



Mejora del acceso a la atención primaria y a los servicios de salud sexual y reproductiva de jóvenes y mujeres en South Omo, Etiopía

Exp.09-PR1-306



ANEXO A.3,
ESTUDIO DE LÍNEA DE BASE



African Medical and Research Foundation (AMREF)



Baseline Survey in Bena Tsemay and Selemago Woredas

Final Report

FINNET CONSULT

ADRESS

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ACRONYM

| | |
|---------------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| AMREF African | Medical Research Foundation |
| ANC | Anti Natal Care |
| ARI | Acute Respiratory Infections |
| ART | Anti-retroviral therapy |
| CBO | Community Based Organization |
| C-IMCI | Community IMCI |
| CPR | Contraceptive Prevalence Rate |
| DHS | Demographic Health Survey |
| DPT | Diphtheria, Pertusis, Tetanus |
| DHS | Demographic Health Survey |
| EOC | Emergency Obstetric Care |
| EPI | Expanded Program on Immunisation |
| Evangadi | Local dance common among Hammer, Benna and others |
| FGD | Focus Group Discussion |
| FGC | Female Genital Cutting |
| FMOH | Federal Ministry of Health |
| FP | Family Planning |
| GAVI | Global Alliance on Vaccines and Immunizations |
| HC | Health Centres |
| HES | Health Extension Service |
| HEW | Health Extension Workers |
| HH | House Hold |
| HIV | Human Immunodeficiency Virus |
| HP | Health Post |
| HSDP-III | Health Sector Development Program |
| HSEP | Health Service Extension Program |

| | |
|--------------|--|
| HTP | Harmful Traditional Practices |
| ICC | Interagency Coordination Committee |
| IDI | In-Depth Interviews |
| IGA | Income Generating Activates |
| IMCI | Integrated Management of Childhood Illnesses |
| KII | Key Informants Interview |
| M & E | Monitoring and Evaluation |
| NGO | Non Governmental Organisation |
| PICT | Provider Initiated Counselling and Testing |
| PMCT | Prevention of mother to child transmission |
| PNC | Post Natal Care |
| RH | Reproductive Health |
| SRH | Service of Reproductive Health |
| SPSS | Statistical Package for Social Sciences |
| STI | Sexually Transmitted Infection |
| TBAs | Traditional Birth Attendants |
| TFR | Total Fertility Rate |
| THCPs | Traditional Health Care Providers |
| TOR | Terms of Reference |
| TT | Tetanus Toxoid |
| UNFPA United | Nations Fund for Population Action |
| VCT | Voluntary Counselling and Testing |

Acknowledgments

First of all, we would like to express our profound gratitude to the Spanish Agency for International Development (AECID) for funding this study through AMREF Spain. Our thanks also go to AMREF-Ethiopia for allowing us to conduct this study. We are equally grateful to AMREF-South Omo program Office staff for their cooperation in facilitating the fieldwork.

We also extend our thanks to Kebele administrators, and officials and experts of line offices in all Woredas and in South Omo zone for facilitating and providing necessary information for the study.

We are also extremely grateful to the community members who spent their precious time patiently to provide the required data for the survey, and their participation in focus group discussions and in-depth interviews.

Executive Summary

In this baseline study a total of 398 study subjects were interviewed (98.8% of the calculated sample). Among the total respondents 208 (53.3%) were from Bena-tsemay while the remaining 190 (48.7%) were from Salamago woreda. As to the sex distribution of the respondents, this study has given major emphasis on females and correspondingly 276 (69.3%) of the respondents were females, while the rest 122 (30.7%) of the respondents were males. The majority of the respondents are Bena and Tsemay in Benatsemay woreda and Bacha, Dime and Mursi in Salamago. The mean age of the respondents was found to be about 25.5 years and 64.6% of the respondents were married followed by widowed women (19.1%) the majority of the respondents (50.6%) got married by the arrangement of their parents followed by 35% were married through elopement and abduction (14.4%). Average age (mean) and median age at marriage of the respondents was 17 years. Protestant and orthodox Christianity comprise 28.4% and 16.8% of the respondents. The majority of the respondents were semi-pastoralists (34.4%), pastoralists (20.6%) and farmers (25.4%). The majority of the respondents were unable to read and write (58.5%), followed those attended formal education (15.3%). The mean and median family size of the respondents was 5.3 and 5.0 respectively.

The majority of respondents 313(78.6%) have heard about HIV/AIDS epidemic. The majority heard about HIV/AIDS, 60 % of the respondents had heard from health facilities, 43.3% from community gatherings and 20.5% from family members and 286(91.4%) were aware of one or more mode of transmission and prevention methods. Regarding modes/routes of its transmission respondents indicated unsafe sex (80.4%), infected sharp instruments (58.1%), infected blood contact (33.8%), mother to child (2.4%) and others (1.7%) to be the major routs of HIV transmission. Significant number of respondents are aware of the prevention methods of HIV/AIDS such as correct and consistent use of condoms (75.2%), being faithful to partner (44.1%) and abstinence (28.8%), followed by avoiding infected blood contact (13.5%). In this baseline study, about 88.4% of the respondents have ever practiced sex while only 46 (11.6%) reported not practicing sex. The mean age to begin the first sexual intercourse for the respondents was 16 with standard deviation of 3.6. The most frequently reported (modal age) at first sexual intercourse was 15 years (15.6% of the respondents). Of those who had sexual intercourse with non-regular sexual partner, 29.6% used condom and more than two-third (70.4%) have never used condom. Of those who used condom, only 11.1% used condom consistently and 14.6% used sometimes.

Of all study subjects, 221(55.5%) have heard about voluntary counselling and testing service and 77.4% received the information about VCT from health service providers. Of all the respondents about 58.4% have ever been tested for HIV. The most common site for the test was health centre accounting about 44% of the total cases followed by hospital (20.7%) and mobile testing centre (18.1%). Unlike the knowledge in the case of HIV/AIDS, 157(39.4%) of the respondents reported that they haven't heard about STIs. Accordingly, 87.6%, 43.1% and 33.3% know gonorrhoea, syphilis and HIV/AIDS as STIs while only 8.5% know genital warts as an STI. About 75.8% of the respondents know the transmission ways of STIs.

In this baseline assessment, 60.9% of the female respondents have heard about reproductive health issues. Asked about which service they are aware of, 38.8% know about ante-natal care, 47.3% know about family planning, 30.3% about delivery care, and 11.5% about post-natal care. Among the the mothers who have given birth during the last two years, 70.9% attended ANC for the last child. More than three-fourth (84.4%) of the respondents has visited health facilities for RH services. Abstinence, condom and injectable were mentioned by 11.7%, 13.6% and 63% of the respondents respectively as methods to prevent unwanted pregnancy. Of all female respondents, 47.1% reported that they use contraceptives. Of the total eligible respondents only 28.1% have ever experienced pregnancy related complications. The common problems faced were excessive passage of liquid (30%), infection (16.9%), high blood pressure (20.8%), leg swelling (15.6%), and vomiting (20.8%). It is also reported that 11.7% of the respondents have faced foetal death.

This study revealed that the majority of mothers (78.9%) delivered their last child at home while about 5.6% of mothers delivered at health post, and 6% of mothers delivered at health centre. Of all mothers 12(5.2%) reported that they delivered their last child in the forest. When they were asked about the presence of Anti-AIDS/RH clubs in their community, about 36 (13.5%) of the respondents reported that the clubs are available in their area and 23(63.9%) of them were members of the clubs they indicated.

Among the total respondents asked about their position 45% reported that they support the fight against harmful traditional practices and a great majority (44.9%) of the respondents are not yet convinced that harmful traditional practices should be abolished. Besides that, some respondents are aware that harmful traditional practices such as FGM, marriage by abduction, widow inheritance, female circumcision, milk teeth extraction, tonsillectomy and uvula cutting have been some of the risk factors which can be the cause for HIV infection.

Background

Ethiopia is the second most populous Sub-Saharan African country, with a population of over 74 million. The Federal Democratic Republic of Ethiopia is administratively divided into nine regional states and two city administrations. Southern Nations Nationalities and Peoples Regional State (SNNPRS) is one of the major regions in the country. It is a culturally diverse and multiethnic region with over 60 distinct ethno-linguistic groups, and a residence for 19.9% of the nation population (CSA, 2007). SNNPRS is administratively divided into 13 zones and 8 special Woredas, in which South Omo is one of its zones. The zone is administratively divided into eight Woredas with a population of 577,673. (CSA, 2007).

A recent document from the Regional Health Bureau indicates that the region is aggressively implementing the Ethiopian Health Extension Service Package. Accordingly, there are 7288 Health Extension Workers (HEWs), to which 221 are trained to serve the pastoral communities. The same document indicates that health posts have been constructed in 89% of the kebeles where the HEWs provide the health service to local communities.

South Omo Zone is bordered by Kenya to the south, the Bench- Maji Zone to the West, the Keficho- Shekicho zone to the North West, the North Omo zone to the North, Derashe and Konso Special Woredas to the North East and the Oromia Region to the East. Jinka is the capital and administrative centre of the zone. It is relatively a large zone covering an area of 22,361 square kilometres and inhabited by various pastoral and agro-pastoral societies. According to the CSA projection report, the population of the zone was 470,751 in 2005. It is one of the sparsely populated zones with a population density of only 21 persons per square kilometer, which is one third of the national average (65 persons per square kilometer) (CSA 2005). It has also poor infrastructural facilities and weak road networks, which has been the outcome of marginalization and historical neglect by previous regimes.

It is one of the most socially diverse zones in the country comprising as many as 21 ethnic groups. The 21 ethnic groups are Arbore, Arri, Banna, Bashada, Bodi, Borena, Dassanech, Dime, Gawada, Hamar, Kara, Konso, Maale, Mago, Mogudji, Murssi, Nyangatom, Ongota, Tsamai, Surma and Woito. Social diversity, therefore, compounds the existing problems of isolation, acute shortage of basic infrastructure as well as scarcity of professional and technical human resources. Only 4% of the inhabitants of South Omo have access to electricity and road network, which is much lower than the national average. The zone has a road density of 22.7 kilometers per 1000 square kilometers which is less than the national

average that is 30 kilometers. Only 37% of all eligible children are enrolled in the primary schools, and only 7% in secondary schools. 77% of the zone is exposed to malaria, and 61% to Tsetse fly (World Bank, 2004).

In relation to the HESP, South Omo has 358 HEWs deployed in 155 health posts. Of the 358 HEWs 135 are trained for pastoralists. The zone planned to graduate 82,215 households in health extension service package in 2001 Ethiopian Fiscal Year, of which it could manage to achieve only 40% of what has been planned. The report¹ indicates that South Omo is one of the most exposed areas for polio and other childhood illnesses and is able to benefit from the immunization services conducted in the region with a performance rate of 68% from the plan. In the same year, the zone is able to perform 59% and 72% of the planned BCG and measles immunization respectively from the eligible children which is the lowest performance compared to other zones in the region. The TT2 performance of the region is 69.5%, which is the most important component for the proposed programmes of AMREF targeting youth and adolescents. In this case, the zone has achieved disproportionately low performance for TT2 immunization, which is 27% for non pregnant women that justify the need to implement the programme from the beginning. The family planning coverage, ANC, and delivery in South Omo seems to be as low as 42.5%, 69%, and 42% respectively.

