

Jimma University
College of Public Health and Medical Sciences
Department of Health education and
Behavioural Sciences



**Health seeking behaviour and associated factors
for childhood illness in Nekemte town, west
Ethiopia**

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A RESEARCH REPORT SUBMITTED TO THE DEPARTMENT OF
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JIMMA, ETHIOPIA

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Abstract

Background: Despite progress made to treat acute common childhood illnesses in recent years still Diarrhoea and ARI are among the five leading causes of infant mortality in the developing countries including Ethiopia. Now a day the traditional trend which consider provision of health care as primarily domain of health providers is slowly changed to current trend which fully recognised the importance of mothers and the family in identifying, caring for and preventing children's illnesses.

Objective: This study intends to assess health seeking behavior and its associated factors for childhood illnesses at household level in Nekemte town.

Method: Community based cross-sectional study was conducted in Nekemte town, Eastern Wollega Zone, Oromia Regional State, west Ethiopia from September 14-30, 2013 among randomly selected 413 households using structured and pre-tested questionnaire and qualitative methods. Analysis was done using SPSS version 16.0. Descriptive, bivariate and multivariate logistic regression analyses were used to show frequency distributions and associations.

Result: A total of 403 mothers or caretakers were involved in the study giving an overall response rate of 97%. The study showed all children included in the study had history of illness in their life. The overall appropriate health care seeking for the recent illness was only 112 (31.3%) which means taken to health facilities either public or private within 24 hours. Perceived illness was not serious 18 (40%) thought getting well without treatment 18 (40%), Lack of money 6 (13.4%) and lack of time 3 (6.6%) were the major reasons for not seeking care. Educational status (OR=2.85, 95% CI (1.09, 7.46)), income (OR= 3.13, 95% CI (1.27, 7.71) and source of information (OR 95% CI: 0.12(0.015, 0.873)) were identified as the major predictors of appropriate health care seeking practices.

Conclusion and recommendation: There was low appropriate health care seeking practices among mothers or caregivers which might have a significant contribution to malnutrition and child mortality. Educational status and income appeared to be important variables predicting health care seeking behaviour. Therefore, health care services should be provided by minimum cost or for free to encourage families with low income. Effective health education strategies to improve mothers' health care seeking behaviours by reducing misperceptions.

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List of Acronyms

ARI Acute Respiratory Infection

AOR Adjusted Odds Ratio

CDC Centers for Disease Control and Prevention

CI Confidence Interval

EDHS Ethiopian Demographic and Health Survey

EPI Expanded Program of Immunization

FMOH Federal Ministry of Health

HP Health post

HC Health Center

HEW Health Extension Worker

IMCI Integrated Management of Childhood illnesses

MDG Millennium Development Goal

NGO Non-governmental Organization

OR Odds Ratio

ORHB Oromia Regional Health Bureau

ORS Oral Rehydration Salt

SPSS Statistical Package for Social Sciences

TV Television

UNICEF United Nations Children's Fund

WHO World Health Organization

Chapter One: Introduction

1.1 Background

Common childhood illness which includes diarrhea, acute respiratory infection, fever and malaria and others are among the major contributors to child mortality and morbidity (1). Diseases among young children are the major causes of morbidity and mortality particularly in the developing countries of the world. What make them common is that almost all of them are preventable and treatable by simple interventions including the mother's awareness and early and proper seeking of treatment for sick child (1, 2).

Every year about 13 million children die before reaching their fifth birthday. Over 70% of these deaths occur in the developing world, and are due to acute respiratory infections, diarrheal diseases, malaria, measles and malnutrition, often in combination (1) In the past decade, major progress has been made to reduce childhood morbidity and mortality, through childhood immunization, diarrheal disease and acute respiratory tract infection control, nutritional programs and through implementation of other primary health care activities. In spite of such interventions under five morbidity and mortality remain at unacceptably high rates especially in sub-Saharan Africa and south Asia (3).

A sick child who is brought to a health institution will very often have more than one condition and yet in a busy clinic. Most children are not brought or brought late to health institutions due to some reasons associated with health seeking behavior of mothers or caregivers which recently gaining attention as one component of IMCI strategy (4).

Integrated management of childhood illness is a strategy to reduce the morbidity and mortality associated with major causes of childhood illness. It was introduced by WHO and UNICEF in 1992. It focuses on improving care at the first level health facilities where millions of children arrive sick each day. A set of generic guidelines for management of childhood illness was completed in 1996. This guideline material cannot be used without substantial adoption according to country specific situation (4).

The IMCI strategy therefore seeks to reduce under 5 morbidity and mortality by adopting three broad and crosscutting approaches such as improving case management, improving the skills of health workers, improving health system, family and community practice through education of care givers and the community with focuses on health seeking behavior, compliance and care at home (4,6).

Ethiopia is one of the developing countries with unacceptably high infant and under five mortality rates (96.8 and 140.1, respectively) and one of the first countries in Africa to implement the integrated management of childhood illness (IMCI) as a national program, with support from donor organizations (4). Ethiopia endorsed IMCI as a key strategy to reduce childhood mortality and morbidity and to promote child health and development in 1997 after national consultant training conducted in Addis Ababa. Oromia Region is one of the three regions which FMOH selected for the early implementation of IMCI in 1998(5). Information on health seeking behavior of caregivers especially mothers are very important, since reduction in morbidity and mortality of children are highly dependent on health seeking behavior of families which is highly emphasized after IMCI program is launched (7,8).

1.2 Statement of the Problem

One of the targets of the Millennium Development Goals (MDGs) is to reduce the under-five mortality rate by two-thirds between 1990 and 2015. Most deaths among children of under five years are still attributable to just a handful of conditions and are avoidable through existing interventions (13, 16).

Despite the substantial reductions in the number of deaths observed in recent decades, around 10 million children still die every year before reaching their fifth birthday. Almost all of these deaths occur in low and middle-income countries (13). Since 1970 there has been a considerable decrease in under-five mortality in the world, from 17 million per year to 10.6 million currently. Between 1970 and 1990, there was a 40% reduction in child mortality (6). More than 70% of these child deaths are due to the five diseases i.e. pneumonia, diarrhea, malaria, measles and malnutrition, and often to a combination of these conditions. As children usually present with more than one of these conditions, it is envisaged that there is a need for an integrated approach in order to manage the child in a holistic manner. Due to this fact, WHO and UNICEF responded to this challenge by developing the Integrated Management of Childhood Illnesses (IMCI) strategy. The IMCI package is useful for the majority of developing countries with an infant mortality rate of over 40/1000 live births. IMCI is becoming effective because of its consideration of improving family and community practices as the main component (16, 4).

The Integrated Management of Childhood Illnesses (IMCI) is an intervention specifically targeted at improving the survival of children by improving the efficacy of diagnostic and therapeutic measures. Specifically, community involvement is a vital component of IMCI and this is directed at recognition of danger signs in childhood illnesses and encouraging early presentation in the hospital for appropriate care (4). Studies have highlighted the problem of non-recognition of danger signs in childhood illnesses and its relationship, direct or indirect, with childhood mortality (31). Therefore, beyond the recognition of danger signs, it is also important to identify factors which may influence healthcare-seeking behaviour for childhood illnesses. Indeed, high cost of available orthodox health services may inhibit appropriate use of such facilities (7). Studies have also related childhood morbidities and mortalities to delay in seeking care. However, appropriate and efficient care could be provided in most health facilities in the developing world if the children are presented early. Thus, it is important to examine factors which may be associated with poor healthcare-seeking behaviours (8, 9).

In recent years, epidemiologists and social scientists have devoted increasing attention to studying health-seeking behaviour associated with common childhood illnesses (11). Maternal practices regarding health care have been recognised as important social and anthropological factors, explaining high mortality rates among children aged less than five years. Maternal literacy and health education, parental age, family's socioeconomic status and access to health care are among the major contributing factors (10, 11). Consequently, efforts to better understand mothers' beliefs, attitudes, and health practices have been carried out, these factors have prompted decision-makers and researchers to involve the family and particularly mothers in community-based health programmes to reduce the burden of this disease (10, 11-14).

The World Health Organization estimates that seeking prompt and appropriate care could reduce child deaths due to acute respiratory infections by 20% (2).

About 472,000 Ethiopian children die each year before their fifth birthdays. This tragic fact places Ethiopia sixth among the countries of the world in terms of the absolute number of child deaths (5). Malnutrition, particularly in combination with ARI, diarrhoea, malaria or measles is another important cause of morbidity in children (4, 5).

Results from the 2011 EDHS data show a remarkable decline in all levels of childhood mortality. Under-five mortality has declined by 47 percent over the same period from 166 deaths per 1,000 live births to 88 deaths per 1,000 live births. Even though not to the same extent, the neonatal mortality has also decreased over the 15-year period preceding the survey by 31 percent from 54 deaths per 1,000 live births to 37 deaths per 1,000 live births (5).

According studies done in different parts of Ethiopia Maternal education is a major determinant of child survival, influencing care-seeking, morbidity and nutritional status. Only 34% of adult Ethiopian women are literate, compared with 49% of men, and 20% fewer girls than boys enrol for primary school. The U5MR for children whose mothers have no schooling is 121% higher than those whose mothers have at least a secondary education (5, 13, 16). According to Nekemte town health office the problem of health seeking behaviour of mothers or care takers is seen as the major contributing factor of child morbidity and mortality.

Chapter Two: Literature Review

Different literatures related to health seeking behavior of mothers or caretakers on childhood illness was reviewed from international to local by focusing on the level of appropriate health seeking practice in different study areas, contribution of appropriate health seeking behavior of families in reducing child death and factors associated with health seeking behavior of mothers or caretakers.

2.1 Contribution of Health Seeking Behaviour in reducing under 5 mortality

Every year about 11 million children in developing countries die before they reach their fifth birthday, many of them during the first year of life. Around 90% of them in 42 countries and 50% of them in just six countries, and Ethiopia are one of them (1, 6).

Ethiopia is one of the developing countries with an unacceptably high infant and under five mortality rates of 113 and 188 per 1000 live births, respectively. More than 70% of these child deaths are due to the five diseases i.e. pneumonia, diarrhea, malaria, measles and malnutrition, and often to a combination of these conditions. These diseases are also the reasons for seeking care for at least three out of four children who come to health facilities (1, 4).

United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO) initiated in 1992 the Integrated Management of Childhood Illness concept (IMCI) (1). The IMCI combines effective treatments that have the potential to reduce childhood mortality and interventions that aim at improving healthy growth and development of children under the age of five. The integrated management of childhood illness (IMCI) strategy, besides improving providers' skills in managing childhood illness also aims to improve families' care seeking behaviour. The health workers are trained to teach the mothers about danger signs and counsel them about the need to seek care promptly if these signs occur (4).

