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# Community Demand Study for the Essential Services for Health in Ethiopia Project

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 **BASICS**

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By

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### **Abstract**

A study was conducted in nine villages in the Southern Nations and Nationalities People's Region to determine community demand for curative and preventive health services. Villagers' perceptions of the quality of services currently delivered by various providers (i.e., governmental and nongovernmental organization providers, traditional healers, drug vendors, community health agents, and traditional birth assistants) were also elicited. Data were collected through eight qualitative and participatory research methods, including group rankings, seasonal diagramming, focus group discussions, provider interviews, and interviews with villagers providing narratives on illnesses, deliveries, and deaths. Overall, communities ranked water, health, and food scarcity as their top priorities. Drug vendors were an important, and often preferred, source of health care. Communities felt community health agents were important but wanted to be involved in their selection.

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Last but not least, we express appreciation to all the villagers in the nine study villages for taking the time to share their experiences with us. We hope their voices come through in this report.

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# Acronyms

BASICS	Basic Support for Institutionalizing Child Survival, a USAID-financed project
CHA	community health agent
ESHE	Essential Services for Health in Ethiopia
HC	health center
HS	health station
KAT	Kambata, Alaba, and Tembarro Zone
MCH	maternal and child health
NGO	nongovernmental organization
ORS	oral rehydration solution
PA	peasant association
SNNPR	Southern Nations and Nationalities People's Region
TBA	traditional birth attendant
USAID	United States Agency for International Development
WVI	World Vision International



# Executive Summary

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

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

## Introduction

The Essential Services for Health in Ethiopia (ESHE) project is a bilateral agreement between the United States Agency for International Development (USAID)/Ethiopia and the Government of Ethiopia. The purpose of ESHE is to improve the health status of the population through increased utilization of essential primary and preventive health services, such as family planning, perinatal care, management of the sick child, immunizations, and prevention and control of sexually transmitted diseases and the human immunodeficiency virus. The ESHE project will be implemented in the Southern Nations and Nationalities People's Region (SNNPR), known at the time of the study as the Southern Ethiopian People's Region.

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

## Methodology

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

### Data Collection Procedures

- A. Ranking the priority of health
- B. Social mapping
- C. Seasonal diagramming
- D. Ranking health problems of men, women, and children
- E. Ranking providers of health services
- F. Interviews with health care providers, including traditional healers and drug vendors
- G. Narratives of experiences with illness, death, and childbirth
- H. Focus group discussions on experiences with community health agents

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The community demand study was conducted in nine villages in four zones (North Omo; Kambata, Alaba, and Tembarro [KAT]; Hadiya; and Sidama) of the SNNPR. Two teams of four data collectors each spent four days in each village over five weeks during June and July 1995.

### **Study Findings**

#### **Health As a Priority**

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

#### **Perceived Health Problems and Demand for Services**

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

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

#### **Care-Seeking Behavior**

When ranking health care providers, men and women were asked which provider they would want if they could have only one. Traditional healers, traditional birth attendants (TBAs), and community health agents (CHAs) were not mentioned by any of the respondents as the one preferred provider; on the other hand, health centers (HCs) and health stations (HSs) were chosen by thirteen of the eighteen groups. In five (three women's and two men's) of the eighteen groups, respondents listed a drug vendor as the one provider they would prefer. Men and women agreed on which provider they would prefer in only three of the sites.

During focus group discussions, men and women were asked to specify the criteria by which CHAs should be selected. The most important criterion was that CHAs be selected by the community, with twelve of the eighteen groups mentioning this. Respondents also said that CHAs should be committed to serving the community, have no addictions to alcohol or *chat* (an herbal stimulant), and have some education (though respondents differed on what level of education). Some health knowledge and experience was also mentioned as important. Some respondents said that CHAs should be married, but not have large families.

Members of only one women's group said the CHA should be a woman, emphasizing that they would be able to discuss their problems freely with a woman. When asked if they would be willing to contribute in cash or in kind for the CHAs, eight out of nine women's groups, but only four of nine men's groups, said they were willing to contribute.

### **Willingness and Ability to Pay for Health Services**

Although preventive services are usually provided free of charge, respondents reported paying large sums for curative services. The average cost of medicine alone ranged from 13 to 745 Birr (U.S.\$1 = 6.7 Birr). Transportation costs are often significant, reaching seventy to eighty Birr in some cases.

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

### **Community-Based Health Care Providers**

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

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

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

## **Recommendations**

### **Revise the CHA Selection Process and Criteria**

Currently, the only criterion for selection of a CHA is that the person be able to read and write. Local communities have recommended a number of additional criteria, including that the CHA not be addicted to anything. The results from this study show that local communities think it is essential that they be involved in selecting CHAs, who should be from their own villages; most respondents said they would not be willing to contribute in cash or in kind unless these two conditions were met. Respondents also said that the CHAs should be held accountable to the peasant association and should be supervised by the



## **Community Demand Study for the Essential Services for Health in Ethiopia Project**

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health centers and health stations. Unless local communities are involved in the selection and supervision of CHAs, the ESHE project runs the risk of CHAs being underutilized and unsustainable over time. The Ministry of Health needs to review the roles of CHAs and provide clear guidelines on such issues as the distribution of contraceptives and tuberculosis drugs and giving injections. There should also be written job descriptions for CHAs and a policy on incentives. Training needs to be strengthened for both CHAs and TBAs.

### **Work with Traditional Community Groups**

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

### **Integrate Programs Whenever Possible**

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

### **Consider Potential Roles of Drug Vendors**

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

### **Recognize Importance of Medicines and Curative Care**

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

### **Recognize Seasonal Patterns**

With the exception of Hadiya Zone, the greatest lack of food, most illness, most work, and least access to health facilities all tended to occur during a few months, though not always during the rainy season. During some months, access to health facilities is limited not only by impassable roads but also by food scar-

city, when “men do not have the strength to carry patients to health facilities.” Health planners should find out which months are the most difficult (these vary somewhat among villages) and provide increased outreach or credit services during those times.

### **Recognize Variation between and within Communities**

Although all nine villages studied were in the SNNPR, there was considerable variation among them because of the geographic and cultural heterogeneity of the region. Health planners must attempt to understand the differences in perceived problems, seasonal patterns, experience with previous development projects, and available resources to plan appropriate health interventions. Similarly, within each community some households are at greater risk of health problems than others. These households are often known in the community (e.g., female-headed households, households with small land plots) and may be targeted for special attention (though this must be done with caution).

### **Continue the Dialogue with Local Communities through Rapid Assessment Methods**

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

## **Topics for Further Research**

### **Traditional Beliefs and Practices**

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

### **Management and Supervision of CHAs**

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

### **Communication Channels**

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

**Traditional Healers and Drug Vendors**

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

# Introduction

## Objectives of the Community Demand Study

The Essential Services for Health in Ethiopia (ESHE) project is a bilateral agreement between the United States Agency for International Development (USAID)/Ethiopia and the Government of Ethiopia. The purpose of ESHE is to improve the health status of the population through increased utilization of essential primary and preventive health services, such as family planning, perinatal care, management of the sick child, immunizations, and prevention and control of sexually transmitted diseases and the human immunodeficiency virus. The ESHE project will be implemented in the Southern Nations and Nationalities People's Region (SNNPR), known at the time of the study as the Southern Ethiopian People's Region.

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

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

The objectives of the community demand study were as follows:

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

## Methodology

The community demand study sought to build local capacity for assessing community demand for health services using appropriate participatory data collection methods. With this in mind, the methodology used did not require expensive resources such as computers or advanced knowledge of statistics. The methodology was participatory in that local people analyzed their own problems and identified potential solutions with the help of a moderator.

