralized model of care. Community-based interventions, of which community members are involved in the development and implementation of programming efforts, may serve to amplify acceptability of learned and normative care seeking behaviors [30]. Expanding home visits using HDA health volunteers or health post curative care may be one powerful strategy for bringing PSBI care and treatment

closer to the households—particularly in contexts where geographic or contextual barriers limit the uptake of life-saving PSBI care at referral facilities or hospitals.

ABBREVIATIONS

FGD: Focus Group Discussion

HEW: Health Extension Worker

IDI: In-depth Interview

PSBI: Possible Severe Bacterial Infection

DECLARATIONS

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Availability of data and materials

The datasets generated and analyzed during the current study are not publicly available to protect confidentiality of participants in the communities studied. However, these data are available from the corresponding author upon reasonable request.

Authors' contributions

MDA, JNC and BLS were primarily responsible for conceptualizing and designing this study. Qualitative data collection methods were informed by DLC, SAS and LA. MDA conducted the literature review, assisted/supervised data collection and data analysis. JNC, DLC and SAS guided and revised review of the literature and data analysis proceedings. MDA, JNC, DLC and SAS supported the interpretation of results with all authors contributing towards the review and editing of manuscript proceedings. Further, all authors contributed towards manuscript preparations and approved the manuscript for submission.

Competing Interests

The authors declare no competing interests.

Ethics approval and consent to participate

Ethical approval was obtained from the Amhara Public Health Institute and the Emory University Institutional Review Board. Oral informed consent was provided by all participants of the study.

Consent for publication

No individual persons' data was reported in this manuscript.

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CHAPTER 5: PUBLIC HEALTH IMPLICATIONS

The objective of this qualitative study is to identify the socio-contextual determinants for newborn possible severe bacterial infection (PSBI) care in the rural Amhara region of Ethiopia. Although there are several existing studies on treatment seeking for newborns with illnesses in low and middle-income contexts (Y. Amare, Paul, & Sibley, 2018; Herbert, Lee, Chandran, Rudan, & Baqui, 2012; Lama, Khatry, Katz, LeClerq, & Mullany, 2017; Tefera et al., 2014), this study is the first to critically examine factors leading to community-level treatment seeking for newborns with PSBI. The aims of this study are to describe household roles and assess intrahousehold decision-making when visiting biomedical (health post, health center, hospital) or informal (traditional healer, church) facilities for treatment. Through analysis, findings suggest that there are five key themes describing care seeking determinants; maternal responsibility of the newborn, familial appreciation of maternal decision-making, improper hygiene and nutrition practices, illness conceptualization based on complexity and care seeking trajectory. The conclusions drawn from this study thus implicate public health programming efforts, policy and potential avenues for future research.

The aforementioned themes largely address household roles (maternal role and decision-making appreciation), conceptualization of illness (severity and perceived causes) and systems of support (household resources, community structures and social networks) that affect care trajectory. Maternal roles were acknowledged repeatedly as helpful or necessary for newborn care seeking, often due to nutrient demands (breastfeeding/breastmilk) of the newborn during this time period. Community-based interventions could employ health campaigns for promoting or influencing intrahousehold care seeking for mothers during the newborn period, as this is known to create a sense of the individual's autonomy in their own care provision (Zora S. Lassi, Kumar, & Bhutta, 2016). Further, several household members

(e.g. siblings of newborn) were identified as systems of support and often praised the mother when taking action for following-up on care upon recognition of symptoms. However, there is a paucity of research aimed to thoroughly understand the mechanisms in which these younger household members assure the health of newborn siblings/newborns in the household. Future studies should aim to research how these peripheral family members secure care for their siblings to inform the extent of which these family members play active roles in their siblings' care provision.

Another finding from this study were the symptoms identified by parental figures. Most often this included fever, lack of (or poor) breastfeeding and excessive or abnormal crying. All of these symptoms have been identified similarly in another study on care seeking practices in Central and Southern Ethiopia (Yared Amare, Degefie, & Mulligan, 2013). Further, mothers in this study and the former were most often the first to identify symptoms in their newborn (Ellis, Doumbia, Traore, Dalglish, & Winch, 2013). However, contrary to a study in rural Oromia, mothers in this study did not often report seeking permission prior to accessing care outside of the home (Shaw, Amouzou, Miller, Bryce, & Surkan, 2017). In fact, family members were adamant about the mothers' ability to make care decisions and "accept[ed]" or "appreciated" the mother's decision when taking action to visit a facility for care. There was minimal mention of obtaining permission from the father prior to securing care. However, parents often stated that decisions should be made with both parent' input, after discussing the matter.

Care seeking trajectories based upon illness characterization was also a key finding. In other studies conducted in similar areas, care seeking trajectories based upon household perceptions were similarly significant for the types of treatment methods that were sought (Y. Amare et al., 2018; Shaw et al., 2017). However, participants in this study did not mention or

acknowledge the health post (peripheral level of care) as a viable facility to receive medications, vaccinations or healthcare advice. This was most likely due to HEW purposive sampling from health center records; participants may have been more likely to be selected for the study if they were more accessible for HEWs to recruit and thus lived close to the health center.

With regard to barriers to care, typical impediments (such as distance, finances and transportation) were rarely mentioned. In fact, participants strongly supported accessing the health center due to limited financial constraints. Logistical barriers were mentioned only in rare instances, potentially due to the readily available health insurance that some participants mentioned. The health insurance was often used as justification for visiting the health center when any health issues arose within the child ("there is no reason not to visit the health center"). Therefore, most constraints that were reported were due to lack of knowledge of appropriate newborn care practices (belief that the illness would resolve on its own). This is a key finding in support of community/government partnerships and provisions for healthcare, most notably with the scale-up of the community-based health insurance in 2015 and the implementation of the social health insurance scheme in 2016 (Admasu, Balcha, & Ghebreyesus, 2016). Notably, participants did discuss barriers upon visiting biomedical facilities for treatment which limited the ability to obtain care for the child. These findings coincide with resource mobilization gaps stated in the Maternal, Newborn, and Child Health Logistics System Assessment, Ethiopia report (Federal Democratic Republic of Ethiopia Ministry of Health, 2018).

Implementation strategies may focus efforts towards expanding proven approaches in low and middle-income contexts to incorporate community mobilization and community health worker strategies (HEWs and HDAs). Community-based interventions, of which community members are involved in the development and implementation of programming

efforts, may serve to amplify acceptability of care seeking approaches (Nair, Tripathy, Prost, Costello, & Osrin, 2010). Improvement in the number of CHWs (HEWs/HDALs) may serve to increase CHW capability to make more postnatal home visits. This would be beneficial, especially considering that illnesses may be mischaracterized within the home affecting appropriate care seeking efforts. Finally, future studies should aim to examine demand and adherence to simplified PSBI treatment regimens once scaled-up at the community level as this simplified treatment regimen is yet to be implemented.

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APPENDICES

Appendix A. Data Collection Tools

Focus Group Guide
Symptomatic Group | Recently-birthed women (FG#1)

Introduction

Thank you for joining us today. I understand all of us have had a child within the past two years.

1. Please tell us the name of your child and what you did to care for them when they were newborns.
    - What were your responsibilities?
    - How do others in your community care for newborns just after childbirth? (first days and weeks)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people get care for their babies to keep them healthy or when they are sick.

2. Tell me about what you do to keep your baby healthy - particularly when they are newborns.
    - What actions did you take to care for your baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did you go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, family members, community leaders, health specialists)

3. Please describe a time when you thought your newborn was sick. How did you know they were sick? (i.e. community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor/stopped feeding?
    - Convulsions (seizures)?

4. How do you make decisions about getting care for your newborn?
    - Who makes decisions for newborn care in the household?
    - How did others influence your decision to seek care?
    - What are the reasons you did or did not go to a clinic? (health post, health centre, hospital)

Newborn Infection and Treatments

I would now like to discuss your thoughts about infections and treatments.

5. What actions did you take when your newborn was sick?
    - How did you treat your newborn? (traditional healers, home treatments, religious ceremonies, medications)

- How effective were these measures in treating your newborn?
- Where did you go to get care? (traditional healers, religious leaders, health post, health centre, hospital)

6. In your community, what measures are taken to care for a baby with an infection? (traditional treatments, home treatments, medications, religious ceremonies)
    - What resources are available?

7. Describe your experiences with newborn death in your community.
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatments when they are sick?
        - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital)

8. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. Please remain seated for a couple of follow-up questions. If you would like any additional information on this discussion, please do not hesitate to let me know.

Focus Group Guide
Symptomatic Group | Fathers (FG#2)

Introduction

Thank you for joining us today. I understand all of us have had a child within the past two years.

