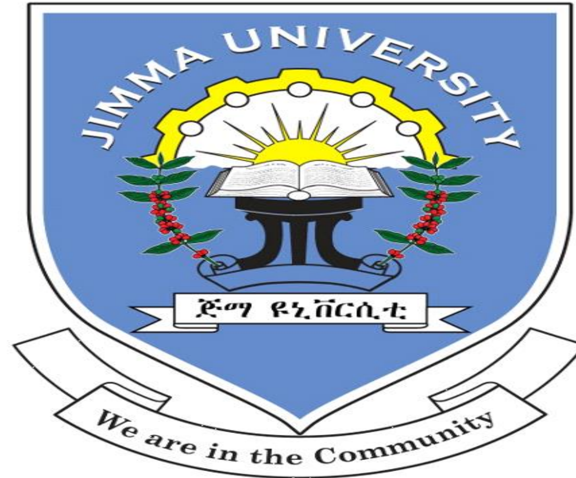
MAGNITUDE OF SUICIDAL BEHAVIOR AND ASSOCIATED FACTORS AMONG ADOLESCENTS IN JIMMA TOWN, SOUTHWEST ETHIOPIA, 2022



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A RESEARCH THESIS SUBMITTED TO JIMMA UNIVERSITY, INSTITUTE OF HEALTH, FACULTY OF MEDICAL SCIENCE, DEPARTMENT OF PSYCHIATRY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR MASTERS OF SCIENCE DEGREE IN INTEGRATED CLINICAL AND COMMUNITY MENTAL HEALTH

MARCH, 2023

JIMMA, ETHIOPIA

JIMMA UNIVERSITY

INSTITUTE OF HEALTH

FACULTY OF HEALTH SCIENCES

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MARCH,2023

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ABSTRACT

Background: *Adolescence is the transitional period between childhood and adulthood. About 1.2 billion people in the world belongs to this age group and it represents a period of higher vulnerability to everyday difficulties leading to impulsive and/or unpredictable behaviour. Despite, most investigations, they fail to consider school or social environment as a factor. Most suicide deaths occur in low- and middle-income countries. In Ethiopia there is scarcity of data on suicidal behavior among adolescents at the community level and some important factor was not addressed. Therefore, this study aims to assess the magnitude and associated factors of suicidal behavior among adolescents in Jimma town, Southwest Ethiopia.*

Objective: *This study aimed at assessing the magnitude of suicidal behaviour, and its associated factors among adolescents in Jimma town, Southwest, Ethiopia, 2022.*

Method: *A Community based cross-sectional study was employed among 633 adolescents of Jimma town using an interviewer-administered pretested structured questionnaire. A Simple random sampling technique was employed. Suicidal behavior questionnaire (SBQR) was used to assess suicidal behavior. Point prevalence was determined. Bivariate and multivariate logistic regression analysis was conducted to identify associated factors. Odds ratio and 95% confidence interval (CI) with P-value <0.05 were used to declare statistical significance.*

Result: *A total of 628 respondents were involved in this study with response rate of 99.2%. Of respondents 321(51.1%) were female and mean age was 15.8 (SD=±2.2) years. Over all prevalence of suicidal behavior was 36.62%. Being female (AOR=1.5; 95%CI: (1.07, 2.17)), age(17-19) (AOR=2.2; 95%CI: (1.31, 3.72)), family history of suicide (AOR=1.9; 95%CI: (1.27, 2.96)) physical abuse (AOR=1.7; 95%CI: (1.23, 2.59))), physical neglect (AOR=1.7; 95%CI: (1.23, 2.53)), sexual abuse (AOR=1.6; 95%CI: (1.02, 2.58)) and current use of khat (AOR=1.7; 95%CI: (1.08 2.65)) were significantly associated with suicidal behavior.*

Conclusion and recommendation: *The study revealed that multiple factors lead to suicidal behavior such as being female, late adolescent age, family history of suicide, physical abuse, physical neglect, sexual abuse and current use of Khat. Early suicidal assessment and primary prevention on identified risk factors was recommended to town health bureau.*

Keywords: *Suicide, suicidal behaviour, Adolescent, Jimma, Ethiopia.*

ACKNOWLEDGMENT

First of all, I would like to acknowledge Jimma University institute of health, department of psychiatry for giving me this chance to conduct this research and also for the financial support. Then my thanks will go to my advisors Dr. Mubarak Abera, Sr. Worknesh Tessema and Dr. Elias Tesfaye for their constructive and valuable comments and advice throughout my thesis work.

Additionally, I would like to acknowledge Jimma town administration and Jimma town health bureau for their co-operation through giving important information's needed for this research and I also want to thank the study participants for their cooperation in giving the necessary data. Also, my deepest gratitude goes to my working and sponsor organization Dilla University. Besides, I would like to thanks my friends for their un-measurable support on this thesis work.

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ACRONYMS AND ABBREVIATIONS

ADHD: Attention Deficit Hyperactivity Disorder

AOR: Odds Ratio

CHP: Child Health Expert

CDC: Centers for Disease Control

ED: Emergency Department

ETB: Ethiopian Birr

GBDS: Global Burden of Disease Study

LAMIC: Low- and Middle-Income Countries

SDG: Sustainable Development Goal

USA: United States of America

CHAPTER ONE: INTRODUCTION

1.1. Background

Suicide occurs when people use violence against themselves in order to terminate their life, and they die as a result of their acts(1). Suicidal behaviour is categorized into Suicidal ideation, planning and attempt, they are recognized as major public health problems among adolescents(2). It is the result of coordinated processes in which at the beginning, the person starts with suicidal ideas that usually intermittently appear and intensify later to become permanent and invasive, then these ideas lead to the establishment of a suicidal plan and the accomplishment of that process leads subsequently to death(3).

Suicide affects young people of any race and socioeconomic status and it accounts for approximately 33.9% or one of every three deaths among adolescents(4). The CDC fact sheet in 2020 reported that suicide was also among the top 9 leading causes of death for people with age range of 10–64 and it is the second leading cause of death for people ages 10–24 in particular(5).

Adolescence is a bridge or a process between youth and adulthood(6). About 1.2 billion people in the world belong to this age group (7). It represents a period of higher vulnerability to everyday difficulties leading to impulsive and/or unpredictable behaviour including suicide, which is death caused by injuring oneself with the intent to die(8).

On one study emphasize that the impact of dysfunction within the family, school or impact in social environment as a reason for suicide(3). In addition to this, mental disorders, substance abuse, childhood and adult trauma, social isolation, economic struggles, relationship loss, and individual psychological traits such as hopelessness and impulsiveness increase the risk of suicide(9). Persons with suicidal behaviour most of the time show behaviour like withdrawing from friends, saying goodbye, giving away important items, taking dangerous risks such as using drugs or alcohol more often, and unbearable emotional or physical pain(10).

It is estimated that half of the adolescent suicides are due to family factors, which directly lose many young lives and have devastating psychosocial and socio-economic adverse effects on a

large social scale(11), as well as strengthening the parent-teen relationship and improving family functioning are critical when treating suicidal youth(12).

Furthermore, family conflict is a known risk factor for adolescent suicide and suicidal behaviour, whereas family cohesion protects against suicidal behaviour and plays an important role in implementing strategies outside of treatment to prevent the adolescent from attempting suicide, such as removing access to lethal means, providing supervision and monitoring, and contacting emergency services when necessary(13).

Additionally, it’s important to get involved early to teach positive coping skills and address environmental situations that may trigger emotional disturbances. Especially for young people to practice identifying and naming emotions, to figure out coping skills that help them to decrease the energy of negative emotions, and to have the repeated, encouraging experience of being heard, understood, respected, and accepted(14).

Due to increased suicidal behaviour outcomes among adolescents, globally, various studies have been conducted but very few studies have been conducted in Ethiopia regarding suicidal behaviour among adolescents at the community level. So, the current study will investigate the magnitude and associated factors of suicidal behaviour among adolescents living in Jimma town.

1.2. Statement of the problem

Suicide is a significant public health concern in adolescence and the second leading cause of death in adolescents aged 10 to 24 years(15). On average, counting suicides under the age of 15 resulted in one adolescent committing suicide every hour and every 19 minutes to 26.9 minutes (16). Globally, the male suicide rate was 13.7 per 100,000, and for females was 7.5 per 100,000. The ratio of men to females is almost three times that of men in high-income countries, which is comparable to that in low and middle-income countries. Suicide was the second leading cause of death among young people aged 15-29 and the third leading cause of death among men and women aged 15-19. The suicide rate in Europe is 12.9 per 100,000, and in Southeast Asia 13.4 per 100,000(17).

In the United States (U.S.), suicide is the 10th leading cause of death for all ages and the 2nd leading cause of death for youth and young adults between the ages of 10-34. According to CDC, a person dies of suicide every 11 minutes (CDC, 2021)(18). The financial toll of suicide on society is also high that in 2019, suicide and nonfatal self-harm cost the nation nearly $490 billion in medical costs, work loss costs, the value of statistical life, and quality of life costs(5).

Despite the efforts of countries around the world to achieve the Sustainable Development Goals (SDG) 3.4 to promote people's mental health and well-being by 2030(19), suicidal behaviour remains a significant public health issue(20). Globally, most suicide deaths occur in low and middle-income countries (79%), where most of the world's population lives (84%). In terms of age, more than half (52.1%) of the world's suicides occurred before age 45. Most of the youth who died from suicide (90%) came from low and middle-income countries, where almost 90% of the world's youth live(17). Suicide is a lifelong problem. It is the second most common cause of death for people aged 10-34(8).

Suicide rates for adolescents aged 14-18 increased by 61.7% from 6.0 to 9.7 per 100,000 population, with about 95,000 people attending the emergency department(4). Despite decades of research on suicide prevention in this age group, suicide rates between 10 and 19 increased by 56% and 17.2% of high school students were seriously considering suicide attempts, 13.6% had suicide plans, and 7.4% had one or more suicide attempts, over the last 15 years, suicide rates have increased in all age groups and are the second leading cause of death between age 10 to 24 (21).

It is estimated that 50% of adolescent suicides are due to family factors, which directly lose many young lives and have devastating psychosocial and socio-economic adverse effects on a large social scale(11).

An estimated 17% of all suicide attempts and 29% of severe suicide attempts were associated with psychotic experiences, based on a large non-clinical sample of adults (22). Loss or violence, sexual abuse, family illnesses, low socio-economic status, family conflicts, dysfunctional parental relationships, childcare styles based on overly restrictive or hostile attitudes, and destructive family prediction experience are associated with suicidal behaviour (23).

Various protective factors for adolescents occur across cultures and societies(24). Family ties, for example, can help to alleviate social isolation and loneliness(25). Strong interpersonal ties are protective across cultures, and effective coping strategies are beneficial on an individual level. When it comes to the epidemiology of teen suicide, the question of what can be done to prevent it arises(26). Limiting access to legal means of suicide, decreasing media reporting of suicides, increasing public understanding of mental illness and suicide, increasing psychiatric training for providers, increasing access to psychiatric care, and decreasing psychosocial stressors leading to suicide were all suggested as specific global strategies(24).

The international recognition of suicide as a major public health problem culminated in the establishment of World Suicide Prevention Day on September 10, 2003. The International Association for Suicide Prevention (IASP) organizes this annual observance, which is co-sponsored by WHO. This day has sparked national and local campaigns, contributing to global awareness and stigma reduction(26).

The suicide rate in Africa is 12.0 per 100,000(17). The 12 months of prevalence suicidal behaviour in Mozambique were 17.7%, 19.6% and 18.5% for suicidal ideation, suicidal plan, and suicidal attempt respectively(27). In Swaziland, the overall proportion of students who considered suicide was 18.3% among females and 15.6% among males(28). The suicidal rates were 3.2% attempting, 5.8% planning, and 7.2% reporting ideation among adolescents in South Africa(29). Approximately 22% of Black South African youths and 60% of Guyanese youths endorsed suicide ideation and attempt or suicide attempt only(30). The prevalence of suicidal behaviour was 26.9%

for brief passing suicidal thoughts, 9.6% for serious suicidal thoughts, and 7.3% for suicide attempts(3).

Adolescents face an increased risk of suicide, a higher likelihood of substance misuse problems, lower academic achievement, and a higher possibility of dropping out of school as a result of our inability to address specifically adolescent and young adult mental health problems. Neglecting adolescent and young adult mental health has long-term negative consequences, such as higher rates of unemployment, drug or alcohol addiction, and other poor health outcomes, higher rates of incarceration, and increased exposure to violence. However, by intervening early and focusing on their health, we are safeguarding our community's future productive energy. Therefore, it is essential to evaluate and find the factors that endanger our youth, especially in Jimma town, as the following research will serve as a benchmark for the next researcher.

Currently, even though a lot of articles published regarding suicide, there are not ample studies that have been published in our context on suicidal behaviour among adolescents at the community level. Therefore, this study aims to assess the magnitude of suicidal behaviour among adolescents at the community level, which might help policymakers, health planners, town health offices and other governmental offices working on it and related issues to design better evidence-based public health strategies and interventions to build a strong society.

1.3. Significance of the study

This study will be a baseline for the study area and make a significant contribution to further research and researcher. Reveal insights into the magnitude of suicidal behaviour for the town administration, to give attention and deal with the problems to prevent the consequences and increase productivity. Additionally, the finding of this study will be used as, evidence for the government to focus and work on the problem since it can affect national productivity.

For the management of the Jimma town administrative office to get an insight into the problem, to design or adapt prevention strategies and support systems to improve the mental health of the community, to provide information for the adolescents and also communities regarding the problem and its determinants and to involve them in prevention activities to increase productivity for the community and also the country at far.

CHAPTER TWO: LITERATURE REVIEW

2.1.Overview

Suicide is a major public health problem among adolescents(2). It is the result of this whole coordinated process in which at the beginning, the person starts with suicidal ideas that lead to the establishment of a suicidal plan and subsequently to death(3), this is why the economic and human cost of suicidal behaviour to individuals, families, communities and society makes suicide a serious public health problem around the world(31). The review in this chapter is focused on two major themes which are related to the prevalence of suicidal behaviour and the factors associated with it.

2.2.The magnitude of suicidal behaviour among adolescents

According to the Global Burden of Disease Study (GBDS), 8.4% of deaths are between 15 and 19 worldwide. Suicide is more common in young men than in young women(32). Adolescent suicide has ended up an international concern and it’s the second main motive of death amongst young people 15 to 29 worldwide(33).

The National Longitudinal multistage study design among adolescents in both public and private high schools in the US showed that 5.1% were more likely to attempt suicide in adolescence but not in young adulthood, and 1.3% were more likely to attempt suicide in adolescence and adulthood(34). A three-stage cluster sample design to produce a representative sample of 9 through 12-grade students from regular public, Catholic, and other private schools in the US were sampled, and the data of a total of 14,765 US adolescents were included, and the proportions of suicidal ideation and suicide attempts were 17.4 and 5.7% among US adolescents(35).

The European School Survey data obtained from 45,806 high school students aged 15–16 years from 17 countries showed that the prevalence of active suicidal ideation among adolescents ranged from 20% to 30%. Regarding suicide ideation, life prevalence corresponds to 18% of adolescents(36). According to the study review among adolescents, the ratio of suicide is 17.9 per 100,000 male patients aged 15 to 19 years and 5.4 per 100,000 female patients aged 15 to 19 years(37,38).

A report from the CDC suggests that about 55% of people with lifelong suicidal ideation and suicide plans are more likely to attempt suicide attempts, so look at all three-suicide behaviour, especially suicide plans. That is important. For unplanned ideas, the probability of attempted suicide was only 15%(2). Suicide and suicide attempts affect the health and well-being of friends, loved ones, co-workers, and the community. When people die by suicide, their surviving family and friends may experience shock, anger, guilt, symptoms of depression or anxiety, and may even experience thoughts of suicide themselves(5).

A cross-sectional and descriptive study conducted with data from the Mexico National Survey on drug use among adolescent students showed the estimated prevalence of attempted suicide was 6.8%(39). The proportions of suicidal ideation and suicide attempts among Chinese adolescents are (suicidal ideation: 13.7% and suicide attempts: 2.7%)(35).

A study done in Malaysia shows that the overall prevalence of suicidal ideation among adolescents was 6.2%. The prevalence was significantly higher among females, 7.6%, than among males, 4.7%(40).

According to a survey of low- and middle-income countries (LAMIC) school children, the overall prevalence of suicidal ideation, planning, and attempts is 16.9%, 17.0%, and 17.0%, respectively(27). Suicide is the leading cause of injury and death, with 79% of suicide-related deaths reported in LAMIC. Increasing evidence suggests that suicide is one of the top 12 causes of death in sub-Saharan Africa aged 10 to 24 years(41). The annual mortality from suicide is estimated at over 34,000 in the general population(42).

According to statistics from the South African report on mortality and causes of death, about 125 adolescents aged 14 to 24 intentionally die from self-harm, including drowning, strangulation, and jumping from dangerous locations(43). In a study conducted in Liberia, 26.8% reported suicide attempts, 36.5% planned specific suicide attempts, and 33.7% attempted suicide attempts 12 months before the study(41). In a study conducted in Nigeria, the one-month prevalence of suicidal ideation was 6.1%, suicidal planning was 4.4%, and a suicidal attempt was 2.8%(44).