Each of the main objectives listed above was further broken into twenty-four specific research questions, developed in collaboration with the Ministry of Health and the Mission. This final report is organized as answers to these research questions. The research questions were investigated using a combination of eight qualitative and participatory research methods. Annex A presents a matrix showing which data

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collection procedures were used to answer which specific research questions. The matrix was a valuable tool in both the design of this study and in the analysis of the data. The matrix was used to decide which data collection procedures would address which research questions. Every effort was made to answer each question using several procedures to ensure the validity of the data. During the analysis, the matrix was used to reference which results were relevant to the different research questions. A brief description of each of the methods is presented below.

- Procedure A: Ranking the Priority of Health—Separate groups of men and women listed their most important problems and then ranked them by drawing a diagram.
- Procedure B: Social Mapping—Separate groups of men and women drew pictures of their villages and showed all the places they go for health care and the distances they must travel. Poor households were also identified.
- Procedure C: Seasonal Diagramming—Separate groups of men and women showed through diagrams the seasonal variations of work in the fields and at home; availability of food; times of income, expenditure, debt, and illness; access to health facilities; and migration.
- Procedure D: Ranking Health Problems—Separate groups of men and women were asked to list all their health problems (men listed men’s health problems; women listed women’s and children’s health problems). They were then asked to rank the six most important health problems according to those that were most common and those that were most severe.
- Procedure E: Ranking Providers—Separate groups of men and women were asked to list all the providers to whom they go for health care. They then ranked the top six providers according to those who were most frequently visited, were most expensive, and provided the best quality service.
- Procedure F: Provider Interviews—In each study site, face-to-face interviews were done with four to six health care providers. Providers included health station (HS) staff, traditional healers, and drug vendors.
- Procedure G: Illness, Death, and Delivery Narratives—In each study site, households that had experienced a death, serious illness, or delivery during the past three months were identified through the social mapping and in discussions with the peasant association (PA). Face-to-face interviews were conducted with members of these households to understand the patterns of care seeking and expenditures for health care.
- Procedure H: Focus Group Discussion—Focus group discussions were held with separate groups of men and women in each village. The topics of discussion included previous experience with CHAs, recommendations for how CHAs should be selected, and willingness to contribute to the support of CHAs. In two villages, focus group discussions were also held with village elders to discuss how CHAs should be managed and held accountable.

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

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

All the procedures were completed in all the villages. The ranking of priority of health (procedure A), social mapping (procedure B), seasonal diagramming (procedure C), ranking of health problems (procedure D), ranking of providers (procedure E), and focus group discussion (procedure H) were completed by one group of men and one group of women in each village (different people were selected to participate in each of the procedures so that the same group of women or men was not asked to complete several procedures). The number of narratives and provider interviews completed differed among the villages, as shown in tables 1 and 2.

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

**Table 1. Number of Narratives of Illnesses, Deaths, and Deliveries Completed in Each Site**

Zone	Village	Illnesses				Deaths				Deliveries	Total
		Adult		Children		Adult		Children			
		M	F	M	F	M	F	M	F		
Sidama	Olola	3	4	4	6	3					20
	Wessa	4	5	3	4		1	1	1	1	20
Hadiya	Borbosa	4	1	2	2	1			1	1	12
	Sagada Bekera	1	3	1	2			1		2	10
KAT	Chaffa	5	3	2	6					1	17
	Hansawa	4	3	7	3						17
North Omo	Oge	3	2	6	2				1		14
	Demeba	3	4	5	3				1	1	17
	Boyne	3	3	7	5	3	2		1	2	26
<b>Total</b>		30	28	37	33	7	3	3	4	8	153

**Table 2. Provider Interviews Completed in Each Site**

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

## Selection of Sites and Respondents

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

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

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

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

## Profiles of the Study Sites

Table 3 presents the main characteristics of the study villages. Pseudonyms have been used for the village names to protect the confidentiality of respondents. As the table shows, the community demand study covered the Sidama, Hadiya, Kambata, and Wolita ethnic groups. A brief description of each of the villages is given below.

### Olola (Sidama)

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

Although a road was under construction at the time of this study, Olola does not have an all-weather road. However, because Olola village is near a meat factory, it has partial electric light twenty-four hours a day. In addition, people provide services using horse-driven carts inside and outside the village.

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

**Table 3. Main Characteristics of the Study Villages**

Zone	Village	Approximate Population	Ethnic Groups	Religions	Distance from HS	CHA
Sidama	Olola	16,000	Sidama, Oromo (Guji)	Protestant, Coptic	Inside village	Inactive
	Wessa	1,500	Sidama	Protestant, Catholic	10 km	
Hadiya	Borbosa	9,000	Hadiya	Protestant		Inactive
	Sagada Bekera	10,500	Hadiya, Guragie	Protestant, Muslim (few), Coptic	Inside village	
KAT	Chaffa	9,000	Kambata	Protestant	4 km	Inactive
	Hansawa	12,000	Kambata	Protestant, Coptic (few), Muslim (few)	4 km	Inactive
North Omo	Oge	5,000	Wolita, Amhara (few)	Coptic, Protestant (few)		Inactive
	Demeba	5,300	Wolita	Protestant, Muslim (few)		Inactive
	Boyne	5,130	Wolita	Protestant, Catholic	Inside village	Active



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Within the village there are four grinding mills, a government HS, private drug vendors, traditional birth attendants (TBAs), and traditional healers. In the semi-urbanized part of the village is a marketplace. There is also a nongovernmental organization (NGO) health center (HC) in an adjacent village, not far from Olola. It is mostly there that Olola villagers go for treatment if referrals are not made to Loke HC or to Yirgalem or Kuyerra hospitals.

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

### **Wessa (Sidama)**

Wessa is in Awassa Zuria Woreda, Sidama Zone. The village is situated about eleven kilometers away from Awassa, the administrative town of the SNNPR. The village is about six kilometers from the main road that passes to other southern regional towns.

The village has a population of about 1,500. Excluding youths in school, the villagers estimate that 20 percent of the men and about 7 percent of the women are literate. The main occupation of the village is farming and related activities such as trading, blacksmithing, and tanning.

The majority of the people are from the Sidama ethnic group and speak Sidamigna. There are traditional groups called *edir* (local language) for helping each other during times of sorrow and happiness, and *debo* or *dea* (a sort of mutual assistance) by which people help each other in preparing land, farming, weeding, sowing, and constructing houses. Every village has these groups; all villagers belong to them, as those who do not will get no assistance at all. Therefore, strictly speaking, it is obligatory to be a member. Most villagers are followers of different Christian churches; some are Catholic or Protestant, but none of them is of the Coptic or Muslim faith.

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

At first, the chairman of the PA of Wessa was not willing to talk to the team. He explained that, a year or two earlier, the Regional Health Bureau had promised to build an HS in the village but had not kept its promise. Meanwhile the villagers had collected a huge amount of gravel and sand for the construction. After some discussion, the PA executive members (the local community leaders) were cooperative in calling the required group of people to carry out the daily work activities.

### **Borbosa (Hadiya)**

Borbosa is in Limu Woreda, Hadiya Zone. The village is densely populated, with approximately 9,000 inhabitants. The major ethnic group is Hadiya, with very few Amhara and Kambatta; Hadiyigna is the language spoken here. The religion of the people, by and large, is Protestant.