1. Please tell us the name of your child and what you did to care for them when they were newborns.
    - What were your responsibilities?
    - How do others in your community care for newborns just after childbirth? (first days and weeks after childbirth)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people get care for their babies to keep them healthy or when they are sick.

2. As a father, tell me about what you do to keep your baby healthy- particularly when they are newborns.
    - What actions did you take to care for your baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did you go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, family members, community leaders, health specialists)

3. Please describe a time when you thought your newborn was sick. How did you know they were sick? (i.e. family members, community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor feeding/stopped feeding?
    - Convulsions (seizures)?

4. As a father, how do you make decisions about getting care for your newborn?
    - Who makes decisions for newborn care in the household?
    - How did others influence your decision to seek care?
    - What are the reasons you did or did not go to a clinic? (health post, health centre, hospital)

5. Who is the primary caretaker of the newborn in the household?
    - How do you feel about providing household care for the newborn? (i.e. feeding, swaddling, bathing)
    - How do you support the primary caretaker in caring for the sick newborn?

Newborn Infection and Treatments

I would now like to discuss your thoughts about infections and treatments.

6. What actions did you take when your newborn was sick?
    - How did you treat your newborn? (traditional healers, home remedies, religious ceremonies, medications)

- How effective were these measures in treating your newborn?
- Where did you go to get care? (traditional healer, religious leader, health post, health centre, hospital)

7. In your community, what measures are taken to care for a baby with an infection? (traditional treatments, home remedies, medications, religious ceremonies)
    - What resources are available?

8. Describe your experiences with newborn death in your community.
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatments when they are sick?
    - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital) What treatments are available in your community?

9. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. Please remain seated for a couple of follow-up questions. If you would like any additional information on this discussion, please do not hesitate to let me know.

Focus Group Guide
Symptomatic Group | Household Unit (FG#3)

Introduction

Thank you for joining us today. I understand all of us have had a child within the past two years.

1. Please tell us the name of your child and what you did to care for them when they were newborns.
    - What were your responsibilities?
        - How do others in your community care for newborns just after childbirth? (first days and weeks after childbirth)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people get care for their babies to keep them healthy or when they are sick.

2. Tell me about what you all do to keep the baby healthy- particularly when they are newborns.
    - What actions did each person take to care for the baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did the baby go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, other family members, community leaders, health specialists)

3. Please describe a time when you thought the newborn was sick. How did you know they were sick? (i.e. community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor feeding/stopped feeding?
    - Convulsions (seizures)?

4. How were decisions made for getting care for the newborn?
    - Who makes decisions for newborn care in the household?
    - How did others influence the decision to seek care?
    - What are the reasons the baby did or did not go to a clinic? (health post, health centre, hospital)

Newborn Infection and Treatments

I would now like to discuss your thoughts about infections and treatments.

5. What actions were taken when the newborn was sick?
    - How did you treat the newborn? (traditional healers, home treatments, religious ceremonies, medications)
    - How effective were these measures in treating your newborn?
    - Where did you go to get care? (traditional healer, religious leader, health post, health centre, hospital)

6. In your community, what measures are taken to care for a baby with an infection? (traditional treatments, home remedies, medications, religious ceremonies)
    - What resources are available?

7. Describe your experiences with newborn death in your community.
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatment when they are sick?
    - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital)

8. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. Please remain seated for a couple of follow-up questions. If you would like any additional information on this discussion, please do not hesitate to let me know.

In-depth Interview Guide
Symptomatic Group | Peripheral Family Members (IDI#1)

Introduction

Thank you for joining us today. I understand you have had a child in the household within the past two years.

1. Please tell us the name of the child in the household and what you did to care for them when they were a newborn.
    - What were your responsibilities?
        - How do others in your community care for newborns just after childbirth? (first days and weeks after childbirth)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people get care for their babies to keep them healthy or when they are sick.

2. Tell me about what you do to keep the baby healthy- particularly when they were a newborn.
    - What actions were taken to care for the baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did the baby go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, family members, community leaders, health specialists)

3. Please describe a time when the newborn was sick. How did you know they were sick? (i.e. community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor feeding/stopped feeding?
    - Convulsions (seizures)?

4. How were decisions made about getting care for the newborn?
    - Who makes decisions for newborn care in the household?
    - How did others influence the decision to seek care?
    - What are the reasons the baby did or did not go to a clinic? (health post, health centre, hospital)

Newborn Infection and Treatments

I would now like to discuss your thoughts about infections and treatments.

5. What actions did you take when the newborn was sick?
    - How did the newborn receive treatment? (traditional healers, home treatments, religious ceremonies, medications)
    - How effective were these measures in treating your newborn?
    - Where did the family go to get care? (traditional healers, religious leaders, health post, health centre, hospital)

6. In your community, what measures are taken to care for a baby with an infection? (traditional treatments, home remedies, medications, religious ceremonies)
    - What resources are available?

7. What do you think are the causes of death for sick newborns in your community?
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatment when they are sick?
    - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital)

8. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. We would like to ask you a couple of follow-up questions so please remain seated. If you would like any additional information on this discussion, please do not hesitate to let me know.

Focus Group Guide
Community Group | Recently-birthed women (FG#4)

Introduction

Thank you for joining us today. I understand all of us have had a child within the past two years.

1. Please tell us the name of your child and what you did to care for them when they were newborns.
    - What were your responsibilities?
    - How do others in your community care for newborns just after childbirth? (first days and weeks after childbirth)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people get care for their babies to keep them healthy or when they are sick.

2. Tell me about what you do to keep your baby healthy – particularly when they are newborns.
    - What actions do you take to care for your baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did you go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, family members, community leaders, health specialists)

3. For those that have had a sick newborn, how did you know they were sick? (i.e. community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor feeding/stopped feeding?
    - Convulsions (seizures)?

4. What did you do to get care for the baby outside of the household? (i.e. traditional healer, health post, health centre, hospital)
    - How did others influence your decision to seek care?
    - Who makes decisions for newborn care in the household?
    - Are there reasons you did or did not go to a clinic for care when your baby was sick? If so, what are those reasons?

Newborn Infection and Treatments

I would now like to discuss your thoughts about infections and treatments.

5. What actions did you take when your newborn was sick?
    - How did you treat your newborn? (traditional healers, home treatments, religious ceremonies, medications)
    - How effective were these measures in treating your newborn?
    - Where did you go to get care? (traditional healers, religious leaders, health post, health centre, hospital)

6. In your community, what measures are taken to care for a baby with an infection? (traditional treatments, home remedies, medications, religious ceremonies)
    - What resources are available? What treatments are available in your community?

7. Describe your experiences with newborn death in your community.
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatment when they are sick?
    - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital)

8. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. Please remain seated for a couple of follow-up questions. If you would like any additional information on this discussion, please do not hesitate to let me know.

Focus Group Guide
Community Group | Fathers (FG#5)

Introduction

Thank you for joining us today. I understand all of us have had a child within the past two years.

1. Please tell us the name of your child and what you did to care for them when they were newborns.
    - What were your responsibilities?
    - How do others in your community care for newborns just after childbirth? (first days and weeks after childbirth)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people get care for their babies to keep them healthy or when they are sick.

2. As a father, tell me about what you do to keep your baby healthy- particularly when they are newborns.
    - What actions did you take to care for your baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did you go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, family members, community leaders, health specialists)

3. For those that have had a sick newborn, how did you know the baby was sick? (i.e. community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor feeding/stopped feeding?
    - Convulsions (seizures)?

4. As a father, how do you make decisions about getting care for your newborn?
    - Who makes decisions for newborn care in the household?
    - How did others influence the decision to seek care?
    - What are the reasons you did or did not go to a clinic? (health post, health centre, hospital)

Newborn Infection and Treatments

I would now like to discuss your thoughts about infections and treatments.

5. What actions did you take when your newborn was sick?
    - How did you treat your newborn? (traditional healer, home treatments, religious ceremonies, medications)
    - How effective were these measures in treating your newborn?
    - Where did you go to get care? (traditional healer, religious leader, health post, health centre, hospital)

6. In your community, what measures are taken to treat a newborn with an infection? (traditional treatments, home remedies, medications, religious ceremonies)
    - What resources or measures are available?

7. Describe your experiences with newborn death in your community.
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatment when they are sick?
    - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital)

8. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. Please remain seated for a couple of follow-up questions. If you would like any additional information on this discussion, please do not hesitate to let me know.

Focus Group Guide
Community Group | Household Unit (FG#6)

Introduction

Thank you for joining us today. I understand all of us have had a child within the past two years.