Prompt and appropriate health care-seeking is one of the ways that can prevent many of the deaths due to childhood illnesses because in developing countries large numbers of children die without ever reaching a health facility and due to delays in seeking care. Studies have shown that practicing appropriate health care-seeking has great prospects of reducing morbidity and mortality due to childhood illnesses (25). The World Health Organization (WHO) for example, estimates that seeking appropriate and prompt care could reduce by 20 percent childhood deaths due to illnesses (6). A number of studies conducted in developing

countries have also shown that delay in seeking appropriate care or not seeking any care causes a large number of child deaths (10, 11, 12).

Maternal practices regarding health care have been recognised as important social and anthropological factors, explaining high mortality rates among children aged less than five years. Maternal literacy and health education, parental age, family's socioeconomic status and access to health care are among the factors mentioned. Consequently, efforts to better understand mothers' beliefs, attitudes, and health practices have been carried out (11, 12).

2.2 Factors influencing Health Seeking Behaviour for childhood illness

2.2.1 Predisposing factors

A number of studies have stressed the role of socio economic and demographic factors in influencing health seeking behaviour of mothers for childhood illnesses (21, 22). Many of these studies have also showed that health seeking behaviour is strongly affected by mother's education. That is educated mothers are more likely to have better health seeking behaviour compared with those not educated (5, 13, 14). Studies conducted in Nepal indicated that maternal educational status as the main predictor of health seeking behaviour for childhood illnesses (11).

According to EDHS 2011 for diarrheal disease Children in urban areas and those whose mothers have secondary education were the most likely to be taken to a health provider (5). The same is true also for ARI, of the children who had ARI symptoms, Treatment was sought more often for children in urban areas (38%) than rural areas (22%), and most commonly for children of mothers with secondary education (45%) and for children from the wealthiest households (40%).

According to the community-based study done in Derra district, North Shoa Zone, Oromia region mothers who live in urban area and who had good knowledge about childhood illnesses were more likely to seek care from the health facilities than the others (13). Similarly, the study done in south west Ethiopia indicated, illiterate mothers and family with low income were less likely to practice health seeking behaviour for their sick child (14).

2.2.2 Characteristics of the service and enabling factors

Not only geographical accessibility but also economical accessibility is considered as one of the major determinant factors of health seeking behaviour for childhood illnesses according some studies (5, 13-16).

According to study done in Nepal most of the mothers reported that they prefer home remedies for treatment (6.5%) as a reason of no money to see doctor or directly they brought their children directly to pharmacy to purchase drugs without diagnosis which they thought better in terms of cost (11, 20).

Worldwide experience verifies that availability of the service/provider and distance from health facility was the major determining factors of health seeking behaviour. In most studies distance from health facility is one of the major reasons why mothers not practicing health seeking behaviour promptly (11, 13-24).

Based on the study in central Ethiopia Mothers' main reasons for not seeking care from health facilities were the distance from health facility 27.7% and perceived illness was not serious 25.3% which places distance from health facility as one of the major reason (13, 22).

2.2.3 Previous experience and perceptions

Different studies conducted in different areas showed that perceptions of the mothers or care takers about severity of the illness are one of the decisive factors for practicing health seeking behaviour. According to study done in Mexico on assessment of factors influencing health seeking behaviour of mothers in childhood diarrhoea about 34.5% of the respondents reported that they brought their child to health facility due to perception of severity of the disease. On other hand, mothers who decided to care for their children at home explained that the illness was mild (62.1%) (26).

Health-education models have demonstrated various stages and characteristics of the perception and reciprocal actions for human illnesses. The knowledge of the causation and characteristics of illness is distinct from the actions taken in respect of that knowledge.

The actions taken may reflect in the attitude and practice of those who are ill or the care-giver. The attitude and practice are highly dependent on the degree of motivation to seek appropriate health care. Furthermore, the healthcare-seeking model describes factors which

may influence the effect of motivation on appropriate action. Some of such factors include the ability to recognize symptoms and signs, perception of severity, social characteristics, availability of treatment resources, and competing needs (26, 28-30))

According to the community-based study done in North Shoa, Ethiopia mothers' responses and practices of health seeking were frequently influenced by their perception of severity of the childhood illness (13).

2.3 Conceptual frame work

The following figure shows that how different factors affect the outcome variable health seeking behavior. The socio demographic factors are as usual includes age, sex, ethnicity, religion, marital status, occupation and educational status of the respondents. The predisposing factors are knowledge of mothers or care takers on childhood illnesses including sign and symptoms and preventive measures, household income and source of information from where they get information about childhood illnesses. Characteristics of the service and enabling factors includes accessibility of health facility by measuring distance of health facility from their living home, preference of the service whether they prefer modern or traditional, private or public and also the overall cost they spent to get their child treated

Under previous experience and perception their previous experience concerning childhood illness was asked during the last visit to health facility, their satisfaction and perception also asked.

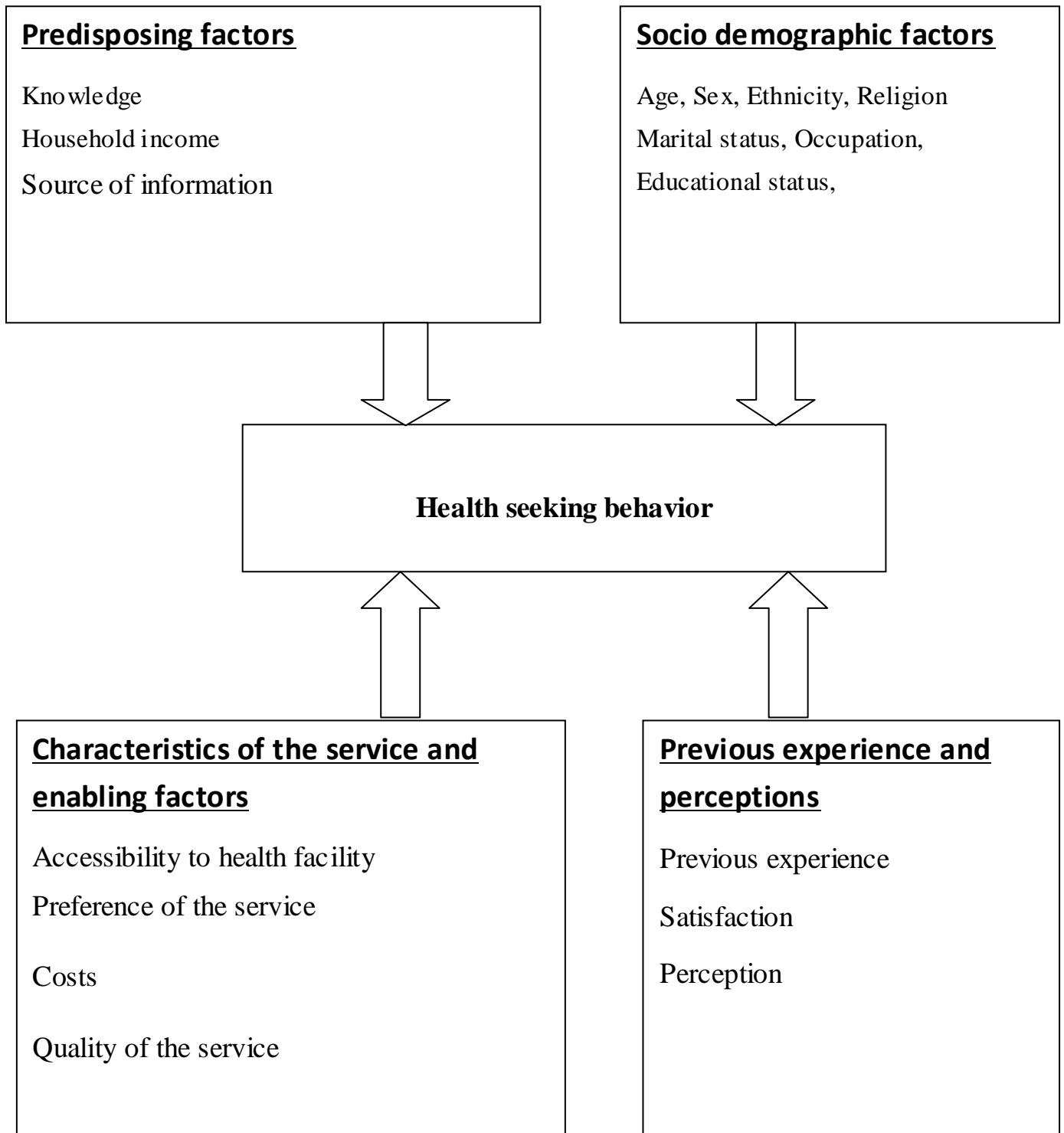


Figure: 1 Schematic diagram showing conceptual frame work of health seeking behavior for childhood illnesses at household level based on modified health care utilization model.

Chapter Three: Significance of the study

The World Health Organization (WHO) estimates that seeking appropriate and prompt care could reduce by 20% childhood deaths due to illnesses. Hence, this research was primarily designed to assess health seeking behavior of childhood illness and factors associated with it among mothers or care takers in Nekemte town. The finding of this research will help the planners and program managers to plan appropriate strategies to improve health seeking behavior. Further, understanding the factors associated with health seeking behavior of childhood illness can help to rethink on how to improve the existing service provision strategy and mobilize resources to integrate with other activities.

This study in essence, would provide evidence to all stakeholders including governments, donor agencies, political structures and health managers and also families as to the possible barriers in health care seeking behaviour for childhood illnesses. The aim is that the provision of such vital information would facilitate better strategy in bridging and or eliminating the barriers to health care seeking behaviour at household level. This would contribute significantly in improving child health status and thereby reducing child morbidity and mortality.

Furthermore the study could possibly generate information in the area of the topic for researchers to investigate further empirical evidences to assess health seeking behavior of childhood illness in other study areas.

Chapter Four: Objective

4.1 General Objective

- ❖ To assess mother's or care takers' Health Seeking Behaviour for childhood illness and its associated factors at house hold level in Nekemte town.

4.2 Specific Objectives

- To describe health seeking behaviour of childhood illness in the study area.
- To identify perceptions of mothers or care takers related to health seeking behavior of child hood illness in the study area.
- To identify socio-demographic factors related to health seeking behavior of childhood illness in the study area.
- To assess health service factors associated with health seeking behaviors of childhood illness in the study area.
- To assess behavioral factors associated with health seeking behaviors of childhood illness in the study area.

Chapter Five: Methods and Materials

5.1 Study Area

Nekemte town is located in Oromia National Regional State, in East Wollega Zone, at a Distance of 331 Km from Addis Ababa. Its astronomical location is 9° 04' North Latitude and 36° 30' East Longitude. Nekemte town was founded in 1872 and it is one of the reform towns in the Oromia region and has a city administration, municipality and six Kebeles. Based on 2007 national census, this city has an estimated total population of 84,506 of whom 42,121 were males and 42,385 were females. The majority of the inhabitants were Protestant, with 48.49% of the population reporting they observed this belief, while 39.33% of the population said they observed Ethiopian Orthodox Christianity, and 10.88% were Muslim. (18 and 19).

Regarding health services in the town there is one government hospital, one government and one private health centre, 3 health posts, 27 private clinics, three private pharmacies, eight private rural drug vendors, seven private drug stores in the town. The town has also one ambulance that gives service for emergency cases. (18).