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

In the village, there are no private or government clinics. It was only recently that the expanded program of immunization outreach services was started. There are trained community health agents (CHAs) and TBAs, with TBAs being active and CHAs being inactive. There are also traditional healers. Because there are no modern health units inside the village, residents are forced to go to Hossanna Hospital or to other providers in Hossanna.

There are no formal village organizations other than PAs. The PA leaders of Borbosa were very cooperative and active in assisting with this study.

### **Sagada Bekera (Hadiya)**

Sagada Bekera is in Limu Woreda, Hadiya Zone about ten kilometers from the main zonal town called Hossanna. This village is on the main road to Addis Ababa and other towns. It has a population of about 10,500. The villagers claim a high literacy rate—about 38 percent for men and 24 percent for women.

The main occupation of this village is farming, and a few people are engaged in trading. The PA provides local leadership in assisting the people with security and the settlement of disputes. There are also traditional groupings for marriage and burial ceremonies (*edir*) and for mutual assistance (*debo*). Villagers help each other in farming, sowing, weeding, and other services in general when more labor is required.

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

There is an HS that was previously established by the Sudan Interior Mission. The campus of the HS is well situated and is large enough to upgrade to an HC if additional health staff are provided. Unlike the other villages of Sidama, this village has consumer services such as shops and a grinding mill. However, scarcity of water is a crucial problem.

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

### **Chaffa (KAT)**

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

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

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

### **Hansawa (KAT)**

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

The main occupation of this village is farming, with very few traders. Compared with other villages, water is especially scarce in Hansawa. Like other villages of Hadiya and Sidama Zones, this village has traditional groupings like *edir* and *debo* with similar functions. The HS is about four kilometers from the village. Sick people mostly go to this HS, called Abonsa, which was built by the Adventist mission. There are churches of Adventists and Protestants; the majority of people are Protestant with very few Coptic and Muslim believers.

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

### **Oge (North Omo)**

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

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

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

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

### **Demeba (North Omo)**

This village is in the Sodo Zuria Woreda, North Omo Zone. It is twenty kilometers from the administrative town of Sodo. There is a main road that leads to Gofa Woreda. The village has an estimated population of 5,300. The literacy rate, excluding the youths who attend schools, is about 14 percent for men and 6 percent for women.

The main occupation of the people is farming, with a few engaging in trading, weaving, blacksmithing, and pottery making. The village groups in this area are the PA and the traditional *debo* and *edir* groups.

Inside this village there is no government HS, but there is a very small private clinic that provides services. There was a piped water supply at a central location in the village, but its motor is not functioning. There is a primary school in the village.

The people in this village are mostly the Wolita ethnic group, speaking the local language called Wolitigna. Most of the people are Protestant, with a few Muslims. The people reported land is scarce because of the dense population.

### **Boyne (North Omo)**

This village is in the Sodo Zuria Woreda, North Omo Zone. It is about twenty kilometers from the administrative town of Sodo and is accessible only by a very rough road. Boyne is typical of remote villages in that it has no services such as shops or grain mills.

The approximate population is 5,130. The main occupation of the people is farming, with a few engaging in blacksmithing, weaving, and pottery making. Like many of the other villages, it has a scarcity of water and land.

The groups in this village are the PA and the traditional *edir* and *debo*. The population is mostly from the Wolita ethnic group, speaking Wolitigna. The main religion is Protestant.

World Vision International (WVI) is working in Boyne in North Omo to promote rural development through health, education, agriculture, and road construction projects. WVI's health activities include supporting the existing HS by providing medicine and equipment, training HS staff, training and providing incentives to CHAs and TBAs, and establishing health posts. Trained TBAs and CHAs in this village actively assist the people through health education. Generally speaking, the level of cooperation from the village PA members was very high.



# Health As a Priority

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

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

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

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

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

Overall, water scarcity, health, and food scarcity were the most important problems mentioned, as shown in table 4.

**Table 4. Most Important Problems and the Priority of Health (by Village)**

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

<sup>1</sup> The numbers indicate what priority health was given by men and women. For example, in Olola, men ranked health as their second-most important problem, whereas women did not list health among their top six problems.

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Water was ranked the most important problem in six of eighteen ranking exercises. Food was ranked most important in four exercises. Health came between water and food, with five groups ranking health their most important problem. Both men and women in Wessa, women in Sagada Bekera, and men in Chaffa and Demeba ranked health as the number one problem. Five groups ranked health as the second most important problem, four groups ranked health third, and three ranked health fourth; women in Olola did not even mention health as one of their most important problems. It should be noted, however, that when respondents discussed health, they sometimes talked about their health problems being most important, whereas at other times they discussed the need for an HC or hospital in their village.

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

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

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

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

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

# Perceived Health Problems and Demand for Services

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

The results of the ranking of men's, women's, and children's illnesses are presented in tables 5 through 8. Men were asked to rank men's health problems, and women were asked to rank women's and children's health problems. Note that the tables present the data using the approximate English terms, but they should be interpreted cautiously because the terms may not correspond to the biomedical definition. For example, when malaria is listed, it may refer to fevers in general.

When asked which illness they would like to be free of, men in all villages reported that they would like to be free of either diarrhea or malaria. Women's responses were more varied. They reported that they would like to be free of kidney pain (which they associated with hard work), incomplete miscarriages, malaria, and diarrhea. When women were asked which illness they would like their children to be free of, in most villages their response was diarrhea and vomiting. In Wessa, they cited measles, and in Demeba, diphtheria. (See table 5.)

The children's illnesses most frequently mentioned by women (shown in table 6) were diarrhea and vomiting, worms, tonsillitis, skin disease, measles, fever, and eye disease. When asked which illness they would like their children to be free of, four groups said diarrhea and vomiting, and one group each said tonsillitis, measles, fever, worms, and diphtheria. Measles was mentioned in Wessa and Borbosa only. Diphtheria was the most common and severe problem in Demeba, though this term may refer to acute respiratory infections.

**Table 5. Perceived Health Problems of Men, Women, and Children: "If you could be free of one illness?"<sup>1</sup>**

Zone	Village	Men's Illnesses	Women's Illnesses	Children's Illnesses
Sidama	Olola	Diarrhea	Tuberculosis	Tonsillitis
	Wessa	Diarrhea	Incomplete miscarriage	Measles
Hadiya	Borbosa	Dysentery	Kidney pain	Fever
	Sagada Bekera	Diarrhea	Diarrhea	Diarrhea and vomiting
KAT	Chaffa	Malaria	Malaria	Diarrhea and vomiting
	Hansawa	Malaria	Yellow fever	Worms
North Omo	Oge	All six illnesses <sup>2</sup>	Fever and headache	Diarrhea and vomiting
	Demeba	Malaria	Diarrhea and vomiting	Diphtheria
	Boyne	Diarrhea and vomiting	Diarrhea and vomiting	Diarrhea and vomiting

<sup>1</sup> Men were asked about men's illnesses, and women were asked about both women's and children's illnesses.

<sup>2</sup> The six illnesses for Oge are stomachache, headache, tuberculosis, skin disease, eye disease, and gastritis.



**Table 6. Women's Perceptions of Children's Health Problems (Based on Frequency Mentioned)**

Health Problem	Six Most Common (N=9)	Six Most Severe (N=9)
Worms <sup>1</sup>	7	7
Vomiting and diarrhea <sup>2</sup>	6	6
Fever <sup>1</sup>	4	4
Diarrhea	3	3
Eye disease	3	3
Measles <sup>1</sup>	3	3
Scabies	3	3
Skin disease	3	3
Tonsillitis <sup>1</sup>	3	3
Cold	2	2
Diphtheria <sup>1</sup>	2	2
Ear disease	2	2
Headache and fever	2	2
Malaria	2	2

<sup>1</sup> Mentioned by one group as the illness it would most like their children to be free of.