1. Please tell us the name of your child and what you did to care for them when they were newborns.
    - What were your responsibilities?
    - How do others in your community care for newborns just after childbirth? (first days and weeks after childbirth)

Newborn Care and Illness

Let's talk about newborn care and illness. Sometimes people seek care for their babies to keep them healthy or when they are sick.

2. Tell me about what you do to keep the baby healthy – particularly when they are newborns.
    - What actions did each person take to care for the baby? (i.e. church blessing, traditional healer, clinic appointments, immunizations)
    - Where did the baby go for care? (i.e. home only, church, health post, health centre, hospital)
    - How do others care for the newborn? (i.e. friends, other family members, community leaders, health specialists)

3. If there was a time the newborn was sick, how did you know they were sick? (i.e. community members, health specialists, symptoms)
    - Fast breathing?
    - Hot to touch?
    - Cold to touch?
    - Chest draws in?
    - Moves only when stimulated/no movement?
    - Poor feeding/stopped feeding?
    - Convulsions (seizures)?

4. How were decisions made for getting care for the newborn?
    - Who makes decisions for newborn care in the household?
    - How did others influence your decision to seek care?
    - What are the reasons the baby did or did not go to a clinic? (health post, health centre, hospital)

Newborn Infection and Treatments

I would now like to discuss your knowledge of infections and treatment options.

5. What actions were taken when the newborn was sick?
    - How was the newborn given treatment? (traditional healer, home treatment, religious ceremonies, medications)
    - How effective were these measures in treating your newborn?
    - Where did you go to get care? (traditional healer, religious leader, health post, health centre, hospital)

6. In your community, what measures are taken to care for a baby with an infection? (traditional treatments, home remedies, medications, religious ceremonies)
    - What resources are available?

7. Describe your experiences with newborn death in your community.
    - What do you think the causes of death are for sick newborns?
    - What happens to newborns that do not receive treatment when they are sick?
    - What happens if newborns do not go to a clinic when they are sick? (health post, health centre, hospital)

8. Is there anything else related to newborn health, illness and infections in your community that you would like to discuss?

Thank you for sharing. We hope that this discussion was informative. Your responses are valuable and provided a depth of information on the experiences shared within this community. Please remain seated for a couple of follow-up questions. If you would like any additional information on this discussion, please do not hesitate to let me know.

Demographic Intake Form
(to be delivered orally)

No	Questions	Response
1	Number of family members residing in the house.	_____
2	What is your age (years)?	_____
3	What is the last year of formal schooling you've completed?	o No formal education o Primary (1-8) o Secondary (9-12) o Technical/vocational certificate o Degree or higher (bachelors and/or post-graduate)
4	What is your current occupation?	o Housewife o Agriculture o Skilled Labor o Unskilled Labor o Professional/Technical/Managerial o Merchant/Petty trade o Other *(specify)* _____
5	What is your religion?	o Christian (Orthodox) o Christian (Protestant) o Christian (Catholic) o Muslim o Traditionalist o Other *(specify)* _____
6	What is your ethnicity?	o Amhara o Agew o Tigre o Oromo o Other *(specify)* _____
7	What is the total income of your family per year? *(in birr)*	_____*(in birr)*
	Obstetric History	
8	How many live births have you had during your lifetime?	_____
9	How many living children do you have now?	_____

የቡድን ውይይት ለማካሄድ የተዘጋጀ የቃል ፈቃድ መጠየቂያ ቅጽ፡ (#1)

መለያ ጥር #: ___

አድራሻ (ቀበሌ): _____

አመቻች: _____

ማስታወሻ ያዥ፡_____

ዓላማ/ርዕስ: ፍላጎትን መሰረት ያደረገ አዲስ ለተወለዱ ጨቅላ ህፃናት የሚሰጥን እንክብካቤና የጤና ክል በተመለከተ ያለውን ልምድ እና ምንነት ለማወቅ ጥናት ማድረግ፡፡

የጥናቱ ዋና ተመራማሪ፦ ሜሮን አሰፋሀን

የጥናቱ መግቢያና የጥናቱ አጭር መግለጫ/ማጠቃለያ ፣

እኛ ኢሞሪ ዩኒቨርስቲ ከሚባል የትምህርት ተቋም የመጣን እና ከኢሞሪ ዩኒቨርሲት ኢትዮጲያ የአማራ ክልል ማስተባበሪያ ጽ/ቤት አዲስ ለተወለዱ ጨቅላ ህፃናት የሚሰጠውን ክብካቤ እና የጤና ክል(ብግነት) ምንነት ለመገንዘብ ጥናት የምነደርግ አካላት ነን፡፡ ለዚህ ጥናት ውጤታማነት በህ/ሰቡ እና ጤና ተቋማት ለቸቅላ ህፃናት የሚሰጥን ክብካቤና የጤና ክል ምንነት መረዳት ይቻል ዘንድ የህ/ሰብ ወከይ አካላት ጋር ውይይት በማካሄድ ጥናቱን እያከሄድን እንገኛለን፡፡

እንኳን ደህና መጡ

ሰላም ፡ ስሜ----------ይባላል(አመቻች)፡፡ ይህ/ይቺ የስራ ባልደረባየ ----------ይባላል/ትባላለች(ማስታዎሻ ያዥ) ፡፡
በዛሬው ዕለት ከእኛ ጋር በመገናኘት አዲስ ለተወለዱ ጨቅላ ህፃናት የሚሰጥን እንክብካቤና የጤና ክል በተመለከተ የእናንተን ልምድ እና የምታውቁትን እውነታ ለማካፈል ውድ ጊዜያችሁን ሰውታችሁ ስለመጣችሁ በጣም እናመሰግናለን፡፡ ውሳኔያችሁን በጣም እናደንቃለን፡፡ በመሆኑም ከጥናት ስልቶች መካከል የህ/ሰቡ ወካይ ከሆኑ አካላት ጋር የቡድን ውይይት በማካሄድ የሚፈለጉ መረጃዎችን በመቀመር ለጥናቱ ግባት ለመጠቀም ጥረት እያደረግን እንገኛለን፡፡
ቅድሚያ መረዳት ወይም መጠየቅ የምትፈልጉት ጉዳይ ካለ መጠየቅ ይቻላል፡፡ ለመሳተፍም የመወሰን ሙብት እንዳላችሁና በሂደቱም ያለመቀጠል ፍላጎት ካለ የማቋረጥ መብታችሁ የተከበረ ነው፡፡
ስለሆነም በዛሬው ዕለት በምናደርገው የጥናት ቡድን ውይይት እንዲሳተፉ በአክብሮት እንጠይቃለን፡፡

የጥናቱ ዓላማ እናቶች፣ አባቶች እና የቤተሰብ አካላት አዲስ ለተወለደ ጤነኛ እና ጤናቸው ለታወኩ ጨቅላ ህፃናት የሚሰጡትን እንክብካቤ በተመለከተ በአማራ ክልል ጥነት ለማድረግ ነው፡፡ ቃለ መጠይቁ እስከ 1፡30 ሰዓት ሊወስድ ይችላል፡፡ በቃለመጠይቁ ወቅት ተሳታፊዎች አዲስ ለተወለዱ ጤናማ እና ጤናቸው የታወኩ ጨቅለ ህፃናት ያላቸውን የህይወት ልምድ እንዲየነሱ ይፈለጋል፡፡ በውይይቱ ወቅት ስሜትን የሚነኩ ያለፉ ልምዶችና ሁኔታዎች ሊነሱና ሊታወሱ ይችላል፡፡በዚህ ወቅት ምንም ዕይነት ችግር ቢከሰት እና እርዳታ ቢያስፈልግዎ አገልግሎትሊያገኙ የሚቹሉበት ሁኔታ ይመቻቻል፡፡

በጥናቱ መሳተፍ የሚያስገኛቸው ጥቅሞችና ማካካሻዎች:

በዚህ ጥናት በመሳተፍዎ ምክንያት ቀጥተኛ ተጠቃሚ ይሆናሉ ማለት እንዳልሆነና የሚያስገኝልዎ ማካካሻ የለም፡፡ ነገር ግን ለወደፊት የጨቅላ ህፃናትን ጤና ለመጠበቅና ለማሻሻል በሚደረገው ጥረት ተደራሽነትን እና አገልግሎትን ለማሻሻልቶችን በመለየት መፍትሄ የሚሆን ያስራር ስልት ለመንደፍ የሚያስችል የመረጃ ግባት እናገኛለን፡፡
ለዚህም በውይይታችን ከእናንተ የሚገኘው መረጃ እጅግ ጠቃሚሻ በመሆኑ ማስታወሽ እና መቅረጸ ድምጽ እንጠቀማለን፡፡ ስለሆነም እናንተ በንቃትና ታማኝ በመሆን ሀሳባችሁን በነጻነት እንድታካፍሉን እንድትገልጹ ይገባል፡፡ በምሰጡን ሀሳብ ስህትተ እና ትክክል ተብሎ የሚፈረጅ አለመሆኑን እና ሁሉም የሚነሳው ሀሳብ ተገቢ መሆኑን መገንዘብ ያስፈልጋል፡፡