5.2 Study Period

The study was conducted from September 14-30, 2013.

5.3 Study Design

Community based cross-sectional study triangulated with qualitative methods were employed in households of Nekemte town.

5.4 Populations

5.4.1 Source Population

For quantitative study: all mothers or care takers of under five children who were residents of Nekemte town.

For qualitative study: health extension workers and health center staffs working in Nekemte town.

5.4.2 Study Population

For quantitative study: randomly selected mothers or care takers of under 5 children who were residents of Nekemte town.

Inclusion Criteria: A mother or care taker who had at least one under 5 children and living in selected Households. If more than one under 5 children in the household the questionnaire is asked for the younger one.

Exclusion Criteria: A mother who had no under 5 child and not capable to be interviewed.

For qualitative study: purposively selected key informant health extension workers and health center staffs working in the town and considered to have better understanding in this issue and also currently working on it because they face mothers or care takers daily on their work and considered they understand about health seeking behavior of them.

5.5 Sample size Determination

Single population proportion formula is employed

$$n = Z_{1-\alpha/2}^2 p(1-p)/d^2$$

As evidenced by the actual calculation of n;

$$Z = 1.96 \quad p = 0.43$$

$$d = 0.05$$

$$n = \frac{1.96^2 \cdot 0.43(0.57)}{(0.05)^2} = \mathbf{376 \text{ households}}$$

Here, n is the minimum sample size required;

$Z_{1-\alpha/2}$ is the Z score corresponding to reliability coefficient of standard error of 5% at 95% confidence level. (Z=1.96); P is proportion of households practicing health seeking behavior living in other similar study (P= 43.2%); (13).

And d is the absolute precision required on either side of proportion (d=0.05), giving minimum sample size of 376 with an estimated non response rate of 10% was added and total minimum sample size gives= **413 house holds**

5.6 Sampling Technique and Procedure

Quantitative part: According to Nekemte town administration, a total of 6 Kebeles are available. Prior to the start of data collection household registration is checked to know the amount of household per Kebele from registration book of respective Kebeles. For this study all Kebeles were selected and number of households for each Kebele allocated based on proportional sampling of their respective number of households. And based on simple

random sampling the finally households for the study were selected, if may be the household with no under 5 children in a case selected the next household were included in the study. . And study units were mothers or care takers with under 5 child in each selected households.

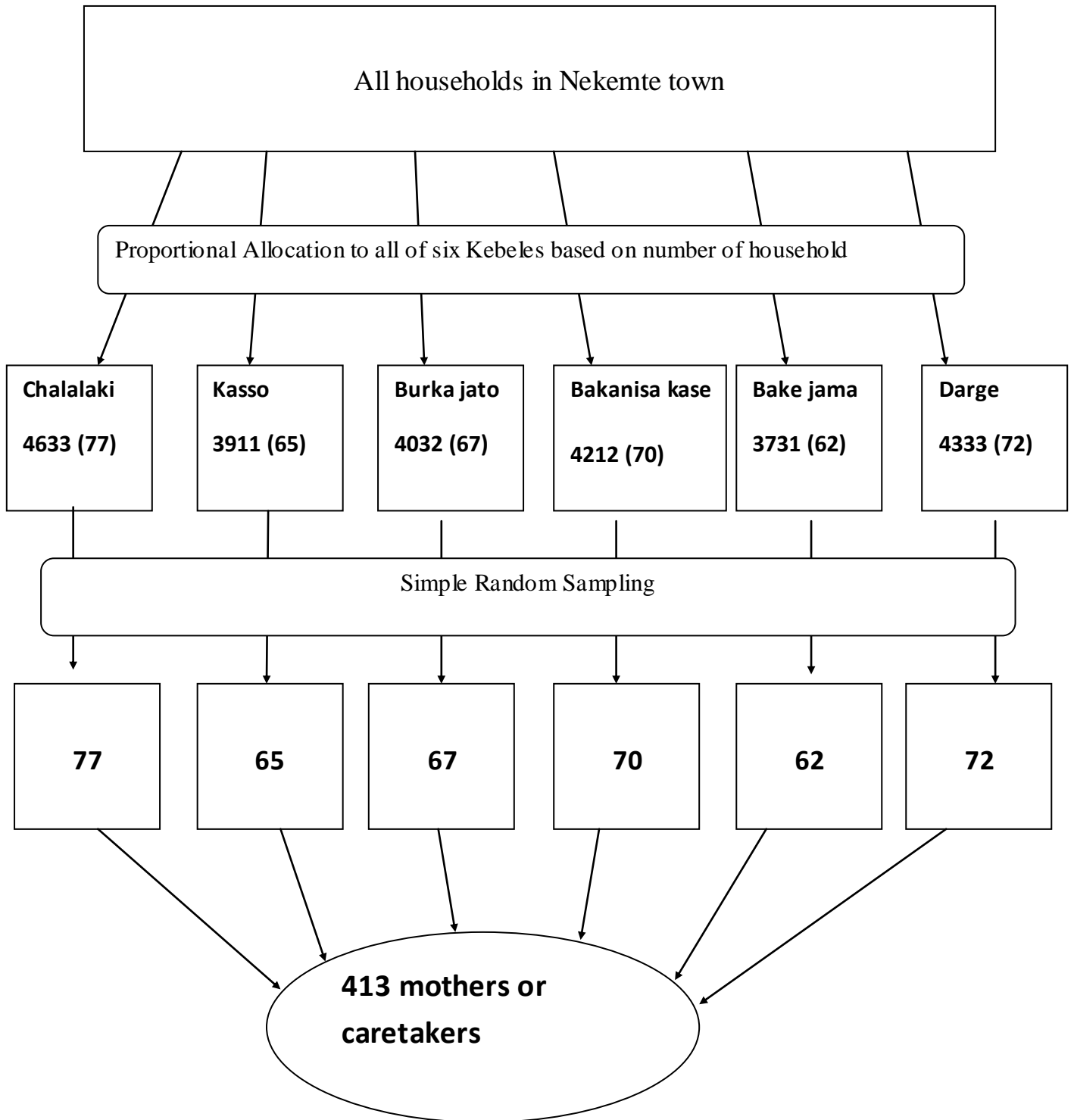


Fig 2. Schematic representation of sampling technique of the study conducted in Nekemte town.

Qualitative part: 6 health extension workers and 6 health center staffs currently working in Nekemte town were interviewed.

5.7 Variables

5.7.1 Dependent Variable:

- Health seeking behavior

5.7.2 Independent Variables:

- Socio demographic factors: Age, Sex, Ethnicity, Religion, Marital status, Status in the household, Occupation, Educational status,
- Predisposing factors: Household income, knowledge, source of information
- Previous experience and perceptions: Previous experience, satisfaction, perception
- Characteristics of the service and Enabling factors: Accessibility to health facility, preference of the service, costs, Quality of the service

5.8 Data Quality Management

To keep the quality of data, first questionnaires were pretested. For data collection health professionals were recruited. Translation of instrument into local language was undertaken to improve uniform understandability of the tools. During data collection supervision was undertaken in order to solve problems during the actual data collection phase and to check for completeness of data and to take prompt corrective action. Before directly proceeding to data analysis data cleaning and assumption checking were executed using exploratory analysis. Data analyses were performed based on the objective by using SPSS version 16.0. During interpretation of findings care was strictly taken to base conventional standards and assumptions by consulting literatures and advisors.

For qualitative study in-depth interview guide were prepared carefully through consultation of literatures and advisors. The principal investigator conducted in-depth interview after getting their consent and transcribed first by the local language and translated into English to keep consistency of the original meaning.

5.9 Operational definitions

Childhood illness: Caretakers' were asked to report if their index child had ever sick (life time history of illness) and health seeking behaviour was asked for the most recent illness episodes.

Households: a group of people habitually eating and sleeping together in the same compound and one form was used for each household

Health seeking behaviour: was defined as mother's or caretaker's response by recognition of their child's illness within 24 hours and if they reported visiting any health institutions; health centre, health post, private clinic or at least community health worker. Mothers or caretakers that did not report visiting any health institution for the perceived common childhood within 24 hours of recognition were considered as not appropriate health seeker.

Knowledge: Measured using 11 items and a respondent's knowledge score was computed by summing up all the items together and used for regression analysis. Mean was computed to summarize it. The higher the score indicates the higher knowledgeable.

5.10 Instruments and Measurements

Pretested and semi structured questionnaire were used, as an instrument for quantitative study. Translation of instrument was made from English language to local language (Afan Oromo) and back to English language by different individuals who were blind to the original version of the questionnaire (English version) in order to facilitate reliable responses to underline questions and keep the original meaning of the instrument.

Study questionnaire for each items were adopted from previously done similar study (13, 27) and modified to the local context. The instrument contains four parts: socio demographic status of the respondents (11 items), knowledge and practice about childhood illnesses (11 items), health system factors (6 items), and care seeking (8 items). For qualitative part of the study in depth interview guide was prepared.

5.11 Data Collection Procedure

The data was collected for 14 days in all Kebeles of the town through face to face interview with mothers or care givers living in selected households using Afan Oromo version instrument. 12 trained health professionals were involved in data collection.

Data collection was supervised by 3 supervisors. For both data collectors and supervisors one day training was given on data collection instrument, interview technique and importance of taking informed consent before data collection starts.

Each day data was checked for completeness and consistency. For qualitative study in-depth interview was conducted with key informants. Before interview Informed consent was obtained.

5.12 Data Processing and Analysis

For the quantitative data: completeness and consistency of the data were checked. Data cleaning and assumption checking were performed before proceeding to analysis. The data was then analyzed using SPSS statistical software 16.0. Descriptive and analytical methods of analysis were applied. Mean medians and frequency were used to describe independent variables. Bivariate analysis was conducted to investigate the association between each independent variables and the outcome variable. Variables which have statistically significant association were analyzed together by controlling their confounding effect to each other using logistic regression and p-value of less than 0.05 was considered significant.

Qualitative data was analyzed by thematic approach manually. The different responses obtained through note taking were transcribed with their own perspective views .Then ideas of similar explanations were organized and interpreted accordingly. Finally the data from quantitative and qualitative was triangulated.

5.13 Dissemination of Finding

The final report will be presented as partial fulfillment of the degree of Master of Public Health in health Education and Promotion to Jimma University College of Public Health and Medical Sciences. Copies of the study will be offered to Federal Ministry of Health Maternal and child health unit, Oromia Regional Health Bureau, study population. Attempts will be made to disseminate the findings through publication on local and international journals and presentation on scientific conferences.

5.14 Limitation of the Study

As the study was cross-sectional, Recall bias is the limitations of this study because mothers or caretakers may not accurately estimate or remember about their last visit for childhood illness, but to minimize the recall bias holy days and spiritual days was used as a reminder during the interview. And also egg chicken dilemma as the study is cross sectional.