Table 1: Prevalence of HIV in South Omo²

| | HCT | VCT | PICT | Service providers |
|-----------|------|-------|-------|-------------------|
| South Omo | 1.9% | 1.4% | 0.9% | 23 |
| SNNPRS | 1.3% | 1.05% | 1.95% | 349 |

Entrenched cultural beliefs, traditional practices, low literacy and predominantly pastoral way of life in the areas necessitate a tailored approach to address problems related to health care systems.. According to the 2007 population and housing census, the total population of the zone was 577,673 (43,302 in urban). Of this, the population of Selamago and Bena-tsemay districts constitute 28,888 and 55,590, respectively.

¹ SNNPRS, RHB performance report for 2001 EFY. August 2009. Hawassa

² Information from the source is analyzed by the consultancy firm.

Background of AMREF

The African Medical and Research Foundation (AMREF) is an international non-for-profit, non-governmental organization that was founded in 1957 in East Africa, seeking to provoke health care improvements of significance important in Africa. Headquartered in Nairobi, Kenya, AMREF has country offices in Ethiopia, Kenya, Tanzania, Uganda and South Africa and field offices in Southern Sudan and Somalia.

AMREF strongly believes that there is an acute gap between vulnerable communities and the health system. To close the gap, AMREF's strategy is designed to create a broader-based culture of health promotion, prevention and care in the Africa Health area.

For its 2007-2017 strategy period, AMREF has chosen to act in a holistic and integrated way and hence focused on three interrelated thematic areas: (1) Partnership with Community for Better Health, (2) Building Capacity for Strengthened Communities and health System Responsiveness and (3) Health Systems Research for Policy and Practice.

Although AMREF has been formally registered in Ethiopia in 1998, and its full-fledged country program was started in 2002. Since then, the country program has grown from one project in Addis Ababa to over 20 projects in four regions (Addis Ababa, Afar, Oromia and Southern Nation Nationalities and People Region State). AMREF in Ethiopia (AMREF ET) is working in health development with the motto of providing better health for the people of Ethiopia.

General Objective of the Project

This project is designed to support and empower youth and adolescents in South Omo and CSOs to promote the sexual and reproductive health and rights of young people and PLHA in pastoralist communities. The goal of the project is to decrease maternal mortality and HIV incidence and to increase uptake of VCT, PMTCT and ART through increasing access to and utilization of health services.

Specific objectives of the project:

- TO empower youth, adolescents and PLHA in pastoralist community to promote their sexual and reproductive health.
- To support young people and PLHA in pastoralist community to have increased access to quality and comprehensive SRH/HIV services.

- To enable civil society organizations and traditional groups in South-Omo provide support for and represent the rights young people and vulnerable groups.
- To generate increased evidence for future replication.

Expected Outcomes and Indicators of the Project

Outcome 1: Pastoralists, particularly young people and PLHA, are empowered and informed to promote their sexual and reproductive health.

Indicators:

- % of people who know about SRH
- % of people who know how to protect themselves from unintended pregnancies, and from HIV and STIs
- % of young people reporting safe sexual practices in target districts
- % of pregnancy related complications among young women/girls in target district
- % of young mothers who attend ANC;
- % of young mothers whose birth was attended by skilled personnel;
- % of pregnant women tested and counselled for HIV
- Membership of community RH/HIV clubs in and out of school, including higher representation of disabled people
- Evidence that influential individuals (parents, men, community leaders, religious leaders, policy makers) have correct knowledge/awareness of adolescent reproductive rights, including rights of people living with HIV, and disabled people.
- Knowledge of people about harmful traditional practices and their support fighting against it.

Outcome 2: Pastoralists, particularly young people and PLHA, have increased access to quality, inclusive and comprehensive SRH/HIV services.

Indicators:

- % of health facilities in target areas providing youth friendly RH services.
- % of correct referrals made to youth by HEW for RH/HIV prevention, testing and counselling.
- % of adolescents who attend facilities for RH/FP;
- % of adolescents who use contraceptive

- % of adolescents who use condom during sexual intercourse
- Referral links established between schools and health centers/outreach facilities
- Number of individuals expressed satisfaction with RH (including PMTCT and VCT) services

Outcome 3: Civil Society organizations and traditional groups in South Omo are able to provide support for and represent the rights of women and young people

Indicators:

- Membership of community post-test clubs/support groups and youth groups.
- Evidence of institutional consultation between local authorities, and CBOs (% of youth and PLHA groups who report having been consulted in decision making forums and programme design, number of regular consultative meetings held).
- Prioritization of RH and HIV/AIDS programmes in zonal and woreda government plans and budgets.
- Evidence of capacity of communities in South Omo to advocate and/or mobilize for rights to health.

Objective of the Study

The general objective of this baseline survey is to conduct an assessment and document benchmark information that help to measure the changes through the contribution of the project in regards to youths, adolescents, PLHA, and CSOs empowerment to promote sexual and reproductive health and rights of young people and PLHA in pastoralist communities.

More specifically, this study will help to give information on:

- The knowledge and empowerment of youths, adolescents and PLHA in regard to promoting their own sexual and reproductive health;
- The access, quality, inclusive and comprehensiveness of SRH/HIV services; and
- The capacity of civil society organizations in South Omo with regard to providing support for and represent young people and vulnerable groups.

Methodology

Generally the study was guided by conceptual and practical framework of community based cross sectional survey design. The consulting firm employed both quantitative and qualitative research methods to collect the primary data from the four project districts. Quantitative

measures were obtained using structured questionnaires with a representative sample of the total population, while qualitative information was collected using focus group discussions and in-depth interviews using semi-structured questionnaires. A Household Survey using structured interviews with a random sample of respondents was utilized to gather quantitative individual and household level information, while in-depth interviews were used with influential people, opinion leaders and religious leaders, and separate Focus Group Discussions involving men, women and male and female adolescents of different age category were employed to collect qualitative information.

Study Population

The study population is determined based on the purpose of the survey to establish baseline benchmark indicators on the to measure the change through the contribution of the projects in regards to youth, adolescents, PLHA and CSOs empowerment to promote SRHR of young people and PLHA in pastoralist communities. As the main purpose of the study was to generate health related information at community and household level, it is believed that households could provide the required information. Thus, the study population were youths and adolescents including mothers in the two districts. Civil societies and PLHA and their associations were also included in the study.

Sampling and Sampling procedure

In this study attention was given to include representative and adequate number of cases in order to perform a meaningful analysis. Thus, two districts namely Bena Tsemay and Selamago were covered with adequate and representative number of respondents. All kebeles in each woreda were included and considered for sampling and a representative sample of households from each Kebele was taken using a multistage cluster sampling technique.

Sample Size Determination

Sample size is the pivotal feature that governs the overall design of the study. In this study, an appropriate sample size was the minimum number of people between ages 15-49 which would allow core indicators to be calculated with a reasonable level of precision. The factors and parameters that were considered are key estimates desired, target populations, precision and confidence level wanted, estimation domains, whether measuring level or change, clustering effect, allowance for non-response and available budget.

The baseline survey is expected to yield a number of indicators that can help project monitoring and evaluation. Given the lack of concrete information from previous studies that

measured the percentage of youth and adolescents having proper knowledge about HIV/AIDS the worst case scenario of (p=50%) was considered. Hence, in the absence of any previous information, we assumed the proportion (p) to be 50%. Thus, the sample size was determined for each Woreda using 90% confidence interval, 5% margin of error and a p (magnitude of effect) value of 50%.

$$[\{ Z_{\alpha/2}^2 * p(1-p) \} / e^2] * d$$

Where n is the required minimum sample size, d = the design effect (1.5 is used assuming that kebele and households was sampled), $Z_{\alpha/2} = 1.64$, $\epsilon = 0.05$ and $p = 0.5$. Substituting the respective values into the above formula, a minimum sample of 403 households was obtained for the study. In this study, the non-response rate was assumed to be zero.s. This sample was proportionally allocated to the population of each district. This is assumed to be large enough to attain a 90% confidence in estimating the expected changes in the indicators. Regarding the selection of respondents, Kebeles and villages were listed down and selected randomly. Then households were randomly picked and the questionnaire was administered by trained interviewers.

Qualitative Study

The qualitative approach, as pointed out earlier, involved focus group discussions, key informant interviews and direct observations.

Study Instruments/Tools

Guided by the proposed methodology, basically two types of study tools were designed. Structured questionnaire for quantitative survey and semi-structure interview guides for the qualitative section. The main data collection instruments (the semi-structured questionnaire for the key informant interviews, the structured questionnaire for the quantitative baseline survey, and the focus group discussion guide) were prepared on the basis of the findings of the documents review, and identified key indicators of the projects.

Recruiting and Training of Field Staff

To conduct the fieldwork with an acceptable level of precision and accuracy, interviewers, supervisors, moderators and note takers were identified, selected, trained and deployed for the fieldwork. The team leaders, note takers, supervisors and interviewers were given a two day training that covers methods of sampling, recruiting participants (including informed

consent), conducting interviews, and taking interview notes (for semi-structured interviews and FGDs).

Field Data Collection

Fieldwork was conducted using the field personnel. The supervisors had served as team leaders and the principal researchers/investigators coordinated the entire fieldwork. After the training of interviewers and supervisors, the field staffs were deployed to their respective sites to start data collection. The structured questionnaire was administered to sample households by the trained interviewers. Supervisors were responsible for the quality of the work of each data collector and ensured that the data collection was done as planned and the information was recorded in the questionnaire as expected.

Data Management

Quality assurance

At each level of the study, we agreed up on setting and using quality assurance checkpoints. Pre-test of all the tools was conducted and modification was made as necessary. Supervision of the data collection process was extensive and includes checking the consistency of the data collection process and responses. Data entry for quantitative and coding of the qualitative parts was also be closely followed. About 5% of the data was re-entered to check for quality of the data entry process. The questionnaire was translated from English into Amharic and revised for its consistency and validity.

Individual household questionnaire

Interviewers returned with completed interview forms and submitted to the supervisor at the end of each day. Then the supervisor checked the questionnaire for completeness, consistency and validity of the data. These forms were rechecked for consistency, open-ended questions were recorded in the office and then the data was entered and analyzed into a computer using SPSS.

Key Informant Interviews

The supervisors interviewed the key informants and took notes using the semi-structured questionnaire. After the interview, they reviewed their notes to ensure clarity and completeness. Then, they returned with completed interview forms and submitted to the team leaders at the end of data collection. In all cases, however, interviews were recorded in the tape recorders after the consent of interviewee has been ensured.

Focus Groups Discussion

Focus group discussions were audio taped. Experienced moderator facilitated the focus group discussions, while the note taker took notes and at the same time recorded the discussion. After the focus group discussion was finished, the note taker and moderator reviewed the notes and made reasonable summaries of the focus group discussion, which were finally used in the production of the report.