<sup>2</sup> Mentioned by four groups as the illness they would most like their children to be free of.

**Table 7. Women's Perceptions of Their Health Problems (Based on Frequency Mentioned)**

Health Problem	Six Most Common (N=9)	Six Most Severe (N=9)
Gastritis	5	5
Cold	4	4
Kidney pain <sup>1</sup>	4	4
Fever and headache <sup>1</sup>	3	3
Headache	3	3
Incomplete miscarriage <sup>1</sup>	3	3
Malaria <sup>1</sup>	3	3
Tuberculosis <sup>1</sup>	3	3
Vomiting and diarrhea <sup>2</sup>	3	3
Womb infection	2	2
Worms	2	2
Diarrhea <sup>1</sup>	1	1
Yellow fever <sup>1</sup>	1	1

<sup>1</sup> Mentioned by one group as the health problem it would most like to be free of.

<sup>2</sup> Mentioned by two groups as the health problem it would most like to be free of.

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

The most frequently mentioned health problems of women include gastritis, cold, and kidney pain. Women associated kidney pain with hard work, especially when they have to carry water from long distances. Men in Wessa said, "Our women have to travel long distances to fetch water from a river which is not clean. Due to this, pregnant women suffer a lot." Delivery problems and miscarriages were also frequently mentioned by women, as shown in table 7.

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

Men's perceptions of their health problems (table 8) were less varied than women's perceptions of their own health problems. Malaria was mentioned more frequently by men than women. Eye disease was not mentioned by women at all, whereas five men's groups ranked eye disease as among the six most common and most severe health problems.

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

Respondents perceived an illness as severe when it causes death quickly, when it spreads to many people, and when there is no medicine to treat it. Respondents also noted that diseases that are debilitating and make a person weak and unable to work are severe.

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

Table 9 shows respondents' perceptions of the root causes of ill health. In all of the eighteen focus group discussions, the lack of clean water was mentioned as a root cause of ill health. The lack of health education and health services and the shortage of food were also seen as important causes of ill

**Table 8. Men's Perceptions of Their Health Problems (Based on Frequency Mentioned)**

Health Problem	Six Most Common (N=9)	Six Most Severe (N=9)
Malaria <sup>1</sup>	6	6
Tuberculosis	6	6
Eye disease	5	5
Typhoid	4	4
Diarrhea <sup>1</sup>	4	3
Cold	3	3
Kidney pain	3	3
Vomiting and diarrhea	3	3
Cancer	2	2
Worms	2	2
Dysentery <sup>2</sup>	1	1

<sup>1</sup> Mentioned by three groups as the health problem they would most like to be free of.

<sup>2</sup> Mentioned by one group as the health problem it would most like to be free of.

health. In four of the nine women's groups, women mentioned their heavy workload as a cause of ill health. Workload was not mentioned by any of the men's groups as a cause of ill health. As women in Boyne said, "We travel from market to market to sell or exchange things to make up for shortages in the house. As a result, we are exposed to many kinds of diseases like kidney problems and tiredness."

Table 10 shows the changes needed to improve health recommended by focus group participants. Clean water was recommended by all except one of the focus groups. Other recommended changes included health education, establishment of an HC or HS, and increased amounts of food.

During focus group discussions, men and women were asked which specific health services they needed. As shown in table 11, the most frequently mentioned response was curative services, which probably included malaria treatment. After curative services, people mentioned immunization, health education, and family planning as important services. Five of the nine men's groups mentioned family planning, despite anecdotal evidence that men are opposed to family planning. However, one respondent said that he wanted family plan-

ning, but not oral contraceptives, because women become sick from the pills. Some respondents were opposed to family planning; as a woman from Borbosa noted, "Our husbands prohibit us from getting family planning because they want to have many children."

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

**Table 9. Root Causes of Ill Health (Based on Frequency Mentioned in Focus Group Discussions)**

Root Cause of Ill Health	Number of Men's Groups (N=9)	Number of Women's Groups (N=9)	Total (N=18)
No clean water	9	9	18
No health education	6	6	12
Shortage of food	5	6	11
No health facilities/services	6	4	10
No malaria control	5	2	7
Poverty	3	2	5
Workload	—	4	4
Ineffective health services	1	2	3
Marshy areas	1	1	2

**Table 10. Recommended Changes to Improve Health (Based on Frequency Mentioned in Focus Group Discussions)**

Recommended Change	Number of Men's Groups (N=9)	Number of Women's Groups (N=9)	Total (N=18)
Clean water	8	9	17
Health education	3	7	10
Establish HS or HC	5	5	10
Provide health services nearby	3	4	7
Increase food availability	4	3	7
Malaria control	3	—	3

**Table 11. Respondents' Perceptions of Needed Health Services (All Villages)**

Service	Number of Men's Groups Mentioning (N=9)	Number of Women's Groups Mentioning (N=9)	Total (N=18)
Curative services	8	5	13
Health education	7	6	13
Immunization	7	5	12
Family planning	5	6	11
Delivery services	5	3	8
Antenatal services	3	4	7
Postnatal services	1	3	4
Preventive services	1	2	3
Malaria	2	—	2
Trained CHAs and TBAs	—	1	1

During the interviews, health care providers were asked what they perceived to be the most essential health services for the people they served. These data are shown in table 12. Immunization and health education were the most frequently mentioned responses. CHAs were more likely than other providers to see family planning, environmental sanitation, and clean water as essential services.

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

Men and women in all villages were asked to diagram the seasonal variations in their workload, income and expenses, availability of food, illness, and access to health facilities. These data were arranged in seasonal charts showing when times are good—that is, when there is some income and not much work in the fields and food is available—and when villagers face difficulties—that is, when there is not much food, a lot of work in the fields, high debt, a lot of illness, and little access to health facilities. An example of these charts for the village of Wessa is shown in table 13. In this table, the data show that the villagers are better off from November to February and in August. They face more difficulties from May to July when there is little food; a lot of work, debt, and illness; and little access to health facilities. This period coincides with the rainy season.

**Table 12. Providers' Perceptions of the Most Essential Health Services <sup>1</sup>**

Services	Government Providers (N=5)	Traditional Healers (N=10)	CHAs (N=10)	TBAs (N=11)	Drug Vendors (N=7)	Total (N=43)
Immunization	60	30	60	18	57	42
Health education	40		70	27	57	37
Family planning	20	10	40		43	21
Environment sanitation	40		60			19
Establishment of HS		20	40		14	16
Antenatal services	20	10	30		9	14
Malaria treatment	20	10	30		9	14
Treatment for various diseases	20	50				14
Clean water	20		40		9	14
Delivery		10	30		9	12
Maternal and child health services		20			18	9

<sup>1</sup> Expressed as percentages.

**Table 13. Least and Most Difficult Times in Village of Wessa (by Month)**

**Least Difficult Times**

	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Most income			●▲	▲	▲							●
Least work in fields			▲	▲	●▲	●▲	▲				●▲	▲
Most food	●▲	●▲										●▲

**Most Difficult Times**

Least access to health facilities											●▲	●▲
Most illness										●▲	●	
Most debt									●	●▲	●▲	
Most work in fields	▲							●▲	●▲			
Least food										●▲	●▲	

● = Reported by men.  
▲ = Reported by women.