የሚሰጡ መረጃዎችን በሚስጥር መያዝ:

በውይይቱ ወቅት ያገኘናቸውን ማናቸውም መረጃ በምስጢር እንደሚያዙ እና ለጥናቱ ዓለማ ብቻ የሚውሉ ይሆናሉ፡፡ ጥናቱ ሲገባደድም በመቅረጸ ድምጽ የነበረው ቃለ መጠይቅ እንዲጠፋ ይደረገል፡፡ የሚሰጡትን መረጃ ሚስጥር ለመጠበቅ ማንንትዎን የሚያመለክቱ ስሞችን አንጠቀምም፡፡ በዚህ ፊንታ የተሳታፊ መለያ ቁጥር እንጠቀማለን፡፡

<u>ተጠሪ አካል</u>

ጥናቱን በተመለከተ ማነኛውም ጥያቄና መነሳት ያለበት ጉዳይ ከለ ሜሮን አስፋሀ (ዋና ተመራማሪን ማግኘት ይቻላልል፣ +251 0901003278.

<u>የፈቃደኝነት መጠየቂያ (የቡድን ተሳታፊዎችን ቢጋራ መጠየቅ)</u>

እኔ ከእያንዳንዱ ተሳታፊ በአራት ሳምንታት ዕድሜ ክልል ስላሉ ጨቅላ ህጻናት ክብካቤ ለመማር ጓጉቸሁ፡፡

ሀሳባችሁን በመቅረጸ ድምጽ መቅረጽ እንችላለን?

-ፈቃደኛ ከሆናችሁ፡ ታላቅ ነግር ነው ፣ መጀመር እንችላልን

-ፈቃደኛ ካልሆናችሁ፡ በመምጣታችሁ እናመሰግናልን፡፡ በማነኛውም ሰዓት መሄድ ትችላላችሁ፡፡

በእውቅና ላይ የተመሰራተውን ውይይት ያዘጋጀው ሰው ፊርማ

_____

_____

ፊርማ

ቀን ሰዓት

_____

በእውቅና ላይ የተመሰራተውን ውይይት ያዘጋጀው ሰው ስም

የቃል ፈቃደኝነት መጠየቂያ ቅጽ (#2)

ጥልቅ ቃለ መጠይቅ

መለያ ቁጥር #: ___

አድራሻ(ቀበሌ): _____

አመቻች: _____

ማስታወሻ ያዥ:_____

<u>እንኳን ደህና መጡ</u>

<u>ሰላም ፡</u> ስሜ----------ይባላል(አመቻች)፡፡ ይህ/ይቺ የስራ ባልደረባየ ----------ይባላል/ትባላለች(ማስታዎሻ ያዥ) ፡፡ በዛሬው ዕለት ከእኛ ጋር በመገናኘት አዲስ ለተወለዱ ጨቅላ ህፃናት የሚሰጥን እንክብካቤና የጤና ክል በተመለከተ የእናንተን ልምድ እና የምታውቁትን እውነታ ለማካፈል ውድ ጊዜያቸሁን ሰውታችሁ ስለመጣችሁ በጣም እናመሰግናለን፡፡ ውሳኔያችሁን በጣም እናደንቃለን፡፡ ቅድሚያ መረዳት ወይም መጠየቅ የምትፈልጉት ጉዳይ ካለ መጠየቅ ይቻላል፡፡ ለመሳተፍም የመወሰን መብት እንዳላችሁና በሂደቱም ያለመቀጠል ፍላጎት ካለ የማቋረጥ መብታችሁ የተከበረ ነው፡፡

ስለሆነም በዛሬው ዕለት በምናደርገው የጥናት ቡድን ውይይት እንዲሳተፉ በአክብሮት እንጠይቃለን፡፡

የጥናቱ ዓላማ እናቶች፣ አባቶች እና የቤተሰብ አካላት አዲስ ለተወለደ ጤነኛ እና ጤናቸው ለታወኩ ጨቅላ ህፃናት የሚሰጡትን እንክብካቤ በተመለከተ በአማራ ክልል ጥናት ለማድረግ ነው፡፡ ቃለ መጠይቁ እስከ ፣፡00 እስከ ፣፡30 ሰዓት ሊወስድ ይችላል፡፡ በቃለመጠይቁ ወቅት አዲስ ለተወለዱ ጨቅለ ህፃናት ጤና እና ክብካቤ ያላወትን የህይወት ልምድ እንዲያነሱ ይፈለጋል፡፡ በውይይቱ ወቅት ስሜትን የሚነኩ ያለፉ ልምዶችና ሁኔታዎች ሊነሱና ሊታወሱ ይችላል፡፡በዚህ ወቅት ምንም ዕይነት ችግር ቢከሰት እና እርዳታ ቢያስፈልግዎ አገልግሎትሊያገኙ የሚቹሉበት ሁኔታ ይመቻቻል፡፡

<u>በጥናቱ መሳተፍ የሚያስገኛቸው ጥቅሞችና ማካካሻዎች:</u>

በዚህ ጥናት በመሳተፍዎ ምክንያት ቀጥተኛ ተጠቃሚ ይሆናሉ ማለት እንዳልሆነና የሚያስገኝልዎ ማካካሻ የለም፡፡ ነገር ግን ለወደፊት የጨቅላ ህፃናትን ጤና ለመጠበቅና ለማሻሻል በሚደረገው ጥረት ተደራሽነትን እና አገልግሎትን ለማሻሻልቶችን በመለየት መፍትሄ የሚሆን ያሰራር ስልት ለመንደፍ የሚያስችል የመረጃ ግባት እናገኛለን፡፡

ለዚህም በውይይታችን ከእናንተ የሚገኘው መረጃ እጅግ ጠቃሚሻ በመሆኑ ማስታወሸ እና መቅረጸ ድምጽ እንጠቀማለን፡፡ ስለሆነም እናንተ በንቃትና ታማኝ በመሆን ሀሳባችሁን በነጻነት እንድታካፍሉን እንድትገልጹ ይገባል፡፡ በምሰጡን ሀሳብ ስህትተ እና ትክክል ተብሎ የሚፈረጅ አለመሆኑን እና ሁሉም የሚነሳው ሀሳብ ተገቢ መሆኑን መገንዘብ ያስፈልጋል፡፡

<u>የሚሰጡ መረጃዎችን በሚስጥር መያዝ:</u>

በውይይቱ ወቅት ያገኘናቸውን ማናቸውም መረጃ በምስጢር እንደሚያዙ እና ለጥናቱ ዓለማ ብቻ የሚውሉ ይሆናሉ፡፡ ጥናቱ ሲገባደድም በመቅረጸ ድምጽ የነበረው ቃለ መጠይቅ እንዲጠፋ ይደረገል፡፡ የሚሰጡትን መረጃ ሚስጥር ለመጠበቅ ማንንትዎን የሚያመለክቱ ስሞችን አንጠቀምም፡፡ በዚህ ፈንታ የተሳታፊ መለያ ቁጥር እንጠቀማለን፡፡

<u>ተጠሪ አካል</u>

ጥናቱን በተመለከተ ማነኛውም ጥያቄና መነሳት ያለበት ጉዳይ ከለ ሜሮን አስፋሀ (ዋና ተመራማሪን ማግኘት ይቻላልል፣ +251 0901003278.

<u>የፈቃደኝነት መጠየቂያ (የቡድን ተሳታፊዎችን በጋራ መጠየቅ)</u>

እኔ ከእያንዳንዱ ተሳታፊ በአራት ሳምንታት ዕድሜ ክልል ስላሉ ጨቅላ ህጻናት ክብካቤ ለመማር ጓጉቸሉሁ፡፡

ሀሳባችሁን በመቅረጸ ድምጽ መቅረጽ እንችላለን?

-ፈቃደኛ ከሆናችሁ: ታላቅ ነግር ነው ፣ መጀመር እንችላልን

-ፈቃደኛ ካልሆናችሁ: በመምጣታችሁ እናመሰግናልን፡፡ በማነኛውም ሰዓት መሄድ ትችላላችሁ፡፡

በእውቅና ላይ የተመሰራተውን ውይይት ያዘጋጀው ሰው ፊርማ

ፊርማ

ቀን ሰዓት

በእውቅና ላይ የተመሰረተውን ውይይት ያዘጋጀው ሰው ስም

የቡድን ውይይት መመሪያ
PSBI በምህበረሰብ/በግለሰቦች ቤት ደረጃ | በቅርብ ቀን ለወለዱ እናቶች (FG#1)

<u>መግቢያ</u>

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁም ዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ አንድና ሁለት ሳምንታት) የሚንከባከቡት እንዴት ነው፡፡

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስቲ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
    - ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
    - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ፣ ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
    - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)
3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
    - ቶሎ ቶሎ መተንፈስ?
    - በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርነድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?