Data Analysis

Data gathered from the key informant interviews and focus group discussions was transcribed and then translated into English before analysis. Qualitative data was thematically analyzed. Quantitative data from the household survey was entered and analyzed using descriptive statistics (percentages and frequencies) and cross-tabulations on SPSS. To ensure data quality 5% of the data was double entered and checked.

Dissemination and utilization of results

The consultancy firm was able to communicate the findings through draft and final reports to AMREF and will provide power point presentation whenever necessary to AMREF and to its partners and stakeholders as required.

Ethical Implications

The aim of the baseline survey is to develop benchmark indicators for programme implementation which by default addresses most of the ethical issues. Therefore, the consultancy firm did not utilize tools which imply invasive procedures. Moreover, the firm worked in close collaboration with AMREF M&E and South Omo health office. In all cases respondents were asked for informed consent to participate in the study.

Results

Background information

In this baseline study a total of 398 study subjects were interviewed (98.8% of the calculated sample). Five of the selected respondents were not willing to provide the information as they were busy in their routine life business. Among the total respondents 208 (53.3%) were from Bena-tsemay while the remaining 190 (48.7%) were from Salamago woreda. The distribution of the study respondents by districts is almost uniform.

As to the sex distribution of the respondents, this study has given major emphasis on females and correspondingly 276 (69.3%) of the respondents were females, while the rest 122

(30.7%) of the respondents were males. The sex distribution of the respondents in the two districts is shown in the table below. The majority of the respondents are in Benatdemay are from Bena ethnic group (59%) followed by Tsemay and Braille which contributed for 36% and 5% respectively. Regarding the respondents from Salamago woreda Bacha, Dime and Mursi in salamago are included for this study.

Table 2: Sex of distribution of the respondents

| Districts | Districts | | | | Total | Percent |
|--------------|---------------|-------|------------|-------|------------|---------|
| | Bena - Tsemay | % | Salamago | % | | |
| Male | 58 | 27.9% | 64 | 33.7% | 122 | 30.7% |
| Female | 150 | 72.1% | 126 | 66.3% | 276 | 69.3% |
| Total | 208 | | 190 | | 398 | |

With regard to the age distribution of the respondents, the mean age of the respondents was found to be about 25.5 years with standard deviation of 7.3 years. The age range was from 12 to 52 years.

Observation of the marital status of the respondents indicates that the majority (64.6%) of the respondents were married followed by widowed women (19.1%). It is true that married persons were preferred for interview and the findings are consistent with the intentions. The distribution of study subjects by their marital status is shown in the next table.

Table 3: Marital status of the respondents

| Marital Status | Districts | | | | Total | Percent |
|----------------|-------------|-------|------------|-------|------------|---------|
| | Bena-Tsemay | % | Salamago | % | | |
| Never married | 25 | 12.0% | 33 | 17.4% | 58 | 14.6% |
| Married | 111 | 53.4% | 146 | 76.8% | 257 | 64.6% |
| Separated | 0 | 0.0% | 5 | 2.6% | 5 | 1.3% |
| Divorced | 1 | 0.5% | 1 | 0.5% | 2 | 0.5% |
| Widowed | 71 | 34.1% | 5 | 2.6% | 76 | 19.1% |
| Total | 208 | | 190 | | 398 | |

Those who are married were asked how they got married. As shown in the table below, the majority of the respondents (50.6%) got married by the arrangement of their parents. The next majority of the respondents (35%) were married through elopement (by their own

decision) followed by those married by abduction (14.4%). The distribution of mean to their marriage is shown in the following table.

Table 4: How respondents got married

| | | Frequency | Percent | Valid Percent | Cumulative Percent |
|--------------|---------------------|------------------|----------------|----------------------|---------------------------|
| Valid | Through abduction | 49 | 12.3 | 14.4 | 14.4 |
| | Through Elopement | 119 | 29.9 | 35.0 | 49.4 |
| | Arranged by parents | 172 | 43.2 | 50.6 | 100.0 |
| | Total | 340 | 85.4 | 100.0 | |
| Missing | System | 58 | 14.6 | | |
| Total | | 398 | 100.0 | | |

The situation is broken to district level and shows that in Bena Tsemay arranged marriage and elopement is dominant (68% and 20% respectively) while elopement by consensus and arranged marriage by parents (53% and 30% respectively) is dominant in Salamago district. In both districts the remaining respondents indicated marriage by abduction.

Average age (mean) and median age at marriage in this study was found to be about 17 years with standard deviation of 3.9 years. The most repeated (modal) age at first marriage was reported to be 16 years – 15.8% of the total respondents reported this age at first marriage. This seems higher than other regions. The religion of the study subjects was also cross-tabulated for the study districts and the findings are shown below in the table. The data revealed that the majority of the community members follow traditional and other types of religion. Protestant and orthodox Christianity are also dominant types of religions followed by 28.4% and 16.8% of the respondents. 2% of the respondents could not mention their religion.

Table 5: Distribution of the respondents by type of their religion

| Religion categories | | | Total |
|----------------------------|--------------------|-----------------|--------------|
| | Bena-Tsemay | Salamago | |
| Protestant | 48 | 65 | 113 |
| Orthodox | 10 | 57 | 67 |
| Catholic | 1 | 14 | 15 |

| | | | |
|--------------|------------|------------|------------|
| Muslim | 0 | 0 | 0 |
| Other | 149 | 46 | 195 |
| Total | 208 | 182 | 390 |

The main occupation of the respondents was also described in this study. The study is consistent with the zonal categorization of the two districts as pastoralist areas and previous findings. The majority of the respondents were semi-pastoralists (34.4%), pastoralists (20.6%) and farmers (25.4%). Women who identified themselves as housewives were 10.8%. The overall distribution of the respondents by their major occupation is shown in the following table.

Table 6: Main occupation of the respondent

| Main Occupation | Districts | | Total |
|------------------|-------------|------------|------------|
| | Bena-Tsemay | Salemago | |
| Sedentary Farmer | 19 | 82 | 101 |
| Pastoralist | 56 | 26 | 82 |
| Agro-pastoralist | 110 | 27 | 137 |
| Employee | 3 | 14 | 17 |
| Trader | 2 | 7 | 9 |
| House wife | 12 | 31 | 43 |
| Dairy labourer | 3 | 2 | 5 |
| Other | 3 | 1 | 4 |
| Total | 208 | 190 | 398 |

Low literacy remains the main challenge and characterisation of the population residing in the two study districts. As shown in table 8, the majority of the respondents were unable to read and write (58.5%), followed by those who attended formal education (15.3%). The majority of those who attended formal education have been the inhabitants of Salamago districts which can be explained in terms of settlement programmes and alternative basic education expansion in the pastoralist districts.

Table 7: Educational status of the study respondents

| Educational Status | | | Total |
|------------------------|-------------|----------|-------|
| | Bena-Tsemay | Salamago | |
| Don't read and write | 166 | 67 | 233 |
| Can only read or write | 21 | 33 | 54 |
| Not formal school | 7 | 43 | 50 |

| | | | |
|------------------------|------------|------------|------------|
| Attended formal school | 14 | 47 | 61 |
| Total | 208 | 190 | 398 |

The mean and median family size of the respondent households was 5.36 and 5.0, respectively with a range from 1 to 20 persons per household with standard deviation of 2.9. The modal family size in those districts was 4 persons per household.

In relation to the above socio-demographic information obtained from respondents, the participants of Focus Group Discussions (FGD) and In-depth Interviews (IDI) were asked about the overall problems affecting their daily life. According to their response the major problems facing the inhabitants of the study area have been high infestation of malaria epidemic, lack of health facilities in close proximity, poor medical services and shortage of drugs in health facilities, lack of access to safe water, poor infrastructural facilities like road networks and transportation services that link the rural K'ebeles with their respective Woredas and zonal capital. With regard to malaria, informants from Biraille alleged that they have been the most seriously affected and highly exposed to its infestation than any other group because they are living in marshy areas and banks of the Woit'o River.

They further underlined that the root causes for most of these problems seem to be abject poverty caused by recurrent drought, and other factors such as economic backwardness, remoteness of the area, illiteracy, ignorance, lack of interest and motivation for work, laziness as well as lack of cooperation with each other. In this connection, the youths participated in FGD from Bodi ethnic group pointed out that lack of knowledge, education and awareness have been their major problems. Consequently, they stated that "we could not attend our classes regularly due to our pastoral way of life characterized by frequent movement from place to place. Even if we have access to education since the opening of mobile schools in our localities, we could not attend them in a proper way because of our responsibility of looking after the livestock. As a result, our mind is predominantly occupied by the idea of having a large number of herds that could enable us to marry two or more number of wives". Particularly the youths participated in FGDs and in-depth interviews underlined that lack of employment opportunities, recreation facilities, effective family planning and the epidemics of HIV/AIDS and Sexually Transmitted Infections (STI) were mentioned to be their major problems.

HIV/AIDS/STI information

Respondents were asked about their knowledge on HIV/AIDS. It was noted that the majority of respondents 313(78.6%) have heard about HIV/AIDS epidemic. Despite ones expectation to find lower level of awareness among the communities about HIV/AIDS, only 85 (21.4%) of the respondents haven't heard about HIV/AIDS. When asked to mention where they have heard about HIV/AIDS, 60 % of the respondents had heard from health facilities, 43.3% from community gatherings and 20.5% from family members. Radio and television played less significant role – which implies for tailor made and contextualised message dissemination. The higher percentage can be attributed to community conversation activities in the past years by AMREF and other partners and the deployment of health extension workers (HEWs).

Table 8: Sources of information for HIV/AIDS

| Sources of information | Number | Percent |
|-------------------------------|---------------|----------------|
| Health Facilities | 187 | 59.9% |
| School | 56 | 17.9% |
| Radio | 10 | 3.2% |
| Television | 1 | .3% |
| Family members | 64 | 20.5% |
| Community gathering | 135 | 43.3% |
| Other | 3 | 1.0% |

Unlike the conventional assumption regarding semi-pastoralist communities' knowledge and awareness about HIV, from all respondents who have heard about HIV/AIDS, 286(91.4%) were aware of one or more mode of transmission and prevention methods. Regarding the source of information in relation to modes of transmission consistent results were reported with general information about HIV/AIDS which is dominated by health facilities, schools and community gatherings. TV played the least significant role for both variables. The sources of information regarding modes of transmission and prevention methods towards HIV/AIDS are shown in the following table.

Table 2: Sources of information for HIV/AIDS transmission and prevention

| Sources of information | Number | Percent |
|-------------------------------|---------------|----------------|
| Health Facilities | 182 | 60.7% |
| School | 58 | 19.3% |
| Radio | 10 | 3.3% |
| Television | 3 | 1.0% |
| Family members | 71 | 23.7% |
| Community gathering | 112 | 37.3% |

Study subjects who have heard about HIV/AIDS were also asked about the modes/routes of its transmission. Accordingly, respondents indicated unsafe sex (80.4%), infected sharp instruments (58.1), infected blood contact (33.8%), mother to child (2.4%) and others (1.7%) to be the major routs of HIV transmission. Despite the availability of the PMTCT service at different facilities mother to child transmission is the least known mode of transmission. The results are displayed in the following table.