A study conducted in Tunisia found that the prevalence of suicidal behaviour was 26.9% for brief passing suicidal thoughts, 9.6% for serious suicidal thoughts, and 7.3% for suicide attempts(3). In

a study conducted in Dangla town in northwestern Ethiopia, the prevalence of suicidal ideation and attempted suicide in adolescence was 22.5% and 16.2%, respectively. The study found that at least one in five adolescents in the sample had suicidal ideation, and one in six attempted suicide(45).

2.3. Factors associated with suicidal behaviour

2.3.1. Sociodemographic-related factors

A cross-sectional study conducted in USA among adolescents and young adulthood, having family history of suicide were associated with suicidal behavior of their children with AOR=2.189, 95%CI(1.76, 2.69)(46). Another study conducted in USA with AOR = 3.1, 95% CI(2.0–4.7)(47), AOR=2.5,95%CI (1.8-3.2)(48) and in China with AOR=6.817, 95%CI(2.338, 19.875)(49).

A cross-sectional study conducted in Mexico on drug use among adolescent students showed increased suicide attempts with being a woman (OR 3.1), and being under 16 years old (OR 1.6)(39). Study conducted among Polish adolescents resulted in that being female were more related to suicidal behavior than boys(50).

Also a cross-sectional study conducted in Malaysia revealed that adolescents who were females (OR= 2.02; 95% CI, 1.40–2.92) (40). The cross-sectional study done on Israel resulted in a positive association between gender and suicidal ideation, that such girls have a 2.66 times higher chance for suicidal ideation than boys (i.e., OR = 2.66, $p < 0.05$) (51).

A descriptive cross-sectional study conducted among adolescents aged 15–19 in Togo showed that family history of suicide associated with adolescent suicidal behavior with AOR= 2.04, 95%CI (1.01–4.13)(52). A cross-sectional study conducted in Tunisia revealed that the female gender (OR=2.56 (1.32-4.95) were associated with suicidal behaviour (3). According to the survey done in Swaziland students of age 17 years were 25% more likely (AOR=1.25, 95% CI [1.19, 1.31]) to consider committing suicide as compared to students aged 18 years or older. Another study conducted in South Africa reported that as age increase the suicidal behavior increase as compared between the 10-14 and 15-19-year age groups and suicide increase in the later age(53). Male students were 17% less likely (AOR=0.83, 95% CI [0.81, 0.85]) to consider committing suicide than females(28).

2.3.2. Psychosocial related factor

Psychosocial risk factors for suicide can include abuse, a sense of isolation, family conflict, personal violence, socioeconomic disadvantage and discrimination(26). A cross-sectional study conducted in Mexico among adolescent students showed that, living in an unfavorable family atmosphere (OR 1.5) or having poor communication with parents (OR 1.8), having low self-esteem (OR 1.9), suffering a mental illness (OR 3.6); drugs use, smoking or alcohol consumption (OR 1.7, 1.2 and 1.7) were associated with suicide attempt(39).

Alcohol use was significantly related to suicidal ideation/suicide attempts only in Chinese adolescents (suicidal ideation: Adjusted odds ratio (AOR) = 1.88, 95% CI: (1.71-2.06); suicide attempts: AOR = 2.12, 95% CI: (1.71-2.63), and marijuana use was associated with suicidal ideation and suicide attempts only in the US adolescent group (suicidal ideation: AOR = 1.23, 95% CI: (1.06-1.44); suicide attempts: AOR = 1.51, 95% CI: (1.21-1.87)(35).

A cross-sectional school survey was conducted in Peninsular Malaysia among school-going adolescents who had no close friends (OR = 2.71; 95% CI: 1.43–5.14), and lack of supportive peers (OR = 1.69; 95% CI: 1.15–2.47) and adolescents who had been in a physical fight (OR = 2.45; 95% CI: 1.62–3.70) were identified as risk factors for adolescents' suicidal ideation(40).

According to Global School-based, Student Health Survey conducted nationwide among secondary school conducted in Liberia indicate that an increased likelihood of suicide attempts was associated with sedentary behaviour (OR:1.48, 95%CI:1.09-2.00), cannabis use (OR: 2.76 95%CI:1.62-4.69), alcohol use (OR: 1.45, 95%CI:1.04-2.01) (41).

The cross-sectional study done on Israeli adolescents showed that a secure attachment style to one's mother is negatively and significantly associated with suicidal ideation (B = -0.05, Z = -2.15, OR = 0.96, $p < 0.05$). In other words, the more secure one's attachment is to his/her mother, the lower the chance for suicidal ideation(51).

Cross-sectional and longitudinal studies done in the USA that evaluate alcohol consumption among adolescents have consistently shown that alcohol misuse is a risk factor for suicidal behaviour in clinical and non-clinical samples(54). A case-control psychological autopsy study among adolescents in Belgium showed parental divorce (AOR=4.16; 95%CI; (1.01-17.31)) and

fights with the mother (AOR=0.16; 95%CI: (0.04-0.78)) were associated with suicidal behaviour (55).

In a population-based birth cohort study in the UK among parents and children, suicidal thoughts, the strongest predictors of transition to attempts were cannabis use (AOR=2.61; 95% CI: (1.11-6.14), other illicit drug use (AOR=2.47; 95%CI (1.02-5.96), exposure to self-harm (family AOR= 2.03; 95%CI: (0.93-4.44); friend AOR=1.85; 95%CI: (0.93-3.69). Among participants with non-suicidal self-harm the strongest predictors were cannabis use (AOR=2.14; 95% CI: (1.04-4.41), other illicit drug use (AOR=2.17; 95%CI: (1.10-4.27)(56).

According to the Global School-based Student Health Survey conducted in Swaziland in 2013 (GSHS) students who were physically attacked AOR=1.12; 95% CI: (1.09, 1.17) or involved in a physical fight AOR=1.13; 95% CI: (1.10, 1.17) were more likely to consider committing suicide than students who were not involved in violence(28). Another school-based cross-sectional study was conducted in Dangla, northwest Ethiopia report, Poor social support was associated with both suicidal ideation AOR= 5.58; 95% CI: (2.25, 13.84), and suicidal attempt AOR= 4.55; 95% CI: (1.40-14.77)(45). Another risk factor is depressive symptoms, which was most commonly reported factors in suicidal behavior (AOR=6.2)(57).

2.3.3. Childhood maltreatment-related factor

A cross-sectional survey conducted among adolescents and young adults in two Indian states of Bihar and Uttar Pradesh showed that the odds of suicidal ideation were significantly higher among adolescents who faced sexual abuse (for boys AOR=7.12; CI: 3.44–14.72 and girls AOR=2.09; CI: 1.54–2.82) compared to their counterparts(58). A survey conducted with children and adolescents aged 10 to 17 years in post-trafficking services in Cambodia, Thailand, Laos, Myanmar, and China showed that physical violence was associated with suicidal ideation (AOR=3.68; 95% CI: 1.77-7.67)(59).

According to Global School-based Student Health Survey conducted in Liberia indicate that an increased likelihood of suicide attempts was associated with a physical attack (AOR=1.81; 95%CI: 1.39-2.34)(41). A cross-sectional study conducted in Mexico among adolescent students showed that having been forced into sexual contact (AOR 2.6) were associated with suicide attempt(39).

A cross-sectional study conducted in China among a total of 181 adolescents and young adults showed that childhood maltreatment (AOR=1.04; 95% CI: 1.01-1.07) was the potentially associated factor of suicide attempts (60). The study in Quiet shows that Physical and emotional maltreatment was reported by 22.5% (95% CI: 20.1%-24.8%) and 18.6% (95% CI: 16.5%-20.9%) among students aged 18 up to 25(61).

The systematic review showed that sexual abuse and nicotine (odds ratio (OR) 0.9-4.2), alcohol (OR 1.4-5.2), and drugs (OR 1.0-8.6); physical abuse and nicotine (OR 1.8-6.1), alcohol (OR 0.8-8.9), and drugs (OR 1.8-20.4); neglect and alcohol (OR 1.2-21.2); emotional maltreatment nicotine (OR 1.4) were related to suicide risk(62). As a school-based cross-sectional study was conducted in Dangla, northwest Ethiopia reports of being physically hurt [AOR 4.25, 95% CI (1.77, 10.20)] were positively associated with a suicide attempt(45).

Academic related factor

According to a survey done on South Korean adolescents, academic stress is a primary risk factor that leads to cause of suicide(63). The multi-stage sampling technique in Kolkata India, among 11th and 12th-grade adolescent students from six schools, showed nearly two-thirds (63.5%) of the students reported stress due to academic pressure(64).

Academically typically achieving adolescents showed higher stressors in peer relationships, planning for the future and suicidal ideation compared to adolescents with academic difficulty. Adolescents face stress regarding worry about examinations, family not understanding what the child has to do in school, too much work in some subjects, afraid of failure in school work, parental expectations, worried about a family member, planning for the future, and fear of the future(65).

The lifetime prevalence of attempted suicide was 3.0% for middle school students and 4.2% for high school students. Among middle school students, statistically adjusted significant associations of suicide attempt with academic performance indicators were: not being a student the year before, worse self-perceived performance and a higher number of failed courses; among high school students, predictors were failed courses and self-perceived academic performance, with ORs of 1.65 and 1.96 for the categories of good and fair/poor respectively, compared to those who reported very good performance(66).

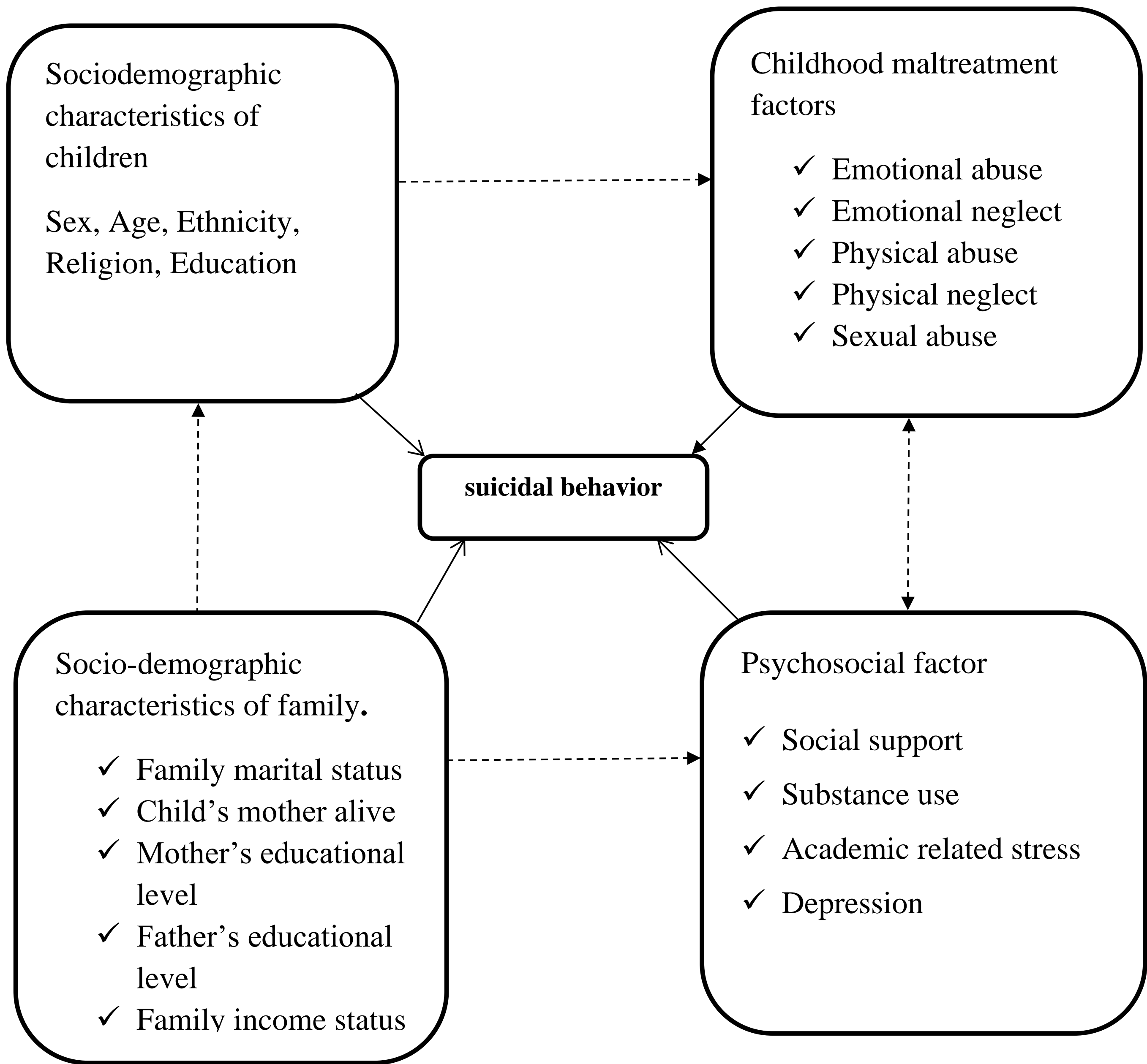

Figure 1. Conceptual framework of factors associated with suicidal behaviour after literature review.

CHAPTER THREE: OBJECTIVES

3.1. General Objective

- To assess the magnitude and associated factors of suicidal behaviour among adolescents in Jimma town, southwest Ethiopia, 2022

3.2. Specific Objective

- To determine the magnitude of suicidal behaviour among adolescents in Jimma town, southwest Ethiopia, 2022
- To identify factors associated with suicidal behaviour among adolescents in Jimma town, southwest Ethiopia, 2022

CHAPTER FOUR: METHOD AND MATERIALS

4.1.Study area and period

The study was conducted in Jimma town on Sebtember-1-30, 2022. Jimma is a town located in the Oromia regional state, Southwest Ethiopia. The town is found 352 km to the Southwest of Addis Ababa, the capital city of Ethiopia, it is located at 7º 4‟ north latitude and 36 º 5‟ East Longitude and the climatic conditions are temperate. According to the 2014 E.C. Data taken from Jimma town health administrative office, the total population of the city is 230,757, with 116,025 males and 114,733 females and the total number of households in the town is 48,074. There were 17 Kebele in Jimma town. The study was conducted in randomly selected 5 kebele.

4.2. Study design

A Community based cross-sectional study design was conducted.

4.3. Population

4.3.1. Source population

All adolescent individuals of Jimma town.

4.3.2. Study population

Randomly selected adolescents who are available during data collection.

4.4. Eligibility Criteria

4.4.1. Inclusion Criteria

Adolescents aged 10 to 19 years old, as well as those with informants present during the research period specifically for those between age 10-17, were included, as were adolescents with a six-month stay in Jimma town.

4.4.2. Exclusion Criteria

Adolescents whose parents or caregivers refuse to give consent. And also, those adolescents with serious illnesses as well as those who were not present at home for more than two times visit during data collection.

4.5. Sample size and sampling technique

4.5.1. Sample size determination

The sample size is calculated using a single population proportion formula. Assumptions taken were proportion of 50% suicidal behaviour among adolescents because there is no data on the adolescent suicidal behavior prevalence specifically on a community level, 95% confidence level ($z\alpha/2$ =1.96) and 5% marginal error (d= 0.05).

Therefore, the sample size is calculated by using the following formula

$$n = \frac{(Z_{\alpha/2})^2 \times pq}{d^2}$$

Where; n= sample size

Z= 95% confidence interval (1.96)

P= Prevalence (50%)

d= Marginal error (0.05)

q = 1-p, Thus, $(1.96)^2(0.5)\ (1-0.5)/\ (0.05)^2$ = 384, by considering 10% non-responsive rate, 10×384/100 = 38.4, Thus, sample size was 384+38.4 = 422. Since multistage sampling was used to select study subjects, a design effect of 1.5 was used to obtain a final sample size of 633.

4.5.2. Sampling Technique

Jimma town has 17 kebeles. Out of these 5 kebeles were selected by using a lottery method. A multistage cluster sampling technique was used. To determine the sample size for each selected kebeles the sample was proportionally allocated to each kebele based on their total household. A list of sub-kebeles or got was taken from each kebele and through lottery method we select the got from each kebele.

The total adolescent in each kebele were taken from each kebele health post and based on that estimation there is more than one adolescent on average in the household. For those household more than one study participants we used lottery method to select study unit.