4. አዲስ ለተወለደ ህፃንሽ ክብካቤ ለመስጠት ውሳኔ የትወስኝውእንዴት ነው?
    - በቤተሰብ ውስጥ ለህጻን ልጃችሁ ክብካቤ ለመስጠት ውሳኔ የሚዎስነው መን ነው?
    - በውሰኔሽ ላይ የሌሎች አወንተዊ ተጽኖ ምን ይመስላል?
    - ጤና ተቋም ላለመሄድ ምክነያት ሊሆኑ የሚችሉ ጉዳዮች ምን ሊሆኑ ይችላሉ? (ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)
    - ምን ሀብቶች ወይም አማራጮች አሉ?

7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
    - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
    - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
    - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

    (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)

8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን፡፡ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል፡፡በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን፡፡ በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል፡፡

የቡድን ውይይት መመሪያ
PSBI በምህበረሰብ/በግለሰቦች ቤት ደረጃ | ከባሎች/ኢጋሮች ጋር (FG#2)

መግቢያ

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው፡፡

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስቲ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣

- ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
- ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
- ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)

3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልከቶችን በመመመልከትና በመረዳት)
    - ቶሎ ቶሎ መተንፈስ?
    - ከመጠን በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርጎድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?

4. እንደ አባት ለጨቅላ ህፃን ልጅህ ክብካቤ ምን ታደርጋለህ?
    - በቤት ውስጥ ለጨቅላ ህፃን ልጅህ ክብካቤና ደህንነት የሚመለከተው ወሳኝ አካል ማን ነው?
    - ሌሎች የቤተሰብ አባላትስ ህጻን ልጃችሁ ቢታመም ምን ዓይነት ድርሻ ወይም ሚና ይኖራቸዋል?
    - ህጻን ልጃችሁ ህመም ቢገጥመው ወደ ህክምና እንዳትሄዱ ምክነያት ሊሆን የውችላል ጉዳይ ይኖር ይሆን? (ጤና ኬላ፣ ጤና ጣቢ፣ ሆስፒታል)

5. በቤታችሁ ለጨቅላ ህጻናችሁ ክብካቤ በዋናነት የማን ኃላፊነት ነው?
    - ለጨቅላ ልጃችሁ በቤት ውስጥ ክብካቤ በመስጠትህ ምን ይሰማህል? (i.e.መመገብ፣ማቀፍ፣ ሰውነት ማጠብ)
    - አዲስ የተወለደ ህፃን ልጃችሁ ህመም ቢገጥመው በቅድመ እርዳታ ምን ይደረግላታል?

<u>የጨቅላ ህጻነት ህመም(መበከል) እና ህክምና</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

6. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

7. በእናንተ ማህበረሰብ, ለታመመ ህፀን ምን የመፍትሄ አገልግሎት ይደረግለታል(ባህላዊ ህክምና፣ በቢት ውስጥ መንከባከብ፣ምዲሃኒት መጠቀም፣ሀይማኖታዊ ጸሎት ማድረግ)
   - ይህን ለማድረግ የሚያግዙ በአካባቢችሁ ምን ሀብቶች ወይም አማራጮች አሉ?
8. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
   - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
   - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
   - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

   (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)
9. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን::ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በሀብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል::በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን:: በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል::

የቡድን ውይይት መመሪያ
PSBI በምህበረሰብ/በግለሰቦች ቤት ደረጃ | ከእያንዳንዱ አባ ወረ/አእማወራ ጋር(FG#3)

<u>መግቢያ</u>

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል። ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን።

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ።.
   - የእንንተ ድርሻ ምንድን ነበር?
   - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው።

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስቲ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር። አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል።

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
   - ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
   - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
   - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)

3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
   - ቶሎ ቶሎ መተንፈስ?
   - ከመጠን በላይ ማተኮስ?
   - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
   - የደረት መሰርነድ?
   - ምንም እንቅስቃሴ አለመኖር?
   - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
   - መንዘፍዘፍ?

4. አዲስ ለተወለደ ህፃንሽ ክብካቤ ለመስጠት ውሳኔ የትወስኚውእንዴት ነው?
   - በቤተሰብ ውስጥ ለህጻን ልጃችሁ ክብካቤ ለመስጠት ውሳኔ የሚዎስነው መን ነው?
   - በውሰኔሽ ላይ የሌሎች አወንተዊ ተጽኖ ምን ይመስላል?
   - ጤና ተቋም ላለመሄድ ምክነያት ሊሆኑ የሚችሉ ጉዳዮች ምን ሊሆኑ ይችላሉ? (ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)

<u>የጨቅላ ህጻነት ህመም(መበከል) እና ህክምና</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
   - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
   - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
   - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)
    - ምን ሀብቶች ወይም አማራጮች አሉ?
7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
    - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
    - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
    - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

    (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)
8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን::ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል::በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን:: በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል::

የቡድን ውይይት መመሪያ
PSBI በምህበረሰብ/በግለሰቦች ቤት ደረጃ | በዝቅተኛ የኑሮ ደረጃ ከሚኖሩት ጋር (IDI#1)

<u>መግቢያ</u>

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው፡፡

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስኪ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

1. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
    - ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
    - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
    - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)
3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
    - ቶሎ ቶሎ መተንፈስ?
    - ከመጠን በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርጎድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?
4. አዲስ ለተወለደ ህፃንሽ ክብካቤ ለመስጠት ውሳኔ የትወስኝውእንዴት ነው?
    - በቤተሰብ ውስጥ ለህጻን ልጃችሁ ክብካቤ ለመስጠት ውሳኔ የሚዎስነው መን ነው?
    - በውሰኔሽ ላይ የሌሎች አወንተዊ ተጽኖ ምን ይመስላል?
    - ጤና ተቋም ላለመሄድ ምክነያት ሊሆኑ የሚችሉ ጉዳዮች ምን ሊሆኑ ይችላሉ? (ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)

<u>የጨቅላ ህጻነት ህመም(መበከል) ና ህክምና</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)
    - ምን ሀብቶች ወይም አማራጮች አሉ?

7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
    - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
    - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
    - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

(ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)

8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን::ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል::በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን:: በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል::

ውይይት መመሪያ
የማህበረሰብ አካል | በቅርብ ለወለደች እናት (FG#4)

<u>መግቢያ</u>
እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡
1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው፡፡

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስቲ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
    - ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
    - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
    - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)
3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
    9. ቶሎ ቶሎ መተንፈስ?
    - ከመጠን በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርነድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?

4. ከቤት ውጭ ለህጻናት ክብካቤና ህክምና ምን አማራጮችን ትተቀማላችሁ? (i.e. በህላዊ ህክምና አማራጭ፣ ጤና ኬላ፣ጤና ጠቢያ፣ሆስፒታል)
    - ሌሎች አካላት የጤና አገልግሎት እንድትጠቀሙ ያላቸው አወንታዊ ተጽኖ ምን ይመስላል?
    - በቤት ውስጥ ለህፃናት ክብካቤ ወይም ህክምና ውሳኔ ሰጭ ማን ነው?
    - ህጻን ልጃችሁ ህመም ቢገጥመው ጤና ተቋም ላለመሄድ ምክነያት የሚሆን ነገር ይኖር ይሆን? ከለ ምክነያቶቹ ምን ሊሆኑ ይችላሉ?

<u>የጨቅላ ህጻነት ህመም(መበከል) እና ህክምና</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.
5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)

- ምን ሀብቶች ወይም አማራጮች አሉ?
- በማህበረሰቡስ ምን ዓይነት የህክምና አማራጮች ይኖራሉ?

7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
   - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
   - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
   - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

   (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)

8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን፡፡ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል፡፡በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን፡፡ በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል፡፡

የቡድን ውይይት
የህብረተሰብ አካላት | ለባሎች (FG#5)

<u>መግቢያ</u>

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው፡፡

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስኪ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
    - ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
    - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
    - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)
3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
    - ቶሎ ቶሎ መተንፈስ?
    - ከመጠን በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርነድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?