5.15 Ethical Consideration

Primarily, ethical clearance was ensured from Jimma University College of Public Health and Medical Sciences' research outcome ethical review committee. Then formal letter was addressed, Oromia regional health bureau and Nekemte city administration, and finally to respective Kebeles of Nekemte town. All respondents were asked for their willingness of participation in the study and verbal consent was obtained after confidentiality of the information would be assured. Questionnaire was labeled with questionnaire ID, not to the respondents' name.

Chapter Six: Results

6.1 Socio-demographic factors

Of 413 households visited in the selected Kebeles, data were collected from 403 households. Thus, the response rate was 97.5 %. Absence of respondents going far from area of resident at the time of data collection was the main reason for none response rate. From the total respondents 377(93.5%) were females and the rest 26(6.5%) were males. The mean age of the respondents were 29.5 years with standard deviation of 5.3, regarding age of the respondents 234(58.1%) of them are less or equal to 30 years of age and 169(41.9%) of them are above or equal to 31 see (Table1).

The larger proportion of respondents, 287(71.2%), were Oromo by ethnicity. The majority of study participants were Protestant by religion comprising 200(49.6%) and Orthodox comprise 115(28.5%) and Majority, 333(82.6%) were married. Regarding occupational status of respondents 112(27.8%) were government employees, 98(24.3%) private employees, and 193(47.8%) others (includes: nongovernmental employees, daily laborers, merchant and farmers). Only 30 (7.4 %) of the respondents were illiterate (did not able to read and write) and 373(92.5%) of respondents were literate (included: formal education and able to read and write). Of the total study participants, 333 (82.6%) were married, and 13 (3.5%) were single, divorced 33 (8.2%), whereas the remaining 23 (5.7%) were widowed. Regarding family income majority of the respondents reported their monthly income as 501-1000 birr 162 (40.2%) followed by more than 1000 birr a month 114(28.3%) and almost all households 398(98.8%) have latrine see (Table 1).

Table 1. Socio-demographic characteristics of the study subjects Nekemte town, Eastern Wollega, Oromia Regional State, 2013

| Variables | Category | Frequency (N) | Percentage |
|-----------------------|----------|---------------|------------|
| Sex | Male | 26 | 6.5 |
| | Female | 377 | 93.5 |
| Age | <=30 | 234 | 58.1 |
| | >=31 | 169 | 41.9 |
| Marital status | Single | 13 | 3.2 |
| | Married | 333 | 82.6 |
| | Divorced | 33 | 8.2 |
| | Widowed | 24 | 5.9 |

| | | | |
|--------------------------------|--------------------|-----|------|
| Religion | Orthodox | 115 | 28.5 |
| | Muslim | 61 | 15.1 |
| | Protestant | 200 | 49.6 |
| | Catholic | 25 | 6.5 |
| | Others | 2 | 0.5 |
| Ethnicity | Oromo | 287 | 71.2 |
| | Amhara | 69 | 17.1 |
| | Gurage | 29 | 7.2 |
| | Tigre | 17 | 4.2 |
| Educational Status | Illiterate | 30 | 7.4 |
| | Read and write | 105 | 26.1 |
| | Primary school | 84 | 20.8 |
| | Secondary school | 133 | 33.0 |
| | Higher level | 51 | 12.7 |
| Occupation | Gov't Employee | 112 | 27.8 |
| | Non Gov't Employee | 50 | 12.4 |
| | Private Employee | 98 | 24.3 |
| | Merchant | 80 | 19.9 |
| | Farmer | 09 | 2.2 |
| | Daily labourer | 21 | 5.2 |
| | Housewife | 23 | 5.7 |
| | Student | 10 | 2.5 |
| Income | Less than 100 birr | 09 | 2.2 |
| | 101-300 birr | 29 | 7.2 |
| | 301-500 birr | 89 | 22.1 |
| | 501-1000 birr | 162 | 40.2 |
| | Above 1000 birr | 114 | 28.3 |
| Availability of latrine | Yes | 398 | 98.8 |
| | No | 05 | 1.2 |

6.2. Knowledge and perceptions related to childhood illness

Significant numbers of the respondents 311(77.2%) were aware about malaria as one of the major childhood illness. Majority of them 249(61.8%) knew about ARI. Nearly half of the respondents 199(49.4%) knew about malnutrition as one among childhood illness. About 350(86.8%) of the respondents knew diarrheal disease as childhood illness and only few 106(26.3%) knew about measles. With regard to sign and symptoms of childhood illness 379(94%) of the respondents were aware of fever, followed by diarrhea 373(92.6%), vomiting 297(73.7%), cough 295(73.2%) and loss of appetite 281(69.7%). About 381(94.5%) of the respondents knew that childhood is preventable see (Table 2).

Majority of the key informants said that there were some perceptions and mal practices in this town on childhood illnesses which includes considering some childhood illnesses as other spiritual illnesses so they did not take them to health institutions rather they take to spiritual places or stay for long time in the house. One female Health extension worker said that:

“...during my home visit session I get many children suffered from common childhood illnesses and taken to spiritual areas after long time and when I asked their parents they told me it’s not medical case....”

Regarding source of information on childhood illness mothers or caretakers responded that more than half of them 248(61.5%) from health professionals, 79(19.4%) from TV, 34(8.4%) from Radio, 23(5.7%) from Health extension workers followed by 19(4.7%) of them from community gatherings see (Table 2). It is also supported by qualitative study result which showed that there are variety of options providing information on childhood illnesses including Health professionals, Medias like radio and TV and also community gatherings. One Key informant described the issue emotionally as:

‘...we consult them and advice them at each visit what they should do and what they should follow but majority of them come back again because they failed to follow what they told but messages by media especially TV had good impact...’

Another health extension worker also explained what she experienced:

“...for I don’t know the exact reason they did not obey my instruction or advice but they respond well to the information of other sources even from higher level health professionals and information from different media...”

Table 2: Behavioral factors of respondent’s Nekemte town, Eastern Wollega, Oromia Regional State, 2013

| Variables | Category | Frequency (N) | Percentage |
|-------------------------------|-----------------|----------------------|-------------------|
| Knew childhood illness | | | |
| Malaria | | 311 | 77.2 |
| ARI | | 249 | 61.8 |
| Mal nutrition | | 199 | 49.4 |
| Diarrheal disease | | 350 | 86.8 |

| | | | |
|--|--------------------------|------|------|
| Measles | 106 | 26.3 | |
| Knew sign and symptoms of childhood illness | | | |
| Fever | 379 | 94.0 | |
| Diarrhea | 373 | 92.6 | |
| Cough | 295 | 73.2 | |
| Vomiting | 297 | 73.7 | |
| Loss of appetite | 281 | 69.7 | |
| Knew if childhood illness was preventable | 381 | 94.5 | |
| Knowledge | | | |
| | Not knowledgeable | 150 | 37.2 |
| | Knowledgeable | 253 | 62.8 |
| Source of information | | | |
| | Health extension workers | 23 | 5.7 |
| | Health professionals | 248 | 61.5 |
| | TV | 79 | 19.6 |
| | Radio | 34 | 8.4 |
| | Community gatherings | 19 | 4.7 |

6.3 Health system factors and previous experience

Majority of the respondents reported that the nearest health facility to their home was private clinic 181 (44.9%) which is followed by Health centre 119 (29.5%) and Hospital 92 (22.8%). Regarding the time they waste to reach to the health facility nearest to them majority 293 (72.7%) of them reported up to 20 minutes, 103 (25.6%) 20-40 minutes whereas the rest of them 7(1.7%) reported above 1 hour or 60 minutes. A total of 240 (59.6%) of the care takers reported the waiting time during the last visit to the health facility is up to 25 minutes and 151 (37.5%) of them as 25-50 minutes and the remaining are reported above 50 minutes.

Regarding their experience during the last visit of health institution more than half 240 (59.6) of them reported the waiting time is less than 25 minutes whereas 151(37.5) reported 26-50 minutes the rest of them reported above that. This is evaluated as acceptable by majority of the respondents 214(53.4) followed by short 124(30.7) the rest evaluated the overall time as long 55(13.6) and too long 10(2.5) see (Table 3).

More than half of the mothers or caretakers 241(59.8) reported that they spent about 51-100 birr during their last visit to health facility for childhood illness followed by 101-150 birr

114(28.3). Regarding the overall satisfaction of them during their last visit of health institution majority of them rated as good 178(44.2) and fair 136(33.7) see (Table 3).

Table 3. Health System factors and previous experience of study subjects Nekemte town, Eastern Wollega, Oromia Regional State, 2013

| Variables | Category | Frequency (N) | Percentage |
|--|----------------------|----------------------|-------------------|
| Nearest health facility | | | |
| | Health center | 119 | 29.5 |
| | Hospital | 92 | 22.8 |
| | Health post | 11 | 2.7 |
| | Private clinic | 181 | 44.9 |
| Time spent to reach the nearest health facility | | | |
| | <=20 minutes | 293 | 72.7 |
| | 21-40 minutes | 103 | 25.6 |
| | >41 minutes | 07 | 1.7 |
| Experience of caretakers during last visit of health facility | | | |
| Waiting time during the last visit | | | |
| | Less than 25 minutes | 240 | 59.6 |
| | 26-50 minutes | 151 | 37.5 |
| | 51-75 minutes | 11 | 2.7 |
| | Above 75 minutes | 01 | 0.2 |
| Feeling concerning the overall time spent | | | |
| | Too long | 10 | 2.5 |
| | Long | 55 | 13.6 |
| | Acceptable | 214 | 53.4 |
| | Short | 124 | 30.7 |
| Total money spent | | | |
| | Less than 50 birr | 28 | 6.9 |
| | 51-100 birr | 241 | 59.8 |
| | 101-150 birr | 114 | 28.3 |
| | 151-200 birr | 19 | 4.7 |
| | Above 201 birr | 01 | 0.2 |
| Overall satisfaction | | | |
| | Very good | 62 | 15.4 |
| | Good | 178 | 44.2 |
| | Fair | 136 | 33.7 |
| | Poor | 27 | 6.7 |

¹ Note: health system factors and previous experience was asked for all of the respondents

6.4 Health seeking behavior for childhood illness

The study showed all children included in the study had history of illness in their life see (Table 4) which presents illness history. But health care seeking was asked for the most recent illness episode. Of those under five children who had diarrhea, fever, ARI and other illnesses in recent time care was sought for majority of them 358(88.8%) even though only

few of them considered as appropriate care seeking. Concerning preferred site by mothers or caretakers majority of them sought care from 175 (43.4%) private clinic, 116 (28.8%) from Public health institutions and the rest from others like pharmacies and traditional healers. Of the total treated episodes of illnesses, care was sought on the first day of perceived onset of illness only for 125 (34.9%) of them. A total of 126(35.2%) of the mothers or caretaker's tried different forms of treatment at home before contacting formal health facility from which 50(39.4%) gave home remedies and also the same number 50(39.4%) gave traditional medicine at home and the rest gave ORS 15(12.5%) and holy water 11(8.7%) respectively.