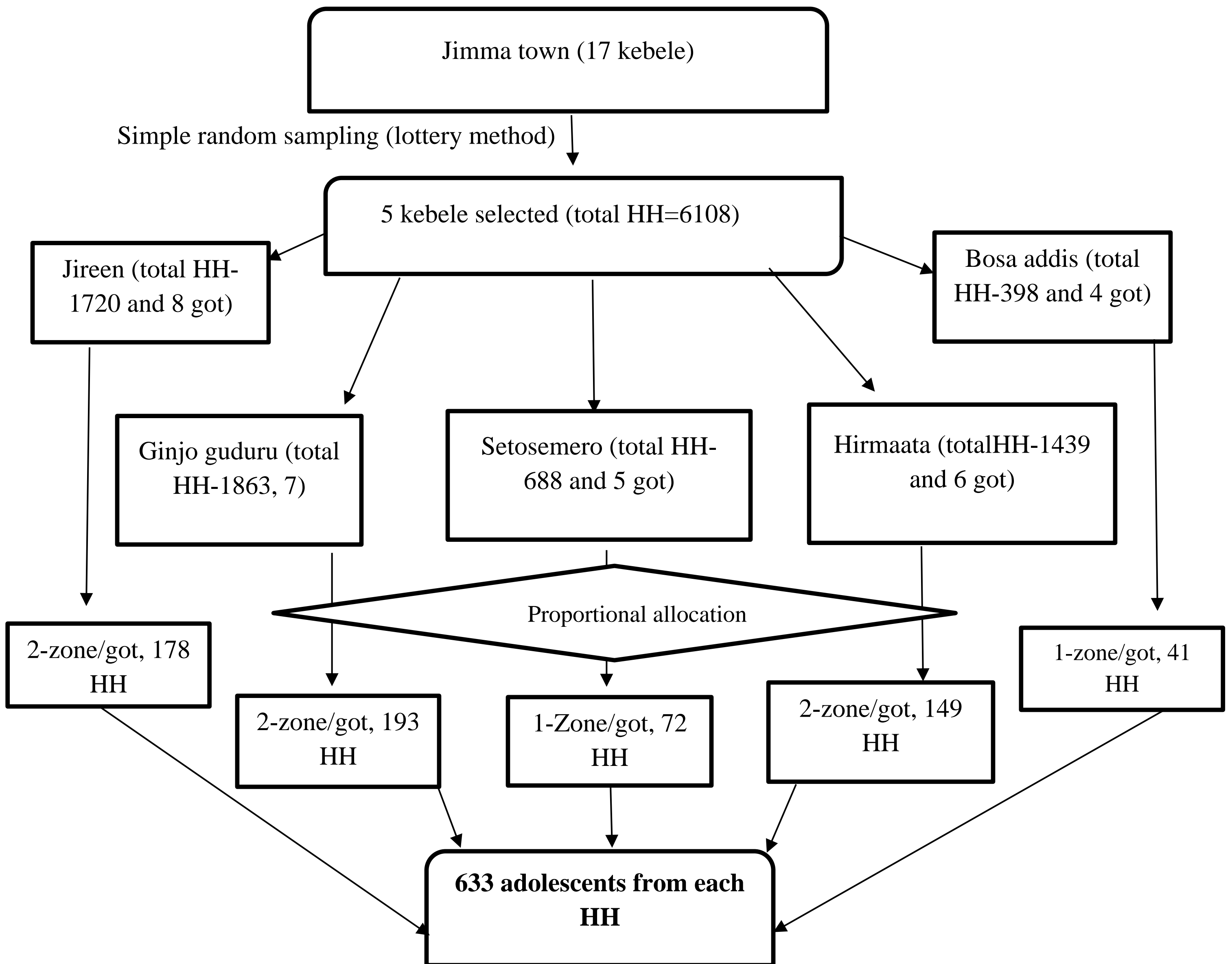

Figure 2. Schematic representation of sampling procedure

4.6. Variables of the Study

4.6.1. Dependent Variables

Suicidal behaviour

4.6.2. Independent Variables

Sociodemographic characteristics of Adolescents

- ✓ Sex
- ✓ Age in year
- ✓ Ethnicity
- ✓ Religion
- ✓ Child educational level
- ✓ Living circumstance

Sociodemographic characteristics of children's family.

- ✓ Parents status
- ✓ Family marital status
- ✓ Mother's educational level
- ✓ Father's educational level
- ✓ Family monthly income

Psychosocial factor

- ✓ Substance use (Khat, Alcohol, Tobacco, other)
- ✓ Social support
- ✓ Academic stress
- ✓ Depression

Childhood maltreatment

- ✓ Emotional abuse
- ✓ Physical abuse
- ✓ Sexual abuse

- ✓ Emotional neglect
- ✓ Physical neglect

4.7. Operational definitions

Adolescent: defined as individuals between 10 and 19 years of age (WHO).

Suicidal behaviour: individuals who scored ≥7 on SBQ-R labelled suicidal behavior, and below 7 as no suicidal behavior(67).

Childhood Emotional Abuse: measured using childhood trauma questionnaires with 5 items on a 5-point Likert scale with the value ranging from 5-25. A total cumulative score of 13 and higher (moderate to the extreme on the CTQ clinical scale) defined childhood emotional abuse(68).

Childhood emotional neglect: measured using childhood trauma questionnaires with 5 items on a 5-point Likert scale with the value ranging from 5-25. A total cumulative score of 15 and higher (moderate to the extreme on the CTQ clinical scale) defined childhood emotional neglect(68).

Childhood physical abuse: measured using childhood trauma questionnaires with 5 items on a 5-point Likert scale with the value ranging from 5-25. A total cumulative score of 10 and higher (moderate to the extreme on the CTQ clinical scale) defined childhood physical abuse(68).

Childhood physical neglect: measured using childhood trauma questionnaires with 5 items on a 5-point Likert scale with the value ranging from 5-25. A total cumulative score of 10 and higher (moderate to the extreme on the CTQ clinical scale) defined childhood physical neglect(68).

Childhood sexual abuse: measured using childhood trauma questionnaires with 5 items on a 5-point Likert scale with the value ranging from 5-25. A total cumulative score of 8 and higher (moderate to the extreme on the CTQ clinical scale) defined childhood sexual abuse(68).

Substance use risk: Current and ever substance uses were considered when participants had used at least one of the specified substances in the last 3 months and used at least one of the specified substances in a lifetime, respectively, by using the adopted alcohol, smoking, and substance involvement screening test (ASSIST).

Social support: Oslo's three-item social support scale was used to measure the student's social support. The total score is ranging from 3–14 which is categorized as 3–8, poor social support, 9–11, moderate social support and 12–14, strong social support(69).

4.8. Data collection procedure and instruments

4.8.1. Data Collection Instrument

SBQ-R

SBQ-R has 4 items, each tapping into a different dimension of suicidality, item one taps into lifetime suicide ideation or attempt, and item assesses the frequency of suicidal ideation over the past twelve months. Item three assesses the threat of suicide attempt and item four evaluates the self-reported likelihood of suicidal behaviour in the future. The total score should range from 3-18 with the cutoff score ≥7 for the general population(67). A validation study in Nigeria shows the Cronbach's alpha for the SBQ-R items was 0.80 with the optimal sensitivity (0.882) and specificity (0.875)(70). The internal consistency, Cronbach's alpha coefficient of SBQ-R in the current study was 0.84.

Oslo social support (OSS-3)

The OSS-3 provides a brief measure of social functioning and it is considered to be one of the best predictors of mental health. It covers different fields of social support by measuring the number of people the respondent feels close to, the interest and concern shown by others and the ease of obtaining practical help from others. Its structure and reliability (Cronbach's alpha of 0.60) have not been well-documented despite widespread use in several European countries. Nonetheless, its brevity and the availability of normative data are strong considerations. The OSS-3 scores ranged from 3-14 with a score of 3-8 = poor support; 9-11 = moderate support; and 12-14 = strong support(69). The internal consistency, Cronbach's alpha coefficient of OSS-3 in the current study was 0.81.

Childhood Trauma Questionnaire (CTQ)

The CTQ was developed by Bernstein and Fink in 1998. The CTQ is a self-reported inventory providing reliable and effective screening for a history of childhood neglect and abuse. It is suitable for adolescents (age 12 and over)(71). The self-report includes 28 items in which

participants are required to rate the frequency (0- never true to 5- very often true) o abuse and neglect events that they had experienced during their childhood(72). CTQ has a five subscale which measures five different types (emotional abuse, physical abuse, sexual abuse, emotional neglect and physical neglect) of maltreatment. Each subcategory of CTQ is measured using five items and the remaining three items minimization/denial scale. The scoring using childhood trauma questionnaires is a total cumulative score for each subscale calculated as a score of ≥13 childhood emotional abuse, a score of ≥15 childhood emotional neglect, a score of ≥10 childhood physical abuse, a score of ≥10 childhood physical neglect, and a score of ≥8 defined childhood sexual abuse. The reliability of the CTQ is good with high internal consistency scores. It has been shown that the CTQ can display test-retest reliabilities between 0.79 and 0.86 and internal consistency reliability ranging from 0.66 to 0.92(72). The childhood trauma questionnaire (CTQ) is not validated in Ethiopia. However, it was validated in various African countries, for instance, in Cal agar, Nigeria CTQ has been validated among adolescents and the result showed that Cronbach alpha for the scale was 0.80. Internal consistency for the subscales was 0.69 for emotional abuse, 0.60 for physical abuse, 0.60 for sexual abuse, 0.79 for emotional neglect and 0.21 for physical neglect. (73). The internal consistency, Cronbach's alpha coefficient of CTQ in the current study was Emotional abuse (0.83), Emotional neglect (0.9), Physical abuse (0.89), Physical neglect (0.85) and Sexual abuse (0.96).

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ-S)

The SDQ has been designed to meet the needs of researchers, clinicians, and educationalists. The 25 SDQ items are divided into 5 scales of 5 items each, as shown below: Hyperactivity Scale, Emotional Symptoms Scale, Conduct Problems Scale, Peer Problems Scale, and Prosocial Scale(74). Each item has to be scored on a 3-point scale with 0 = 'not true', 1 = 'somewhat true', and 2 = 'certainly true'. Subscale scores can be computed by summing scores on relevant items (after recoding reversed items; range 0–10). Higher scores on the prosocial behaviour subscale reflect strengths, whereas higher scores on the other four subscales reflect difficulties. A total difficulties score can also be calculated by summing the scores on the emotional symptoms, conduct problems, hyperactivity-inattention, and peer problems subscales (range 0–40)(75). The Strengths and Difficulties Questionnaire (SDQ) is a measure of mental health problems in children

aged 4–17 which can be administered to parents, teachers and young people aged 11 or over(76). Although SDQ scores can be convenient to categorize scores as 'normal', 'borderline' and 'abnormal'. The Self-Completed SDQ total difficulty score is normal 0-15, borderline 16-19, and abnormal 20-40(77). The parent version was validated in our country, but not the self-completed SDQ-S version which was validated in Ghana Cronbach's alpha was 0.72 with the above cutoff score(78). The internal consistency, Cronbach's alpha coefficient of SDQ-S in the current study was 0.85.

STUDENT STRESS INVENTORY (SSI)

The Student Stress Inventory (SSI) was developed to measure the level of stress among university students. SSI contained 40 negative items to measure 4 subscales (10 items for each subscale) which are subscale 1: Physical (10 items), subscale 2: Interpersonal relationship (10 items), subscale 3: Academic (10 items) and subscale 4: Environmental factor (10 items). As for scoring, the SSI was designed with the ordinal scale of 'Never', 'Somewhat frequent', 'Frequent' and 'Always'. The value mark given for each choice is 1 for 'Never', 2 for 'Somewhat Frequent', 3 for 'Frequent' and 4 for 'Always'. The validity for all four subscales was also accepted by the experts. Thus, the SSI content validity was high. The values of Cronbach's alpha for all the scales in this inventory where most of the expertise showed acceptable consistency as they were greater than 0.7. The scoring for this subscale is severe (8-10), moderate(4-7), and mild(1-3)(79). The internal consistency, Cronbach's alpha coefficient of SSI in the current study was 0.78.

PHQ-9-A

PHQ-9 modified for adolescent will be used to screen or assess depression among adolescents. PHQ-9 score ≥10 had a good sensitivity and specificity(14). The cut-off score allows consistency in diagnosing depression with the Diagnostic Statistical Manual (DSM-V) criteria for major depression. The internal consistency, Cronbach's alpha coefficient in the current study was (α = 0.84).

4.8.2. Data Collection Procedure

The data was collected through an interviewer-administered structured questionnaire, through a face-to-face interview to assess socio-demographic, substance use, psychosocial factors, childhood

maltreatment-related factor, depression, academic-related factor and suicidal behaviour. Two data collectors (2 BSc Psychiatry) were employed for one-month data collection periods and supervised by two supervisors (MSc Psychiatry). The training was given for one day regarding the administration protocol of the data collection procedures for the data collectors by the main investigator.

4.9. Data quality control

The data quality was assured by training the data collectors by observing closely the data collection process and by checking that each questionnaire is complete and coherent at the end of the data collection. The questionnaire was pre-tested on 5% (31 adolescents) of the sample size out of the study area (in Bossa kito) to ensure its validity. The main survey was not containing the results of the pre-test. Based on the pre-test findings, questionnaires were updated and the time required for an interview was also decided.

4.10. Data processing and analysis

The collected data was checked for its completeness before entry into the computer. Then, data were cleaned and edited then entered into Epidata version 4.6 and then exported to SPSS window version 26 for analysis. Descriptive statistics were presented in frequency, tables, texts, and summary measures. Bivariate and multivariate analysis was done to see the association between each independent variable and outcome variable by using binary logistic regression. The goodness of fit was checked by the Hosmer-Lemeshow statistic at a *P*-value of greater than 0.05. All variables with $P<0.25$ in the bivariate analysis were included in the final model of multivariate analysis to control all possible confounders. The statistical association was measured by Adjusted odds ratio along with 95% CI was estimated to identify the associated factors with suicidal behavior by using multivariate analysis in binary logistic regression. In this study, a P-value<0.05 was considered statistically significant.

4.11. Ethical consideration

The ethical clearance was obtained from Jimma University institutional review board (IRB) with the Ref. Number-**JUIH/IRB/64/22** before the actual data collection and permission letter was obtained from both department and Jimma town health bureau. The objective and purpose of the study were verified briefly for the study participants and confidentiality was assured. Finally,

consent was obtained from the study participants and assent from the family before conducting the interview. The right was given to the study participants to refuse or discontinue participation at any time they want and the chance to ask anything about the study. All protection measurements for COVID-19 were taken. To ensure privacy, study respondents were far apart or alone, so that they could complete their questionnaires without being overlooked by significant other. In some instance we breach the confidentiality for the sake of the participant and also, we linked to psychiatric clinic those who are at risk.

4.12. Dissemination of the finding

The finding of the study will be disseminated to all relevant stakeholders through Presentation and publication in National or international peer-reviewed journals. Copies of the research were submitted to the psychiatry department, Jimma university research and dissemination office, and also the final report will be communicated with Jimma town health bureau and other concerned institutions and stakeholders for possible applications of the study findings.

CHAPTER FIVE-RESULT

5.1. Sociodemographic related factors

Among a total of the 633 sampled participants, 628(99.2%) participants completed our questionnaire. The remaining 5 participants did not respond to all of the questions and were, therefore, excluded from the analysis. From the total sampled participants, 307(48.9%) were male and 321(51.1%) were female with the mean age of the participants being 15.8 (SD=±2.2) years. Of the study participants nearly half of their family, 285(45.4%) were married.

More than three-fourths of 518 (82.5%) participants were living with their families. Majority 455 (72.5%) of study participants live with parent who are above poverty line (with an average monthly income greater than 3418.5ETB) based on World bank poverty line cut point <2.15/day. One fifth of the participants (20.7%) have family history of suicide.

Table 1. Sociodemographic characteristics of adolescents in Jimma town, Southwest Ethiopia, 2022 (N=628).

Variable	*Category*	*Frequency (n)*	*Percentage (%)*
Sex	1. Male	307	48.9
	2. Female	321	51.1
Age	1. 10-13	94	15.0
	2. 14-16	245	39.0
	3. 17-19	289	46.0
Religion	1. Orthodox	192	30.6
	2. Muslim	259	41.2
	3. Protestant	156	24.8
	4. Other	21	3.3
Ethnicity	1. Oromo	233	37.1
	2. Amhara	101	16.1
	3. Kafa	125	19.9
	4. Dawro	114	18.2
	5. Others	55	8.8

Educational level	1. No formal education	21	3.3
	2. Primary school	318	50.6
	3. Secondary school and above	289	46.0
Current parents' status	1. Both alive	389	61.9
	2. Only mother alive	138	22.0
	3. Only father alive	85	13.5
	4. Both deceased	16	2.5
Living status	1. With my family	518	82.5
	2. Alone	24	3.8
	3. Other	86	13.7
Occupation of father	1. Government employee	301	47.9
	2. Non-government employee	106	16.9
	3. Merchant	116	18.5
	4. Daily laborer	38	6.1
	5. Unemployed	24	3.8
	6. Other	43	6.8
Occupation of mother	1. Government employee	254	40.4
	2. Non-government employee	64	10.2
	3. Merchant	132	21.0
	4. Daily laborer	20	3.2
	5. Unemployed	53	8.4
	6. Other	105	16.7
Educational status of the father	1. No formal education	52	8.3
	2. Primary level	94	15.0
	3. Secondary level	142	22.6
	4. More than secondary	340	54.1
Educational status of the mother	1. No formal education	72	11.5
	2. Primary level	177	28.2
	3. Secondary level	90	14.3

	4. More than secondary	289	46.0
Parents marital status	1. Married	285	45.4
	2. Single	44	7.0
	3. Divorced	68	10.8
	4. Widowed	145	23.1
	5. Separated	86	13.7
*Average family income**	1. Above poverty line	455	72.5
	2. Below poverty line	173	27.5
Family history of suicide	No	498	79.3
	Yes	130	20.7

Notes: Other religions: Catholic, Wakefata and Adventist. Other occupations: Private work, another living status: Grand family, Uncle, Aunt etc., another ethnicity: Tigray, Yem, Gurage etc.

*Based on the World Bank poverty line cut point

5.2. Psychosocial and substance-related factors of the participants

Nearly three forth of the participants (74.4%) have used khat in their life time and with around one fourth of them current used khat. Nearly half of the participants (47.5%) had borderline psychosocial problems with one fourth (22.3%) of the participants having abnormal psychosocial problems. Nearly one-third (26.6%) of the participants had poor social support. In addition to this majority (88.2%) of the participants are active student, with around one-fifth (19.3%) of them had severe academic stress.