4. አዲስ ለተወለደ ህፃንሽ ክብካቤ ለመስጠት ውሳኔ የትወስኝውእንዴት ነው?
    - በቤተሰብ ውስጥ ለህጻን ልጃችሁ ክብካቤ ለመስጠት ውሳኔ የሚዎስነው መን ነው?
    - በውሰኔሽ ላይ የሌሎች አወንተዊ ተጽኖ ምን ይመስላል?
    - ጤና ተቋም ላለመሄድ ምክነያት ሊሆኑ የሚችሉ ጉዳዮች ምን ሊሆኑ ይችላሉ? (ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)

<u>የጨቅላ ህጻነት ህመም(መበከል) ና ህክምና</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኝለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)

- ምን ሀብቶች ወይም አማራጮች አሉ?

7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
   - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
   - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
   - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
   (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)

8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን::ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል::በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን:: በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል::

የቡድን ውይይት መመሪያ
የማህበረሰብ አካል |የቤተሰብ አባል (FG#6)

መግቢያ

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው፡፡

የጨቅላ ህፃናት ክብካቤ እና ህመም

እስቲ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
    - ለህጻን ልጅሽክብከቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
    - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
    - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)

3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
    - ቶሎ ቶሎ መተንፈስ?
    - ከመጠን በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርጎድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?

4. አዲስ ለተወለደ ህፃንሽ ክብካቤ ለመስጠት ውሳኔ የትወስኝውእንዴት ነው?
    - በቤተሰብ ውስጥ ለህጻን ልጃችሁ ክብካቤ ለመስጠት ውሳኔ የሚዎስነው መን ነው?
    - በውሰኔሽ ላይ የሌሎች አወንተዊ ተጽኖ ምን ይመስላል?
    - ጤና ተቋም ላለመሄድ ምክነያት ሊሆኑ የሚችሉ ጉዳዮች ምን ሊሆኑ ይችላሉ? (ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)

የጨቅላ ህጻነት ህመም(መበከል) እና ህክምና

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)

- ምን ሀብቶች ወይም አማራጮች አሉ?

7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
   - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
   - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
   - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

   (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)

8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን::ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል::በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን:: በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል::

ጥልቅ ቃለ መጠይቅ መመሪያ
የማህበረሰብ አካል(ዝቅተና የኑሮ ደረጃ ከሚገኙ የቤተሰብ አባላት(IDI#2)

<u>መግቢያ</u>

እዚህ ዛሬ እናንተን ስላገኘናችሁ ደስ ብሎናል፡፡ ሁላችሁምዕድሜው እስከ ሁለት ዓመት የሆነው ህጻን እንደላችሁ እንረዳለን፡፡

1. የህጻኑን/ኗን ስም እና ጨቅላ በነበሩበት ወቅት የነበረውን ክብካቤ ልትነግሩኝ ትችላላችሁ፡፡.
    - የእንንተ ድርሻ ምንድን ነበር?
    - ሌሎች በአካባቢያችሁ ያሉ ሰዎች አዲስ የተወለዱ ጨቅላ ህጻናትን (በተወለዱ የመጀመሪዎቹ ቀናቶች እና ሳምንታትበል) የሚንከባከቡት እንዴት ነው፡፡

<u>የጨቅላ ህፃናት ክብካቤ እና ህመም</u>

እስቲ ስለ ጨቅላ ህፃናት ክብካቤ እና ህመም እንነጋገር፡፡ አንዳንዴ ሰዎች ለህጻኖቻቸው ክብካቤ የሚያደርጉት ጤናቸውን ለመጠበቅ ወይም ህመም ሲገጥማቸው ሊሆን ይችላል፡፡

2. እስኪ የጨቅላ ልጅሽን ጤና በተለይም አድስ እንደተወለዱ እንዴት ነበር የሚጠብቁት፣
    - ለህጻን ልጅሽክብካቤ ምን ምን ተግባራትን ታደርጊ ነበር? (i.e. በቤተ ክርስቲያን መስባረክ፣ በበህላዊ መዳህኒት አዋቂዎች፣ በህክምና ተቋም በመሄድ፣ክትባት)
    - ለክብካቤ የት ሄድሽ? (i.e. ቤት ብቻ, ቤተ ክርስቲያን፣ ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)
    - ሊሎችሽ እንዴት ነው ክብካቤ ሚሰጡት? (i.e.ጓደኞችሽ፣የቤተሰብ አባላት፣የማህበረሰብ ተወካዮች፣የጤና ሙያተኞች)

3. ህጻን ልጅሽ ታመመ የምትይው ምን ሲሆን ነው. መታመሙንስ እንዴት ትረጃለሽ (i.e. በአካባቢው ሰው፣በቴና ባለሙያ፣ ምልክቶችን በመመመልከትና በመረዳት)
    - ቶሎ ቶሎ መተንፈስ?
    - ከመጠን በላይ ማተኮስ?
    - ከመጠን በታች መቀዝቀዝ(በረዶ መሆን)?
    - የደረት መሰርጎድ?
    - ምንም እንቅስቃሴ አለመኖር?
    - የምግብ ፍላጎት መቀነስ/ መመገብ ማቆም?
    - መንዘፍዘፍ?

4. አዲስ ለተወለደ ህፃንሽ ክብካቤ ለመስጠት ውሳኔ የትወስኝውእንዴት ነው?
    - በቤተሰብ ውስጥ ለህጻን ልጃችሁ ክብካቤ ለመስጠት ውሳኔ የሚዎስነው መን ነው?
    - በውሰኔሽ ላይ የሌሎች አወንተዊ ተጽኖ ምን ይመስላል?
    - ጤና ተቋም ላለመሄድ ምክነያት ሊሆኑ የሚችሉ ጉዳዮች ምን ሊሆኑ ይችላሉ? (ጤና ኬላ፣ጤና ጣቢያ፣ሆስፒታል)

<u>የጨቅላ ህጻነት ህመም(መበከል) ና ህክምና</u>

አሁን ስለ ጨቅላ ህጻናት ህመም(መበከል) እና ህክምና በተመለከተ ስለለሽ ሀሳብ መወያት እፈልጋለሁ.

5. ጨቅላ ህፃንሽ በታመመ ወቅት ምን ዓይነት ውሳኔ ወይም ተግባር ትወስኛለሽ?
    - የታመመ ህጻን ልጅሽን እንዴት እና የት እንዲታከም ታደርጊያለሽ? (በባህላዊ መድኒት ዋቂዎች፣ቤት ውስጥ በመንከባከብ፣ሀይማኖታዊ መፍትሄዎችን መጠቀም፣ መድሀኒት መጠቀም)
    - እነሂህ የህክምና አማራጮች ምን ያክል ውጤታማ ናቸው?
    - አገልግሎቱን ለማግኘት የሄድሽው የት ነው? (ባህላዊ አዋቂዎች፣በደ ሀይማኖት ተቋማት፣ጤና ኬላ፣ ጤና ጣቢያ፣ሆስፒታል)

6. በማህበረሰባችሁ የታመመ ህፃን ህክምና አገልግሎት እንዴት ይሰጣል?(ባህላዊ ህክምና፣ቤት ውስጥ መንከባከብ፣መድሀኒት መጠቀም፣ሀይማኖታዊ መፍትሄዎችን መጠቀም)
    - ምን ሀብቶች ወይም አማራጮች አሉ?

7. በማህበረሰባችሁ የጨቅላ ህፃናት ሞት በተመለከተ ያለው ሁኔታ ምን ገጽታ አለው፣
    - ለጨቅላ ህፃናት ህመም ምክነያቶች ምን ሊሆኑ ይችላሉ?
    - ታመው ህክምና ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?
    - ታመው ለመታከም የህክምና ተቋም ማግኘት ያልቻሉ ጨቅላ ህፃናት ምን ይሆናሉ?

    (ጤና ኬላ፣ ጤና ጣቢያ፣ ሆስፒታል)
    -

8. ምን አልባት በማህበረሰባችሁ በጨቅላ ህጻናት ጤና፣ህመም ዙሪያ መነሳት ያለበትና መወያየት የሚገባን ጉዳይ ይኖር ይሆን?