Table 14 summarizes some of the seasonal patterns of all the study villages. With the exception of Hadiya Zone, the greatest lack of food, most illness, most work, and least access to health facilities all tended to occur during a period of a few months. The most difficult months in Sidama and KAT Zones are May to July, whereas in North Omo the difficult times are earlier, from March to May. In Hadiya responses varied, with some months characterized as difficult because of food shortages and other months because of debt and work in the fields. In all villages, food shortages were associated with illness. September was the month of the highest expenditures for the Meskel festival and school fees. Women had more work at home

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**Table 14. Seasonal Patterns of Well-Being (Summary of All Villages)**

Zone	Village	Most Difficult Months	Comments by Respondents
Sidama	Olola	May–September	May–June: Malaria and children’s illness because of lack of food. August–September: Migration to eastern side of village because of flooded homes.
	Wessa	May–July	July: “There is no food at all.” “A time of starvation.” July–August: Muddy roads because of rains. June: More illness because “it’s hot and insects that cause illness breed easier.”
Hadiya	Borbosa	December, July (mixed responses)	December: “It is harvest time and we are so busy even children do not go to school, and we cannot visit health facilities.” Some migration of men in October, March, and April.
	Sagada Bekera	July–August	August: Acute shortage of food; children die. October: Food still scarce; chickens die. August, October: Men migrate to jobs in sugar factories.
KAT	Chaffa	May–June	May: “Due to drought, people will have no food and no strength to carry patients to health facilities.” June: “Due to malnutrition, many will be sick.” <i>Enset</i> decortification; having to buy food to eat. May–July: No money for health care. November–January: Harvest.
	Hansawa	June–July	March–May: Men migrate as agricultural laborers. June–July: Asthma and malaria because of cold weather. October: Men migrate to sugar factories. November: Harvest.
North Omo	Oge	February–May	February–May: Shortage of food and money.
	Demeba	January–July (mixed responses)	February–March: Women travel long distances to fetch water and grind cereal. February–July: Men migrate to towns for work. September: No money for transportation.
	Boyne	March–May	February–March: Men migrate to state farms as laborers. March–June: There is illness because of food shortages, which causes malaria and swelling of the body. April: “There is not enough food; we lose our resistance to illness.”

during this month to prepare food for the festival. In Chaffa, men reported that, during food shortages, they do not have the strength to carry patients to health facilities, making access difficult even though the roads may be passable.

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

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

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

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

When ranking health care providers, men and women were asked which provider they would want if they could have only one. Traditional healers, TBAs, and CHAs were not mentioned by any of the respondents as the one preferred provider; on the other hand, HCs and HSs were chosen by thirteen of the eighteen groups. In five (three women’s and two men’s) of the eighteen groups, respondents listed a drug vendor as the one provider they would prefer. Men and women agreed on which provider they would prefer in only three of the sites.

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

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

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

As the above quotation illustrates, villagers perceive medicine to be perhaps the most essential component of quality health care. In general, people feel they are paying for the medicine and not for any special knowledge of providers. Thus, when they have what they think is the same illness, they may just buy the

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same medicine they used the last time. As one woman put it, “Since my illness was treated by them long ago, I went back there. But this time, I only bought the same medicine without consultation.”

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

Table 15 shows the availability of and charges for selected medicines for different types of health care providers. Chloroquine, oral rehydration solution (ORS), antibiotics, and worm medicine are available at all government and NGO facilities and drug vendors. Oral contraceptives are available at all government facilities, about half of the traditional healers, and a third of the drug vendors. No traditional healers had antibiotics, and only some had chloroquine, ORS, or worm medicine. Government facilities provide some medicine free of charge; other health care providers’ charges ranged from 0.60 Birr for chloroquine to 12 Birr for antibiotics.

In general, medicines are readily available, though their type and quality could not be assessed. (Table 20 shows that villagers often spend exorbitant amounts on medicines, in one case reaching 980 Birr, which reflects the priority given to medicines as an important aspect of quality medical care.)

**Table 15. Availability of and Charges for Medicine in All Sites**

Providers	Chloroquine		ORS		Antibiotics		Oral Contraceptives		Worm Medicine	
	Avail-ability (%)	Charge (in Birr)	Avail-ability (%)	Charge (in Birr)	Avail-ability (%)	Charge (in Birr)	Avail-ability (%)	Charge (in Birr)	Avail-ability (%)	Charge (in Birr)
Government facilities	100	free, <sup>1</sup> .83	100	free, <sup>1</sup> .50	100	1.63	100	0	100	free, <sup>1</sup> 1.10
NGO facilities	100	.60	100	.50	100	12.00	0		100	1–1.5
Traditional healers	25	1.00	75	.60	0		50	NA	50	1.00
Drug vendors	100	1.25	100	1.10	100	4.85	33	3.00	100	.96

<sup>1</sup> Some facilities provide the medicine free of charge.

# Care-Seeking Behavior

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

There is a wide range of health care providers in all of the villages, as shown in table 16. All the study villages have traditional healers, including bone setters and TBAs. Five of the nine villages have trained TBAs. Only Boyne has an active CHA who was trained by WVI. Two villages have no CHAs at all, and the CHAs in the rest of the villages are inactive. The distance from health centers to villages ranged from five to twenty-five kilometers. Health stations were located in three of the villages. All of the villages have access to at least two drug vendors, and some have as many as seven.

**Table 16. Number and Types of Providers in Each Site**

Zone	Village	Health Center		Health Station		Traditional Healer	CHA	TBA	Drug Vendor
		Government	NGO	Government	NGO				
Sidama	Oloia	None	5–25 km outside	Inside village	None	Bone setter	Inactive	2 trained	1 inside and 3 outside village
	Wessa	11 km outside	2 hrs on foot	10 km outside	None	Bone setter	None	1 untrained	3 outside village
Hadiya	Borbosa	None	None	None	None	Bone setter	Inactive	1 trained	6 outside village
	Sagada Bekera	None	None	Inside village	None	Bone setter	None	1 trained	1 inside and 1 outside village
KAT	Chaffa	None	None	4 km away	10 km away	Bone setter	Inactive	1 untrained 1 trained	1 inside and 4 outside village
	Hansawa	None	None	4 km away	2 km away	Bone setter (3)	Inactive	1	3 outside village
North Omo	Oge	12 km away	None	None	None	Bone setter	Inactive	2 trained	1 inside and 6 outside village
	Demeba	20 km away	None	None	11 km away	Bone setter (4)	Inactive	5 untrained	1 inside and 3 outside village
	Boyne	15 km away	None	Inside village	None	Bone setter	Active	2 untrained	5 outside village



**Table 17. Ranking Health Care Providers: “If you could have only one provider?”**

<b>Zone</b>	<b>Village</b>	<b>Men’s Group</b>	<b>Women’s Group</b>
Sidama	Olola <sup>1</sup>	Government HS	Drug vendor
	Wessa	Bushulo HC	Bushulo HC
Hadiya	Borbosa	Hossanna Hospital	Drug vendor
	Sagada Bekera <sup>1</sup>	Hossanna Hospital	Government HS
KAT	Chaffa	Drug vendor	Government HS
	Hansawa	Mission HS	Mission HS
North Omo	Oge	Sodo Hospital	Drug vendor
	Demeba	Drug vendor	Sodo HC
	Boyne <sup>1</sup>	Government HS	Government HS

<sup>1</sup> The government health station is inside the village.

When asked how their sources of health care had changed over the past five to ten years, respondents mentioned that there had been little change, except that some CHAs and TBAs had been trained and there were new drug vendors. Respondents in seven of the nine villages mentioned that TBAs and/or CHAs had been trained in the past five to ten years. In Borbosa, outreach immunization services were started recently.