Table 2. Psychosocial and substance-related factors characteristics of adolescents in Jimma town, Southwest Ethiopia, 2022 (N=628)

Variable	*Category*	*Frequency*	*Percentage (%)*
Ever(lifetime) use of Khat	0. No	161	25.6
	1. Yes	467	74.4
Ever(lifetime) use of tobacco	0. No	547	87.1
	1. Yes	81	12.9
Ever(lifetime) use of alcohol	0. No	496	79.0
	1. Yes	132	21.0

*Other **	0. No	536	85.4
	1. Yes	92	14.6
Current use of khat	0. No	502	79.9
	1. Yes	126	20.1
Current use of tobacco	0. No	567	90.3
	1. Yes	61	9.7
Current use of alcohol	0. No	530	84.4
	1. Yes	98	15.6
*Other **	0. No	558	88.9
	1. Yes	70	11.1
Psychosocial problems	1. Normal	190	30.3
	2. Borderline	298	47.5
	3. Abnormal	140	22.3
Social support	1. Poor social support	167	26.6
	2. Moderate social support	280	44.6
	3. Strong social support	181	28.8
Are you currently an active student	1. Yes	554	88.2
	2. No	74	11.8
Academic stress	1. Mild	134	21.3
	2. Moderate	299	47.6
	3. Severe	121	19.3
Depression	1. No	428	68.2
	2. Yes	200	31.8

Other: Ganja, cannabis or cocaine and more than one substance

5.3. Childhood maltreatment-related factor

The majority of respondents in our study had a history of childhood maltreatment, with roughly one-fifth having experienced emotional abuse (21.5%), the majority having experienced emotional

neglect (72.3%), roughly more than one-third having experienced physical abuse (37.1%) and physical neglect (36.6%), respectively, and less than one-fifth having experienced sexual abuse (15.4%).

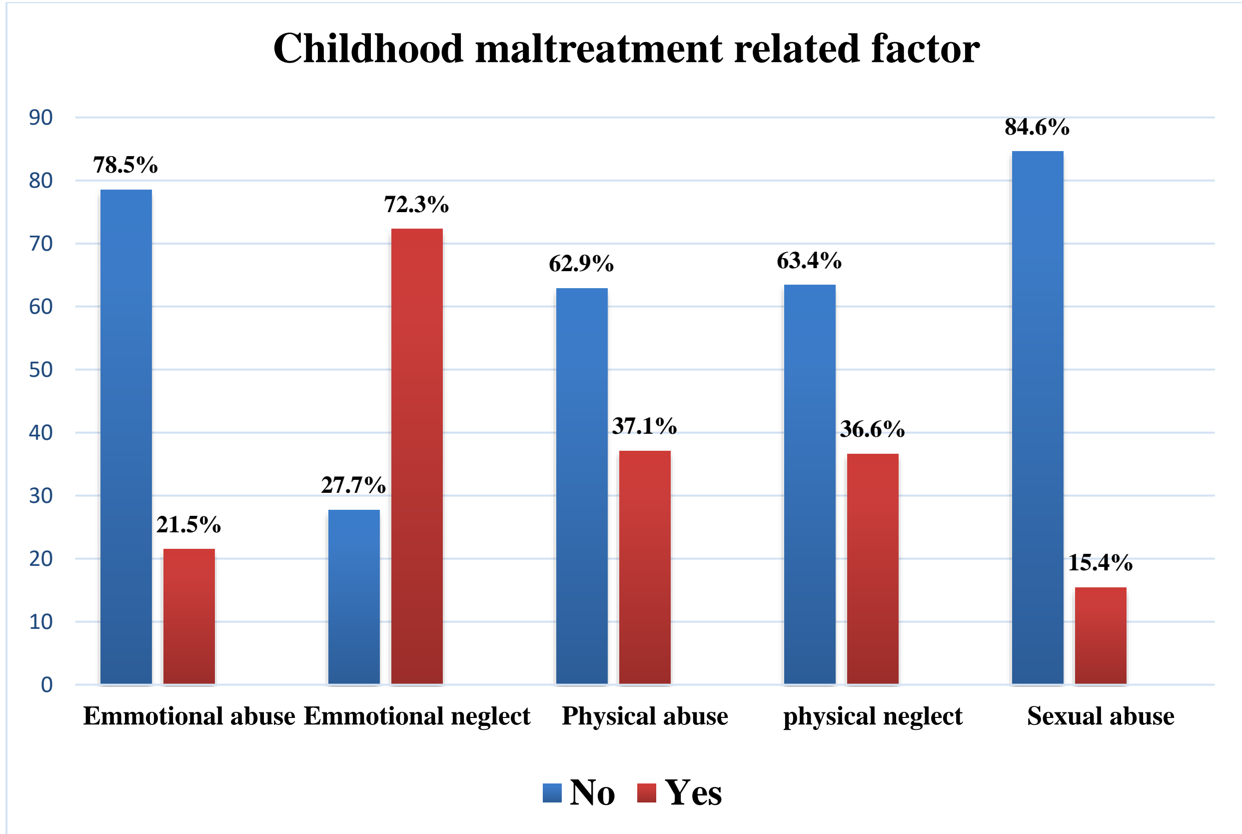

Figure 3. Childhood maltreatment-related factor characteristics of adolescents in Jimma town, Southwest Ethiopia, 2022 (N=628).

5.4. Prevalence of suicidal behavior.

The overall prevalence of suicidal behaviour in this study was 230(36.62%) with 95% CI (32.8, 40.5).

Figure 4. Prevalence of suicidal behavior among adolescents in Jimma town, southwest Ethiopia, 2022.

5.5. Factors associated with suicidal behavior

Bivariate logistic regression analysis

Bivariate logistic regression analysis was used to examine association between independent and dependent variables. Hence, being female, age (17-19), family income, family history of suicide, emotional abuse, emotional neglect, physical abuse, physical neglect, sexual abuse, current khat use and current use of alcohol, social support and depression was found to be associated with suicidal behaviour and entered into multivariate analysis (Table 3 and 4).

Table 3. Bivariate analysis of Socio-demographic characteristics of adolescents in Jimma town, Southwest Ethiopia, 2022 (N=628).

Variables	*category*	*Suicidal behavior*		*COR & 95%CI*	*P-value*
		Yes	**No**		
Sex	Male	94(36.6%)	213(63.4%)	1	
	Female	136(42.4%)	185(57.6%)	1.67(1.19, 2.31)	0.002*
Age	10-13	30(31.9%)	64(68.1%)	1	
	14-16	63(25.7%)	182(74.3%)	.74(0.44, 1.24)	0.25

	17-19	137(47.4%)	152(52.6%)	1.92(1.18, 3.14)	0.009*
Educational level	No formal education	9(42.9%)	12(57.1%)	1.2(0.5, 2.9)	0.66
	Primary school	111(34.9%)	207(65.1%)	0.87(0.63, 1.22)	0.42
	Secondary school and above	110(38.1%)	179(61.9%)	1	
Currently, your parents living status?	Both alive	149(36.7%)	257(63.3%)	1	
	Only mother alive	35(31.2%)	77(68.2%)	.78(0.5, 1.22)	0.29
	Only father alive	38(40.4%)	56(59.6%)	1.2(0.7, 1.9)	0.5
	Both deceased	8(50%)	8(50%)	1.7(0.63, 4.7)	0.28
With whom you are living now	With my family	194(37.2%)	328(62.8%)	1	
	Alone	9(42.9%)	12(57.1%)	1.3(0.53, 3.1)	0.59
	Other	27(31.8%)	58(68.2%)	.79(0.48, 1.3)	0.34
Occupation of father	Government employee	103(34.2%)	198(65.8%)	1	
	Non-government employee	42(39.6%)	64(60.4%)	1.26(0.8, 1.9)	0.32
	Merchant	46(39.7%)	70(60.3%)	1.26(0.8, 1.9)	0.3
	Daily laborer	11(28.9%)	27(71.1%)	.8(0.4, 1.6)	0.52
	Unemployed	10(41.7%)	14(58.3%)	1.37(0.59, 3.2)	0.46
	Other	18(41.9%)	25(58.1%)	1.38(0.72, 2.7)	0.33
Occupation of mother	Government employee	89(35%)	165(65%)	1	
	Non-government employee	18(28.1%)	46(71.9%)	.73(0.39, 1.33)	0.29
	Merchant	53(40.1%)	79(59.9%)	1.2(0.81, 1.92)	0.32
	Daily labourer	9(45%)	11(55%)	1.5(0.61, 3.8)	0.37
	Unemployed	23(43.4%)	30(56.6%)	1.4(0.78, 2.59)	0.25
	Other	38(36.2%)	67(63.8%)	1.1(0.65, 1.68)	0.84

Educational status of the father	No formal education	21(40.4%)	31(59.6%)	1.16(0.64, 2.15)	0.61
	Primary level	39(41.5)	55(58.5%)	1.2(0.77, 1.94)	0.40
	Secondary level	45(31.7%)	97(68.3%)	.78(0.53, 1.21)	0.28
	More than secondary	125(36.8%)	215(63.2%)	1	
Educational status of the mother	No formal education	31(43.1%)	41(56.9%)	1.3(0.77, 2.21)	0.32
	Primary level	56(31.6%)	121(68.4%)	.79(0.54, 1.19)	0.27
	Secondary level	37(41.1%)	53(58.9%)	1.2(0.74, 1.95)	0.45
	More than secondary	106(36.7%)	183(63.3%)	1	
Parents marital status	Married	102(37.8%)	183(64.2%)	1	
	Single	13(29.5%)	31(70.5%)	.75(0.38, 1.50)	0.42
	Divorced	26(38.2%)	42(61.8%)	1.1(0.64, 1.91)	0.71
	Widowed	60(41.4%)	85(58.6%)	1.3(0.84, 1.91)	0.26
	Separated	29(33.7%)	57(66.3%)	.91(0.55, 1.52)	0.73
Average family income	Above poverty line	160(35.2%)	295(64.8%)	1	
	Below poverty line	70(40.5%)	103(59.5%)	1.3(0.88, 1.79)	0.219*
Family history of suicide	No	170(34.1%)	328(65.9%)	1	
	Yes	60(46.2%)	70(53.8%)	1.65(1.1, 2.4)	0.012*

* Factors that have an association at p-value <0.25; 1= reference category

Table 4. Bivariate analysis of Psychosocial and childhood maltreatment-related factors among adolescents in Jimma town, southwest Ethiopia, 2022 (N=628)

Variables	***category***	***Suicidal behavior***		***COR & 95%CI***	***P-value***
		Yes	**No**		
Emotional abuse	Yes	57(42.2%)	78(57.8%)	1.4(0.92, 1.99)	0.128*
	No	173(35.1%)	320(64.9%)	1	
	Yes	173(38.1%)	281(61.9%)	1.3(0.87, 1.83)	0.214*

Emotional neglect	No	57(32.8%)	117(67.2%)	1	
Physical abuse	Yes	100(42.9%)	133(57.1%)	1.5(1.09, 2.14)	0.012*
	No	130(32.9%)	265(67.1%)	1	
Physical neglect	Yes	100(43.5%)	130(56.5%)	1.6(1.13, 2.21)	0.007*
	No	130(32.7%)	268(67.3%)	1	
Sexual abuse	Yes	50(51.5%)	47(48.5%)	2.1(1.34, 3.21)	0.001*
	No	180(33.9%)	351(66.1%)	1	
Ever(lifetime) use of Khat	No	165(35.3%)	302(64.7%)	1	
	Yes	65(40.4%)	96(59.6%)	1.2(0.85, 1.79)	0.253
Ever(lifetime) use of tobacco	No	198(36.2%)	349(63.8%)	1	
	Yes	32(39.5%)	49(60.5%)	1.2(0.71, 1.85)	0.564
Ever(lifetime) use of alcohol	No	184(37.1%)	312(62.9%)	1	
	Yes	46(34.8%)	86(65.2%)	0.9(0.61, 1.35)	0.634
*Other **	No	201(37.5%)	335(62.5%)	1	
	Yes	29(31.5%)	63(68.5%)	0.8(0.47, 1.23)	0.272
Current use of khat	No	176(35.1%)	326(64.9%)	1	
	Yes	54(42.9%)	72(57.1%)	1.4(0.93, 2.07)	0.105*
Current use of tobacco	No	207(36.5%)	360(63.5%)	1	
	Yes	23(37.7%)	38(62.3%)	1.1(0.61, 1.81)	0.854
Current use of alcohol	No	188(35.5%)	342(64.5%)	1	
	Yes	42(42.9%)	56(57.1%)	1.4(.88, 2.11)	0.164*
*Other **	No	208(37.3%)	350(62.7%)	1	
	Yes	22(31.4%)	48(68.6%)	0.77(0.45, 1.31)	0.339
Psychosocial problems	Normal	69(36.3%)	121(63.7%)	1	
	Borderline	108(36.2%)	190(63.8%)	.99(0.68, 1.45)	0.99
	Abnormal	53(37.9%)	87(62.1%)	1.1(0.68, 1.68)	0.77
Social support	Poor social support	71(42.5%)	96(57.5%)	1.35(0.877, 2.08)	0.172*
	Moderate social support	95(33.9%)	185(66.1%)	0.93(0.63, 1.39)	0.752

	Strong social support	64(35.4%)	117(64.6%)	1	
Are you currently an active student	Yes	204(36.8%)	350(63.2%)	1	
	No	26(35.1%)	48(64.9%)	1.1(0.65, 1.78)	0.777
Academic stress	Mild	49(36.6%)	85(63.4%)	1	
	Moderate	103(34.4%)	196(65.6%)	0.91(0.59, 1.39)	0.669
	Severe	52(43%)	69(57%)	1.3(0.79, 2.16)	0.297
Depression	No	148(34.6%)	280(65.4%)	1	
	Yes	82(41%)	118(59%)	1.3(0.93, 1.85)	0.120*

* Factors that have an association at p-value <0.25 1= reference category

Multivariate logistic regression analysis

Variables associated with suicidal behavior on bivariate analysis were checked for multicollinearity before the final model, and all the candidates for the final models had Variance Inflation Factor (VIF) less than 1.2 and a tolerance of greater than 0.87. Therefore, there was no problem with multicollinearity. Multivariate logistic regression analyses have revealed that being female, age (17-19 or late adolescent), family history of suicide, physical abuse, physical neglect, sexual abuse, and current khat use were significantly associated with suicidal behavior.

The finding from this study shows that those adolescents who are females compared to males had 1.5 times experienced suicidal behaviour with (AOR=1.5; 95%CI: (1.07, 2.17)). The study also reveals that those whose age category is between 17-19 are 2.2 times more affected than those whose age category is between ages 10-13 with (AOR=2.2; 95%CI: (1.31, 3.72)) and having family history of suicide were also significant predictor of suicidal behavior (AOR=1.9; 95%CI: (1.27, 2.96)) than those who do not have family history of suicide.

Additionally, those adolescents who experience physical abuse were 1.7 times more likely to have suicidal behavior (AOR=1.7; 95%CI: (1.23, 2.59)) than those who do not experience physical. Similarly, those adolescents who have been experiencing physical neglect were 1.7 times more likely to have suicidal behavior (AOR=1.7; 95%CI: (1.23, 2.53)) than those who hadn't physical neglect.

In addition, the odds of having suicidal behavior were 1.6 times higher (AOR=1.6; 95%CI: (1.02, 2.58)) among adolescents who have experienced sexual abuse as compared with those who didn't experience the sexual abuse. Adolescents who report current use of khat were about 1.7-fold more likely to have suicidal behavior (AOR=1.7; 95%CI: (1.08 2.65)) than non-users.

Table 5. Multivariate logistic regression analysis of factors associated with suicidal behavior among adolescents in Jimma town, southwest Ethiopia, 2022 (N=628).

Variables	***Category***	***Suicidal behavior***		***COR & 95%CI***	***AOR & 95CI***	***P/value***
		Yes	**No**			
Sex	Male	94(36.6%)	213(63.4%)	1	1	
	Female	136(42.4%)	185(57.6%)	1.67(1.19, 2.31)	1.5(1.07, 2.17)	0.02*
Age	1. 10-13	30(31.9%)	64(68.1%)	1	1	
	2. 14-16	63(25.7%)	182(74.3%)	0.74(0.44, 1.24)	0.8(0.49, 1.45)	0.546
	3. 17-19	137(47.4%)	152(52.6%)	1.92(1.18, 3.14)	2.2(1.31, 3.72)	0.003*
Family history of suicide	1. No	170(34.1%)	328(65.9%)	1	1	
	2. Yes	60(46.2%)	70(53.8%)	1.65(1.1, 2.4)	1.9(1.27, 2.96)	0.002*
Physical abuse	Yes	100(42.9%)	133(57.1%)	1.53(1.09, 2.14)	1.7(1.23, 2.59)	0.002*
	No	130(32.9%)	265(67.1%)	1	1	
Physical neglect	Yes	100(43.5%)	130(56.5%)	1.59(1.13, 2.21)	1.7(1.23, 2.53)	0.002*
	No	130(32.7%)	268(67.3%)	1	1	
Sexual abuse	Yes	50(51.5%)	47(48.5%)	2.07(1.34, 3.21)	1.6(1.02, 2.58)	0.039*
	No	180(33.9%)	351(66.1%)	1	1	
Current use of khat	No	176(35.1%)	326(64.9%)	1	1	
	Yes	54(42.9%)	72(57.1%)	1.39(0.93, 2.07)	1.7(1.08, 2.65)	0.019*

*Variables with significant association at P-value <0.05, 1= reference category

CHAPTER SIX-DISCUSSION

The overall prevalence of suicidal behavior among adolescents in the current study is found to be 36.6%. This finding is comparable with those studies done among school adolescents in Dangla which accounts for 38.7% (45) and 34.7% among Chinese children and adolescents(80).