Table 10: Routes for HIV/AIDS transmission as indicated by respondents

| Sources of infection | Number | Percent |
|-----------------------------|---------------|----------------|
| Unsafe sex | 238 | 80.4% |
| Infected blood contact | 100 | 33.8% |
| Sharp instruments | 172 | 58.1% |
| Mother to child | 7 | 2.4% |
| Others | 5 | 1.7% |

According to the participants of FGD and in-depth interviews, the availability of alcoholic drinks and the Traditional Dance “Evangadi”, especially among the Bena and Tsemay have been the major factors that led them to be exposed to unprotected sex and vulnerability to HIV/AIDS. They also added that their tradition which allows males to have sex with anybody at any time in throughout their life, and which prohibits females from such privilege except during Evangadi has been the other factor that increases the males’ vulnerability to HIV/AIDS and sexually transmitted infections ac compared to females. In this connection, health education and advice have been provided by health workers concerning prevention modes of transmission and methods of HIV transmission.

On the other hand, there are several misconceptions about the modes of transmission and prevention methods of HIV/AIDS among the communities in South Omo zone. The most common misconception was that a healthy looking person can’t have HIV/AIDS Significant

proportions of the respondents also believe that HIV can be transmitted by supernatural power and mosquito bites which imply the need for continuous awareness raising activities. It should also be noted that in all the misconceptions there exist significant proportion of respondents reporting ‘don’t know’ which in most cases may imply inability to correctly identify modes of transmission. Moreover, correct and comprehensive knowledge of modes of transmission serves as a tool to fight against stigma and discrimination towards PLWHA. In relation to this, the participants of FGD and in-depth interviews pointed out that some of the rural inhabitants still perceive the HIV/AIDS as a problem of urban dwellers only. Most of the misconceptions are described in the following

Table 3: Misconceptions about HIV/AIDS transmission and prevention

| Types of Misconception (N=314) | Yes | | No | | Don't know | |
|--|-----------|-------|-----------|-------|------------|-------|
| | Frequency | % | Frequency | % | Frequency | % |
| HIV can be transmitted by mosquito bite | 70 | 22.3% | 170 | 54.1% | 74 | 23.6% |
| HIV can be transmitted by sharing feeding plates | 41 | 13.1% | 233 | 74.2% | 40 | 12.7% |
| HIV can be transmitted by shaking hands | 34 | 10.8% | 244 | 77.7% | 36 | 11.5% |
| HIV can be transmitted by sharing toilet/shower | 51 | 16.2% | 215 | 68.5% | 48 | 15.3% |
| HIV can be transmitted by supernatural force | 84 | 26.8% | 132 | 42.0% | 98 | 31.2% |
| Healthy looking person can't have HIV | 72 | 22.9% | 138 | 43.9% | 104 | 33.1% |
| HIV preventable | 228 | 72.6% | 49 | 15.6% | 37 | 11.8% |

In addition among 314 it is worthy mention that respondents asked about whether it is possible to prevent HIV transmission significant majority 228 (72.6%) reported that it is possible while only 49(15.6%) indicated it is not possible. The remaining 37(11.8%) reported that they don’t know.

The table below summarizes the responses regarding the means of HIV/AIDS prevention. Most of the responses indicate that a significant number of respondents are aware of the prevention methods of HIV/AIDS such as correct and consistent use of condoms (75.2),

being faithful to partner (44.1%) and abstinence (28.8%), followed by avoiding infected blood contact (13.5%).

Table 12: Respondents' knowledge about HIV prevention methods

| Types of Prevention methods and misconception | Number | Percent |
|--|---------------|----------------|
| Correct and consistent use of condom | 167 | 75.2% |
| Limit sex to one uninfected faithful partner | 98 | 44.1% |
| Abstain from sexual intercourse | 64 | 28.8% |
| Avoid blood contact | 30 | 13.5% |
| Use of alcoholic drink | 15 | 6.8% |
| Eating raw meat | 4 | 1.8% |
| Other | 1 | .5% |

Respondents were also asked about their sexual practice. In this baseline study, about 88.4% of the respondents have ever practiced sex while only 46 (11.6%) reported not practicing sex. The mean age to begin the first sexual intercourse for the respondents was 16 with standard deviation of 3.6. The most frequently reported (modal age) at first sexual intercourse was 15 years (15.6% of the respondents). From those respondents who practiced sex, about 73.9% committed their first sexual intercourse with their spouse, while 15.1% of the respondents perform it with their ex-spouses. Among respondents, 9.4% practiced their first sex with a person whom they don't know.

The prevalence of sex with non-regular sexual partner (neither spouse nor cohabiting partner) in the last 12 months among the respondents of this study was found to be 8.8%. Similarly, the prevalence of sex with non-regular sexual partner (neither spouse nor cohabiting partner) in the last 3 months among the respondents of this study was found to be 7.7%. Out of these respondents, about 48.1% practiced sex with two partners followed by those having three partners (25.9%). The remaining 22.2% and 3.7% practiced sex with one and 5 partners respectively.

Of those who had sexual intercourse with non-regular sexual partner, 29.6% used condom and more than two-third (70.4%) have never used condom. Of those who used condom, only 11.1% used condom consistently while 74.1% never used at all and 14.6% used sometimes.

According to the information obtained from the participants of FGD and in-depth interviews, a significant number of informants were aware that using condom could prevent them from HIV/AIDS and sexually transmitted infections. Nonetheless, they could not practically use it in their daily life due to unwillingness of their partners. As a result, the number of people presently using condom seems to be very low. In this connection, most of the informants confirmed that they mostly refuse seeking treatment in health facilities for sexually transmitted infections fearing the opinion from health workers and others. As a result, they mostly consult drug vendors that could sale them antibiotics without any prescription and disclosing their health status.

Of all study subjects, 221(55.5%) have heard about voluntary counselling and testing service. The remaining 44.5% never heard about VCT services. Among those who have heard about VCT the majority (54.3%) reside in Bena Tsemay district. In accordance with this, the participants of FGD affirmed that they heard about the availability of voluntary counselling and testing services in the capital of each Woreda from health workers. However, the majority of them have not yet been tested due to lo having long distance between the Woreda capital and because there is no VCT services in most of the health facilities in rural areas. Nevertheless, there are a number of youths who are willing to be tested before marriage and to know their health status.

Table 13: Respondents awareness about VCT

| Districts | Heard about VCT | % | Haven't heard about VCT | % | Total |
|------------------|------------------------|----------|--------------------------------|----------|--------------|
| Bena-Tsemay | 120 | 54.3% | 88 | 49.7% | 208.543 |
| Salamago | 101 | 45.7% | 89 | 50.3% | 190.457 |
| Total | 221 | | 177 | | 398 |

The sources of information about VCT for the respondents are of several types – as it is true for most of the information sources related to HIV majority of the respondents (77.4%) received the information about VCT from health service providers followed by community gatherings (28.1%) , family members (25.8%) and schools (14.9%). The following table shows the major sources of information.

Table 4: Sources of information for VCT among respondents

| Sources of information | Number | Percent |
|------------------------|--------|---------|
| Health Facilities | 171 | 77.4% |
| School | 33 | 14.9% |
| Radio | 4 | 1.8% |
| Television | 1 | .5% |
| Family members | 57 | 25.8% |
| Community gathering | 62 | 28.1% |
| Other | 1 | .5% |

Of those who have ever heard about VCT, 58.4% have ever been tested for HIV while 41.6% reported that they have never undergone test for HIV. Of those who have ever been tested for HIV, 89% were tested before 12 months of the study period. Surprisingly, 89.1% of those who got tested received their test results. The most common site for the test was health centre accounting about 44% of the total cases followed by hospital (20.7%) and mobile testing centre (18.1%).

Table 15: VCT service utilization

| Districts | Have you ever been tested for HIV? | | Total |
|--------------|------------------------------------|-----------|------------|
| | Yes | No | |
| Bena-Tsemay | 66 | 54 | 120 |
| Salamago | 63 | 38 | 101 |
| Total | 129 | 92 | 221 |

Unlike the knowledge in the case of HIV/AIDS, 157(39.4%) of the respondents reported that they have heard about STI while the majority 241(60.6%) reported that they haven't heard about STIs. Most of the respondents who have heard about STIs indicated that the source of information is health facilities, community gatherings and schools. For those who have heard about STIs the sources of information are displayed in the following table.

Table 16: Sources of information for STI among respondents

| | Responses | | Percent of Cases |
|-----------------|-----------|---------|------------------|
| | N | Percent | N |
| Health facility | 95 | 47.7% | 60.5% |
| School | 29 | 14.6% | 18.5% |

| | | | |
|---------------------|-----|--------|--------|
| Radio | 6 | 3.0% | 3.8% |
| Family members | 24 | 12.1% | 15.3% |
| Community gathering | 45 | 22.6% | 28.7% |
| Total | 199 | 100.0% | 126.8% |

Respondents were also asked about the types of STI they know about. Accordingly, 87.6%, 43.1% and 33.3% know gonorrhoea, syphilis and HIV/AIDS as STIs while only 8.5% know genital warts as an STI. About 75.8% of the respondents know the transmission ways of STIs. Of these 91.6% indicated unprotected sex, 37.8% indicated contact with infected needle and 5.9% indicated mother to child transmission. Among the prevention method indicated in the list 46.2% indicated abstinence, 41.2% being faithful to one uninfected partner, 54.6% protected sex (condom use) and 27.7% seeking treatment.

This project has some high level indicators such as HIV incidence and VCT uptake that might be captured at the end of the project life from national survey results. However, an attempt was made to capture some of these indicators from the Zonal Health Bureau Report and it was indicated that according to the 2009 Zonal Health Bureau Report, about 21,211 people received VCT services and there were 769 people who started ART. The HIV incidence at Zonal level was estimated at 2.10%.

Reproductive Health

In this baseline assessment, 60.9% of the female respondents have heard about reproductive health issues. Of these, 38.8% know about ante-natal care, 47.3% know about family planning, 30.3% about delivery care, and 11.5% about post-natal care. The survey indicated that among women who have delivered a child in the last two years period of time, 70.9% of have attended ANC during their last pregnancy while 29.1% didn't attend ANC.

Table 17: Knowledge about reproductive health issues among female respondents

| Districts | ANC | Family planning | Delivery care | Post-natal care |
|------------------|------------|------------------------|----------------------|------------------------|
| Bena-Tsemay | 34 | 48 | 31 | 6 |
| Salamago | 30 | 30 | 19 | 13 |
| Total | 64 | 78 | 50 | 19 |

More than three-fourth (84.4%) of the respondents has visited health facilities for RH services and 130 (77.8%) of these respondents know how to prevent unwanted pregnancy. Abstinence, condom and injectable were mentioned by 11.7%, 13.6% and 63% of the respondents respectively for the prevention of unwanted pregnancy. Other means of preventing unwanted pregnancy that were mentioned by informants are Norplant, pills, safe period and breast feeding which accounted for 11.7%, 47.4%, 10.4% and 4.5% respectively.