When ranking health care providers, men and women were asked which provider they would want if they could have only one. As table 17 shows, traditional healers, TBAs, and CHAs were not mentioned by any of the respondents as the one preferred provider; on the other hand, HCs and HSs were chosen by thirteen of the eighteen groups. In five (three women’s and two men’s) of the eighteen groups, respondents listed a drug vendor as the one provider they would prefer. Men and women agreed on which provider they would prefer in only three of the sites.

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

TBAs perform most deliveries. In six villages, immunization is provided through monthly outreach services. Government health units provide other preventive services (e.g., family planning). Growth monitoring was not being conducted in any of the study sites, though a few of the sites were receiving relief food grain from various NGOs.

**Table 18. Source of Health Care for Those Who Went to Only One Provider (Based on Narratives)**

Zone	Village (No. of Narratives)	Government Provider (%)	Drug Vendor (%)	NGO Facility (%)	Traditional Healer (%)
Sidama	Olola (6)	33	33	33	
	Wessa (9)	44	44		11
Hadiya	Borbosa (5)	100			
	Sagada Bekera (8)	62	37		
KAT	Chaffa (7)	14	43	43	
	Hansawa (7)	14	14	71	
North Omo	Oge (6)		100		
	Demeba (15)	33	53		7
	Boyne (16)	75	25		

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

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

As described in question 7 and shown in table 16, people have a wide range of health care providers to choose from. Respondents reported seeking care from a variety of providers, including traditional healers, drug vendors, and government health facilities. Table 18 shows which providers were chosen when only one was visited (data are from the narratives of illnesses, deaths, and deliveries). There is significant variation among the nine study villages. In Bobbosa, 100 percent of the respondents visited a government provider, whereas in Oge 100 percent of the respondents visited a drug vendor. (Note that, because of small sample sizes, only broad patterns can be observed.) In general, it is important to note the relatively high utilization of drug vendors and low utilization of traditional healers.

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

The most frequently mentioned criteria for choosing a health care provider were the distance to the provider, the expense, and the quality of the provider. As a woman in Olola said, "I go to the drug vendor because he is near and I do not have money to go to other providers." Other respondents reported that they were referred to providers, but did not have the money to go. Other important criteria for selecting provid-

ers and perception of quality include the availability of medicine and laboratory and x-ray equipment. A number of respondents mentioned the importance of good interpersonal skills, whereas other respondents mentioned the importance of knowing a provider personally. A man in Wessa explained why he took his wife to Bushulo HC: “I decided to take her to Bushulo HC because from my own experience I knew that, if there is not anybody whom you know in the health unit, you do not get a turn for treatment. Since I know someone at Bushulo, I took her there.”

It is important to recognize the dynamics that occur within households when treatment decisions are being made. The patient is often only one of several people involved in the decision to seek treatment. Older relatives and neighbors often advise the use of specific providers or treatments. A woman in Chaffa said, “When I got seriously sick my neighbors insisted I use herbal medicine at home, otherwise it will become complicated and cause me to die.” When money must be borrowed or assets sold to pay for treatment, other people become involved and make recommendations. This is especially true for decisions regarding treatment for women and children, who often have less authority and access to cash, as the following quotation illustrates:

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

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

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

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

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

In general, traditional healers were rarely utilized (except in Wessa), even when three or four providers were visited. Government providers (primarily HSs) were used as the first provider as much as drug vendors. There is no fixed sequence of provider utilization. Sometimes government providers are chosen, sometimes NGO providers or drug vendors; there is a certain amount of shifting back and forth for the same illness episode. It is likely that the type of health problem influences the sequence and type of pro-

viders visited. However, this study was unable to investigate how utilization patterns differed for different health problems.

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

Overall, there was little previous experience with CHAs, and what little experience there was had not been good. Previously, Demeba had a CHA, but the villagers did not know what he did. Women said, “He either hid or sold the medicine for his own benefit. The health post which had been constructed was destroyed four years ago.” In North Omo, a health post was constructed and a CHA trained. The health post was destroyed when the Ethiopian People’s Revolutionary Democratic Front took power, and the CHA became a local provider of injections.

In a separate discussion, the men agreed, saying, “Previously some people came and gave false promises. The people who come from outside the village are not trustworthy.” Men in Chaffa said that “even if we select and train someone from our village, we don’t think it will improve our health because the type of person you are talking about is hardly better than an ordinary farmer and will not be able to assist us. We would not trust such a person.”

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

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

During focus group discussions, men and women were asked to specify the criteria by which CHAs should be selected. The results are shown in table 19. The most important criterion was that CHAs should be selected by the community, with twelve of the eighteen groups mentioning this. Men in Sagada Bekera said that “the CHA should be selected by the villagers. If a CHA is assigned by someone else, it would be futile.” Women in Chaffa said that the health agents “used to be selected by leaders without any participation of the community and this brought about the lack of services.” They also said that the CHA should be supported by a responsible person who would implement the program. Elders in Boyne said that CHAs should be selected by the villagers and that the CHA should be supervised by the *kebele* (peasant association). In all the focus group discussions, participants said they preferred a CHA to be from their own village. They reported that they would not trust someone from another village, and that that person would not be available for emergencies.

**Table 19. Selection Criteria for CHAs (Based on Frequency Mentioned)**

<b>Selection Criteria</b>	<b>Men's Groups (N=9)</b>	<b>Women's Groups (N=9)</b>	<b>Total (N=18)</b>
Selected by the community	6	6	12
Committed to serve community	4	5	9
No addictions	4	4	8
Educated above 12th grade	4	3	7
Can read and write	2	4	6
Basic education	2	3	5
Some health knowledge and experience	2	3	5
Must be trustworthy	2	1	3
Respect and love villagers	2	1	3
Have patience	0	2	2
Must have free time	0	2	2
Must be respected	2	0	2
Must be healthy	0	2	2
Should be married	2	0	2
Not have large family	0	1	1
Male	1	0	1
Female	0	1	1

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

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

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

# Willingness and Ability to Pay

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

Respondents in all the study villages repeated that immunizations are provided free. Table 14 shows that oral contraceptives are provided free of charge by most providers, though drug vendors reported charging 3 Birr. Table 20 shows some of the costs for deliveries, ranging from 29 Birr in Sagada Bekera to 405 Birr in Boyne.

**Table 20. Costs of Consultation, Medicine, and Transport (in Birr; Based on Narratives)**

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

Notes: NA=not applicable; —=not available.

**Table 20. Costs of Consultation, Medicine, and Transport (in Birr; Based on Narratives) (cont.)**

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

Notes: NA=not applicable; ---=not available.

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

*I have paid out everything for treatment. I have nothing left. I have no hope anymore.—Woman with cancer in Olola*

Table 20 presents the range and average costs of consultation, medicine, and transportation for illnesses, deaths, and deliveries. Illnesses and causes of deaths varied among men, women, and children. Because the sample size was small and the health problems varied, these numbers must not be interpreted as expenditure estimates for the general population. However, some patterns can be observed about the range of expenditures and the relative costs of consultation, medicine, and transportation. The most expensive part of treatment is the medicine, whereas the consultation fee is relatively less expensive and often simply included in the charge for medicine. The average cost for medicine ranged from 13 Birr in Demeba to 745 Birr in Olola. Not surprisingly, respondents reported spending more on people who subsequently died. Transportation costs were often significant, in some cases reaching seventy to eighty Birr.