However, the findings of the current study is higher than those studies conducted among US adolescents 20.2%(81), Spain 17.1%(82), Uganda 23.5%(83), and Germany 19.1%(84). The disparity might be explained by the fact that developed countries have easy access to advanced health safety training, as well as a superior socioeconomic position and high-quality health care, which poor countries lack(85),(86).

Another piece of evidence is that most governments in developing countries have been unable to deal with the suicide problem, instead depending largely on non-governmental groups(87). However, the developed country invests a lot on public education and awareness creation to control the problem of suicide in adolescents(88).

The prevalence in our study is lower than in a study done in Poland 44.6%(50) and Ghana 52.4%(89,90). The discrepancy is most likely due to changes in the study setting, the instrument used, sociocultural differences, and the overall sample size, which was larger than the total sample size we employed.

In our study being female is associated with suicidal behavior. This finding is consistent with other studies from Gondar, Ethiopia(91), Nigeria(44), Malaysia(40), India(92), Nepal(93), and German(94). One probable explanation is that female are more exposed to sexual abuse(95), and those who experienced suicidal behavior have high serum progesterone concentration of the patients than the others(96). Girls are more sensitive to interpersonal interactions, such as those with friends and family, than boys. They are also more prone than males to mask unpleasant feelings(97).

This study also revealed that those adolescents' mainly older adolescents between the ages of seventeen to nineteen were more likely to experience suicidal behavior than younger adolescent. This is consistent with the study done in South Africa(53), Swaziland(98), German(84), USA(81),

Australia(99,100) Philippines(101), Republic of Korea(102), and England(103). Interpersonal issues such as (trouble establishing new friends, frequent disputes with people in authority and peers, frequent harshness toward peers, loneliness, and interpersonal isolation) in late adolescence might be the probable clarification(104).

In this study having a family history of suicide was significantly associated with adolescent suicidal behavior than those who do not have the same experience. This result was congruent with the study conducted in Germany(105), USA(48) (47)(106), China(49) and Togo(52). The possible explanation for the association might be due to influenced primarily by genetic (a propensity to react with aggression or hostility when frustrated). And also by shared environmental factors such as social learning of inadequate handling or direct role modelling or imitation of self-destructive behaviors(107).

Our findings show that adolescents who experience physical abuse were associated with suicidal behaviour as compared to those who don't experience physical abuse. This finding were in line with study done in Dangla, Ethiopia(45), Liberia(41), Malaysia(40), Ghana(89), USA(108–110) China(80,111) Canada(112). This connection might be described as maltreated youngsters having the insufficient ability to cope with stress or incorrect adaptation(113). Another possibility is that persons who have been subjected to physical violence may attempt suicide to avoid more physical abuse or harm(114).

This study also revealed that physical neglect was associated with suicidal behaviour more than those adolescents who are not physically neglected. The finding was congruent with a study done in, China(113,115,116). This might be due to thwarted belongingness, which is unfulfilled need for social connectivity with others, or perceived burdensomeness, in which the sensation that one's presence is burdensome to society or loved ones(117).

In our study, there is an association between sexual abuse and suicide that shows those adolescents who experience sexual abuse are associated with suicidal behaviour. This finding is consistent with the study done in Uganda (83), the USA (110,118,119) Jamaica (120), India (58), China (80,113,115,116), and Iran(121). The likely explanation for the association could be due to interpersonal-psychological components of suicide, in which an individual acquires the capability

for suicide by becoming habituated to pain and fear as a result of repeated exposure to the abuse, which indirectly facilitates the capability for suicide(117). The second description could be due to people who suffer sexual abuse being more prone to dissociate, which is associated with self-harm, suicide thoughts(122).

In the current study, the current use of Khat was an independent predictor of suicidal behavior and this is consistent with the study done in Gondar, Ethiopia(123), and Jimma, Ethiopia(124). The most likely reason might be that khat chewing was linked to mental suffering(125). On the other side, adolescents become khat addicts to receive relief from symptoms such as stress.

Limitations of the study

The following are some of the study's potential limitations that should be considered when interpreting the results; the study design was also prone to recall bias and underreporting on variables like substance use are possible limitation of the study (social desirability bias). It can lead to unrepresentative samples because large sections of populations may not be selected for sampling, leading to under coverage bias, which lead to the inferences about the entire population would be biased as well. Generally, the samples drawn using the cluster method are prone to higher sampling error than using simple random sampling method.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATION

7.1. CONCLUSION

The prevalence of suicidal behavior and its related factors among adolescents in Jimma town is high. Contributing factors to suicidal behavior include being female, being a late adolescent, family history of suicide, having childhood maltreatment such as physical abuse, physical neglect, sexual abuse, and current khat use.

7.2. RECOMMENDATION

For Jimma town administration and city health bureau

- Train community in mental health first-aid principles in collaboration with significant organizations (e.g., Jimma university), along with safe communication techniques which promote open dialogues among all members of the community.
- The Town Health Bureau may organize events to establish mental health resource centers in the community where adolescents can receive free counseling and other resources to help manage their mental health and cope with difficulties in life.
- The Town Health Bureau should create outreach community health education programs that teach parents, teachers, and community members how to recognize signs of suicidal behavior in adolescents and how to address them properly.
- Provide access to suicide hotlines and crisis supports, so that adolescents' attempts at self-harm are treated quickly.

Ministry of Health

- The ministry of health should give ample attention to the high level of suicidal behaviour among adolescents in Ethiopia; therefore, they should develop policies and guidelines to address these concerns.
- The Ministry of Health should strive to ensure that mental health care is widely available and easily accessible to adolescents.
- The Ministry of Health should establish crisis intervention services, such as suicide hotlines and youth centers, at the country level.

- Policies should prioritize efforts to improve early detection and intervention, with more emphasis placed on early detection and assessment of suicidal behaviour among adolescents.
- Community programs should include screenings as well as educational campaigns designed to help identify at-risk individuals and refer them for professional treatments or support services.
- The ministry should collaborate with schools, communities' organizations, and healthcare providers to promote awareness of the signs and symptoms associated with suicidal behaviors among adolescents.
- Promote peer-to-peer support programs and community engagement activities.
- Collaborate with mass media agencies to develop responsible media reporting.

For future researchers

- A longitudinal study is required to investigate the cause-effect relationship between risk factors.
- Long-term studies that assess trends in suicidal behavior over time may provide further understanding of why rates differ across different age groups and genders and identify effective preventive strategies.
- In addition, greater attention should be paid to exploring protective factors – those characteristics or resources associated with decreased risks of suicidal behaviors.

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ANNEXES

Annex 1: English version consent form and agreement form

Parent Assent Letter

Dear Parent or Caregiver:

This letter provides information about a research study that will be conducted in Jimma town by an investigator from Jimma University. The study will examine adolescents aged 10-19 in Jimma town to assess the magnitude of suicidal behaviour and its associated factors.

I'm Tadese Teferi currently doing master's degree in Integrated Clinical and Community Mental health at Jimma University. I'm planning the study in cooperation with Jimma town administration to ensure the study provides information that will be helpful to the town. This study is being conducted in partial fulfilment of the requirements for masters of science in integrated clinical and community mental health and it's titled ***"Magnitude of suicidal behaviour and associated factor among adolescents aged in Jimma town."***

Why Your Child Should Participate:

There is a great need for educators and researchers to understand the suicidal behaviour and its associated factors among adolescents. The information that will be collected from your child may help to increase our overall knowledge about the suicidal behaviour and its associated factors among adolescents.

Please Note: Your decision to allow your child to participate in this research study must be completely voluntary. You are free to allow your child to participate in this study or to withdraw him or her at any time. You or your child's decision to participate, not to participate, or to withdraw participation at any point during the study will in no way affect your child

Confidentiality of Your Child's Responses: Your child's privacy and research records will be kept confidential to the extent of the law. Your child's completed surveys will be assigned a code number to protect the confidentiality of his or her responses. Please note that your child's specific responses on the surveys will not be shared with others.

What will be done With Your Child's Responses:

The information from this study is used to inform educators, psychologists and psychiatrists about the magnitude of the suicidal behaviour and its associated factors among adolescents aged 10-19 years. The results of this study may be published; however, the data obtained from your child will be combined with data from other people in the publication. The published results will not include your child's name or any other information that would in any way personally identify your child. If you have any questions about this research study, please contact me (Mr Tadese Teferi) at +251970299413/(tadeseteferi19@gmail.com) or my advisors Dr Mubarek Abera at +25918968803/(abmubarek@gmail.com), Sr.Workinesh Tesema +251911740105/ (fitsumbeselot@gmail.com) or Dr Elias Tesfaye +251902644898/(elias.tesfaye2@gmail.com).

Assent for a child to take part in this research study

I freely give my permission to let my child take part in this study. I understand that this is research. I received a copy of this letter and the consent form for my records.

Age of child________________________________ Date

Name of parent_____________________________

Signature of parent__________________________

Statement of Person Obtaining Informed Consent

I certify that participants have been provided with an informed consent form that has been approved by the Jimma University Institutional Review Board and that explains the nature, demands, risks, and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions.

_______________________ ____________________ _________________

Signature of person obtaining consent | Name of person obtaining consent | Date

Informed assent /Consent agreement

Dear participant:

Today you will be asked to take part in a research study titled, *"Magnitude of suicidal behaviour and associated factor among adolescent in Jimma town."* You will be asked to complete questionaries' that inquire about different information like demographic information, questions to assess health related factors**,** psychosocial factor, suicidal behaviour and substance use history. Completing these questionaries will take you approximately 20-30 minutes. You are being asked to participate in this study because you are in a stage of adolescents. Your parent or guardian has already permitted you to take part in this study.

Even though your family permitted you to take part in the process you have the right to ask about what is going on, why you give the information and you can ask the collector about anything you want and in this process your answers will be kept confidential to the extent of the law.

You are free to stop or withdraw from participating from the interview at any time between continued interview if you want, and you will not be penalized for such kind of decision you will make and no one means either family or interviewer have the right to ask you why you decide in such away they want.

I understand what participating in this study requires.

_______________________________ ____________

Signature of adolescent date

_______________________________ ________________________________ ___________

Signature of the person obtaining assent printed name of person obtaining assent date

Annex: 2 English version questionnaires

Part I: Socio-Demographic and family-related factors			
S/N	Questions	Response	Remark
101	Sex	1. Male 2. Female	
102	Age	1.10-13 2.14-16 3.17-19	
103	Religion	1. Orthodox 3. Protestant 2. Muslim 4. Other	
104	Ethnicity	1. Oromo 3, Kafa 4, Dawro 2. Amhara 5, Others	
105	Education level	1. No formal education 2. Primary school 3. Secondary school and above	
106	Currently, your parents are	1. Both alive 2. Only mother alive 3. Only father alive 4. Both deceased	
107	With whom you are living now?	1. With my family 2. Alone 3. Other	
108	Occupation of father	1. Government employee 2. Non-government employee 3. Merchant 4. Daily laborer	

		5. Unemployed 6. Other	
109	Occupation of mother	1. Government employee 2. Non-government employee 3. Merchant 4. Daily laborer 5. Unemployed 6. Other	
110	Educational status of father	1. No formal education 2. Only read and write 3. Primary level 4. Secondary level 5. College and above	
111	Educational status of the mother	1. No formal education 2. Only read and write, 3. Primary level, 4. Secondary level 5. College and above	
112	Parents marital status	1. Married 2. Single 3. Divorced 4. Widowed 5. Separated	
113	Average family monthly income in Et. Birr	______________	

Part II: Questionaries to assess suicidal behavior among adolescents (SBQ-R)

S. N	Questions	Response	Mark
201	Have you ever thought about or attempted to kill yourself?	1.Never	
		2.It was just a brief passing thought	
		3a.I have had a plan at least once to kill myself but did not try to do it	
		3b. I have had a plan at least once to kill myself and really wanted to die	
		4a. I have attempted to kill myself, but did not want to die	
		4b. I have attempted to kill myself, and really hoped to die	

202	How often have you thought about killing yourself in the past year?	1.Never	
		2.Rarely (1 times)	
		3.Sometimes (2 times)	
		4.Often (3-4 times)	
		5.Very often (5 or more times)	
203	Have you ever told someone that you were going to commit suicide, or that you might, do it?	1. No	
		2a. Yes, at one time, but did not really want to die	
		2b. Yes, at one time, and really want to do it	
		3a. yes, more than once, but did not want to do it	
		3b. Yes, more than once, and really want to do it	
204	How likely is it that you will attempt suicide someday?	0.Never	
		1.No chance at all	
		2.Rarther unlikely	
		3.Unlikely	
		4.Likely	
		5.Rather likely	
		6.Very likely	

205. Family history of suicide 1. Yes 2. No

Part III: Questions to Assess Childhood Maltreatment By using Childhood Trauma Questionaries' (CTQ)						
While you were growing up, DURING YOUR FIRST 18 YEARS OF LIFE, how true were each of the following statements:						
S/N	Questions	Never true (1)	Rarely true (2)	Sometimes true (3)	often true (4)	Very often true (5)
EMOTIONAL ABUSE SUBSCALE						
301	People in your family called you things like "stupid", "lazy", or "ugly."					

302	You thought that your parents wished you had never been born					
303	People in your family said hurtful or insulting things to you.					
304	You felt that someone in your family hated you.					
305	You believe you were emotionally abused.					
EMOTIONAL NEGLECT SUBSCALE						
306	There was someone in my family who helped me feel that I was important or special (R)					
307	You felt loved (R)					
308	People in your family looked out for each other (R)					
309	People in your family felt close to each other (R)					
310	Your family was a source of strength support (R)					
PHYSICAL ABUSE SUBSCALE						
311	I got hit so hard by someone in my family that had to see a doctor or go to the hospital					
312	People in my family hit me so hard that it left me with bruises or masks					
313	I was punished by a belt, a board, a cord, or some other hard object					
314	I believe that I was physical abused					
315	I got hit or beaten so badly that it was noticed by someone like a teacher neighbor, or doctor					
PHYSICAL NEGLECT SUBSCALE						
316	I didn’t have enough to eat					
317	I knew that there was someone to take care of me and protect me (R)					
318	My parents were too drunk or high to care of the family					
319	I had to wear dirty clothes					

320	There was someone to take me to the doctor if I needed it (R)					
CHILDHOOD SEXUAL ABUSE						
321	Someone tried to touch me in a sexual way or tried to make me touch them					
322	Someone threatened to hurt me or tell lies about me unless I did something sexual with them					
323	Someone tried to make me do sexual things or watch sexual things.					
324	Someone molested me					
325	I believe that I was sexually abused					

Part IV: Strength and difficult questionary (SDQ-S)

S. N	**Strengths and Difficulties Questionnaire**	Not True (0)	Somewhat true (1)	Certainly true (2)
401	I get a lot of headaches, stomach-aches, or sickness			
402	I worry a lot			
403	I am often unhappy, depressed or tearful			
404	I am nervous in new situations. I easily lose confidence			
405	I have many fears, I am easily scared **''E''**			
406	I get very angry and often lose my temper			
407	I usually do as I am told			
408	I fight a lot. I can make other people do what I want			
409	I am often accused of lying or cheating			
410	I take things that are not mine from home, school or elsewhere **''C''**			
411	I am restless, I cannot stay still for long			
412	I am constantly fidgeting or squirming			
413	I am easily distracted; I find it difficult to concentrate			
414	I think before I do things			
415	I finish the work I'm doing. My attention is good **'H'**			
416	I would rather be alone than with people of my age			
417	I have one good friend or more			
418	Other people my age generally like me			
419	Other children or young people pick on me or bully me			

420	I get along better with adults than with people my own age ‘’Peer’’			
421	I try to be nice to other people. I care about their feelings			
422	I usually share with others, for example CDs, games, food			
423	I am helpful if someone is hurt, upset or feeling ill			
424	I am kind to younger children			
425	I often volunteer to help others (parents, teachers, children) **‘Pro’**			

Part V: Question to assess social support (OSS-3)

SN	Question	Response			
501	How many people are so close to you that you can count on them if you have great personal problems?	1) None	2) 1-2	3) 3-5	4) >5
502	How much interest and concern do people show in what you do?	1. None	7. Little	3.Uncertain	4.Some
503	How easy is it to get practical help from neighbors if you should need it?	1.very difficult	2. difficult	3. possible	4. easy

Part VI: Questionary to assess academic stress

601. Do you currently active student? 1.YES 2. NO, if no skip to Q.601

No	Questionary to assess academic stress	Never (1)	Somewhat frequent (2)	Frequent (3)	Always (4)
602	I have a financial problem because of the expenses of the school or university				
603	I find difficult to juggle time between study and social activity				
604	I feel nervous delivering the class presentation				
605	I feel stressed as submission deadline neared				
606	I feel stressed to sit for examination				
607	I find difficult to juggle time between study and society involvement				
608	I loss interest towards courses				
609	I feel burden of academic workloads				
610	I feel stressed dealing with difficult subject				
611	I feel difficult in handling my academic problem				

Part VII: Substance use assessment

701	In your life have you ever used substance?	1. Yes 2. No	
702	If your response to Question 801 is „yes", which substance you used	1. Khat 2. Cigarette 3. Alcohol 4. If other, specify	
703	In the past three months, have you used any of the above psychoactive substances?	1. Yes 2. No	
704	If "yes" to **803** which psychoactive substance, did you use? (Choose all substances you used)	1. Khat 2. Cigarette 3. Alcohol 4. If other, specify	

PHQ-9 modified for Adolescents (PHQ-A)

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
801. Feeling down, depressed, irritable, or hopeless?				
802. Little interest or pleasure in doing things?				
803. Trouble falling asleep, staying asleep, or sleeping too much?				