Most of the participants of FGD and in-depth interviews underline that they are aware of methods of preventing unwanted pregnancy by using family planning methods like Norplant. They also mentioned that parents and youths have started to discuss about reproductive issues together since the last few years. But their awareness towards reproductive right seems to be very low due to lack of adequate education and sensitization activities. They further underlined that family planning has not been used effectively so far due to various reasons. First, a husband is a decision maker regarding the number of children to be born within his family. In other words, a wife has limited role or no say on the issue of family planning unless her husband accepted her request and approved it.

Second, some of the communities whose population is less than a few hundred thousand such as Tsemay, Bodi, Bume and others perceive the family planning as it goes against their cultural ethos of bearing many children. The informants from Bodi further stated “we want to see our ethnic group multiplied and large enough in the coming few years. Above all, we want to have many female children who could bring us a large number of cattle through bide price”.

Of all female respondents, 47.1% reported that they use contraceptives. The distribution of contraceptive users by the type of contraceptive indicates that Injectables, Pills, Norplant and safe period are the major types used by most of the respondents as indicated by 67.4%, 41.9% and 9.3% (both) respectively. Most of the users obtained these contraceptives from health posts (60.5%) and health centres (22.5%). The distribution of contraceptive users in the four districts is shown in the following table.

Table 18: The distribution of contraceptive users among the two districts, Jan 2010

| Districts | Do you use contraceptive? | | Total |
|-----------|---------------------------|----|-------|
| | Yes | No | |
| | | | |

| | | | |
|--------------|------------|------------|------------|
| Bena-Tsemay | 81 | 69 | 150 |
| Salamago | 48 | 76 | 124 |
| Total | 129 | 145 | 274 |

About 46% of the respondents have given birth in the past 2 years. About 70.9% of those who got pregnant during the last two years had got at least one antenatal care visit during their pregnancy. In this assessment, it is reported that about 63.3% of those who got ANC in the last two years were assisted by HEWs, while 23.3% were assisted by Health workers. The most predominant service provided during ANC is abdominal examination followed by weight measurement. The types of services mothers have received during their ANC visit are displayed in the following table.

Table 5: Types of services received by mothers during ANC visit

| Sources of information | Number | Percent |
|-------------------------------|--------|---------|
| Abdominal examination | 76 | 88.4% |
| Measurement of weight | 33 | 38.4% |
| Measurement of blood pressure | 23 | 26.7% |
| Urine examinations | 3 | 3.5% |
| Blood examinations | 12 | 14.0% |
| Other | 1 | 1.2% |

Of the total eligible respondents only 28.1% of them, reported that they have ever experienced pregnancy related complications. The common problems faced were excessive passage of liquid (30%), infection (16.9%), high blood pressure (20.8%), leg swelling (15.6%), and vomiting (20.8%). It is also reported that 11.7% of the respondents have faced foetal death.

The informants were asked about their common attendant when mothers deliver in their area. The baseline study revealed that about 27.5% of mothers deliver without any assistance, while 29.2% are assisted by a family member. About 26.2% are assisted by traditional birth attendants and 8.2% by health extension workers. Only 7.7% were found to be assisted by a health worker. Also there exist tendency towards growing role of health extension workers home delivery remains the most common.

Institutional delivery is still at its infancy stage, which is challenging at the national level too. This study revealed that the majority of mothers (78.9%) delivered their last child at home while about 5.6% of mothers delivered at health post, 6% at health centre and 12(5.2%) in the forest—implying mothers whose last birth was attended by skilled health worker accounted for only 15.9% . The major reasons for delivering outside the health facility as reported in this study were that ‘it is not our tradition to deliver in the health facility’ (23.7%) and ‘it is too far’ (28.4%). A total of 23 respondents (12.1%) reported that health facilities are expensive places to deliver. Of the mother respondents, 48(18.1%) were pregnant at the time when this study was carried out. Of these mothers only 10 (20%) were counselled and tested for HIV.

When they were asked about the presence of Anti-AIDS/RH clubs in their community, about 36 (13.5%) of the respondents reported that the clubs are available in their area and 23(63.9%) of them were members of the clubs they indicated.

Last set of interview questions included information on harmful traditional practices. Participants were asked about what were the commonly practiced harmful traditional practices in their community. Responses were categorised in the following table.

Secondary data was sought to include some of the impact indicators of this project such as maternal mortality and PMTCT uptake. According to the 2009 Zonal Health Bureau Report, 2, 495 women received PMTCT services. It was however learnt that no data on maternal mortality rate was available.

Table 20: Common harmful traditional practices

| Type of HTP | Number | Percent |
|------------------------|--------|---------|
| Female Genital Cutting | 12 | 5.2% |
| Female abduction | 113 | 48.7% |
| Early marriage | 85 | 36.6% |
| Tooth extraction | 123 | 53.0% |
| Other HTPs | 4 | 1.7% |

According to the participants of FGDs and in-depth interviews, there are several harmful traditional practices among the societies in South Omo zone such as female abduction, rape, teeth extraction, early marriage, polygamy, widow inheritance, high bride price,

tonsillectomy, infanticide, lip- plate and others. In this connection, FGM is not common among the local communities of the study area except by members of Arbore and Dasenech ethnic groups. Nevertheless, FGM it is widely performed by highlanders who settle in the urban centres of the area during the last few decades. Similarly, lip- plate is practiced by members of Mursi ethnic group. According to the tradition of Mursi, women are expected to have lip- plates because it is a symbol of beauty and gaining acceptance by a wider community. Viewed from gender perspective, the custom may be regarded as a design made to dominate woman and render them vulnerable. However, a woman or a girl without a lip-plate is subject to a serious of sanctions, mockery and alienation by the community although the practice has been gradually declining especially since the last couple of years.

Admittedly, the practices of abduction, rape and infanticide have declined significantly since the last few years as a result of serious legal measures taken by law enforcing bodies though they have not yet been totally eradicated from the area. In the former time, infants whose incisors of the upper jaw started to grow before the lower jaw were considered to be “Mingi” (unwanted ones) who would bring a curse, misfortune or drought and famine, and immediately thrown into to the bush. Similarly, anyone found committing sex with animals was considered “Mingi” and ordered by elders to be stoned and killed.

Among the total respondents asked about their position 45% reported that they support the fight against harmful traditional practices and a great majority (44.9%) of the respondents are not yet convinced that harmful traditional practices should be abolished.

Health Facility Assessment

In relation to the HESP, South Omo has 358 HEWs deployed in 155 health posts. Of the 358 HEWs 135 are trained for pastoralists. The zone planned to graduate 82,215 households in health extension service package in 2001 Ethiopian Fiscal Year, of which it could manage to achieve only 40% of what has been planned. The report³ indicates that South Omo is one of the most exposed areas for polio and other childhood illnesses and is able to benefit from the immunization services conducted in the region with a performance rate of 68% from the plan. In the same year the zone is able to perform 59% and 72% of the planned BCG and measles respectively immunization from the eligible children which is the lowest performance compared to other zones in the region. The TT2 performance in the region is 69.5%. The

³ SNNPRS, RHB performance report for 2001 EFY. August 2009. Hawassa

most important component for the proposed programmes of AMREF is interventions targeting youth and adolescents. In this case the zone has achieved disproportionately low performance for TT2 immunization (27%) for non pregnant women which justifies the need to implement the programme from the beginning. The family planning coverage, ANC, and delivery in South Omo seems to be as low as 42.5%, 69%, and 42%⁴

The Key interviews and secondary data review was conducted in the project woredas.

Table 21: Number of Health Facilities

| <i>Woreda</i> | <i>Hospital*</i> | <i>Health Center</i> | <i>Health Post</i> | <i>Health Officer</i> | <i>HEW</i> |
|-------------------|------------------|----------------------|--------------------|-----------------------|------------|
| <i>Benatsemay</i> | - | 3 | 14 | 1 | 43 |
| <i>Salamago</i> | - | 2 | 7 | 1 | 38 |
| <i>Total</i> | 0 | 2 | 21 | 2 | 81 |

*Jinka hospital is serving the whole population of South Omo

Jinka hospital equipped with 290 technical and 60 supportive administrative staff is the only hospital providing comprehensive health care service for over half million population of South Omo. It is recipient institution for all referrals from the health centres on issues related to pregnancy and delivery complications, surgery, and other complications which demand for admission. There is no blood bank in South Omo, and the hospital reported fatality due to scarcity of blood for transfusion. The other challenge for the hospital is high burden of patients – referred from nearby facilities – some of them could have been managed at the health centre level.

According to key informants from all health centres provide preventative and curative services including maternal and child health care services including ANC, delivery and PNC, VCT and PICT, family planning and related services. The most comprehensive services are provided at Jinka Hospital, which include maternal, and child health care, surgery, emergency medical and surgical services, ophthalmic, dental, ART, and immunization services.

Head of health centre from Salamago reported malaria, pneumonia, typhoid, and acute diarrheal diseases as major causes of outpatient visit while malaria, pneumonia and respiratory tract infections and injury/trauma – mostly caused by battering are major causes.

⁴ Information from the source is analyzed by the consultancy firm.

None of the health facilities assessed provide youth friendly services. Neither youth nor adolescents have special services or the design includes these special needs. In Salamago and Keyafer health centres except health education youth and adolescent targeting message is not yet disseminated.

The major causes of referral from Salamago and Keyafer health centres to Hospital are pregnancy and delivery related complications and malaria. Mothers first try with health extension workers, and found it difficult to be managed at that level they come to health posts. Patients that need admission based treatment are also referred to hospital. The health centre receives referral from health posts on pregnancy and delivery related complications, complicated malaria.

According to an informant from Salamago Health Centre, girls having unwanted pregnancy (for safe abortion) and VCT clients are mostly referred by HEW in Salamago district. In Keyafer an informant indicated that the referral from health extension workers is inconsistent. Most referrals are on pregnancy related issues and interventions that require specialised services.

The weak referral linkage and data management is reflected in terms of absence/lack of clear information about referral linkage. Most receiving health facilities have no clear statistics/record about the proportion of correct referrals from Health Extension Workers.

Finally, the link between schools and health facilities is non-existent and there is no report of referral linkage between health centres and schools.

The most reliable data regarding the five top causes of OPD visits 2009/10 are summarized as follows.

Table 22: Top five diseases in the Zone

| Disease | Percent |
|--------------------------------------|-------------|
| <i>Malaria - all types</i> | 22.8 |
| <i>Acute and other types of RTI</i> | 15.8 |
| <i>Other unspecified dysenteries</i> | 9.1 |
| <i>Helmentiasis/excluding</i> | 9.0 |
| <i>All other diseases of skin</i> | 4.7 |

According to the 2009 Zonal Health Bureau Report, the Zonal health service coverage was estimated at 79.3%.

Client Satisfaction Survey

To assess the level of client satisfaction structured questionnaire dealing on the attitude and opinion of the clients on the services providers, waiting time, the health facility general environment, tendency to visit back and recommend for others was developed and administered. To assess these variable five major health facilities serving the majority of the project area population, namely Jinka Hospital, Keyafer and Salamago Health centres were identified. From each health facility three clients were randomly communicated and asked for consent and the structured questionnaire was administered by a trained professional nurse.