When we see the overall health care seeking, out of 403 sick children only 112 (31.3%) were taken to health facilities either public or private within 24 hours which is considered as appropriate health seeking behavior.

Caretakers' main reasons for not seeking care from health facilities were perceived illness was not serious 18 (40%), thought getting well without treatment 18 (40%), Lack of money 6 (13.4%) and lack of time 3 (6.6%) as presented in table 4.

Table 4: Health seeking pattern of respondents Nekemte town, Eastern Wollega, Oromia Regional State, 2013

| Variables | Category | Frequency (N) | Percentage |
|--|---|----------------------|-------------------|
| Did you seek treatment for the recent childhood illness | | | |
| | Yes | 358 | 88.8 |
| | No | 45 | 11.2 |
| Source or type of care sought | | | |
| | Self treatment | 07 | 1.7 |
| | Traditional healer | 15 | 4.2 |
| | Private clinics | 175 | 43.4 |
| | Private pharmacies or drug vendors | 45 | 11.2 |
| | Public health institutions including HP, HC and Hospital | 116 | 28.8 |
| Reason for preferences | | | |
| | Treatment is good | 102 | 25.8 |
| | Reception is good | 45 | 11.2 |
| | Qualified personnel | 94 | 23.3 |
| | Short distance | 44 | 10.9 |
| | Short waiting time | 28 | 6.9 |
| | Cost is cheaper | 45 | 11.2 |
| After how long you brought your children to health facility | | | |
| | Within a day | 125 | 34.9 |
| | After one day | 233 | 65.1 |
| Appropriate seeking | | | |
| | Yes | 112 | 31.3 |
| | No | 246 | 68.7 |
| Did you do anything at home to child before seeking help? | | | |

| | | |
|---|-----|------|
| Yes | 126 | 35.2 |
| No | 232 | 64.8 |
| What did you do at home? | | |
| Gave home remedies | 50 | 39.4 |
| Gave traditional medicine | 50 | 39.4 |
| Gave ORS | 15 | 12.5 |
| Holy water | 11 | 8.7 |
| Who was child's usual care taker? | | |
| Mother | 357 | 88.6 |
| Father | 39 | 9.7 |
| Co-mother | 02 | 0.5 |
| Grand mother | 05 | 1.2 |
| What is your most important reason of your children not receiving any treatment? | | |
| Symptom not serious | 18 | 40.0 |
| Thought getting well from symptom without treatment | 18 | 40.0 |
| Lack of time | 03 | 6.6 |
| Lack of money | 06 | 13.4 |

² Note: Appropriate care seeking: if a caretakers sought care within 24 hrs from modern health care system (government, and private clinic), otherwise inappropriate

6.5 Determinants of Health Seeking

Significant association was observed on bivariate logistic regression between appropriate Health seeking and educational status (OR 95% CI: 3.23(1.060, 9.814)), educational status (OR 95% CI: 3.12(1.462, 6.650)), source of information (OR 95% CI: 0.12(0.015, 0.873)) and income 301-500 birr (OR 95% CI: 3.83(1.830, 8.027)). The above variables together with other less significant variables were taken to multiple logistic regressions to control confounder if any and to construct the final model for health seeking behavior. Caretakers whose educational status are read and write level were almost 3 times to not seek health care for their children compared to those with higher level educational status (AOR 95% CI: 2.85(1.09, 7.46). As well as caretakers with income 301-500 birr were 3.13 times more likely to not seek appropriately when compared to with those income above 1000 birr (AOR 95% CI: 3.13(1.27, 7.71). Those who use Health professional as source of information were likely to seek health care for their children 10% when compared to those using community gatherings as primarily source of information. (AOR 95% CI: 0.10(0.01, 0.88)

It is also supported by Qualitative findings in which Majority of the key informants reported the cause of poor health seeking behavior is related with low educational level of the mothers or care takers, Socio economic status of the family and some personal perception about

childhood illness. When they asked about specific group who are better in terms of health seeking behavior most of them replied that those who are better educated and better socioeconomic status have better health seeking behavior. One male health professional in one of health centre described this as:

“... Here in this health center majority of the service users are usually the same means new users are rare and I think it is based on their educational and status socioeconomic status of caretakers...”

However, occupation and knowledge of the caretakers were no longer significant after adjusted to the other factors see (Table 5). However, majority of key informants of in depth interview explained those who considered knowledgeable in the community as well as with better occupation like government employee were considered as better health care seeker.

Table 5: Factors associated with health seeking for childhood illnesses among caretakers, Nekemte town, Eastern Wollega, Oromia Regional State, 2013

| Variables | Health seeking | | Unadjusted | and | Adjusted OR |
|---------------------------|----------------|----------|--------------------|-----|-------------------|
| | Seek | Not Seek | OR(95% CI) | | AOR(95% CI) |
| Educational Status | | | | | |
| Illiterate | 05 | 25 | 3.23(1.06, 9.81)* | | 2.94(0.71, 12.12) |
| Read and write | 18 | 87 | 3.12(1.46, 6.65)* | | 2.85(1.09, 7.46)* |
| Primary school | 28 | 56 | 1.29(0.63, 2.66) | | 1.33(0.56, 3.18) |
| Secondary school | 41 | 92 | 1.45(0.74, 2.83) | | 1.37(0.63, 2.97) |
| Higher Level | 20 | 31 | 1 | | 1 |
| Occupation | | | | | |
| Gov't Employee | 31 | 81 | 1.12(0.27, 4.60) | | 1.85(0.4, 8.61) |
| Non Gov't Employee | 11 | 39 | 1.52(0.34, 6.87) | | 1.46(0.27, 7.85) |
| Private Employee | 27 | 71 | 1.12(0.27, 4.68) | | 0.79(0.17, 3.82) |
| Merchant | 22 | 58 | 1.13(0.27, 4.76) | | 1.02(0.21, 4.88) |
| Farmer | 01 | 08 | 3.43(0.29, 40.94) | | 0.76(0.05, 12.95) |
| Daily laborer | 05 | 16 | 1.37(0.25, 7.39) | | 0.63(0.08, 4.8) |
| Housewife | 12 | 11 | 0.39(0.08, 1.90) | | 0.37(0.07, 2.14) |
| Student | 03 | 07 | 1 | | 1 |
| Income | | | | | |
| Less than 100 birr | 04 | 05 | 0.68(0.17, 2.66) | | 0.36(0.07, 1.87) |
| 101-300 birr | 05 | 24 | 2.59(0.92, 7.32) | | 1.82(0.45, 7.27) |
| 301-500 birr | 11 | 78 | 3.83(1.83, 8.03)** | | 3.13(1.27, 7.71)* |
| 501-1000 birr | 52 | 110 | 1.14(0.69, 1.89) | | 0.98(0.53, 1.81) |
| Above 1000 birr | 40 | 74 | 1 | | 1 |

| | | | | |
|--------------------------------|----|-----|-------------------|-------------------|
| Nearest Health Facility | | | | |
| Health Centre | 29 | 90 | 1.35(0.80, 2.29) | 1.42(0.79, 2.53) |
| Hospital | 27 | 65 | 1.05(0.61, 1.82) | 0.97(0.52, 1.83) |
| Health post | 01 | 10 | 4.36(0.55, 34.94) | 5.39(0.51, 56.52) |
| Private Clinic | 55 | 126 | 1 | 1 |
| Knowledge | | | | |
| Non knowledgeable | 36 | 114 | 1.36(0.86, 2.16) | 1.22(0.73, 2.05) |
| Knowledgeable | 76 | 177 | 1 | 1 |
| Overall satisfaction | | | | |
| Very good | 23 | 39 | 0.38(0.13, 1.16) | 0.30(0.09, 1.04) |
| Good | 59 | 119 | 0.46(0.17, 1.27) | 0.38(0.12, 1.16) |
| Fair | 25 | 111 | 1.01(3.48, 2.92) | 0.69(0.22, 2.18) |
| Poor | 05 | 22 | 1 | 1 |
| Source of information | | | | |
| Health Extension Workers | 04 | 19 | 0.26(0.03, 2.59) | 0.22(0.02, 2.6) |
| Health Professionals | 81 | 167 | 0.12(0.02, 0.87)* | 0.10(0.01, 0.88)* |
| TV | 19 | 60 | 0.17(0.02, 1.40) | 0.19(0.02, 1.69) |
| Radio | 07 | 27 | 0.21(0.02, 1.89) | 0.16(0.02, 1.66) |
| Community gatherings | 01 | 18 | 1 | 1 |

*P-value < 0.05 , **P-value <0.001*

Finally, Majority of the respondents of the in-depth interview agreed on the solutions to solve poor or in appropriate health seeking behavior concerning childhood illnesses as providing appropriate and continuous health education for mothers or care takers. And also they recommended that it is better if overall cost of treatment is substantially reduced. One male key informant of about 30 years old stated that:

“...each of us should do our job correctly and in continuous manner for example we as health professional should provide the mothers or caretakers effective health education in every possible place like health facilities, in public meetings including spiritual places churches and mosques ...”

Chapter Seven: DISCUSSION

Care seeking interventions have the potential to substantially reduce child mortality, in the country where common childhood illnesses are a major problem. Appropriate care seeking practices have importance to avoid many deaths attributed to delays and not seeking care particularly in developing countries (12, 13). However, in this study, care was sought from health facilities only for few children in addition for most care seeking was started on the second and subsequent days. The possible reason for not care seeking could be trying of home care including traditional treatment by underestimating the illness, lack of money and time. Similar findings were reported from Ethiopia (3, 13) and other developing countries (27, 28).

Maternal or caretakers educational status was one of the factors associated with health seeking behavior. Mothers or caretakers with high level of educational status were more likely to appropriately seek care for childhood illness when compared to mothers or caretakers with low level of educational status. Maternal or care takers educational status might played an important role in health seeking behavior for childhood illnesses. This finding is similar with other studies conducted in Ethiopia and other developing countries like Malawi, South Africa and Nepal (27, 11, 15) Highly educated mothers are known to be better users of health information and services and are thus expected to have better care-seeking behaviours for their ill children. Similarly, they are better equipped for initiating and controlling decision making with regard to health (27, 28, 29).

The other variable that is associated with health seeking appropriately was family income; according to this study families with better income had better health seeking practice when compared with those with low family income which is consistent with other studies. Family income or socio economic status has proved to be important factor for health seeking practice in studies conducted in Ethiopia (13) and other countries Nigeria and Nepal (11, 28).

In this study, Health seeking behavior was not found significantly associated with age and sex of the caretakers in this study. Similar findings were reported in Ethiopia and South Africa (13, 15). However, studies conducted in Nigeria (28) reported young mothers or caretakers tend to seek health care appropriately compared to the older ones.

In addition, mothers who had good knowledge about childhood illnesses were more likely to seek care from health facilities than mothers who had poor low knowledge similar to reports from other studies (13, 26) and also studies conducted in Ghana and Mali revealed the same result (31, 35).