804. Poor appetite, weight loss, or overeating?				
805. Feeling tired, or having little energy?				
806. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
807. Trouble concentrating on things like school work, reading, or watching TV?				
808. Moving or speaking so slowly that other people could have noticed? or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
809. Thoughts that you would be better off dead, or of hurting yourself in some way?				

Annex II: AMAHARIC QUESTIONARIE

የወላጆች ስምምነት ደብዳቤ

ውድ ወላጂት ወይ ተንከባከቢ:

ይህ ደብዳቤ ከጅማ ዩኒቨርሲቲ መርማሪ በጅማ ከተማ ስለሚከናወን የምርምር ጥናት መረጃ ይሰጣል:: ጥናቱ በጂማ ከተማ ከ11 እስከ 17 ዓመት ባለው የዕድሜ ክልል የሚገኙ በጉርምስና ዕድሜ ላይ የሚገኙ ወጣቶች የሥነ ልቦና ችግሩን፣ የራስን ሕይወት የማጥፋት ባሕርይውንና ከዚህ ጋር ተያይዘው የሚመጡ ነገሮችን ለመረዳት ይመረምራል::

እኔ ታደሰ ተፈሪ በአሁኑ ጊዜ በጂማ ዩኒቨርሲቲ ኢንተግሬትድ ክሊኒካል እና ማህበረሰብ የአእምሮ ጤና የማስተርስ ዲግሪዬን እየሰራሁ ነው። ጥናቱ ለከተማው ጠቃሚ የሚሆን መረጃ እንዲሰጥ ለማድረግ ከጅማ ከተማ አስተዳዳሪዎች ጋር በመተባበር ጥናቱን እያቀድኩ ነው።

ይህ ጥናት በተዋሃደ ክሊኒካል እና ማህበረሰብ የአእምሮ ጤና ረገድ የሳይንስ ባለሙያዎች የሚጠበቅባቸውን መስፈርት በከፊል በማሟላት እየተካሄደ ሲሆን የራስን ሕይወት የማጥፋት ባሕርይ እና በጂማ ከተማ የ ኣስራዎቹ እድሜ ዓመት ባለው የዕድሜ ክልል ውስጥ የሚገኙ ወጣቶች ከዚህ ጋር ተያያዥነት ያለው ነገር" የሚል ርዕስ አለው።

<u>ልጃችሁ መሳተፍ ያለበት ለምንድን ነው?</u>

በኣስራዎቹ እድሜ ዓመት ባለው የዕድሜ ክልል ውስጥ በሚገኙ ወጣቶች ላይ የሚከሰተውን የራስን ሕይወት የማጥፋትና ተያይዘው የሚመጡ ነገሮችን መረዳት በጣም ያስፈልጋል። ከልጃችሁ የሚሰበሰበው መረጃ ስለ የራስን ሕይወት የማጥፋት በኣስራዎቹ የዕድሜ ክልል ውስጥ በሚገኙ ወጣቶች ላይ ስለሚያሳድሩት ተጽዕኖ ያለንን አጠቃላይ እውቀት ለማሳደግ ሊረዳን ይችላል።

እባክዎ ልብ ይበሉ- በዚህ ጥናት ላይ ልጃችሁ እንዲሳተፍ ለመፍቀድ የምታደርጉት ውሳኔ ሙሉ በሙሉ በፈቃደኝነት መሆን አለበት። ልጃችሁ በዚህ ጥናት እንዲካፈል ወይም በማንኛውም ጊዜ እንዲያነሳው የመፍቀድ ነፃነት አለዎት። እርስዎ ወይም ልጅዎ ለመሳተፍ እንጂ ለመሳተፍ ወይም በጥናት ወቅት በማንኛውም ጊዜ ተሳትፎ ንቆ የመውጣት ውሳኔ በልጅዎ ላይ ምንም ዓይነት ተጽእኖ አይፈጥርም

<u>የልጃችሁ ምስጢር</u>: የልጃችሁ የግላዊነት እና የምርምር መዝገቦች እስከ ሕጉ ድረስ በሚስጥር ይቀመጡ። ልጃችሁ የምላሹን ምስጢር ለመጠበቅ የኮድ ቁጥር ይመደባል። ልጃችሁ በጥናቶቹ ላይ የሰጠው ምላሽ ለሌሎች እንደማይካፈል ልብ በል።

<u>በልጅዎ ምላሾች ምን ይደረግ?</u>

ከዚህ ጥናት የተገኘው መረጃ በኣስራዎቹ ዓመት ባለው የዕድሜ ክልል ውስጥ በሚገኙ ወጣቶች ላይ ስለሚደርሰው የራስን ሕይወት የማጥፋት ድርጊትና ከዚህ ጋር ተያያዥነት ስላለው ነገር ለምሁራን፣ ለሥነ ልቦና ባለሙያዎችና ለሥነ አእምሮ ሐኪሞች ለማሳወቅ ያገለግላል። የዚህ ጥናት ውጤት ሊታተም ይችላል፤ ይሁን እንጂ ከልጃችሁ የሚገኘው መረጃ በጽሑፉ ላይ ከሚገኙ ሌሎች ሰዎች ከሚገኘው መረጃ ጋር ይዋሃዳል። የታተመው ውጤት የልጃችሁን ስም ወይም በምንም መንገድ ልጃችሁን ለይቶ የሚያሳውቅ ማንኛውንም ሌላ መረጃ አይጨምርም። ይህን የምርምር ጥናት በተመለከተ ጥያቄ ካለዎት እባክዎ እኔን ያነጋግሩኝ (Mr Tadese Teferi) በ +251970299413/(tadeseteferi19@gmail.com) ወይም አማካሪዎቼ Dr Mubarek Abera at +25918968803/(abmubarek@gmail.com) ወይም Sr.Workinesh Tesema +251911740105/(fitsumbeselot@gmail.com) እና Dr Elias Tesfaye at +251902644898/(elias.tesfaye2@gmail.com)

በዚህ የምርምር ጥናት ላይ አንድ ልጅ እንዲሳተፍ የተደረገ ስምምነት

ልጄ በዚህ ጥናት እንዲካፈል በነፃነት እፈቅዳለሁ ። ይህ ምርምር እንደሆነ ተረድቻለሁ ። የዚህን ደብዳቤ ቅጂና መዝገቤ ላይ የሰፈረውን የስምምነት ቅጽ ደረሰኝ ።

የልጅ ዕድሜ ________________________________ ቀን

የወላጅ ስም ________________________________

የወላጅ ፊርማ ________________________________

በእውቀት ላይ የተመሠረተ ስምምነትን ያገኘ ሰው መግለጫ

ተሳታፊዎች በጂማ ዩኒቨርስቲ ተቋማዊ የምርመራ ቦርድ የፀደቀና በዚህ ጥናት መሳተፍ ምንነት፣ ፍላጎት፣ አደጋ፣ እና ጥቅም የሚያብራራ በቂ እውቀት ያለው የስምምነት ፎርም እንደተሰጣቸው አመሰግናለሁ። በተጨማሪም ተጨማሪ ጥያቄዎች በሚነሱበት ጊዜ የስልክ ቁጥር እንደተሰጠ አመሰግነዋለሁ።

__________________________ ______________________ ___________________

ስምምነት የሚያገኝ ሰው ስም ስምምነት የሚያገኝ ሰው ስም ቀን

በመረጃ የተደገፈ አስተኔ /የስምምነት ስምምነት

ውድ ተሳታፊ፡- በዛሬው ጊዜ "በጂማ ከተማ በኣስራዎቹ ዓመት ባለው የዕድሜ ክልል ውስጥ በሚገኝ በጉርምስና ዕድሜ ላይ የሚገኙ ወጣቶች የሥነ ልቦና ችግር፣ የራስን ሕይወት የማጥፋት ባሕርይና ከዚህ ጋር ተያያዥነት ያለው ነገር" በሚል ርዕስ በጥናት እንድትካፈሉ ይጠየቃችኋል። እንደ ዲሞግራፊ መረጃ፣ የሕክምና ችግሮች፣ የሥነ ልቦና ችግሮች፣ ራስን የማጥፋት ባሕርይ እና የቁስ አካል አጠቃቀም ታሪክን የመሳሰሉ የተለያዩ መረጃዎችን የጠየቁትን ጥያቄዎች እንድታጠናቅቁ ይጠየቃችኋል። እነዚህን ጥያቄዎች ማጠናቀቅ በግምት 20-30 ደቂቃዎች ይወስዳል. ከ11-17 ዓመት ባለው የዕድሜ ክልል ውስጥ የሚገኙ ወጣቶች በዚህ ጥናት እንድትካፈሉ እየተጠየቃችሁ ነው። ወላጅህ ወይም አሳዳጊህ በዚህ ጥናት እንድትካፈል ፈቅዶልሃል ። መልስህ እስከ ሕጉ ድረስ በምሥጢር ይያዛል። በማንኛውም ጊዜ ተሳትፎ ከማድረግ ነፃ ነህ፣ እናም አትቀበሉም።

አሰንት ለመሳተፍ

በዚህ ጥናት መሳተፍ ምን እንደሚጠይቅ ገብቶኛል፤ በዚህ ጥናት ለመካፈልም ተስማምቻለሁ።

________________________________ _____________

በጉርምስና ዕድሜ ላይ የሚገኝ ሰው ፊርማ ቀን

________________________________ ________________________________ ____________

Assent ያገኘውን ሰው ፊርማ የህትመት ስም አሰኝቶ ትግሉን ያገኘ ሰው ቀን

ማጣቀሻ: 2 የአማርኛ ትርጉም ጥያቄዎች

ክፍል ኣንድ- ማህበረሰብ-ዴሞግራፊእና ከቤተሰብ ጋር የተያያዙ ነገሮች			
ተ/ቁ	ጥያቄዎች	ምላሽ	አስተያየት
101	ፆታ	1. ወንድ 2. ሴት	
102	ዕድሜ	_______	
103	ሃይማኖት	1. ኦርቶዶክስ 3. ፕሮቴስታንት 2. ሙስሊም 4. ሌሎች ግለጽ _________	

104	ጎሰኝነት	1. ኦሮሞ 3, ትግሬ 4, ጉራጌ 2. አማራ 5, ሌላ _______	
105	የትምህርት ደረጃ	1. መደበኛ ትምህርት የለም 2. የመጀመሪያ ደረጃ ትምህርት ቤት 4. ሁለተኛ ደረጃ ትምህርት ቤት እና ከዚያ በላይ	
106	በአሁኑ ጊዜ ወላጆችህ	1. ሁለቱም በሕይወት አሉ 2. እናቴ ብቻ በህይወት ኣለች 3. ኣባቴ ብቻ በሕይወት ኣለ 4. ሁለቱም ሞተዋል	
107	አሁን ከማን ጋር እየኖርክ ነው?	1. ከቤተሰቤ ጋር 2. ብዬን 3. ሌላ (ግለጽ)_____	
108	የአባት ሥራ	1. የመንግስት ሰራተኛ 2. የመንግስት ያልሆነ ሰራተኛ 3. ነጋዴ 4. የቀን ሰራተኛ 5. ሥራ አጥ 6. ሌላ	
109	የእናት ሥራ	1. የመንግስት ሰራተኛ 2. የመንግስት ያልሆነ ሰራተኛ 3. ነጋዴ 4. የቀን ሰራተኛ 5. ሥራ አጥ 6. ሌላ	
110	የአባት የትምህርት ደረጃ	1. ያልተማረ 2. የመጀመሪያ ደረጃ ትምህርት ቤት 3. ሁለተኛ ደረጃ ትምህርት ቤት እና ከዚያ በላይ	
111	የእናት የትምህርት ደረጃ	1. ያልተማች 2. የመጀመሪያ ደረጃ ትምህርት ቤት 3. ሁለተኛ ደረጃ ትምህርት ቤት እና ከዚያ በላይ	
112	የወላጆች የጋብቻ ሁኔታ	1. ያገባ/ች 2. ያላገባ/ች 3. ይተፋታ/ች 4. ባል የሞተባት/ሚስት የሞተችበት 5. የተለያየ/ች	
113	የቤተሰብ ወርሃዊ ገቢ በአማካይ በኢት. Birr	____________	

ክፍል ሁለት፡- በጉርምስና ዕድሜ ላይ የሚገኙ ወጣቶች ራሳቸውን የመግደል ባሕርያቸው ምን እንደሆነ ለመገምገም የሚጠየቁ ጥያቄዎች (SBQ-R)፣ እባክህ ለአንተ ከሚሠራበት ሐሳብ ወይም ሐረግ አጠገብ ያለውን ቁጥር ምልክት አድርግ።

ተ/ቁ	ጥያቄዎች	ምላሽ	አስተያየት
201	ራስህን ለመግደል አስበህ ወይም ሙከራ አድርገህ ታውቃለህ?	1. በፍጹም	
		2. አጭር የሽውታ ሀሳብ ነበር	
		3a. ቢያንስ አንድ ጊዜ እራሴን ለመግደል እቅድ ቢኖረኝም ለማድረግ አልሞከርኩም	
		3b. ቢያንስ አንድ ጊዜ ራሴን ለመግደል እቅድ ነበረኝ እና መሞትን ፈልጌ ነበር	
		4a. ራሴን ለመግደል ሞክሬ ያለሁ ቢሆንም መሞት አልፈለኩም	
		4b. ራሴን ለመግደል ሞክሬአለሁ ፣ ደግሞም ለመሞት ተስፋ አድርጌያለሁ	
202	ባለፈው ዓመት ራስህን ለመግደል ምን ያህል ጊዜ አስበህ ታውቃለህ?	1. በፍጹም	
		2. እምብዛም ኣይደለ (1 ጊዜ)	
		3. አንዳንዴ (2 ጊዜ)	
		4. ብዙ ጊዜ (3-4 ጊዜ)	
		5. በጣም ብዙ ጊዜ (5 እና ከዚያ በላይ)	
203	ለአንድ ሰው ራስህን ለማጥፋት/ለመግደል እንደ ሆነ ወይም ይህን ልታደርግ እንደምትችል ነግረህ ታውቃለህ?	1. አይ	
		2a. አዎን ፣ በአንድ ወቅት ቢሆንም መሞት አልፈለኩም	
		2b. አዎ በአንድ ወቅት እና በእርግጥ ማድረግ እፈልግ ነበር	
		3a. አዎ, ከአንድ ጊዜ በላይ, ነገር ግን ማድረግ አልፈለኩም	
		3b. አዎ, ከአንድ ጊዜ በላይ, እና በእርግጥ ማድረግ እፈልግ ነበር	
204	አንድ ቀን ራስን ለማጥፋት የመሞከር አጋጣሚህ ምን ያህል ነው?	0. በፍጹም	
		1. ምንም ዕድል የለውም	
		2. ሳይሆን አይቀርም	
		3. የማይመስል ነገር ነው	
		4. ምናልባት	
		5.ሊሆን ይችላል	
		6.በጣም ሊሆን ይችላል	

205. በቤተሰብ ውስጥ ራሱን ለማጥፋት ሙከራ ያደረገ ወይም ያጠፋ ኣለ? 1. ኣዎ ኣለ 2. ኣይ የለም

CHILD TRAUMA QUESTIONARY

ክፍል ሦስት ልጅነት በደል ጋር የታያያዙ መጤጥያቂዎች						
ከዚህ በታች ያሉት እድሜዎት 18 ዓመት ሳይሞላ ልደርስቦት የሚችሉት ክስተቶች(በደሎች) ዝርዝር ናቸው፡፡ እባክዎን ያጋጠሞትን ክስተት እና ምን ያህል እንደደረሰቦት ይሙሉ፡፡						
ተ/ቁ	ጥያቄ	በጭራሽ እውነት አይደለም (1)	አልፎ አልፎ እውነት ነው(2)	አንዳንድ ጊዜ እውነት ነው(3)	ብዙ ጊዜ እውነት ነው(4)	በጣም ብዙ ጊዜ እውነት ነው(5)
ስሜታዊ በደል በተመለከተ						
301	በቤተሰቤ ውስጥ ያሉ ሰዎች እንደ “ሞኝ” ፣ “ሰነፍ” ወይም “አስቀያሚ” በሚባሉ ነገሮች ይጠሩኝ ነበር					
302	ወላጆቼ በጭራሽ በልወለድ ይመኙ ነበር ብዬ አስብ ነበር					
303	በቤተሰቤ ውስጥ ያሉ ሰዎች መጥፎ ነገር ወይም ስድብ ይናገሩኝ ነበር					
304	በቤተሰቤ ውስጥ የሆነ ሰው እንደሚጠላኝ ይሰማኝ ነበር					
305	ስሜታዊ በደል እንደ ተፈጸመብኝ አምን ነበር					
ስሜተዊ ቸልተኝነት በተመለከተ						
306	እኔ አስፈላጊ ወይም ልዩ እንደሆንኩ እንዲሰማኝ የሚያደርግ በቤተሰቤ ውስጥ የሆነ ሰው ነበር (R)					
307	እንደተወደድኩ ይሰማኝ ነበር					
308	በቤተሰቤ ውስጥ ያሉ ሰዎች ለእርስ በርሳቸዉ ይጠናቀቁ ነበር (R)					
309	በቤተሰቤ ውስጥ ያሉ ሰዎች እርስ በርስ ይቀራረቡ ነበር (R)					
310	ቤተሰቦቼ የብርታትና የድጋፍ ምንጭ ነበሩ (R)					
አካላዊ ጥቃት በተመለከተ						
311	በቤተሰቤ ውስጥ አንድ ሰው በጣም መቶኝ ዶክተር ማየት ወይም ወደ ሆስፒታል እስከመሄድ ጉዳት ደርሶብኝ ነበር					
312	በቤተሰቤ ውስጥ ያሉ ሰዎች በጣም በጥፊ ይመቱኝ ነበር እናም በእብጠት ወይም ምልክቶች ይታዩብኝ ነበር					
313	እኔ በቀበቶ ፣ ቦርድ ወይም ገመድ ወይም በሌላ ከባድ ነገር ተቀጥቼ ነበር					
314	አካላዊ ጉዳት እንደደረሰብኝ አምን ነበር					