Table 23: Health Facilities included for client satisfaction survey

| | <i>Frequency</i> | <i>Percent</i> | <i>Valid Percent</i> | <i>Cumulative Percent</i> |
|----------------|------------------|----------------|----------------------|---------------------------|
| HANA HC | 3 | 33.3 | 33.3 | 33.3 |
| JINKA HOSPITAL | 3 | 33.3 | 33.3 | 66.7 |
| KEYAFER HC | 3 | 33.3 | 33.3 | 100.0 |
| Total | 9 | 100.0 | 100.0 | |

Generally a total of 9 health facility clients among which 44% women and 56% men were asked about their satisfaction in the service provided by the respective health facility at exit.

Regarding the age of the respondents the mean and median age was 36.6 and 38 with standard deviation of 10. The minimum age of the respondents for the satisfaction survey was 25 while the maximum recorded was 50 years with one missing value.

Among the respondents 66.7% have a positive attitude towards the health workers provided the service at the visit time, while 33.3% are not satisfied by the service provider. South Omo is characterised by severely limited health facilities both in terms of quantity (in relation to the geographic distribution of the population) and quality of the services. The population over 1 million is served only by one hospital and few health centres. Thus, measuring satisfaction is highly affected by the lack of alternatives.

66.7% of the total respondents also indicated that they are satisfied with the waiting time indicating that it is acceptable. Unlike the health centers, who are relatively serving reasonable number of patients Jinka hospital is serving the Zonal population yet all the three respondents from the hospital indicated the fairness of the waiting time which can be attributed to the Business Process Re-engineering Process.

Regarding the satisfaction of the clients on overall service provision of the respective health facilities 66.7% reported that they are satisfied with the services being provided.

The respondents reasoned out that their satisfaction with services being provided by existing health facilities is due to lack of better alternative and unaffordability of private facilities.

Regarding the general environment of the health facility 67.3% consider it as friendly. One respondent from Jinka hospital mainly focused on the hygiene and sanitation issues of health facilities, which he considers as below standard. Finally, respondents were asked whether they recommend the health facility they are served for others and/or come again if they felt the need. The majority of the respondents (55.6%) reported that they will 'come again.'

Asked about the major causes of dissatisfaction and areas for improvement most of the respondents indicated lack of manpower, drugs and laboratory facility as major ones. Significant number respondents also indicated the need for respecting entry and exit time by the health workers. Moreover, lack of comprehensive services including immunization and emergency services are mentioned as causes of dissatisfaction.

Community Based Organizations and Civil Society organizations in South Omo

Civil societies in South Omo are playing a significant role in diverse areas of development including HIVAIDS prevention and control, micro-credit and income generating activities, women and children right. Most of the CSOs are concentrated to the centre of South Omo – either around Jinka town or district. The least numbers of CSOs are present in Salamago district. Regarding the CSOs 17 different civil society organizations were assessed ranging from those at an inception level to those reached to a mature NGO level. Moreover, 1 in-depth interview was held with the multispectral HIVAIDS prevention and control work stream. To this end the gain insights about the CSO situation in south Omo data was collected on issues related to capacity of CSOs partners in South Omo [whether they are equipped with appropriate governance structures; management policies/systems (including strategic plans implementation and M & E systems in place); HR systems/policies; Finance resource mobilization and management (increase in income/improved accounting practices); external relationships management (frequency of contact with higher and lower level organizations within the public and non for profit sector); gender/inclusion practices (e.g. % of CSO leadership positions held by marginalized groups - PLHA, disabled) and technical skills for participatory/inclusive service provision]

Table 24: Status of registration of CSOs

| <i>Indicator</i> | <i>Registration Status</i> | | <i>Both Sex Eligibility</i> | <i>Deal with HIVAIDS</i> | <i>Deal with RH</i> | <i>External relation management</i> | <i>Explicit Disability inclusion</i> |
|-------------------------|-----------------------------------|------------------------|------------------------------------|---------------------------------|----------------------------|--|---|
| | <i>Locally⁵</i> | <i>Formally</i> | | | | | |
| Yes | 100% | 6% | 89% | 44% | 0% | | 0% |
| No | 0 | 94% | 11% | 56% | 100% | Very limited | 100% |

Regarding legal registration and accreditation most of the CSOs indicated that they are registered in respective government offices. The newly adopted Ethiopian civil society law

⁵ Some civil society organizations such as youth, women or anti-HIV clubs refer that they are not formally registered as per the new CSO legislation which requires registration at the Charities and Societies Agency (CSA). Yet they refer that they are either registered or accredited by local authorities and line offices. Thus, except AFD none of the civil society organizations have certificate of registration from CSA. Therefore, formal registration refers to registration at CSA. Locally registered CSOs are mostly idirs, youth and women associations.

requires all Ethiopian CSOs to register, yet at the time of this survey data collection, none of the CSOs have registered except Action for Development (AFD) (1/17). AFD started operation in 2004 in South Omo, According to the person participated in the in-depth interview, AFD is working in line with the national policies and strategies of the government. Another CSO informant indicated their status as follows. ‘We [Andinet] are organized and accredited by the government because we are able to fulfil all the requirements by the government. Andinet is legally registered CSO. We have statue of organization and own rules and regulations. All the leadership and members are loyal to these rules and regulations.’

Table 25: Strategic Issues related to CSOs

| Indicator | HR Policy | Strategy | Accounting policy/system | Positive relationship with local authorities and partners | Disability inclusive |
|------------------|------------------|-----------------|---------------------------------|--|-----------------------------|
| Yes | 11% | 6% | 11% | 94% | 0% |
| No | 91% | 94% | 91% | 6% | 100% |
| Total (n=17) | 100% | 100% | 100% | 100% | 100% |

Regarding organizational policies and procedures most of the CSOs are dependent up on government policies. Few organizations have their own human resources, financial and operational policies. None of the CSOs except AFD have strategic plan.

Although 94% of the CSOs have reported that they have positive relationship with local authorities, but none of them reported being consulted on policy issues and major decisions affecting their life or members situation. In some cases they are “called” or “invited” for meetings by local authorities. The institutional culture to engage in dialogue with local authorities is found to be premature and involvement of youth who are not in the mainstream politics to represent groups in national and regional meetings is not reported at all.

One of the major observations about the CSOs is extremely limited capacity as it is repeatedly indicated in terms of manpower needs. Despite huge needs to be addressed on health and health related issues most civil societies are constrained to specific tasks such as information and education or providing financial support to members. The activities of the CSOs are specific and limited. Thus, most of the respondents indicated that ‘existing human

resource is enough for our current activity/intervention or project which implies the associations are severely constrained from expansion or reaching further beneficiaries. ' One CSO indicated that it needs more manpower which shows aspiration to grow.

Regarding source of income, most of the CSOs rely on membership fees and contributions. It is also learnt that many CSOs receive financial and technical support from other NGOs. Significant proportion of the CSOs also indicated that they receive loan and credit services from micro finance institutions. Some CSOs also indicated that they have diverse sources of funding: members' contribution, national and international NGOs, zonal HIV secretariat, individuals and FBOs. The money will be transferred to Bank account designated to the association. One NGO in South Ari indicated that they raise money from income generating activities/recreational service provision.

Regarding inclusion and exclusion criteria, many CSOs have a policy of involving both sex yet significant number have shown that they are exclusively either for women or men. None of the members indicated that they have disabled individuals in the membership. A participant from AFD said *"the involvement of women in AFD is in a good stage. Even I can say it is exemplary. We have women in all levels of the organization starting from the top management to field units. Gender equity is the core principle in AFD."* Another CSO exclusively working with PLWHA also indicated that *"we encourage both men and women. Among 196 members 126 are women and 70 are men. We have 2 women in leadership positions and are actively participating."* In some CSOs also membership is possible for both sexes practically it is found that either men or women are missing from membership list. For instance, although both sexes are eligible, in some CSOs we have found that only men or women constitute the whole membership. PLWHA associations are found to be more inclusive of women than other economic – based associations. In these associations we found more women members and some women in leadership. In their five-member management structure two are women and three are men. It has been learnt that RH/HIV/AIDS is not a priority intervention for the majority of the CSOs and yet the problem is there. Only 8 (47.1%) CSOs have activities related to HIV/AIDS. However, none of the CSOs have included and prioritized broader RH issues in their programs/interventional areas. One CSO indicated that they don't have 'even a plan.' Some have holistic programme approach, as indicated by one informant *"we provide technical support and skills. In this zone the organization delivers support on cooperatives development, fight against harmful traditional practices, life skills training and peacemaking forums for youth, adolescents and women. We have a very good recognition and acceptance."*

CSO Activities related with HIVAIDS include prevention, care and support – IEC activities, AIDS day celebration, home based care loan and credit services. The activities of the CSOs are fragmented and not well coordinated. From the Zonal finance and economic development department perspective there are recent initiatives to coordinate NGO activities which AMREF is playing greater role. Recently, consecutive meetings were held with active NGOs working in the Zone such as Catholic development, AMREF, PACT, AFD, EPARDA and others. But there are no formally established coalitions/networks for joint action on project issues.

With the implementation of the BPR vertical programming is being replaced by integration and work processes which have implication on assessing prioritization of RH and HIVAIDS. Yet there is clear indication that limited resources are allocated and RH and HIVAIDS are major areas to be dealt by the zonal and woreda plans.

Conclusion

Having Information on youth, adolescents, People Living with HIV/AIDS and Civil Society Organizations of the intervention Woredas has paramount importance not only for the implementing organization, but also for researchers, policy makers and service providers. Accordingly, the results of this survey will serve as a bench mark to measure the progress made as result of the project activities in Bena-Tsemay and Selamgo Woredas.

The findings showed that most of the respondents have heard about HIV/AIDS. In this case, most of them obtained information from health facilities, community gatherings, schools, family members and the radio. The respondents were also able to describe the modes of HIV transmission, such as unsafe sex, blood contact, infected sharp materials and mother to child transmission. The findings revealed that there are several misconceptions about the modes of transmission and prevention methods of HIV/AIDS among the communities. The most widely known misconceptions are a healthy looking person can't have HIV/AIDS, HIV can be transmitted by supernatural force, HIV can be transmitted by mosquito bite and HIV can't be prevented. There is also erroneous assumption of perceiving HIV/AIDS as the only problem of urban inhabitants. However, most of the respondents are aware of the prevention methods of HIV/AIDS such as correct and consistent use of condoms, being faithful to partner and abstinence.

In terms of health seeking behaviour, more than three-fourth of the respondents have visited health facilities for reproductive health services and have knowledge of preventing unwanted pregnancy such as abstinence, using condom and injectable. Some of them were also aware of other means of preventing unwanted pregnancy like Norplant, pills and safe period:

The result of the survey showed that a significant number of respondents were able to describe common harmful traditional practices among their communities such as marriage by abduction, rape, widow inheritance, polygamy, teeth extraction, tonsillectomy, uvulectomy and others. These practices are performed due to being deeply rooted tradition of the community and lack of awareness regarding the health hazards that could be caused by performing such practices.

Although the number of CSOs is few, in relation to the large geographic area, complexity of problems and needs to be addressed, CSOs are playing a significant role in ensuring rights and access to basic services of the population of South Omo. Most CSOs are not yet formally

registered and not well organised. It is very clear that given the remoteness and socio-economic status of the zone, the challenges which the CSOs may face are multifaceted.