ሀሳብዎን ስላጋሩን እናመሰግናለን::ይህ የመነሻ ውይይታችንና ጥልቅ ቃለ መጠይቅ በህብረተሰቡ ዘንድ የታወቁና የተለመዱ ጠቃሚ ጉዳዮችን እንድንረዳ ረድቶናል::በተጨማሪ ውስን ተከታታይነትያላቸው ጥያቄዎችን ስለምጠይቅ በአለንበት እንቀጥላለን:: በዚህ ውይይታችን ማንሳት የምትፈልጉት ጉዳይ ወይም መረጃ ሲኖር ያለ ምንም መሳቀቅ አማንሳት እና መወያየት ይቻላል::

ደራዊ መረጃ መሙያ ቅጽ
(ቢቃል የሚሞላ)

ተ.ቁ	መጠይቅ	መልስ
1	አብረው የሚኖሩ የቤተሰብ አባላት ብዛት	_____
2	ዕድሜወት ስንት ነው (በዓመት)?	_____
3	የመጨረሻው የትምህርተ ደረጃ ስንት ነው?	○ ኢ መደበኛ ትምህርተ ○ መጀመሪየ ደረጃ (1-8) ○ ሁለተና ደረጃ (9-12) ○ ሙና ቴክኒክ ሰርቲፊኬት ○ ዲግሪና ከዚያ በላይ
4	አሁን ላይ ያለህ የስራ ሁኔታ?	○ የቤት እመቤት ○ ግብርና ስራ ○ ባለሙያ የጉልበት ስራ ○ ባለሙያ ያልሆነ የጉልበት ስራ ○ ተቀጣሪ ባለሙያ ○ ነጋዴ ○ ሌላ ከሆነ (ይጠቀስ)_____
5	ሀይማኖትሽ ምንድን ነው?	○ ኦርቶዶክስ ○ ፕሮቴስታነት ○ ካቶሊክ ○ ሙስሊም ○ ባህለዊ ○ ሌላ ከሆነ (ይጠቀስ)_____
6	ብሔርሽ ምንድን ነው?	○ አማራ ○ አገው ○ ትግሬ ○ ኦሮሞ ○ ሌላ ከሆነ (ይጠቀስ) _____
7	የቤተሰብ ዓመታዊ ገቢ ምን ያክል ነው? *(በብር)*	_____*(በብር)*
	የወሊድ ታሪክ	
8	በህይወትሽ በህይወት ያለ ልጅ ስንት ጊዜ ወለድሽ?	_____
9	አሁን በህይወት ያሉ ስንት ህጻኖች አለዎት?	_____

Appendix B. Emory IRB Determination Letter

Date: July 3, 2018

Meron Asfaha
Principal Investigator
Unassigned Department

RE: **Exemption of Human Subjects Research**
IRB00103799
Analyzing the Socio-Contextual Determinants of Community-Level Care Seeking for Neonatal Possible Severe Bacterial Infection (PSBI) in Amhara, Ethiopia

Dear Principal Investigator:

Thank you for submitting an application to the Emory IRB for the above-referenced project. Based on the information you have provided, we have determined on **July 2, 2018** that although it is human subjects research, it is exempt from further IRB review and approval.

This determination is good indefinitely unless substantive revisions to the study design (e.g., population or type of data to be obtained) occur which alter our analysis. Please consult the Emory IRB for clarification in case of such a change. Exempt projects do not require continuing renewal applications.

This project meets the criteria for exemption under 45 CFR 46.101(b)(2). Specifically, you will observe health-care workers within the Ethiopian community will be conducted to describe how community members seek treatment and will conduct focus groups of mothers, fathers and family members to understand how the treatment for sick newborns occurs. No identifiable data is being collected or brought back to the states for analysis.

- Protocool:
  - IRBProtocol_06-05
- Questionnaires:
  - Focus Group and Interview guides uploaded 6/27/18
- Consents:
  - VerbalConsent_FocusGroups
  - VerbalConsent_Interviews

Please note that the Belmont Report principles apply to this research: respect for persons, beneficence, and justice. You should use the informed consent materials reviewed by the IRB unless a waiver of consent was granted. Similarly, if HIPAA applies to this project, you should use the HIPAA patient authorization and revocation materials reviewed by the IRB unless a

waiver was granted. CITI certification is required of all personnel conducting this research.

Unanticipated problems involving risk to subjects or others or violations of the HIPAA Privacy Rule must be reported promptly to the Emory IRB and the sponsoring agency (if any).

In future correspondence about this matter, please refer to the study ID shown above. Thank you.

Sincerely,

Maria-Gracia Beltran, BA
Research Protocol Analyst
This letter has been digitally signed

CC:

Spratt Brandon Unassigned Department

Emory University
1599 Clifton Road, 5th Floor - Atlanta, Georgia 30322
Tel: 404.712.0720 - Fax: 404.727.1358 - Email: irb@emory.edu - Web: http://www.irb.emory.edu/

Appendix C. APHI Ethical Review Letter

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Amhara National Regional State Health Bureau
Amhara Public Health Institute
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Ref.noHRTT 02/105/2018
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Date 23/07/2018 G.C

Amhara Public Health Institute Research Ethics Review Committee Response Form

To Meron D Asfaha, BS

Bahir Dar

Subject: Human Subject Ethical Clearance

You have submitted a project proposal"Analzying the Socio-Contextual Determinants of Community-Level Care Seeking for Neontal Possible Severe Bacterial Infection (PSBI) In Amhara, Ethiopai. " to Amhara public Health Institiute Health Review Board for Ethical approval. The Amhara public Health Institiute Research Ethics Review Committee /RERC/ has reviewed This Project that will be done In Amhara Region. We are writing to advise you that the RERC has granted **Full approval**.

The project indicated above for a period of **ONE YEAR july 23/2018 to july 22/2019**/. All your more recently submitted documents have been approved for use in this study. The study should comply with the standard international and national scientific and ethical guideline. Any change to the approved protocol or consent material must be reviewed and approved through the amendment process prior to its implementation. In addition, any adverse or unanticipated events should be reported within 24-48 hours to RERC. Please insure that you submit progressive report prior the expiry date of project.
We, therefore, request your esteemed organization to ensure the commencement and conduct of the study accordingly and wish for the successful completion of the project.

Taye Zeru
Public Health Research and Technology Transfer D/Director

CC//
- APHI G/Director
- APHI D/Director
  Bahir Dar

✉ 477 Tell. 0582263223 0582220191

Appendix D. Final Codebook

Code	**Definition**	**Criteria**	**Example**
Caretaking Actions & Responsibility	Captures references to actions taken to care for the child. May include: direct parental references of how they care for the child, their responsibilities or how family and community members participate in caretaking	Use for: breastfeeding/feeding, cleaning/bathing, changing/buying clothes, transporting child	"After my child was born I bought clothes and I took the responsibility of protecting the child from anything harmful and I also took him to the health center when he became sick."
Decision-Making	Captures references to factors/people that impact the decision to seek care. May include: family members, community members, social factors or healthcare providers	Use for: direct references to influencers in seeking/not seeking care	"In my family me and my wife make the decisions for our child. When there is a problem I quickly make the decision and when the mother observes any problems she also makes decisions."
Hygiene	Code when references to keeping the child or direct environment clean is used in the context of health	Use for: cleaning, washing and maintaining hygiene	"As it is known mothers keep their child hygienic by cleaning their body and clothes and washing [them], giving their child showers three times a day. And they also care for their child to keep them safe from anything harmful."
Nourishment	Any mention of the participant describing provision of foods/drinks for consumption. May include milk, juice or food	Use for: breastmilk, cow milk, bread and other types of drinks/foods	"At this time, he is six months old and I started feeding [my child] cow milk. And then I'm also preparing additional foods."