315	እጅግ በጣም በጥፊ ተመትቼ ወይም ተደብድቤ ፣መምህር ፣ ጎረቤት ወይም ዶክተር አይቶኝ ነበር					
አካላዊ ቸልተኝነት በተመለከተ						
316	ለመብላት በቂ ምግብ አልነበረኝም					
317	የሚንከባከበኝ እና የሚጠብቀኝ ሰው እንዳለ አውቅ ነበር ፡፡ (R)					
318	ወላጆቼ ቤተሰባችንን እንዳይንከባከቡ በጣም ይሰክሩ ነበር					
319	የቆሸሹ ልብሶችን መልበስ ነበረብኝ					
320	በሚያስፈልግበት ጊዜ ወደ ሐኪም የሚወስደኝ የሆነ ሰው ነበረ (R)					
ወሲባዊ ጥቃትን በተመለከተ						
321	የሆነ ሰው ወሲባዊ በሆነ መንገድ ሊነካኝ ወይም እኔ እንዲነካው ለማድረግ ሞክሯል					
322	አንድ ሰው ከእነሱ ጋር ፆታዊ ግንኙነት ካልፈፀምኩ ሊጎዳኝ ወይም ስለ እኔ ውሸት እንደሚናገር አስፈራርቶኝ ነበር					
323	አንድ ሰው ወሲባዊ ነገሮችን እንድሠራ ወይም ወሲባዊ ምስሎችን እንድመለከት ሊያደርገኝ ሞከሮ ነበር					
324	የሆነ ሰው ፆታዊ ጥቃት አድርሶብኛል					
325	ወሲባዊ ጥቃት እንደተፈጸመብኝ አምናለሁ					
መቀነስ/መካድ						
326	በሕይወቴ ውስጥ ለመቀየር የፈለግኩት ምንም ነገር አልነበረም					
327	ፍጹም እና ደስ የሚል ልጅነት ነበረኝ					
328	በዓለም ላይ ምርጥ ቤተሰብ ነበረኝ					

Part IV: SDQ-S Amaharic

ተ/ቁ	መጠይቅ	እውነት ኣይደልም (0)	የሆነ ያክል እውነት ነው (1)	Certainly true (2)
401	ብዙ ራስ ምታት፣ የሆድ ሕመም ወይም ሕመም ይደርስብኛል።			
402	በጣም እጨነቃለሁ			
403	ብዙ ጊዜ ደስተኛ አይደለሁም፣ ይደብረኛል ወይም ኣለቅሳለሁ።			
404	በአዳዲስ ሁኔታዎች ውስጥ እጨነቃለሁ፡ በራስ መተማመንን በቀላሉ አጣለሁ።			
405	ብዙ ፍርሃቶች አሉኝ፣ በቀላሉ እፈራለሁ። ‘’E’’			
406	በጣም እናደዳለሁ እናም ብዙ ጊዜ ንዴቴን ኣጠፋለሁ።			
407	ብዙውን ጊዜ እንደ ተነገረኝ አደርጋለሁ			
408	በጣም እታገላለሁ። ሌሎች ሰዎች የምፈልገውን እንዲያደርጉ ማድረግ እችላለሁ			

409	ብዙ ጊዜ በመዋሸት ወይም በማጭበርበር እከሰሳለሁ።			
410	የእኔ ያልሆኑ ነገሮችን ከቤት፣ ከትምህርት ቤት ወይም ከሌላ ቦታ እወስዳለሁ። ''C''			
411	እረፍት አጣለሁ፣ ለረጅም ጊዜ መቆየት አልችልም።			
412	ያለማቋረጥ እበሳጫለሁ ወይም እንቀጠቀጣለው።			
413	በቀላሉ ትኩረቴ ይከፋፈላል; ማተኮር ይከብደኛል።			
414	ነገሮችን ከማድረጌ በፊት አስባለሁ			
415	የምሰራውን ስራ እጨርሳለሁ. ትኩረቴ ጥሩ ነው።''H''			
416	በእኔ ዕድሜ ካሉ ሰዎች ጋር ብቻዬን ብሆን እመርጣለሁ።			
417	አንድ ወይም ከዚያ በላይ ጥሩ ጓደኛ አለኝ			
418	በአጠቃላይ በእኔ ዕድሜ ያሉ ሌሎች ሰዎች እኔን ይወዳሉ			
419	ሌሎች ልጆች ወይም ወጣቶች ያዙኝ ወይም ጉልበተኛ ይሆኑኛል።			
420	በራሴ ዕድሜ ካሉ ሰዎች ይልቅ ከአዋቂዎች ጋር እስማማለሁ። ''P''			
421	ለሌሎች ሰዎች ጥሩ ለመሆን እሞክራለሁ። ስሜታቸው ግድ ይለኛል።			
422	እኔ ብዙውን ጊዜ ለሌሎች አካፍላለሁ፣ ለምሳሌ ሲዲዎች፣ ጨዋታዎች፣ ምግብ			
423	አንድ ሰው ከተጎዳ፣ ከተናደደ ወይም ቢታመም እረዳለሁ።			
424	ለትናንሽ ልጆች ደግ ነኝ			
425	ብዙ ጊዜ ሌሎችን (ወላጆችን፣ አስተማሪዎችን፣ ልጆችን) ለመርዳት ፈቃደኛ ነኝ። ''Pr''			

Part V: ክፍል ስድስት ማህበራዊ ድጋፍን ለመገምገም ጥያቄ

ተ/ቁ	ጥያቄዎች	ምላሽ			
501	ከባድ የግል ችግሮች ካሉብህ ከአንተ ጋር በጣም የሚቀራረቡ ምን ያህል ሰዎች አሉ?	1) ምንም የለም	2) 1-2	3) 3-5	4) >5
502	ሰዎች በምታደርገው ነገር ምን ያህል እንደሚያስቡና እንደሚያሳስባቸው ያሳያሉ?	1. ምንም የለም	1. ትንሽ	3.እርግጠኛ ያልሆነ	4.የተወሰኑት
503	የሚያስፈልግህ ከሆነ ከጎረቤቶችህ ተግባራዊ እርዳታ ማግኘት ምን ያህል ቀላል ነው?	1. በጣም አስቸጋሪ	2. አስቸጋሪ	3. ሊሆን ይችላል	4. በቀላሉ

Part VI: የትምህርት ውጥረትን ለመገምገም መጠይቅ

601. በአሁኑ ጊዜ ተማሪ ነዎት? 1. አዎ 2. አይ ከልሆነ ወደ ተ.ቁ **801** ዝለል

ተ/ቁ	ጥያቄዎች	በጭራሽ(1)	በተወሰነ ጊዜ ተደጋጋሚ(2)	ተደጋጋሚ(3)	'ሁልጊዜ(4)'
602	በዚህ ምክንያት የገንዘብ ችግር አለብኝ የዩኒቨርሲቲ ወጪዎች				
603	በጥናት እና መካከል ጊዜን መጨቃጨቅ ይከብደኛል።				

	ማህበራዊ እንቅስቃሴ				
604	የክፍሉን አቀራረብ ሳቀርብ ፍርሃት ይሰማኛል።				
605	የማስረከቢያ የመጨረሻ ቀን ሲቃረብ ውጥረት ይሰማኛል።				
606	ለምርመራ መቀመጥ ውጥረት ይሰማኛል።				
607	በጥናት እና መካከል ጊዜን መጨቃጨቅ ይከብደኛል። የህብረተሰብ ተሳትፎ				
608	የኮርሶች ፍላጎት አጣሁ				
609	የአካዳሚክ የሥራ ጫና ሸክም ይሰማኛል				
610	ከአስቸጋሪ ርዕሰ ጉዳይ ጋር በመገናኘቴ ውጥረት ይሰማኛል።				
611	የአካዳሚክ ችግሬን ለመቋቋም አስቸጋሪ ሆኖ ይሰማኛል።				

Part VII: Substance use assessment

701	በህይወትዎ ውስጥ ኣደንዛዥ እጽ ተጠቅመህ ታውቃለህ?	1. ኣዎ 2. በፍጹም	
702	መልሶ ለ ተ/ቁ **801** ኣዎ ከሆነ ዬትኛውን ነው የተጠቅሙት	1. ጫት 2. ሲጋራ 3. ኣልኮል 4. ሌላ ካለ ይገልጽ	
703	ባለፉት ሶስት ወራት ውስጥ፣ ከላይ ከተጠቀሱት የስነ-አእምሮ ንጥረ ነገሮች ውስጥ አንዱን ተጠቅመህ ታውቃለህ?	1. ኣዎ 2. በፍጹም	
704	መልሶ ለ ተ/ቁ **803** ኣዎ ከሆነ ዬትኛውን ነው የተጠቅሙት	1. ጫት 2. ሲጋራ 3. ኣልኮል 4. ሌላ ካለ ይገልጽ	

<u>ለጉርምስና ዕድሜ ላይ ለሚገኙ ሰዎች PHQ-9 የተሻሻለ (PHQ-A)</u>

መመሪያዎች:- ባለፉት ሁለት ዓመታት የሚከተሉት ምልክቶች ምን ያህል ጊዜ ይረብሹህ ነበር? ሳምንታት? ምክንያቱም እያንዳንዱ የሕመም ምልክት ስሜትህን በተሻለ መንገድ ከሚገልጸው መልስ በታች ባለው ሣጥን ውስጥ "X" አስቀምጥ።				
	(0) አይደለም ሁሉንም	(1) አያሌ ቀናት	(2) ተጨማሪ ግማሽ ቀኖቹ (2)	(3) ማለት ይቻላል እያንዳን ዱ ቀን
801. ተስፋ መቁረጥ፣ መጨነቅ፣ መናደድ፣ ወይም ተስፋ መቁረጥ?				

802. ነገሮችን ለማድረግ እምብዛም ፍላጎት ወይም ደስታ የላቸውም?				
803. እንቅልፍ መተኛት፣ መተኛት፣ ወይስ ከመጠን በላይ መተኛት?				
804. የምግብ ፍላጎት ማጣት, ክብደት መቀነስ, ወይም ከመጠን በላይ መብላት?				
805. የድካም ስሜት, ወይም ትንሽ ጉልበት ማግኘት?				
806. ስለራስህ መጥፎ ስሜት ይሰማሃል - ወይም ውድቀት እንዳለህ ወይም ራስህን ወይም ቤተሰብህን እንደፈቀቅክ ይሰማሃል ወደ ታች?				
807. በትምህርት ቤት ሥራ፣ በንባብ፣ ወይም ቴሌቪዥን በማየት ላይ ማተኮር ይቸግረናል?				
808. በዝግታ መንቀሳቀስ ወይም መናገር ሌሎች ሰዎች ሊያስተውሉ ይችሉ ነበር? ወይስ ከወትሮው የበለጠ ከቦታ ቦታ እየተዘዋወርክ ያለኸው በጣም ደከም ያለህ ወይም የማትረበሽ መሆንህ ነው?				
809. ብትሞት ይሻላል ወይስ በሆነ መንገድ ራስህን መጉዳት ይሻላል ብለህ ታስባለህ?				

Annex III: Oromiffa

Xalayaan kun qorannoo qorannoo magaalaa Jimmaa keessatti qorataa Yuunivarsiitii Jimmaa irraa gaggeeffamu ilaalchisee odeeffannoo kenna. Qorannoon kun dargaggoota umriin isaanii 11-17 magaalaa Jimmaa keessa jiran qorachuun rakkoo saayikooshawaasummaa, amala of ajjeesuu fi wantoota kanaan walqabatan hubachuuf kan oolu ta'uu ibsameera.

Ani Tadese Teferi yeroo ammaa Yuunivarsiitii Jimmaatti barnoota Integrated Clinical and Community Mental health tiin digrii lammaffaa koo hojjechaa jira. Qorannichi odeeffannoo magaalichaaf gargaaru akka kennuuf bulchitoota magaalaa Jimmaa waliin ta'uun qorannoo kana karoorfadheen jira. Qorannoon kun kan gaggeeffamu ulaagaalee mastersii saayinsii fayyaa sammuu kilinikaa fi hawaasaa walitti hidhame keessatti barbaachisan gartokkoon guutuudhaan yoo ta'u, mata dureen isaas "Magnitude of suicidal behavior and associated factor among adolescents aged in Jimma town" jedhu qaba.

<u>Mucaan Keessan Maaliif Hirmaachuu Qaba:</u>

Barsiisonni fi qorattoonni rakkoo saayikooshawaasummaa, amala of ajjeesuu fi wantoota kanaan walqabatan dargaggoota gidduu jiru hubachuun barbaachisaa ta'uu isaati. Odeeffannoon daa'ima keessan irraa walitti qabamu beekumsa waliigalaa waa'ee rakkoo saayikooshawaasummaa, amala

of ajjeesuu fi wantoota kanaan walqabatan dargaggoota biratti qabnu guddisuuf gargaaruu danda'a.

Hubachiisa: Murtoon ati daa'imni kee qorannoo qorannoo kana irratti akka hirmaatu hayyamuuf goote guutummaatti fedhii ofiitiin ta'uu qaba. Mucaan keessan qorannoo kana irratti akka hirmaatu ykn yeroo barbaaddetti akka ofirraa baasu hayyamuuf bilisa ta'uu dandeessa. Murtoon ati ykn mucaan kee yeroo qo'annichaa yeroo kamiyyuu hirmaachuuf, hin hirmaanne, ykn hirmaannaa ofirraa baasuu kee karaa kamiinuu daa'ima kee irratti dhiibbaa hin geessisu.

Iccitii Deebii Mucaa Keessanii:

Galmeen iccitii fi qorannoo daa'ima keessanii hanga seeraatti iccitii ta'ee ni eegama. Qorannoon daa'imni keessan xumurame iccitii deebii isaa eeguuf lakkoofsa koodii ni kennamaaf. Deebii addaa daa'imni keessan qorannoowwaniif kenne namoota biroof akka hin qoodamin hubadhaa.

Deebii Mucaa Keessaniitiin maaltu hojjetama:

Odeeffannoon qorannoo kana irraa argame barsiisota, ogeeyyii xiin-sammuu fi ogeeyyii sammuu waa'ee guddina amala of ajjeesuu fi wantoota kanaan walqabatan dargaggoota umuriin isaanii waggaa 11-17 ta'an beeksisuudhaaf kan ooludha. Bu'aan qorannoo kanaa maxxanfamuu danda'a; haa ta'u malee, daataa daa'ima keessan irraa argattan daataa namoota biroo maxxansa keessatti argaman waliin ni walitti makama. Bu'aan maxxanfame maqaa daa'ima keessanii ykn odeeffannoo biroo karaa kamiinuu dhuunfaan daa'ima keessan adda baasu hin dabalatu. Waa'ee qorannoo qorannoo kanaa gaaffii yoo qabaattan na (Obbo Tadese Teferi) +251970299413/(tadeseteferi19@gmail.com) ykn gorsitoota koo Dr Mubarek Abera +25918968803/(abmubarek@gmail.com) ykn, Sr. Workinesh Tesema +251911740105/(fitsumbeselot@gmail.com) fi Dr Eliyaas Tesfaayee +251902644898/(elias.tesfaye2@gmail.com) jechuun ni danda'ama.

Qo'annoo qorannoo kana irratti daa'imni tokko akka hirmaatu hayyama kennuu

Mucaan koo qorannoo kana irratti akka hirmaatu hayyama koo bilisaan nan kenna. Kun qorannoo akka ta'e naaf gala. Koppii xalayaa kanaa fi unka hayyamaa galmee kootiif naaf kenname.

Umurii mucaa_____________________________________ Guyyaa_____________

Maqaa warraa_____________________________________

Mallatoo warraa__________________________________

Ibsa Nama Hayyama Beekaa Argate

Hirmaattotaaf unka hayyama beekumsa qabu kan Boordii gamaaggama Dhaabbilee Yuunivarsiitii Jimmaatiin mirkanaa'ee fi qorannoo kana irratti hirmaachuu keessatti maalummaa, gaaffii, balaa,

fi faayidaa qabu ibsu akka kennameef nan mirkaneessa. Dabalataanis gaaffiin dabalataa yoo uumame lakkoofsi bilbilaa akka kenname nan mirkaneessa.