Recommendations

Based on the findings of the survey the following recommendations are suggested.

1. AMREF and other CSOs should expand awareness raising activities, especially with focus to vulnerable groups. For STIs and HIV, individuals who have multiple partners are most vulnerable. Abduction (related to absence of VCT before the sexual relation and not known sero-status) and polygamous union are more susceptible increase exposure.
2. It is also indicated that the number of people who have visited to VCT centres is still low (58%) as compared to the total population. There is a need to mobilise PLWHA who have disclosed their status and work to reduce stigma and discrimination. It is also recommended to establish more VCT centres in pastoralist areas of close distance to community members or introduce innovative approaches to deliver mobile or outreach services.
3. The HIV/AIDS awareness campaign should go hand in hand with VCT services. This may include encouraging and involving those who have been infected, to publicly speak out about their sero-status. It may even involve prominent or public figures like politicians, administrators, businessmen, religious leaders, sportsmen and artists to take test and disclose their results.
4. The availability of essential drugs and treatment should be ensured to those who will be tested positive and strengthening the capacity of VCT facilities to provide effective counselling and testing services. Furthermore, continuous training should be given on new knowledge and skills to effectively provide accurate information about the implications of HIV/AIDS tests and ways in which the patients can protect their families, partners and casual contacts from HIV transmission.
5. The survey result indicates that the majority of respondents have knowledge concerning the modern family planning methods. However, the number of women who are using contraceptives is lower than the average for SNNPR. This might be due to women domination by their husbands and they are not allowed to use family planning methods. To reverse such situation, continuous education on family planning should be given for both men and women.

6. The survey shows that contraceptive prevalence rate is low and the majority of women are not using it. Therefore, it is recommended that access to family planning services be expanded and awareness about permanent and long term methods be improved.
7. The findings indicate that there are a number of harmful traditional practices in South Omo. It is recommended that AMREF and all concerned bodies should provide continuous and effective awareness raising education on harmful traditional practices using influential persons in the area such as traditional and religious leaders, traditional healers and respected individuals to eradicate the practices from the area.
8. Civil societies are playing indispensable role in South Omo. However, their capacities are severely constrained and the working environment is extremely difficult. Thus, AMREF should work to strengthen the capacity of civil societies in terms of organizational, institutional and human resource capacity to reach the communities and address diverse health needs. In this regard, major trainings on project management, leadership, finance and human resource should be delivered. AMREF should also advocate for increased funding to be channelled to its programmes and partners. The capacity of existing initiatives and associations by vulnerable groups (especially youth, women, and PLWHA) should be addressed in particular to enhance uptake of services and ensure rights.

AMREF/Ethiopia

South Omo Health Programme

Baseline Survey on Health and Health Related Issues

House Hold Level Questionnaire

Informed consent

Good morning/ Good afternoon!

My name is _____. I come from a non-governmental organization called African Medical Research Foundation (AMREF), which has been implementing various activities in South Omo Zone. Currently AMREF is conducting a research on health related issues in South Omo Zone. You are selected to provide information for this research. The information you provide will help us to plan health services.

The interview may take between 10 and 15 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Your name will not be written on this form, and will never be used in connection with any of the information you provide to us.

Consent given Yes No

Name of the Interviewee _____

Name of the Data Collector _____

Date of the interview _____

Name of the Supervisor _____

Date _____

Result: 1. Complete 2) Incomplete

Section One: Socio-demographic information

| S# | Questions | Response categories |
|-----|--|--|
| 101 | Address of the respondent | Woreda _____ Kebele _____ |
| 102 | Age of the respondent | _____ Years |
| 103 | Sex of the respondents | 1. Male 2. Female |
| 104 | Ethnicity of the respondent | 1. Ari 2. Male 3. Benna 4. Tsemay 5. Mursi 6. Dime 7. Bacha 8. Others (specify) _____ |
| 105 | Marital status | 1. Never married—skip to Q #108 2. Married 3. Separated 4. Divorced 5. Widowed |
| 106 | How did you get married | 1. Through abduction 2. Through Elopement (by my own decision) 3. Through my families arrangement & decision 4. Other (specify) _____ |
| 107 | Age at marriage | _____ years |
| 108 | Religion of the respondent | 1. Protestant 2. Orthodox 3. Catholic 4. Muslim 5. Traditional 6. Others (specify) _____ |
| 109 | Main occupation of the respondent | 1. Farmer 2. Pastoralist 3. Semi-pastoralist 4. Employee 5. Trader 6. Housewife 7. Daily laborer 8. Other (specify) _____ |
| 110 | Educational status | 1. Don't read and write—skip to #112 2. Can only read and write without formal education---go to #112 3. Attended formal education |
| 111 | If formal education attended | _____ Grade completed |
| 112 | Number of household members (those who live in the house and cook | _____ people |

| | | |
|--|----------------------------|--|
| | and consume food together) | |
|--|----------------------------|--|

Section Two: Data on HIV/AIDS/STI

| | | |
|-----|---|---|
| 201 | Have you ever heard about HIV/AIDS? | 1. Yes 2. No---skip to # 216 |
| 202 | From where did you get the information? | 1. Health Facilities 2. Schools 3. Radio 4. Television 5. Family members 6. Community gathering 7. Others (specify) _____ |
| 203 | Do you know the modes of transmission of HIV/AIDS? | 1. Yes 2. No—skip to # 216 |
| 204 | Where did you get the information? | 1. Health Facilities 2. Schools 3. Radio 4. Television 5. Family members 6. Community gathering 7. Others (specify) _____ |
| 205 | What are the modes (routes) of HIV transmission? (Multiple answer is possible) | 1. Unsafe sex 2. Blood contact 3. Infected Needle/sharps 4. Mother to child 5. Other (specify) _____ |
| 206 | Can HIV be transmitted by mosquito bite? | 1. Yes 2. No 3. I am not sure |
| 207 | Can HIV be transmitted by sharing feeding plates? | 1. Yes 2. No 3. I am not sure |
| 208 | Can HIV be transmitted by shaking hands? | 1. Yes 2. No 3. I am not sure |
| 209 | Can HIV be transmitted by sharing bathroom/shower/toilet? | 1. Yes 2. No 3. I am not sure |
| 210 | Can HIV be transmitted by a supernatural force? | 1. Yes 2. No 3. I am not sure |
| 211 | Can a health looking person have HIV? | 1. Yes 2. No 3. I am not sure |
| 212 | Is it possible to prevent HIV transmission? | 1. Yes 2. No---skip to # 216 3. I am not sure---go to # 216 |
| 213 | Do you know the methods of preventing HIV/AIDS? | 1. Yes 2. No—skip to #216 |

| | | |
|-----|---|--|
| 214 | Where did you get the information? | 8. Health Facilities 9. Schools 10. Radio 11. Television 12. Family members 13. Community gathering 14. Others (specify)_____ |
| 215 | What are the methods of preventing the transmission of HIV? (Multiple answer is possible) | 1. Correct and consistent use of condom 2. Limit sex to one uninfected faithful partner 3. Abstain from sexual intercourse 4. Avoid blood contact 5. Use of local alcoholic drink 6. Eating raw meat 7. Other (specify)_____ |
| 216 | Have you ever practiced sex? (crosscheck with question # 105) | 1. Yes 2. No---skip to # 224 |
| 217 | At what age had you had a sexual debut (first sexual intercourse)? | -----Years of age |
| 218 | With who had you had your first sexual intercourse? | 1. With a person whom I don't know 2. With my spouse 3. With my ex-cohabitating partner (friend) 4. With my current cohabitating partner (friend) 5. Other (specify)_____ |
| 219 | Have you had a sex with a non regular partner (neither spouse nor cohabitating partner) in the last 12 months | 1. Yes 2. No |
| 220 | Have you had a sex with a non regular partner (neither spouse nor cohabitating partner) in the last three months? | 1. Yes 2. No---go to # 222 |
| 221 | If Yes to # 220, with how many sexual partners? | 1. -----sexual partners 2. I don't know |
| 222 | Did you use condom during your last sex with a non regular partner? | 1. Yes 2. No |
| 223 | How often do you use condom when you have sex with a non-regular partner? | 1. Always 2. Sometimes 3. Don't use at all |
| 224 | Have you ever heard about HIV testing (VCT)? | 1. Yes 2. No---skip to # 230 |

| | | |
|-----|--|---|
| 225 | Where did you get information about VCT | <ol style="list-style-type: none"> 1. Health Facilities 2. Schools 3. Radio 4. Television 5. Family members 6. Community gathering 7. Others (specify)_____ |
| 226 | Have you ever been tested for HIV? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 230 |
| 227 | When did you take your last test? | ----- months before |
| 228 | Did you receive your last test result? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 230 |
| 229 | Where did you get tested for HIV? | <ol style="list-style-type: none"> 1. Mobile testing center 2. Clinic 3. Health center 4. Hospital 5. Other (specify)_____ |
| 230 | Have you ever heard about STI? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 301 (section III) |
| 231 | Where did you get the information? | <ol style="list-style-type: none"> 1. Health Facilities 2. Schools 3. Radio 4. Television 5. Family members 6. Community gathering 7. Others (specify)_____ |
| 232 | Can you name or list STIs that you know?(Multiple answer is possible) | <ol style="list-style-type: none"> 1. Syphilis 2. Gonorrhea 3. HIV/AIDS 4. Genital warts 5. Other (specify)_____ |
| 233 | Do you know the transmission ways of STIs? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 301 (section III) |
| 234 | If Yes to # 233, mention the transmission modes of STIs. | <ol style="list-style-type: none"> 1. Unprotected sex 2. Contact with infected blood/sharing infected needles 3. Infected mother to children 4. Others (specify)_____ |
| 235 | What are the methods of preventing the transmission of STIs? (Multiple answer is possible) | <ol style="list-style-type: none"> 1. Abstinence 2. Limit sex to one uninfected faithful partner 3. Protected sex (use of condom) 4. Seeking treatment 5. Other (specify)_____ |