Table 21 shows the average cost of treatment and medicine (excluding transportation costs) by type of provider. In general, traditional healers were the least expensive providers in all the villages. Drug vendors were often less expensive than NGO or government facilities. In Sidama Zone, costs at NGO facilities were higher than in government facilities, whereas in other zones NGO facilities cost less than government facilities.

**Table 21. Average Cost of Treatment and Medicine by Type of Facility (in Birr; Based on Narratives)**

Zone	Village	Government HS and HC	NGO Facility	Drug Vendors	Traditional Healers
Sidama	Olola	45	88	18	NA
	Wessa	49	96	47	37
Hadiya	Borbosa	60	NA	62	NA
	Sagada Bekera	72	NA	15	1
KAT	Chaffa	128	34	10	NA
	Hansawa	73	12	10	NA
North Omo	Oge	207	NA	47	10
	Demeba	42	13	11	6
	Boyne	31	NA	23	NA

Note: NA=not applicable.

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

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

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

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

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

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



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

Table 22 shows how much the focus group participants think they should have to pay for curative health services. Many groups felt that they could not make any recommendations because the decision rested completely with the provider. Women were often reluctant to mention specific recommendations, saying they had to consult their husbands first. Four of the men's groups specified what should be paid for minor illnesses, severe illnesses, and hospitalizations. For minor illnesses, the recommended amount to pay ranged from two to ten Birr, and for severe illnesses, from three to fifty Birr. Respondents in Chaffa thought the government should pay for charges over fifty Birr.

**Table 22. Focus Groups' Recommended Amounts to Pay for Curative Health Services**

Zone	Village	Men's Groups	Women's Groups
Sidama	Olola	5–8 Birr for minor illness 10–20 Birr for severe illness 50 Birr for admission into a facility, including medicine and food	Have providers decide charges
	Wessa	Willing to pay according to the service provided	Willing to have the government decide
Hadiya	Borbosa	Have providers decide charges	50% of the amount charged by providers
	Sagada Bekera	According to each person's ability to pay	50% of the amount charged by providers
KAT	Chaffa	5–10 Birr for minor illness 10–50 Birr for severe illness If more than 50 Birr, government should pay	Have providers decide charges
	Hansawa	25% of the amount charged by providers	5–10 Birr for getting good treatment
North Omo	Oge	3–5 Birr for minor illness 5–10 Birr for severe illness >10 Birr for hospitalization	Have providers decide charges
	Demeba	Have providers decide charges	No more than 5 Birr for all curative treatments
	Boyne	2–3 Birr for minor illness 3–5 Birr for less severe illness 15–30 Birr for severe illness	Depends on the type of illness and treatment provided

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

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

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

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

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

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

Almost all health care is paid for by borrowing or selling some assets. There were some examples of people going into tremendous debt to pay for health care. One man in Wessa said, “The treatment was not worth the money because I lost all my wealth by selling [what I owned] to pay for treatment and I still have not recovered.” Table 23 shows the patterns of borrowing, selling, and pawning in the nine study villages. The last column of Table 23 shows the types of items sold or pawned to pay for health care. The percentage of people who had to borrow money for health care ranged from 18 to 65 percent, and the amounts borrowed ranged from three to a thousand Birr.

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**Table 23. Borrowing to Pay for Health Services (Based on Narratives)**

Zone	Village (No.)	Percentage Who Borrowed or Pawned	Range of Amount Borrowed in Birr	Items Sold or Pawned
Sidama	Olola (20)	65	3–330	Oxen, cow, calf, heifer, sheep, chicken, food grain, <i>chat</i> (local drink)
	Wessa (20)	25	50–200	Food grains, <i>chat</i> , <i>injera</i> , cow, sheep, rented farm land
Hadiya	Borbosa (12)	50	100–900	Cow, goat, food grains, potato
	Sagada Bekera (10)	30	5–1000	—
KAT	Chaffa (17)	35	4–125	Oxen, calf, goat, chicken, coffee, butter, cheese
	Hansawa (17)	41	6–300	Chicken, calf, food grains
North Omo	Oge (14)	23	4–20	Sheep, food grains; pawned half of farm land; got cash from <i>ikub</i> (traditional organization)
	Demeba (17)	18	20–30	Potato, eucalyptus tree, coffee
	Boyne (26)	65	7–300	Food grains, coffee, sheep, oxen, donkey, chicken

# Community-Based Health Care Providers

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

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

Table 24 shows the range of fees providers reported charging, though it should be noted that most providers were reluctant to discuss their fees. Drug vendors usually charge only for the medicine; traditional healers typically charge two to ten Birr.

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

**Table 24. Range of Provider Fees According to Providers**

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

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

During discussions in North Omo, the elders said that the CHAs and TBAs fit within the health committees of the PAs, and that the CHAs are selected by either the PA executive leader or the PA committee. They added that the CHAs are not held accountable, however. In the future, the elders said, CHAs should be accountable to the PA. The PA should supervise their working hours and distribution of medicine, and the health offices should supervise the technical aspects of their work. The elders in Boyne said that WVI paid only for training the CHAs and then sent them to the village without payment. “Nobody paid them, nobody supervised or provided the necessary materials.”

In every village visited, there are traditional groups called *edir* and *ikub*. The purpose of an *edir* is to provide overall assistance when a death occurs, including providing food and drinks during the funeral, preparing temporary shelter, providing a fixed amount of money, and participating in the burial ceremony. An *ikub* is an organization for saving money and providing credit according to the bylaws. Men and women often have separate *edir* and *ikub* groups. There was no evidence that CHAs and TBAs have been financed or supervised by these groups.

Several CHAs recommended forming a health committee to enable providers and the community to work together and prepare an action plan.

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

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

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

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

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

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

A CHA in Chaffa said, “They [HS and HC staff] don’t want to have a relationship with us because it reduces their income.” A CHA in Olola said, “Better service can be given to the community when there is a joint meeting with all service providers in the village and when CHAs and TBAs can be given support and medicine.” Both CHAs and TBAs reported their need for medicine, equipment, and additional training. Many of the CHAs reported that they needed better supervision from the HC and HS staff.

**22. What are the perceived roles and responsibilities of TBAs and CHAs? Do they include education, prevention, and referral?**

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

Table 25 presents perceived roles and responsibilities of CHAs and TBAs. Whereas TBAs see their role as giving delivery services only, CHAs see their role as primarily giving preventive services, including providing health education and promoting environmental sanitation.

**Table 25. Perceived Roles and Responsibilities of CHAs and TBAs**

Zone	Village	CHAs	TBAs
Sidama	Olola	Treatment of minor illness Health education	Delivery services Health education for pregnant women
	Wessa		Helping women during delivery Referrals for pregnant women who have difficulties
Hadiya	Borbosa	Health education about environmental sanitation and clean water Treatment for minor illness	Giving care and advice
	Sagada Bekera	Education about health and environmental sanitation	Delivery services

**Table 25. Perceived Roles and Responsibilities of CHAs and TBAs (cont.)**

Zone	Village	CHAs	TBAs
KAT	Chaffa	Health education	Delivery services
	Hansawa	Health education about immunization, spread and cause of illness Advising people to boil water before drinking Advising people to dig latrines Providing drugs for minor illnesses	
North Omo	Oge	Health education	Services related to delivery
	Demeba	Preventive services (contraceptives)	Delivery services
	Boyne	Health education about child spacing, clean water, and environmental sanitation Reporting outbreaks of epidemics	Delivery services Health education about child care

### **23. What referral networks currently exist?**

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

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

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

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

# Conclusion

The community demand study could not investigate in depth all the issues relevant to the implementation of community health activities. However, the study did identify some key topics for further research, which are described below.