Maqaa Gallatoo Guyyaa

____________________ _________ __________

Waliigaltee hayyamaa /Hayyama odeeffannoo qabu

Har'a qorannoo qorannoo mata duree, "Magnitude of suicidal behavior and associated factor among adolescent in Jimma town" jedhuun qophaa'e irratti akka hirmaattan isin gaafanna. Gaaffiiwwan' kanneen waa'ee odeeffannoo adda addaa kan akka odeeffannoo dimogiraafii, gaaffilee sababoota kilinikaa madaaluuf gargaaran, sababa saayikooshawaasummaa, amala of ajjeesuu fi seenaa itti fayyadama wantootaa gaafatan akka guuttu si gaafatama. Gaaffiiwwan kana xumuruun tilmaamaan daqiiqaa 20-30 si fudhata. Sadarkaa dargaggoota keessa waan jirtuuf qorannoo kana irratti akka hirmaattu si gaafatamaa jirta. Warri ykn guddiftuu kee qorannoo kana irratti akka hirmaattu duraan siif hayyameera. Deebiin keessan hanga seeraatti iccitii ta'ee ni eegama. Yeroo barbaaddetti hirmaachuu irraa of baasuuf bilisa ta'uu dandeessa, akkasumas hin adabamtu.

Hirmaachuuf hayyama kennuu

Qorannoon kana irratti hirmaachuun maal akka gaafatu naaf gala, qorannoo kana irrattis hirmaachuuf walii gala.

Mallatoo Guyyaa

_____________ ____________

Mallattoo nama hayyama argate maqaa nama hayyama argate maxxanfame Guyyaa

_________________________ _________________________________ ________

Kutaa I: Wantoota Hawaas-Demogiraafii fi maatii wajjin walqabatan			
Lakk	Gaaffiilee	Deebii	Yaada
101	Saala	3. Dhiira 2. Durba	
102	Umrii	______	
103	Amantii	4. Ortodoksii 3. Pirootestaantii 5. Musliima 4. Kan bira ibsii_____	
104	Saba/ sabuummaa	4. Oromoo 3, Tigree 4, Guraagee	

		5. Amaaraa 5, Kan bira ibsii ______	
105	Sadarkaa barnoota	1. No formal education 2. Primary school 3. Secondary school and above	
106	Yeroo ammaa kana warri keessan	1, Lachuu jiru 2, Haadha qofa jira 3, Abbaa qofa jira 4, Lachuu boqataniiru	
107	Amma eenyu wajjiin jiraata?	1, Warra kiyya waliin 2, Qophaa koo 3, Kan bira ibsii______	
108	Hojii abbaa	1. Hojjetaa mootummaa 2. hojjataa mootummaa miti 3. Daldalaa 4. Hojjetaa guyyaa guyyaa 5. Hojii dhabeeyyii 6. Kan biroo	
109	Hojii haadha	1. Hojjetaa mootummaa 2. hojjataa mootummaa miti 3. Daldalaa 4. Hojjetaa guyyaa guyyaa 5. Hojii dhabeeyyii 6. Kan biroo	
110	Sadarkaa barnoota abbaa	1. Barnoota idilee hin qabu 2. Dubbisuu fi barreessuu qofa 3. Sadarkaa tokkoffaa 4. Sadarkaa lammaffaa 5. Kolleejjii fi isaa ol	
111	Educational status of the mother	1. Barnoota idilee hin qabu 2. Dubbisuu fi barreessuu qofa 3. Sadarkaa tokkoffaa 4. Sadarkaa lammaffaa 5. Kolleejjii fi isaa ol	
112	Haala gaa'ilaa warraa	1. Kan hin heerumne yk hin fuune 2. Kan Fuudhe / heeruma 3. Hiikaan 4. Kan abbaan manaa irraa du'e 5. Addaan bahe	

113	Giddugaleessaan galii maatii ji'aa Birrii Et.	________________	

Kutaa II: Gaaffiiwwan amala of ajjeesuu dargaggoota gidduu jiru madaaluuf gargaaran

Maaloo ibsa ykn kutaa caalaatti si ilaallatu cinatti lakkoofsa mallatteessi.

Lakk	Gaafiilee	Deebii	Yaada
201	Of ajjeesuuf yaaddee ykn yaaltee beektaa?	1.Lakkii	
		2. Yaada darbaa gabaabaa qofa ture	
		3a. Yoo xiqqaate yeroo tokko of ajjeesuuf karoora qabadheera garuu gochuuf hin yaalle	
		3b. Yoo xiqqaate yeroo tokko of ajjeesuuf karoora qabadheera, dhuguma du'uu barbaadeen ture	
		4a. Of ajjeesuuf yaaleera, garuu du'uu hin barbaanne	
		4b. Of ajjeesuuf yaaleera, dhugumas du'uuf abdadheera	
202	Waggaa darbe keessa yeroo meeqa of ajjeesuu yaaddee?	1.Lakkii	
		2. Darbee darbee (yeroo 1)	
		3.Yeroo tkko tokko (yeroo 2)	
		4. Yeroo hedduu (yeroo 3-4)	
		5. Yeroo baayyee (5 fi isaa ol)	
203	Of ajjeesuuf akka jirtu, ykn akkas gochuu dandeessa jettee nama tokkotti himtee beektaa?	1.Lakkii	
		2a. Eeyyee, yeroo tokko, garuu dhuguma du'uu hin barbaanne	
		2b. Eeyyee, yeroo tokko, dhugumas gochuu barbaadee	
		3a. Eeyyee yeroo tokkoo ol, garuu gochuu hin barbaanne	
		3b. Eeyyee, yeroo tokkoo ol, dhugumas gochuu barbaadee	
204	Gaaf tokko of ajjeesuuf yaaluun kee carraan kee hangam qaba?	0.Lakkii	
		1. Carraa tokkollee hin qabu	
		2. hin fakkaanne	
		3. ta'u maluu	
		4. Waan ta'u fakkaata	

		5. Ta'uu danda'a	
		6.Sirritti ta'uu danda'a	

205. Maatii keessan keessaa namni lubbuu isaa balleessuuf yaadee ykn balleesse jiraa?

1. Eyyeen jira 2. Lakkii hin jiru

Kutaa III: gaaffilee dhiibbaa maatiin gaafa ijoollummaa ijoollee isaa irraa itti gahu qoratan chaayildii wuud tiroomaa kuweeshinaarii						
Yeroo guddina keessani waggoottan 18 jalqabaa irratti, himoonni kanneen gadi hangami dhugaadha.						
Lakk	Gaaffiilee	Gonku maa dhugaa miti (1)	Xiqqoosh e dhugadha (2)	Darbe al tokko tokko dhuga dha (3)	baayee dhugaa dha (4)	Baayee baayee dhugaa dha (5)
CUNQURSAALEE YKN MIIDHAALEE MIIRAA GEESSISAAN (EMOTIONAL ABUSE SUBSCALE)						
301	Namoonni maatiikoo keessaa jechoota hin taane kanneen akka dhibooftuu/dhiba’a, fokkisa/stu, doofaa jechuun na waamu turan					
302	Maatiin koo otuu isa/ishee argachuu baannee jedhanii hawwu turan jedheen yaadeen ture					
303	Namoonni maatiikoo keessaa jecha nama miidhuu fi arrabsoo natti dubbatu turan					
304	Maatiikoo keessa namni ta’e na jibba jedheen yaada ture					
305	Miidhamni miiraa narra gaheera jedheen amana ture					
EMOTIONAL NEGLECT SUBSCALE						
306	Maatiikoo keessa namni an akkan faayidaqabeessa ta’e yaaduuf na gargaare jira ture (R)					
307	Jaalatamaa akkan ta’e natti dhagahama ture(R)					
308	Namoonni maatiikoo keessaa wal kunuunsu turan(R)					

309	Namoonni maatiikoo keessaa hariiroo gaarii qabu turan (R)					
310	Maatiin koo madda ciminaa fi gargaarsaa turan.					
Cunqursa ykn miidhaa qaamaa						
311	Maatii koo keessaa namni ta'e akka hamaatti na rukutee gara hospitaalaa geeffameen ture					
312	Namoonni maatiikoo keessaa akka hamaatti na rukutanii madaa ykn godaannisa natti uumee ture					
313	Ani watoota akka qabattoo, garaftuu fi qacceetiin adabameen ture					
314	Cunqursaan qaamaa narra gahee ture jedheen amana					
315	Ani akka hamaatti rukutamee namoonni akka barsiisaa, ollaa fi ogessi fayyaa narratti baranii turan					
PHYSICAL NEGLECT SUBSCALE						
316	Nyaata gahaa hin argadhun ture					
317	namni na kunuunsu ykn na eegu akkan jiru nan amanan ture(R)					
318	Abbaa fi haatikoo baay'ee dhuganii waan machaa'aa turaniif maatii kunuunsuu hin danda'an turan					
319	wayaa xuraawaa uffachuun qaba ture					
320	Yeroo barbaachisetti namni gara ogeessa yaalaa na geessu jira ture(R)					
CHILDHOOD SEXUAL ABUSE						
321	Namoonni bifa saalquunnamtiin na tuquuf yaalanii turan ykn akkan isaan tuqu na taasisanii turan					
322	Namoonni yoon ani waan saal quunnamtii wal qabatu isaan waliin gochuu baadhe na miidhuuf ykn waa'ee koo sobachuun na doorsisanii turan					

323	Namni ta’e wayii waan saalquunnamtiin walqabatu akkan godhu yookiin ilaalu na taasisee ture.					
324	Namni ta’e wayii gidiraa saalaa narraan gahee ture					
325	Cunqursaan saalquunnamtii narra gahee ture jedheen amana					
Xiqqeessuf haaluu /Minimization/denial						
326	Waa’ee jireenya kootii wantin jijjiiruuf hawwu tokkollee hin jiru ture					
327	Ijoollummaa milkaa’aan qaba ture					
328	Akka addunyaatti maatii bbay’ee gaariin qaba ture.					

Kutaa IV: Gaaffii Ciminaa fi dadhabinnaa -SDQ

Lakk	**Gaaffiilee**	Dhugaa miti (0)	Hamma tokko dhugaadha (1)	Dhugaa ta’uun isaa hin oolu (2)
401	Mataa dhukkubbii, garaa-dhukkubbii ykn dhukkuba baay'een natti dhagahama			
402	Baay'een dhipadha			
403	Yeroo baay’ee gammachuu hin qabu, dhiphina ykn imimmaan natti dhaga’ama			
404	Haala haaraa keessatti nan rifadha. Salphaatti ofitti amanamummaa dhaba			
405	Sodaa hedduu qaba, salphaatti sodaadha ‘’E’’			
406	Baay’ee nan aaree yeroo baay’ee nan aarsa			
407	Yeroo baayyee akkuma natti himame nan godha			
408	Namoota biroo waanan barbaadu akka godhan gochuu nan danda'a			
409	Yeroo baay’ee soba ykn gowwoomsuu jedheen himatama			
410	Wantoota kan koo hin taane manaa, mana barumsaas ta'e bakka biraa irraan fudhadha ‘’C’’			
411	Boqonnaa hin qabu, yeroo dheeraaf tasgabbaa'ee turuu hin danda'u			
412	Yeroo hundumaa fiigicha nati jira			
413	Salphaatti yaadniko hirama; Xiyyeeffachuuf natti ulfaata			
414	Waan tokko hojjechuu koo dura nan yaada			

415	Hojii ani hojjedhu sana nan xumura. Xiyyeeffannaan koo gaarii dha’’H’’			
416	Namoota umuriin koo ta’an wajjin kophaa koo jiraachuu naaf wayya			
417	Hiriyaa gaarii tokko ykn isaa ol qaba			
418	Namoonni kaan umuriin isaanii akka waliigalaatti na jaallatu			
419	Ijoolleen ykn dargaggoonni kaan na fudhatu ykn na doorsisu			
420	Namoota umuriin isaanii akka kootti ta’e caalaa namoota ga’eessotaa wajjin walii ga’a ‘’P’’			
421	Namoota biroof gaarii ta'uuf nan yaala. Miira isaaniif nan yaada			
422	Yeroo baayyee namoota biroof nan qooda, fakkeenyaaf taphoota, nyaata fa’a			
423	Namni tokko yoo miidhame, yoo mufate ykn yoo dhukkubsate nan gargaara			
424	Ijoollee xixiqqoodhaaf gaarummaa qaba			
425	Yeroo baayyee namoota biroo (warra, barsiisota, ijoollee) gargaaruuf tola ooltummaa nan hojjedha. ‘’Pr’’			

Kutaa V: Gaaffii deeggarsa hawaasummaa madaaluuf

Lakk.	Gaaffilee	Deebii			
501	Namoota meeqatu sitti dhihoo waan ta’eef rakkoo dhuunfaa guddaa yoo qabaatte isaanitti lakkaa’uu dandeessa?	1) homaa	2) 1-2	3) 3-5	4) 5 ol
502	Namoonni wanta ati hojjettu irratti hammam fedhii fi yaaddoo argisiisu?	1. Homaa	8. bicuu	3. Mirkanaa'aa miti	4.Muraasa
503	Gargaarsa qabatamaa ollaa irraa argachuun hammam salphaadha yoo gargaarsa si barbaachisuu qabaate?	1. baayyee rakkisaadha	2.Rakkisaadha	3. Ni danda’ama	4. Salphaatti

Kutaa VI: Questionary to assess academic stress

601. Ammarratti barataadha? Eeeyyen (1) Lkkii (0), yoo hin ta'in gara laakoofsa 601 tti darbaa.

Lakk	Gaafiilee	'Gonkum aa'	'Hamma tokko irra deddeebi'e'	'Irra deddeebi'e'	'Yeroo hundaa'
601	Rakkoo maallaqaa qaba sababa baasii yuunivarsiitichaaf bahu				
602	Yeroo qo'annoo fi gidduutti juggle gochuun natti ulfaata sochii hawaasummaa				
603	Dhiyeessii daree dhiyeessuun na rifachuun natti dhagahama				
604	Yeroon xumuraa dhiyaachuu yeroo dhihaatu dhiphinni natti dhagahama				
605	Qormaataaf taa'uun dhiphinni natti dhagahama				
606	Yeroo qo'annoo fi gidduutti juggle gochuun natti ulfaata hirmaannaa hawaasaa				
607	Fedhii gara koorsootaatti nan dhaba				
608	Ba'aan hojii barnootaa natti dhaga'ama				
609	Dhimma rakkisaa wajjin wal'aansoo qabuun dhiphinni natti dhaga'ama				
610	Rakkoo barnootaa koo to'achuun natti ulfaata				

Kutaa VII: Gaafiilee araada wajjiin wal qabatan

701	Jireenya kee keessatti wantoota araada nama qabsiisan fayyadamtee beektaa?	1. Eyyeen 2. Lakki	
702	Yoo deeebiin ke lakk 801 eyyeen ta'e kam fayyadamtee?	1. Caatii 2. Sigaara 3. Alkoolii 4. Kan biraa ibsi	
703	Ji'oota sadan darban keessatti wantoota araada nama qabsiisan armaan olitti ibsaman keessaa tokko fayyadamtaniittu?	1. Yes 2. No	
704	Yoo deebiin keessan lakk 803 eyyeen ta'e kam fayyadamtan?	1. Khat 2. Cigarette 3. Alcohol 4. If other, specify	

Kutaa VIII: PHQ-9 Dargaggootaaf fooyya'e (PHQ-A).

Qajeelfama: Yeroo lamaan darban keessatti mallattoolee armaan gadii tokkoon tokkoon isaaniitiin yeroo meeqa si dhiphise torbanitti? Tokkoon tokkoon mallattoodhaaf saanduqa deebii jala jiru keessatti "X" kan akkaataa sitti dhaga'amaa ture akka gaariitti ibsu kaa'i.				
	(0) Gonku maa miti	(1) guyyo ota heddu udhaaf	(2) walakkaa guyyaa ol ta'a	(3) guyyaa guyyaan jechuun ni danda'a ma
801. Miirri gaddee, dhiphina, aarii ykn abdii dhabuu?				
802. Wantoota hojjechuuf fedhii ykn gammachuu xiqqoo qabaachuu?				
803. Rakkoo hirriba dhabuu, hirriba keessa turuu ykn garmalee rafuu?				
804. Fedhii nyaataa dhabuu, ulfaatina qaamaa hir'isuu ykn garmalee nyaachuu?				
805. Miira dadhabbiin sitti dhaga'amuu, ykn humna xinnoo qabaachuu?				
806. Miira gadhee ofitti dhaga'amuu – ykn kufaatii ta'uu kee, ykn ofii keetii ykn maatii keetiif akka hayyamte sitti dhaga'amuu gadi?				
807. Wantoota akka hojii mana barumsaa, dubbisuu ykn TV ilaaluu irratti xiyyeeffachuuf rakkachuu?				
808. Namoonni kaan hubachuu danda'anitti suuta jedhanii socho'uu ykn dubbachuu? ykn faallaa kanaa – baay'ee fiigicha ykn boqonnaa dhabuu waan barame caalaa baay'ee socho'aa turte ta'uu?				
809. Du'uu naf wayya jettee yaadu, ykn karaa biraan of miidhuu naf wayya jette yaadu?				