Other reports have noted that other factors, different from clinical data, still influence mothers' decision to seek medical care. Among the most commonly mentioned reasons are: access to health services and money to pay for the visit or prescribed drugs (19). On the other hand, reasons for not looking for medical care were related to the mothers' perception that the illness was mild or self-limited. Nonetheless, most patients in our study were not taken to a medical care facility because of limited access or the maternal decision to give treatment at home.

In contrast with other studies distance of health facility is not associated with health seeking practice of mothers or caretakers which might be due to difference of study places because this study is conducted in urban area where health institutions are easily accessible.

This study showed that the possible reasons of mothers or caretakers not seeking health care appropriately were related to the mothers' perception that the illness was mild or self-limited, Which is consistent with others studies conducted in Ethiopia (13, 14) and other countries like Mexico, Guatemala and Kenya (26,32 , 33) where as studies done in Malawi and Uganda focus mainly on financial constraints and poor access to health facilities as main reason (24, 27).

The finding from the logistic regression analysis showed that mothers or caregivers who mentioned the source of information concerning childhood illness as health professional were seek better than those who mentioned the other sources which is similar with other studies conducted in Nigeria (28). In contrast the in-depth interview with treatment provider showed that, the mothers or care takers respond well to other Medias than advice from them. This all showed that if caregivers get appropriate information from any source their possibility of seeking health care appropriately will increase. This finding similar with the findings of a study conducted in Ethiopia (13, 14) and other countries Kenya, Bangladesh and Mexico (10, 21, 26).

Chapter Eight: Conclusion and Recommendation

Conclusion

The study identified that substantial proportion of mothers or caretakers in this study area did not practice health seeking behavior properly.

It can be concluded from the findings in this study that maternal or caretakers educational status, family income, as well as source of information are independent predictors of appropriate care-seeking behavior for childhood illnesses.

Recommendations

- Regional health bureau and town health office should design strategies to encourage mothers or other caretakers to bring their children on time to health institutions by using all means of communication available.
- The regional health bureau should design health-education program by involving private health facilities because majority of the study participants use private institutions than the public ones.
- Town health office and all categories of health professionals should design and provide the health education sessions emphasized Cause, treatment options and prevention of childhood illnesses to avoid some misconceptions and perceptions.
- Regional health bureau and town health office should design strategies to minimize costs or providing free services in order to encourage those families with low income to bring their children to health facilities.
- Finally, further community based studies are recommended for further assessment of factors associated with health seeking behaviours of childhood illness in surrounding rural areas.

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Annexes II: Instruments English Version

JIMMA UNIVERSITY COLLEGE OF PUBLIC HEALTH & MEDICAL SCIENCE, DEPARTMENT OF HEALTH EDUCATION AND BEHAVIORAL SCIENCES

Instruction for data collectors:

First you will find the informed consent. Please make sure that all the stated sections & questions are present, and read (inform verbally) the consent for the interviewee before beginning the interview. Please circle the answers against the code numbers or write if stated otherwise on the space provided.

Section I Informed Consent Form

My name is _____. I am working temporarily as a data collector with the department of Health education and behavioural science Jimma University, which is conducting a study among households in Kebele of Nekemte town on assessment of health seeking behaviour for childhood illness. The objective of the present study is to assess health seeking behaviour at household level on childhood illness.

During the interview you will be asked some short questions about your background, about Common childhood illnesses, your feelings, about your treatment choices etc. Your answers will be recorded on a questionnaire. You may feel uncomfortable or experience some emotional stress from being asked some of the personal questions. No personal identifiers will be attached/ recorded to the interview. All the data obtained will be kept strictly confidential by using only code numbers, and destroyed immediately when the study is finalized.

Your participation in the study is upon voluntary basis. What we learn from this study will be used to generate information necessary for designing effective intervention on addressing common childhood illnesses. The interview will be conducted in private and will take 20-25 minutes. During the interview (discussion) period, if you feel inconvenient, you can interrupt and clarify inconvenience, appoint to other time or even withdraw any time after you get involved in the study. Your honest and genuine participation in responding to the questions prepared is very important & highly appreciated. If you agree to participate in this study I will interview you.

Would you be willing to participate? If yes, proceed. If no, thank and stop here.

_____ (Signature of interviewer certifying that respondent has given Informed Consent verbally).

Section II: Interviewer Agreement

I certify that I have filled this questionnaire in accordance with the training I was given and instructions stated in it. I confirm that the information in it is correct.

Name of Kebele -----

| Questionnaire No ID _____ | Date | Name of interviewer | Name of the Kebele | Time |
|---|------------------|---------------------|--------------------------|--------------------------------|
| This section should be filled by principal investigator _____ | ____//____//____ | | | Start _____ End _____ |
| A. Socio demographic information | | | | |
| 101. Sex of care taker 1. Male 2. Female <input type="checkbox"/> | | | | |
| 102. Age of mother or care taker | | | _____years | |
| 103. Religion 1. Orthodox 3. Protestant 2. Muslim 4. Catholic 00. Others | | | <input type="checkbox"/> | |
| 104. Ethnicity 1. Oromo 4. Tigre 2. Amhara 5. Kefa 3. Gurage 6. Dawuro 00. other, specify _____ | | | <input type="checkbox"/> | |
| 105. Marital status 1. Single 3. Divorced 2. Married 4. Widowed | | | <input type="checkbox"/> | |

| | |
|---|----------------------|
| 00. Others Specify _____ | |
| 106. Educational status of mother or Care taker 1. Illiterate 4. Secondary school 2. Read and write 5. High school 3. Primary school 6. Graduate 00. Other specify _____ | <input type="text"/> |
| 107. Educational status of Child's father 1. Illiterate 4. Secondary school 2. Read and write 5. High school 3. primary school 6. Graduate 00. Others specify _____ | <input type="text"/> |
| 108. Occupation 1. Government employee 5. Farmer 2. Non government employee 6. Daily Laborer 3. Private employee 7. House wife 4. Merchant 8. Student 00. Others Specify _____ | <input type="text"/> |
| 109. What is your family monthly income 1. Less than 100 birr 3. 301- 500 birr 2. 101 - 300 birr 4. 501 - 1000 birr 5. more than 1000 birr | <input type="text"/> |
| 110. Number of under five children 1. One 3. Three 2. Two 4. Four 5. More than four | <input type="text"/> |
| 111. Availability of latrine 1. Yes | <input type="text"/> |

| | |
|--|--|
| 2. No | |
| B. Health system | |
| <p>201. Which health facility is nearest to your home?</p> <p>1. Health Centre 3. Health post 2. Hospital 4. Private Clinic 00. Others</p> | <input style="width: 100px; height: 30px;" type="text"/> |
| <p>202. How long ago did it take you to get to the nearest Health facility?</p> <p>in minutes _____</p> <p>minutes</p> <p>99- does not know</p> | <input style="width: 100px; height: 30px;" type="text"/> |
| <p>203. How long did you wait to have your child seen in your last visit to the Health facility?</p> <p>_____minutes</p> <p>99-does not know</p> | <input style="width: 100px; height: 30px;" type="text"/> |
| <p>204. How do you feel about the time you had wait to get your child treated in your last visit to Health centre</p> <p>1. Too Long 3. Acceptable 2. Long 4. Short 99. Doesn't know</p> | <input style="width: 100px; height: 30px;" type="text"/> |
| <p>205. How much money did you spent to get your child treated</p> <p>1. Transportation _____</p> <p>2. Treatment _____</p> <p>(Including)</p> <p>- Card</p> <p>- Medication</p> | <p>Total birr _____</p> |

| | |
|--|--|
| <p>- Laboratory</p> <p>Total - Please add up the Total _____</p> | |
| <p>206. How do you rate your satisfaction for the service provided?</p> <p>1. Very good 3. Fair</p> <p>2. Good 4. Poor</p> <p>5. Very poor</p> | <div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div> |
| <p>207. What is your source of information on childhood illnesses</p> <p>1. Health Extension workers</p> <p>2. Health professionals</p> <p>3. TV</p> <p>4. Radio</p> <p>5. Community gatherings</p> <p>6. Other (specify) _____</p> | <div style="border: 1px solid black; width: 100px; height: 60px; margin: 0 auto;"></div> |
| C. Knowledge | |
| <p>301. Do you mention some of common childhood illnesses in your area?</p> <p>Malaria 1. mentioned 2. not mentioned</p> <p>ARI 1. mentioned 2. not mentioned</p> <p>Malnutrition 1. mentioned 2. not mentioned</p> <p>Diarrheal disease 1. mentioned 2. not mentioned</p> <p>Measles 1. mentioned 2. not mentioned</p> | <p style="text-align: center;">Total mentioned _____</p> |
| <p>302. Do you know the symptoms of common childhood illnesses?</p> <p>1. Yes 2. No</p> | <div style="border: 1px solid black; width: 100px; height: 40px; margin: 0 auto;"></div> |
| <p>303. If your answer for the above question is Yes, can you mention some of them?</p> | |

| | |
|--|----------------------|
| Fever 1.mentioned 2.not mentioned Diarrhea 1.mentioned 2.not mentioned Cough 1.mentioned 2.not mentioned Vomiting 1.mentioned 2.not mentioned Loss of appetite 1.mentioned 2.not mentioned Others(specify)_____ | Total mentioned_____ |
| 304. Do you think common childhood illnesses are preventable? 1. Yes 2. No 99. Don't know | |
| D. Care seeking | |
| 401. Did you seek treatment for the recent childhood illness occurred in this household? If no go to 408 1. Yes 2. No 3. Don't remember | <input type="text"/> |
| 402. For the most recent childhood illness in this household, from which one have you received service? 1. Self-treatment 2. Treatment from traditional healers 3. Private clinics 4. private pharmacies or drug vendors 5. public health institutions (including HP,HC,Hospitals) | <input type="text"/> |
| 403. What was the most important reason your children receiving treatment from the first treatment source? Circle only one 1. Treatment is good 4. Short distance 2. Reception is good 5. Short waiting time 3. Qualified personnel 6. cost is cheaper | <input type="text"/> |
| 404. How long did you first notice that child was sick? < Hours to 1 Day= 1 day (in days) | _____ days |
| 405. Did you do anything at home to child before seeking help? 1. Yes 2. No- Skip to question 407 3. Don't know- Skip to question 407 | <input type="text"/> |

| | |
|--|--|
| <p>406. What did you do at home?</p> <ol style="list-style-type: none"> 1. Gave home remedies, specify _____ 2. Gave medicine, specify _____ 3. Gave ORS 4. Holy water 5. Other- Specify _____ | |
| <p>407. Who was child's usual care taker?</p> <ol style="list-style-type: none"> 1. Mother 2. Father 3. Co-Mother 4. Grand mother 5. Grand father 6. Others, Specify _____ | <input data-bbox="1129 562 1289 647" type="checkbox"/> |
| <p>408. What is your most important reason of your children not receiving any treatment?</p> <ol style="list-style-type: none"> 1. Symptom not serious 2. Thought getting well from symptom without treatment 3. Don't know where it can be treated 4. No effective treatment is available 5. Lack of time 6. Lack of money 7. Long distance 8. Others (specify) _____ | <input data-bbox="1166 1043 1326 1128" type="checkbox"/> |

Section: III

Data collection instrument for qualitative study

Informed consent (To be read for key informants)

Hello, my name is _____ and I am of a member of Jimma university research team. I'm here to collect information for the research conducted on assessment of health seeking behavior for common childhood illnesses at household level in Nekemte town. The purpose of this research is to bring important information for designing effective intervention to address common childhood illnesses in the town.