The results of this study point to some clear recommendations for the development and implementation of community health interventions. In essence, the specific recommendations focus on the need for communities to be involved in such decision making as the selection of CHAs and the need to build on existing community resources, whether traditional healers or drug vendors.

## Recommendations

### Revise the CHA Selection Process and Criteria

Currently the only criterion for selection of a CHA is that the person be able to read and write. Local communities have recommended a number of additional criteria, including that the CHA not be addicted to anything. The results from this study show that local communities think it is essential that they be involved in selecting CHAs, who should be from their own villages; most respondents said that they would not be willing to contribute in cash or in kind unless these two conditions were met. Respondents also said that the CHAs should be held accountable to the PA and should be supervised by the HCs and HSs. Unless local communities are involved in the selection and supervision of CHAs, the ESHE project runs the risk of CHAs being underutilized and unsustainable over time. The Ministry of Health needs to review the roles of CHAs and provide clear guidelines on such issues as the distribution of contraceptives and tuberculosis drugs and giving injections. There should also be written job descriptions for CHAs and a policy on incentives. Training needs to be strengthened for both CHAs and TBAs.

### Work with Traditional Community Groups

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

### Integrate Programs Whenever Possible

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

### Consider Potential Roles of Drug Vendors

In all the study villages, drug vendors are an important source of health care, and are often preferred even to a nearby government HS. Hence, drug vendors should not be ignored, although they are not part of the



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formal health care system. The ESHE project should explore opportunities to involve drug vendors, possibly by training them to refer serious cases, using them to supply drugs to CHAs, or teaching them safer, more affordable, and more effective ways to manage pediatric illness.

### **Recognize Importance of Medicines and Curative Care**

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

### **Recognize Seasonal Patterns**

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

### **Recognize Variation between and within Communities**

Although all nine villages studied were in the SNNPR, there was considerable variation among them because of the geographic and cultural heterogeneity of the region. Health planners must attempt to understand the differences in perceived problems, seasonal patterns, experience with previous development projects, and available resources to plan appropriate health interventions. Similarly, within each community some households are at greater risk of health problems than others. These households are often known in the community (e.g., female-headed households, households with small land plots) and may be targeted for special attention (though this must be done with caution).

### **Continue the Dialogue with Local Communities through Rapid Assessment Methods**

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

## **Topics for Further Research**

### **Traditional Beliefs and Practices**

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

### **Management and Supervision of CHAs**

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

### **Communication Channels**

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

### **Traditional Healers and Drug Vendors**

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



# **Annex A. Matrix of Data Collection Procedures and Questions**

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

Research Question	A: Ranking the Priority of Health (M/W)	B: Social Mapping (M/W)	C: Seasonal Diagramming (M/W)	D: Ranking Health Problems (M/W)	E: Ranking Providers (M/W)	F: Provider Interviews	G: Illness, Death, and Delivery Narratives	H: Focus Group Discussion (M/W)
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**Health as a priority**

1. How high a priority do local communities place on health compared with other problems they face (especially lack of food and water)?	X							
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**Perceived health problems and demand for services**

2. What are the five most important health problems of <i>men, women, and children</i> in the village?				X				
3. What are the five most important health services that people want provided to them?				X				X
4. What are the seasonal variations in time availability, cash availability, food availability, illness, access to clinics/medicine, and migration?			X					
5. How do people perceive the health services intended for them in terms of cost, hours, quality of service and care, and staff?					X		X	

Note: M = men's group; W = women's group

**Research Question**

**A: Ranking the Priority of Health (M/W)**

**B: Social Mapping (M/W)**

**C: Seasonal Diagramming (M/W)**

**D: Ranking Health Problems (M/W)**

**E: Ranking Providers (M/W)**

**F: Provider Interviews**

**G: Illness, Death, and Delivery Narratives**

**H: Focus Group Discussion (M/W)**

<p>6. What are the costs of medicines? How accessible are medicines in terms of distance and time to reach the sources of medicines? How important are commercial medicines in the assessment of the quality of service?</p>					<p>X</p>		<p>X</p>	<p>X</p>
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**Care-seeking behavior**

<p>7. Where do people go for health care—government, traditional, or informal sources? How has this changed over the past five to ten years?</p>		<p>X</p>					<p>X</p>	
<p>8. Where do people go for deliveries, immunizations, and other preventive services?</p>		<p>X</p>			<p>X</p>			
<p>9. Where do people go for curative care?</p>		<p>X</p>			<p>X</p>		<p>X</p>	
<p>10. What are the most important criteria that people use to decide <i>where</i> to go for treatment (e.g., type of illness, geographic accessibility, availability of medicine, perceived quality)?</p>					<p>X</p>		<p>X</p>	

**Research Question**

**A: Ranking the Priority of Health (M/W)**    **B: Social Mapping (M/W)**    **C: Seasonal Diagramming (M/W)**    **D: Ranking Health Problems (M/W)**    **E: Ranking Providers (M/W)**    **F: Provider Interviews**    **G: Illness, Death, and Delivery Narratives**    **H: Focus Group Discussion (M/W)**

11. What is the pattern of utilization of government, NGO, and traditional health services (especially TBAs and CHAs)? In other words, do people seek care from several providers simultaneously or do they see providers sequentially? Whom do they visit first, second, third?					X		X	
12. What is the role of CHAs, TBAs, and other extension agents as perceived by the community?					X		X	X

**Willingness and ability to pay**

13. What do people currently pay for <i>preventive health services</i> ?							X	X
14. What do people currently pay for <i>curative health services</i> ?							X	X
15. What do people consider a reasonable or affordable amount of money to pay for <i>preventive health services</i> ?			X					X
16. What do people consider a reasonable or affordable amount of money to pay for <i>curative health services</i> ?			X					X

**Research Question**

**A: Ranking the Priority of Health (M/W)**

**B: Social Mapping (M/W)**

**C: Seasonal Diagramming (M/W)**

**D: Ranking Health Problems (M/W)**

**E: Ranking Providers (M/W)**

**F: Provider Interviews**

**G: Illness, Death, and Delivery Narratives**

**H: Focus Group Discussion (M/W)**

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

18. What is the range of provider fees? How do providers determine how much to charge? Do providers charge less to poorer people?						X		
19. Into which community structures or organizations do CHAs and TBAs fit (e.g., health or development committees)? How are they selected and held accountable to the community?						X		
20. What types of financing mechanisms have CHAs and TBAs experienced (e.g., revolving drug funds, community funds)?						X		
21. What are the perceived needs of CHAs and TBAs?						X		



Research Question

A: Ranking the Priority of Health (M/W)

B: Social Mapping (M/W)

C: Seasonal Diagramming (M/W)

D: Ranking Health Problems (M/W)

E: Ranking Providers (M/W)

F: Provider Interviews

G: Illness, Death, and Delivery Narratives

H: Focus Group Discussion (M/W)

Research Question	A: Ranking the Priority of Health (M/W)	B: Social Mapping (M/W)	C: Seasonal Diagramming (M/W)	D: Ranking Health Problems (M/W)	E: Ranking Providers (M/W)	F: Provider Interviews	G: Illness, Death, and Delivery Narratives	H: Focus Group Discussion (M/W)
22. What are the perceived roles and responsibilities of TBAs and CHAs? Do they include education, prevention, and referral?						X		
23. What referral networks currently exist?						X		
24. How do health center/station staff see the role of CHAs? What is their capacity to provide support?						X		