Section Three: Data on Reproductive Health (Ask only Females)

| S# | Questions | Response categories |
|-----------|--|---|
| 301 | Have you heard about Reproductive health? | 1. Yes 2. No--- skip to # 306 |
| 302 | Which of the following components of sexual and reproductive health do you know? (Multiple answer is possible) | 1. Antenatal care 2. Family planning 3. Delivery care 4. Postnatal care 5. HIV/STI 6. Others (specify)_____ |
| 303 | Have ever attended health facilities for RH/FP services? | 1. Yes 2. No |
| 304 | Do you know how to prevent unwanted pregnancy? | 1. Yes 2. No |
| 305 | What are the methods to prevent unwanted pregnancy? (Multiple answer is possible) | 1. Abstinence 2. Condom 3. Injection 4. Norplant 5. Pills 6. Safe period 7. Breast feeding 8. Others(specify)_____ |
| 306 | Do you use contraceptive? | 1. Yes 2. No---go to # 309 |
| 307 | Which type of contractive do you use? | 1. Condom 2. Injection 3. Norplant 4. Pills 5. Safe period 6. Breast feeding 7. Other (specify)_____ |
| 308 | Where do you get the contraceptive? (Multiple answer is possible) | 1. Drug vendors 2. Community health agents 3. Health post/HEWs 4. Pharmacy 5. Health center 6. Hospital 7. Other (specify)_____ |
| 309 | Did you give birth in the last two years? (crosscheck with questions # 105 and 214) | 1. Yes 2. No---go to # 315 |
| 310 | Did you get ANC during your last pregnancy of the last two years? | 1. Yes 2. No---skip to 315 |
| 311 | Where did you get the service? (Multiple answer is possible) | 1. Traditional birth attendant (TBA) 2. Health extension worker (HEW) 3. Health worker (different from HEW) 4. Community health agent 5. Other (specify)_____ |
| 312 | When did you get the service? | At the -----months of my pregnancy |

| | | |
|-----|--|---|
| 313 | How many times did you get the service? | <ol style="list-style-type: none"> 1. -----times 2. I don't remember |
| 314 | Which service did you get? (Multiple answer is possible) | <ol style="list-style-type: none"> 1. Abdominal Examination 2. Weight was measured 3. Blood pressure was measured 4. Urine test was made 5. Blood test was made 6. Other (specify)_____ |
| 315 | Have you ever experienced pregnancy-related complications? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 317 |
| 316 | Please indicate the complications you faced. (Multiple answer is possible) | <ol style="list-style-type: none"> 1. Excessive passage of liquor 2. Infection 3. Hypertension 4. Face and leg swelling 5. Vomiting even after three months of pregnancy 6. Fetal death 7. Other (specify)_____ |
| 317 | Who attended your last delivery? | <ol style="list-style-type: none"> 1. No body was there 2. Family members 3. Traditional birth attendant (TBA) 4. Health extension worker (HEW) 5. Health worker (different from HEW) 6. Community health agent 7. Other (specify)_____ |
| 318 | Where did you give your last birth? | <ol style="list-style-type: none"> 1. Home 2. Community health agent home 3. Health post 4. Health center 5. Hospital 6. Forest 7. Other (specify)_____ |
| 319 | If 1, 2, or 3 for # 318, why you didn't go to the health facility? | <ol style="list-style-type: none"> 1. It is not our tradition 2. I don't trust health facilities/workers 3. Husband/Family member was unwilling 4. It is very far 5. There is no female health worker 6. It is expensive 7. Other (specify)_____ |
| 320 | Are you currently pregnant? (crosscheck with questions # 105 and 214) | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 322 |
| 321 | If Yes to # 320, have you been counseled and tested for HIV? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 322 |
| 322 | Is there RH/HIV club in your community? | <ol style="list-style-type: none"> 1. Yes 2. No---skip to # 324 |
| 323 | Are you a member of the RH/HIV club? | <ol style="list-style-type: none"> 1. Yes 2. No |
| 324 | What are the commonly practiced harmful traditional practices in your community? (Multiple answer is possible) | <ol style="list-style-type: none"> 1. Female genital cutting 2. Female abduction 3. Early marriage 4. Tooth extraction 5. Other (specify)_____ |
| 325 | Do you support the fight against the commonly practiced HTPs in your community? | <ol style="list-style-type: none"> 1. Yes 2. No 3. I don't know |

AMREF/Ethiopia

South Omo Health Program

Baseline Survey on Health Related Issues

In-depth Interview with Parents, Community and Religious leaders and policymakers

Background Information

1. Category of the respondent _____
2. Age of the respondent _____
3. Sex of the respondent _____
4. Name of the interviewer _____
5. Date interviewed _____ Signature _____
6. Checked by (name of supervisor) _____
7. Date checked _____ Signature _____

Guiding questions

1. What are the common problems of youths and adolescents in this community?
2. What do you think are the root causes of these problems?
3. What do you know about youth and adolescent reproductive health rights? What practical evidences do exist in this community in regard to ensuring the RH rights of youths and adolescents?
4. What are the rights of people living with HIV in your community? What practical evidences do exist in this community in regard to ensuring the rights of PLWHA?
5. Are there RH/HIV clubs in your community? IF yes, how they are youth/adolescent inclusive? Through what criteria do people become members of the clubs? Can disabled people be members of a club? If No, why not? If Yes, are there RH/HIV clubs in your community where disabled people are members
6. Do you think that disabled people should be given due attention? Why?
7. What special rights do disabled people need in your community? Probe: In regard to RH, HIV,... Are these rights well addressed? How? Why? Can you give us practical evidences showing that the rights of disabled people in this community are ensured?
8. What are the commonly practiced harmful traditional practices (HTPs) in your community? Why people practice them? Do you think that community members are ready to fight against these practices? Why? How? What interventions do you suggest to properly fight against HTPs?
9. What general recommendations do you have with regard to improving the reproductive health status of adolescents, people living with HIV and disabled people in your community?

Thank You

FGD with Youths/Adolescents

1. Name of the interviewer _____
2. Date interviewed _____ Signature _____
3. Checked by (name of supervisor) _____
4. Date checked _____ Signature _____

List of participants

| Sr.# | Name or Identifier | Sex | Age |
|------|--------------------|-----|-----|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |

Guiding questions

1. What are the common problems of youths and adolescents in this community?
2. What do you think are the root causes of these problems?
3. What do you know about youth and adolescent reproductive health rights? What practical evidences do exist in this community in regard to ensuring the RH rights of youths and adolescents?
4. What are the rights of people living with HIV in your community? What practical evidences do exist in this community in regard to ensuring the rights of PLWHA?
5. Are there RH/HIV clubs in your community? IF yes, how they are youth/adolescent inclusive? Through what criteria do people become members of the clubs? How many of you are members of the RH/HIV club? Can disabled people be members of a club? If No, why not? If Yes, are there RH/HIV clubs in your community where disabled people are members? How many disabled people are members in your club?
6. Do you think that disabled people should be given due attention? Why?
7. What special rights do disabled people need in your community? Probe: In regard to RH, HIV,... Are these rights well addressed? How? Why? Can you give us practical evidences showing that the rights of disabled people in this community are ensured?
8. What are the commonly practiced harmful traditional practices (HTPs) in your community? Why people practice them? Do you think that community members are ready to fight against these practices? Why? How? What interventions do you suggest to properly fight against HTPs?

9. What general recommendations do you have with regard to improving the reproductive health status of adolescents, people living with HIV and disabled people in your community?

Thank You

AMREF/Ethiopia

South Omo Health Program

Baseline Survey on Health Related Issues

In-depth Interview with Head of Health Facility

Background information

1. Name of the interviewee _____
2. Position of the interviewee _____
3. Name of Health Facility _____
4. Type of Health Facility _____
5. Number of technical staffs _____
6. Number of administrative staffs _____
7. Name of the interviewer _____
8. Date interviewed _____ Signature _____
9. Checked by (name of supervisor) _____
10. Date checked _____ Signature _____

In-depth Interview Questions

1. What type of health services are being provided in this health facility?
2. What are the common types of health problems you are treating?
3. Does this health facility provide youth friendly Reproductive Health services? What RH services are being provided to youths?
4. What are the common causes of referral to this health facility?
5. What are the common causes of referral from this health facility?
6. Do HEWs refer youths to you (to this health facility?) If yes, do they make correct referrals? Or do they refer appropriately? What are the major issues that they refer youths to you? (Ask whether referrals include RH/HIV and VCT).
7. If there is an appropriate record, how many referrals were made to youth to you by HEWs for RH/HIV prevention, testing and counseling in the last year? And how many of these referrals were considered to be correct referrals?
8. Is there a referral linkage between schools in this district and this health facility? If yes, what does it look like?

9. Do you have any other recommendation for us?

AMREF/Ethiopia
South Omo Health Program
Baseline Survey on Health Related Issues
Inventory of Community and IGA Groups

1. Name of district _____
2. Position of the respondent _____
3. Name of interviewer _____
4. Name of the interviewer _____
5. Date interviewed _____ Signature _____
6. Checked by (name of supervisor) _____
7. Date checked _____ Signature _____

| Community and IGA Groups | Number | Membership | | | | | Remarks |
|---|--------|------------|-------|-------|------|----------|---------|
| | | Total | Youth | Women | PLHA | Disabled | |
| Community groups in the district | | | | | | | |
| community groups which have capacity to manage IGAs | | | | | | | |
| IGA groups established in the district so far | | | | | | | |
| Successful IGA groups (ensured their survival and repaying loans) | | | | | | | |

AMREF/Ethiopia
South Omo Health Program
Baseline Survey on Health Related Issues

Exit interview of Clients of the Health Facility

Name of the health facility _____

Age of the interviewee _____

Sex of the interviewee _____

Type of service the interviewee received _____

Name of interviewer _____

Date interviewed _____

Signature _____

Checked by (name of supervisor) _____

Date checked _____

Signature _____

Exit interview Questions

| Sr# | Question | Yes | No | Remarks |
|-----|---|-----|----|---------|
| 1 | Are you satisfied with the health workers' approach? | | | |
| 2 | Are you satisfied with the waiting time to get the service? | | | |
| 3 | Are you satisfied with the services you received? | | | |
| 4 | Are you comfortable with the general health facility environment? | | | |
| 5 | Would you recommend others to come to this | | | |

| | | | | |
|---|--|--|--|--|
| | health facility? | | | |
| 6 | Would you like to come again to seek health care in this health facility | | | |

7. What things should be improved in this health facility? _____

AMREF/Ethiopia

South Omo Health Program

Baseline Survey on Health Related Issues

In-depth Interview with CSO and CBO Representatives

I. CSO partners: In-depth interview Questions

Name of CSO _____

Position of the respondent _____

Name of interviewer _____

Date interviewed _____

Signature _____

Checked by (name of supervisor) _____

Date checked _____

Signature _____

1. **In-depth Interview Questions** Is your CSO equipped with appropriate governance structures?
2. Is your CSO equipped with management policies/systems? Please describe
3. Is your CSO equipped with Human Resources systems/policies? Please describe
4. Is your CSO equipped with Finance resource mobilization and management? Please explain
5. Is your CSO equipped with External relationships management? Please explain
6. Is your CSO equipped with Gender/inclusion practices? Please elaborate
7. Is your CSO equipped with Technical skills for participatory service provision? Please describe
8. Do you have any questions to us?

II. CBO Partners:

Name of CBO _____

Position of the respondent _____

Name of interviewer _____

Date interviewed _____

Signature _____

Checked by (name of supervisor) _____

Date checked _____

Signature _____

In-depth interview Questions

1. In your CBO, is there an equitable Membership of community post-test clubs/support groups and youth groups, and equitable composition of women, young people, disabled represented?
2. What does your institutional consultation between local authorities, and CBOs looks like (Probe for: % of youth and PLHA groups who report having been consulted in decision making forums and programmed design, number of regular consultative meetings held)?
3. How do you perceive willingness of government institutions to engage in dialogue?
4. What is your view about representation of youth, PLHA at regional and national events?
5. What Coalitions/networks are formed for joint action on project issues, and running effectively?
6. What does Prioritization of RH and HIV/AIDS programmes in zonal and woreda government plans and budgets looks like?
7. Do you have any recommendation to us?