Participation is based on your willingness besides; you can withdraw from the study anytime. However, your kin participation would mean. In addition, no personal identification will be written and we assure you that whatever information you are providing will only be used for the research purpose and only the research team will handle the data. While we are collecting the data it is difficult to jot down everything thus we will tape record our discussion.

Are you willing to participate in the study?

Agreed _____ continue interview

Not agreed _____ say thank you and search another voluntary

If you need any further information about the study, please contact the following person.

Tsegaye Getachew

Mobile Phone 0910673857

E-mail: gechtsegaye@gmail.com

Q1 how do you assess health seeking behavior of families on childhood illnesses?

Probe:

- A. What is the cause of poor health seeking behavior?
- B. Which is specific group is better on health seeking behavior?
- C. why do you think this specific group is better health seeking behavior?

Q2. Can you tell us if there are any perceptions and practices in relation to Health seeking behavior among families in this specific Kebele?

Q3. Where does your Kebele population get information about common childhood illnesses and related information?

A. Who provide the information? Probe for health workers, HEWs or other

B. Which one is the most preferred source of information about childhood illnesses? Why? Probe for different media, radio, TV, Posters, Billboards, road show, community meetings, etc...

C. Any special program that a community preferred to attend or listen?

D. The most trusted source of information, why?

E. When is the appropriate time for the community to receive information about childhood illnesses? Probe for time of a day and specific days in a week

Q4. What do you think is the solution to solve poor or in appropriate health seeking practice in your specific settings? Why?

Annexes III: Instruments Afan Oromo Version

Meeshaa ragaleen Qorannoo ittin sassabamu

UNIVERSITII JIMMAA, KOLLEJII FAYYAA HAWAASAA FI SAYINSII
MEDIKAALAA, KUTAA BARNOOTAA BARUMSA FAYYAA FI SAYIINSII
AMAALAA

Qajeelfama ragaa sassabdotaaf:

Jalqaba irraatti kutaa unka eyyama gafannoo argatta. Maloo kutaan gafannoo kanaa hundinuu jirachuu isaa mirkaneffadhu. Itti aansudhaan unka eyyama gafannoo dubbisiif gaffii jalqabuu kee dura. Lakko fisa deebii isaanii bakka qopha'ee irrattii haala gafatameen sirritti guuti.

Kutaa I Unkaa Eyyama hubannoo irratti hunda'e

Maqaan kiyyaa _____jedhama. Yeroo amma kana yeroodhaaf akka ragaa sassabdutti Yunversitii Jimma kutaa barnootaa barumsa fayyaa fi sayinsii amalaa waliin qorannoo wa'ee fedhii barbaacha tajaajila fayyaa matii dhibee da'imani ilaalchisee magaala Naqamteetti gaggefamu irratti hojjechhan jira. Kayyoon qorannoo kanas amalli fi fedhiin tajaajila barbaacha matii dhukkubaa da'imani ilaalchisee maali akka fakkatu qo'achuuf dha.

Yeroo gafannoon gaggefamu kessatti gaffii gaggababoo wa'ee mataa kessanii ibsaan gafatamuu dandeessuu akkasumaas wa'ee dhibee da'imaanii beekamoo ta'an irratti hubanno qabdan, waan isnitti dhaga'amu fi filanno tajaajila yaala kessani fi KKF irrattii gafiilee tokko tokko gafatamuu dandessu. Deebiiin kessan waraqoo gafanno kana irraatti galmeeffama, tarii yeroo gafatamtan gaffiin tokko tokko muxanno garii hin taane kana dura dabarsitan isin yaadachisuu danda'a. wa'ee kessan kan ibsu ragaan tokkolee waraqaa gafannoo kana irratti hin galmaa'u. ragaaleen hundinuu icitiidhaan qabamu kodii fayyadamudhaan akkasumas yeroo qorannon kun rawwatutti waraqaan kun akka barbada'uu ta'a.

Hirmannaan kessanii gutumma gututtii fedhii irrattii kan hunda'e dha. Bu'aan qoranno kana muxanno fi ragaa argameen gara fulduratti dhibee da'imani fi du'aa walqabatee dhufu hiriisuu irratti bu'aa gudda qaba. Gafannoon kun kan guutamu bakka mijaataa fi qofatti ta'ee walumaa galatti daqiiqaa 20-25 fudhaachuu danda'a. Yeroo gaffii fi marii kessaatti tarii yoo waan sitti hin tole jiraate ykn waan siin gale jiraate giddutti dhaabdee waan siin galle gafachuu dandeessa ykn yeroo kan birattis beelama qabachuu dandeessu akkasumaas gutumma gutuutti qorannoo kana kessa ba'uu dandessa. Amanamummaa fi sirritti hirmanaan

kessan baayee waan nubarchisuuf haala gariin akka hirmaatan isinirraa eegna. Yoo hirmachuudhaaf fedhii qabdu ta'ee gaffii itti fuufuun danda'a.

Hirmachuudhaaf fedhii qaabduu? Yoo deebiin isaanii "Eyyee" ta'e gaffii itti fufi. Yoo deebiin isaanii "Miti ykn feedhii hin qabu" ta'ee moo asumarratti dhaabii galateffadhuu deemi.

_____ (Mallattoo gaafata gaffii jalqabuu dura eyyaama argachuu isaa kan ibsu.

Kutaa II: Waligaaitee gaafataa

Ani gaffannoo kana haala qajeelfama fi barnoota leenjii irratti naaf kennameen gutuu koo fi ragaaleen gutaaman kun sirri ta'uu isaanii nan mirkaneessa.

Maqaa gandaa ykn kutaa bulchiinsaa _____

| Lakk. Waraqaa gafaannoo | Guyyaa | Maqaa gafataa | Maqaa kutaa bulchiinsaa | Yeroo |
|---------------------------------------|------------------|---------------|-------------------------|-----------------------|
| koodii _____ | | | | |
| Kutaan kun kan guutamu PI dhaan _____ | ____//____//____ | | | Jalqabaa _____ xumura |

A.Ragaalee bu'uraa

| | | | | |
|--|--|--|--|----------------------|
| 101. Saala Guddistuu Mucaa 1. Dhiira 2. Dhala | | | | <input type="text"/> |
| 102. Umuriin Kessan Meeqa? | | | | _____ (waggaa) |
| 103. Amantaan kessan maali? 1. Ortodoksii 3. Protestantii 2. Muslima 4. Katolikii 00. kanbiroo | | | | <input type="text"/> |
| 104. Sablammii keessan maali? 1. Oromoo 4. Tigree 2. Amaraa 5. Kafaa 3. Guragee 6. Dawuroo | | | | <input type="text"/> |

| | |
|--|--|
| 00. kanbiroo, (addabaasi)_____ | |
| <p>105. Haala ga'elaa kessanii maal fakkaata?</p> <p>1. hin fuune/hin herumne 3. Kan hike/hiikte</p> <p>2. kan fudhe/herumte 4. Kan jala du'e</p> <p>00. kanbiroo, (addabaasi)_____</p> | <input style="width: 100px; height: 40px;" type="text"/> |
| <p>106. Sadarkaan barnoota kessaanii hagam?</p> <p>1. hin baranne 4. Sadarkaa 2ffaa</p> <p>2. baressu fi dubbisu 5. Sadarkaa olaanaa</p> <p>3. barumsa sadarkaa 1ffa 6. Kan ebbifame</p> <p>00. kanbiroo, (addabaasi)_____</p> | <input style="width: 100px; height: 40px;" type="text"/> |
| <p>107. Sadarkaa barnotaa Abba da'imaa hagami?</p> <p>1. hin baranne 4. Sadarkaa 2ffaa</p> <p>2. baressu fi dubbisu 5. Sadarkaa olaanaa</p> <p>3. barumsa sadarkaa 1ffa 6. Kan ebbifame</p> <p>00. kanbiroo, (addabaasi)_____</p> | <input style="width: 100px; height: 40px;" type="text"/> |
| <p>108. Hojiin kessan maali?</p> <p>1. hojjetaa/tuu motummaa 5. Qotee bulaa</p> <p>2. hojjetaa/tuu miti motummaa 6. Dafqaan bulaa</p> <p>3. hojjetaa dhunfaa 7. Hojjetuu mana kessaa</p> <p>4. daldalaa 8. barataa</p> <p>00. kanbiroo, (addabaasi)_____</p> | <input style="width: 100px; height: 40px;" type="text"/> |
| <p>109. Galiin matii kessaanii ji'aan hangami?</p> <p>1. Qarshii 100 gadi 3. Qarshii 301- 500</p> <p>2. Qarshii 101 - 300 4. Qarshii 501 - 1000</p> <p>5. Qarshii 1000 oli</p> | <input style="width: 100px; height: 40px;" type="text"/> |

| | |
|--|--|
| <p>110. da' iman waggaa 5 gadii meeqa qabdu?</p> <p>1. Tokko 3. Sadii</p> <p>2. Lama 4. Afuur</p> <p>5. Afurii fi isaa ol</p> | |
| <p>111. Mana fincanii qabduu?</p> <p>1. Eyyee</p> <p>2. Hin qabnu</p> | <div style="border: 1px solid black; width: 100px; height: 30px; margin: auto;"></div> |
| <p>B.Sirna fayyaa</p> | |
| <p>201. Mana yaala kamitu mana kessanitti dhiyaata?</p> <p>1. Buufata fayyaa 3. Kella fayyaa</p> <p>2. Hospitaala 4. Mana yaalaa dhunfaa</p> <p>00. kanbiroo, (addabaasi) _____</p> | <div style="border: 1px solid black; width: 100px; height: 30px; margin: auto;"></div> |
| <p>202. Gara mana yaala isa mana kessanitti dhiyoo demuuf ammam isinitti fudhata daqqaatiin _____</p> <p>99- hin beeku</p> | <div style="border: 1px solid black; width: 100px; height: 30px; margin: auto;"></div> |
| <p>203. Yeroo dhumatiif yeroo da' imaa kessani gara mana yaalaa gessitani turtii ammamii booda tajaajila argatani? daqiqatiin _____</p> <p>99- hin beeku</p> | <div style="border: 1px solid black; width: 100px; height: 30px; margin: auto;"></div> |
| <p>204. Walumaa galatti tajaajila argachuuf yeroo isinitti fudhatte akkamitti gamagamtu?</p> <p>1. Baayee dheeraa 3. Giddu galessaa</p> <p>2. Dheeraa 4. Gabaabaa</p> <p>99. hin beeku</p> | <div style="border: 1px solid black; width: 100px; height: 30px; margin: auto;"></div> |