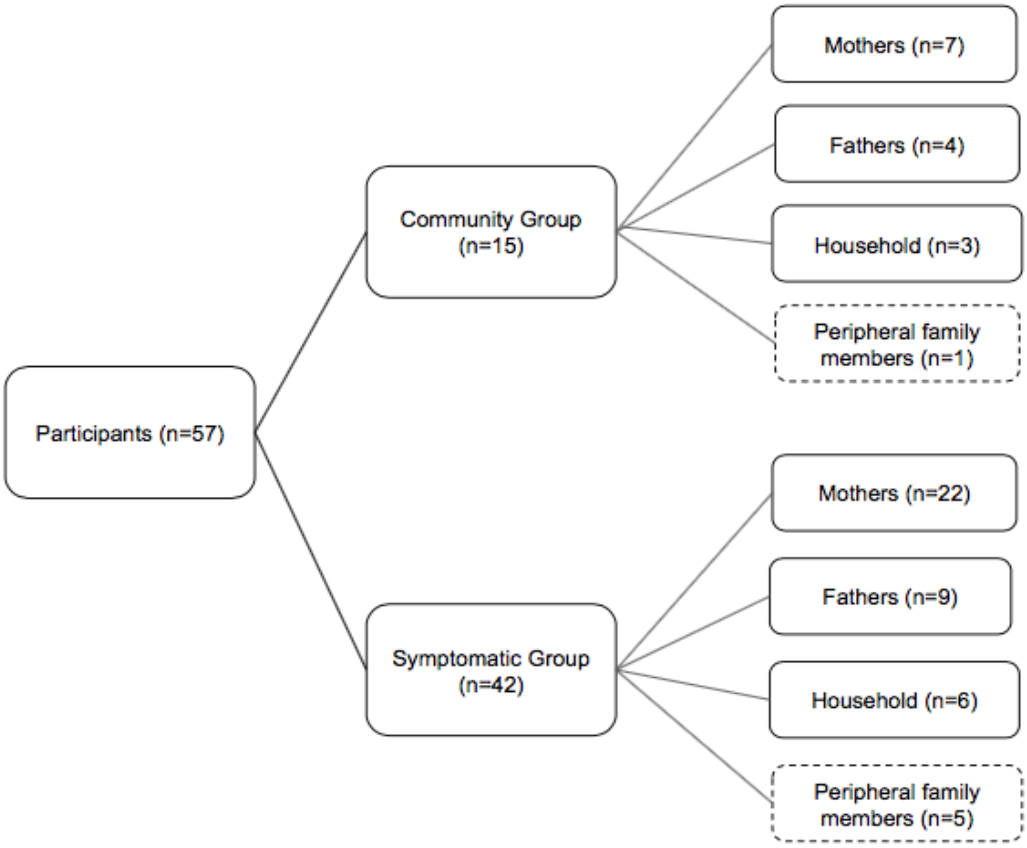
Social/Familial Context	Captures references to general community/familial context in providing care for the child of the family. May include: gatherings, familial discussions	Use for: intersections of background/culture with care-delivery	"Friends and neighbors gave food and fruits to the child when they began eating other foods. The people around us care for the child even by carrying them on their back and playing."
Community Norms	Code when participants mention common community practices in child care/support in general. May include: general perceptions of how families provide care	Use for: generalizations of how care is provided in the community/by community members	"As I said before in our community every father does his best to care for his child. Almost all fathers care for their child."
Illness Recognition	Captures references of how families and community members understand the child is sick. May include: physical symptoms and mood changes	Use for: high temperature, lack of appetite, consistent crying and other symptoms/changes	"At the middle of the night she began crying, and in the next day had pain in the abdomen and she was sick in all days [everyday]. After that we took her to the health center."
Illness Causation	Captures references of perceptions of what causes child illness. May include: environmental causes	Use for: "wind stroke," poor hygiene, poor/no feeding	" One of the causes of sickness is water pollution. Water pollution is the cause for infant disease. The other cause is the cold and lack of the infant's personal hygiene."
Severity	Code when symptoms/negative health outcomes are exacerbated or in reference to perception of certain diseases as grave. May include:	Use for: disease progression, absence of symptom improvement after treatment, perceived severity of symptoms/disease	"The infants may suffer a lot if they do not get medical treatment. Before death, because of life, the infants may suffer great

	progression of negative health outcomes or specific diseases seen as particularly dangerous		illness. They may suffer different kinds of problems."
Treatment Options	Captures references to curative resources that can be utilized to improve or maintain health. May include: medical or community treatments	Use for: vaccinations, medicines (injections), holy water, evil eye treatment medical procedures, medical resources	"But after birth my child was sick and I went to the health center and they gave him different medicines. They gave my child injection medicines for fourteen days."
Treatment Facilities	Code when participants mention places/facilities that provide services. May include: Medical or social infrastructures	Use for: health post, health center, hospital, church	"Yes, before that we decide together where to visit- health center, church or traditional medical doctors- according to the types of diseases."
Healthcare Advice	Advice given from healthcare professionals regarding healthful practices or methods to access care (facilities). May include: hospital referrals	Use for: referrals, instructions, suggestions to improve/maintain health	"Due to the doctor's advice the community feeds their children different types of food. For example, my brother's wife prepares different types of food items to feed her child after six months."
Vaccinations	Use code when participants mention vaccinating their child. May include: vaccination practices/actions within the community	Use for: discussions of practices, actual vaccination instances	"As they said before, I vaccinated my child according to the doctor's instruction."

Quality of Care	Use code when participants mention strengths/weaknesses of services provided. May include: perceptions of care-delivery	Use for: discussions of quality of care-delivery	"We even called the health worker several times, he couldn't help us just told us it is not the right time for delivery. So, there is a problem with health workers but I do not know the reasons why they are reluctant to help pregnant and sick people."
Systems Barriers	Obstacles or challenges in accessing care/resources to improve or maintain child's health. May include: perceived/actual infrastructural barriers	Use for: lack of resources, materials, personnel available; long wait times; poor quality of services	""When any infant becomes sick we take them to the health center but in the health center the health workers tell us there is no medicine for infants. So, why isn't there enough medicine for infants?"
Consequences	Use code when participants mention implications of not seeking or having access to treatment and/or care. May include: disease progression, exacerbations of disease, or severe consequences	Use for: illness progression or death due to lack of access to treatment or insufficient treatment	"Yes, if they couldn't get enough medical treatment, they may die. But this is in the hands of God."
Child Mortality	Captures references to child death. May include: discussions of death within community, actual/theoretical instances of death	Use for: discussions and/or direct experiences of child death	"When I was ready to do something for my child, she died."

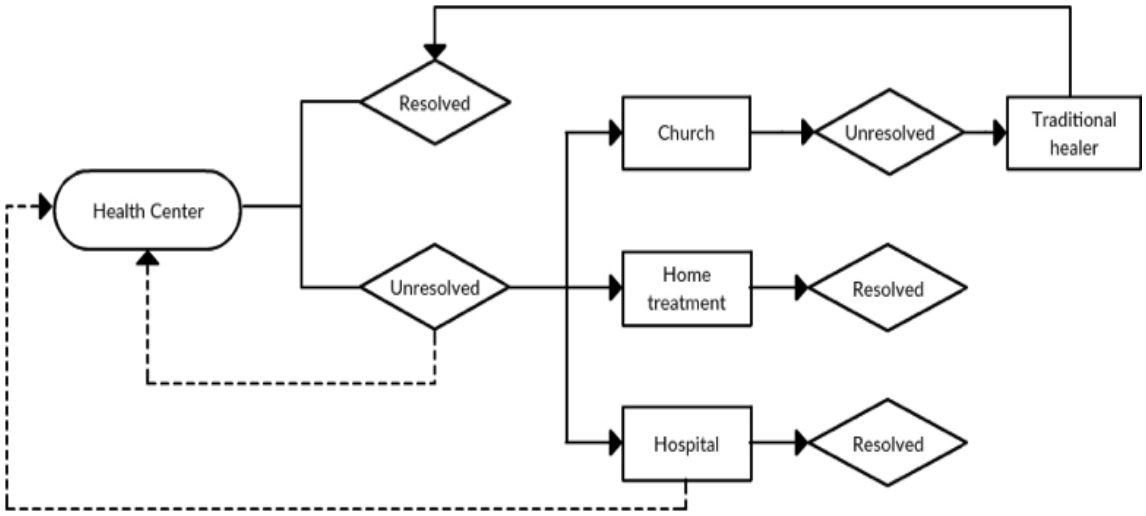
LIST OF FIGURES

Figure 1. Sampling Frame



--- : in-depth interviews; –– : focus groups

Figure 2. Care Trajectory Diagram



LIST OF TABLES

Table 1. Characteristics of Woreda and Kebele Sites

Zone	**Woreda and *kebele***	**Number of households**[a]	**Population size**	**Rural**	**Urban**
West Gojam					
	Woreda A	6,405	292,080	269,403	22,677
	Site 1	*1,348*	*5,764*	--	--
	Site 2	*7,719*	*1,832*	--	--
East Gojam					
	Woreda B	767	132,883	130,299	2,584
	Site 3	*2,332*	*10,183*	--	--
	Site 4	*1,640*	*8,082*	--	--

Source: Central Statistical Agency – Ethiopia. *The 2007 Population and Housing Census of Ethiopia: Statistical Report for Amhara Region.* Addis Ababa, Ethiopia; 2012.

[a] Households refer to housing units, per the Central Statistical Agency – Ethiopia definition

Table 2. Sampling Strategy per Woreda

Target Group and Collection Method	**Number by woreda**	**Total Recruitment Goal**	**Total Recruited**
Mothers (FDG)	2 (5-8)	4 (10-16)	4 (29)
Fathers (FDG)	2 (5-8)	4 (10-16)	4 (13)
Household Members (FDGs)	2 (5-8)	4 (10-16)	3 (9)
Peripheral Family Members (IDIs)	4	8	6 (6)
Total	*10 (19-36)*	*20 (38-48)*	*17 (57)*

* Numbers are reported per the number of groups and range of participants in each group