| | |
|---|--|
| <p>205. Da'ima kessani yalchisuuf walumagalatti qarshii meeqa baastan?</p> <p>1. Gejjibaaf _____</p> <p>2. yaalaaf _____</p> <p>(kannen kana dabalatee)</p> <p>- kardi</p> <p>- Qoricha</p> <p>- Laboratorii</p> <p>Dimshaasha – hundaa isaa walitti ida'i) _____</p> | <p>Dimshaasha qarshii _____</p> |
| <p>206. Tajaajila isiniif kenname irraa gammachuu ammam argatan?</p> <p>1. Baayee garii 3. Ga'aa</p> <p>2. Garii 4. Gad bu'aa</p> <p>5. Baayee gad bu'aa</p> | <div style="border: 1px solid black; width: 100px; height: 50px; margin: 0 auto;"></div> |
| <p>207. Wa'ee dhibee da'imani ilaalchisee ragalee tokko tokko essa argatu?</p> <p>1. Ekstenshinii fayyaa</p> <p>2. Ogessa fayyaa</p> <p>3. TV</p> <p>4. Radio</p> <p>5. Wal gahii ummataa</p> <p>00. kanbiroo, (addabaasi) _____</p> | <div style="border: 1px solid black; width: 100px; height: 50px; margin: 0 auto;"></div> |
| <p>C. Beekumsa</p> | |
| <p>301. Dhibee da'imani bekamoo ta'an kessaa natti himuu dandessaa?</p> <p>Busaa <input style="width: 30px; height: 20px;" type="text"/> 1 aqasameera <input style="width: 30px; height: 20px;" type="text"/> 2 in caqafamne</p> <p>Dhukkuba ujumoo afuraa <input style="width: 30px; height: 20px;" type="text"/> 1 aqasameera <input style="width: 30px; height: 20px;" type="text"/> 2 Hin caqafamne</p> | |

| | | | | |
|---|----------------------------|-------------|----------------------------|---------------|
| Hanqinaa nyaataa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Garaa kasaa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Gifira | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Waliigala kan caqafaman _____ | | | | |
| 302. Mallatolee dhibee da' imanii beektaa? | | | <input type="text"/> | |
| 1. Eyyee | | | 2. Hin beeku | |
| 303. Yoo deebiin gaffii kana olii EYYE ta'e, malattolee beektu kessaa natty himuu dandessa? | | | | |
| Nafa ho'isaa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Garaa kasaa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Qufaa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Hoqqisaa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 2 | Hin caqafamne |
| Nyaataa jibbisiisa | <input type="checkbox"/> 1 | Caqasameera | <input type="checkbox"/> 1 | Hin caqafamne |
| Waliigala kan caqafaman _____ | | | | |
| 304. Dhukkuboota da' imanii kana ittisuun hindanda'ama jettanii yaddu? | | | <input type="text"/> | |
| 2. Eyyee | | | 2. Miti | |
| 99. Hin beeku | | | | |
| D.Fedhii yaala barbaduu | | | | |
| 401. Dhibee Da' imanii yeroo dhiyotti mana keessanitti isin | | | | |

| | |
|--|--|
| <p>qunnameef yaala barbadanittu?</p> <p>1. Eyyee Hin beeku</p> <p>2. Miti</p> | <input data-bbox="1134 235 1374 331" type="text"/> |
| <p>402. Dhibee da' imanii yeroo dhihotti isiin mudateef yaala essaa barbadanii?</p> <p>1. Ofiin yaaluu 2. Tajaajila fayyaa aadaa 3. Klinika dhunfaa 4. Farmasii ykn mana qorichaa dhunfaa 5. Mana yaalaa motummaa(kella fayyaa, buufata fayyaa fi Hospitaala dabalatee</p> | <input data-bbox="1155 423 1347 508" type="text"/> |
| <p>403. Sabaabni guddaan da'imni kessan tajaajila fayyaa bakka armaan olitti ibsame argateef malii? Tokko qofa filaadhu</p> <p>1. Tajaajila yaalaa garii 2. Simannaa gaarii 3. Ogessii gahumsa olaanaa qaban jiraachuu isaanii 4. Fageenya gabaabaa 5. Yeroo egumsaa gabaabaa tajaajila argachuuf 6. Gatii salphaa</p> | <input data-bbox="1168 875 1359 983" type="text"/> |
| <p>404. Yeroo ammamii booda da'imni kessani akka dhukkubsate bartani mana yaalaa gessitani?</p> <p>Guyyaa 1 gadii yoo ta'e akka guyya 1 tti fudhu</p> | <p>guyyaa_____</p> |
| <p>405. Otuu gara mana yaalaa hin deemiin dura manatti waan gootaan jiraa?</p> <p>1. Eyyee 2. Hin jiru- gara 407 tti darbi 3. Hin beeku- gara 407 tti darbi</p> | <input data-bbox="1168 1543 1359 1650" type="text"/> |
| <p>406. Manatti maal gotaniif?</p> <p>1. qoricha adaa kennineef, addan basii_____</p> <p>2. qoricha kennineef, addan baasi _____</p> <p>3. ORS kennineef</p> | <input data-bbox="1182 1803 1374 1919" type="text"/> |

| | |
|--|---|
| <p>4. bishaan qulqulla'aa</p> <p>00. kanbiroo, (addabaasi)_____</p> | |
| <p>407. Yeroo bayee da'ima kan kunuunsu enyudha?</p> <p>1. Haadha</p> <p>2. Abbaa</p> <p>3. Haadha budeenaa</p> <p>4. Akkayyaa</p> <p>5. Akakayyuu</p> <p>6. kanbiroo, (addabaasi)_____</p> | <div data-bbox="1166 483 1361 584" style="border: 1px solid black; width: 122px; height: 45px; margin: auto;"></div> |
| <p>408. Yoo debiin gaffii 405 miti ta'e, sababni guddaan da'imni tajaajila fayyaa hin arganneef maali?</p> <p>1. Mallatoleen dhkkubaa cimaa tahuu dhabuu</p> <p>2. Tajaajila yaalaa malee fayyuu danda'aa jedhanii ereguu</p> <p>3. Bakka itti tajaajilli fayyaa itti kennamu walaaluu</p> <p>4. Qorichi tkn yallii garii ykn sirri hin jiru jedhanii ereguu</p> <p>5. Hanqina yeroo</p> <p>6. Hanqina qarshii</p> <p>7. Fageenya dheeraa</p> <p>8. Kanbiroo, (addabaasi)_____</p> | <div data-bbox="1182 949 1390 1081" style="border: 1px solid black; width: 130px; height: 59px; margin: auto;"></div> |

Kutaa: III

Meeshaa ragaleen Qorannoo ittin sassabamu

Unkaa Eyyama hubannoo irratti hunda'e kan namoota gafatamaniif dubbifamu

Maqaan kiyyaa _____jedhama. Yeroo amma kana yeroodhaaf akka ragaa sassabdutti Yunversitii Jimma kutaa barnootaa barumsa fayyaa fi sayiinsii amalaa waliin qorannoo wa'ee fedhii barbaacha tajaajila fayyaa matii dhibee da'imaniif ilaalchisee magaala Naqamteetti gaggefamu irratti hojjechhan jira. Kayyoon qorannoo kanas amalli fi fedhiin tajaajila barbaacha matii dhukkubaa da'imaniif ilaalchisee maali akka fakkatu qo'achuuf dha.

Hirmannaan kessanii gutumma gututtii fedhii irrattii kan hunda'e dha. Bu'aan qoranno kana muxanno fi ragaa argameen gara fulduratti dhibee da'imaniif fi du'aa walqabatee dhufu hiriisuu irratti bu'aa gudda qaba. Gafannoon kin kan rawwatamu bakka mijaataa fi qofatti kan gaggefamuuf walumaa galatti daqiiqaa 20-25 fudhaachuu danda'a. yeroo gaffii fi marii kessaatti tarii yoo waan sitti hin tole jiraate ykn waan siin gale jiraate giddutti dhaabdee waan siin galle gafachuu dandeessa ykn yeroo kan birattis sagantaa qabachuu dandeessa akkasumaas gutumma gutuutti qorannoo kana kessa ba'uu dandessa. Amanamummaa fi siritti hirmannaan kessan baayee waan nubarchisuuf haala gariin akka hirmaatan isinirraa eegna Ragaleen sassabaman kun icitiin kan qabamaniif meshaleen itti sagalee warabuuf fayyadamne kun yeroo qorannoon kun rawwatametti kan dhabamsifaman ta'a.

Qoranno kanatti hirmachuudhaaf fedhii qaabduu?

Eyyee _____ gaffii itti fufi

Hirmachuuf fedhii hin qabu _____ galateffadhu nama kan biraa kan fedhii qabutti darbi

Yoo tarii odefannoo dabalataa barbadaniif qoranno kana ilaalchisee, namoota armaan gaditti maqaan isaanii caqafame kana qunnamuu dandessu.

Tsaggaayee Getaachoo

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1. Amala barbaacha tajaajila fayyaa matii dhibee da'imaniif ilaalchisee akkamitti gamagamtu?

- Qoraadhuu gaafadhu:
 - a) Sababni amala barbaacha tajaajila fayya gad bu'aa maal jettanii yaaddu?
 - b) Garee ykn kutaa hawaasaa kessaa isaan kamtu amala barbaacha tajaajila fayyaa garii qaba?
 - c) Gareen amma ibsitan kun maliif amala barbaacha tajaajila fayyaa foyya'aa qabaatani isinitti fakkaata?
- 2. Waanti adaa ta'ee ykn waanti baratame hawaasa keessatti kan shakaalamu amala barbaacha tajaajila fayya da'imaanii irratti dhiiba kan uumuu natty himuu dandessu?
- 3. Hawaasni ganda kessanii odeffannoo wa'ee dhibee da'imani ilaalchiisee essa argata?
 - a) Enyuuti odefanno isannif kenna? Siritti qoradhu hojjetoota ekstenshini fayyaa dhamoo kan biraati?
 - b) Odeffanno wa'ee dhibee fi fayya da'imani ilaalchisee argachuuf karaa ykn mala isa kamtu filatamaadha? Maliif? Siritti qoraadhuu gafaadhu midiyaalee, radiyoo, TV, posterii, biilbordii, walgahii ummataa fi KKF
 - c) Sagantaa adda tarii yoo jirateef kan hawwaasni hordofuu fi dhaggefachuuf filatu.
 - d) Maloota ykn karaalee odefannoo itti argatan kessaa amanamaan kami, maliif?
 - e) E.Hawaasaa fi yeroo filataaman kamidha odefannoo wa'ee dhibee da'imani argachuuf? Siritti qoradhuu gaafadhu torbe kessa guyyaa kamii fi sa'aatii kami akka ta'e.
- 4. Furmatnni amala barbaacha tajaajila fayya dhibee da'imani sirri hin taane ykn gadibu'aa ta'e kana ilalchiisee jira jettan maali? Maliif?