

**RESEARCH PROTOCOL**  
**Médecins Sans Frontières**  
**Version THREE**  
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Assessing barriers and enablers to reproductive health care in Dollo zone, Somali Regional State: a *qualitative study*

**Research Question: What are the perceptions of women and men living in the Somali region of Wardher toward reproductive health care ?**

Study Sites: Dollo Zone, Somali Regional State, Ethiopia

Proposed start date of data collection for study: November.2016

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Glossary:

ANC:	Ante Natal Care
RHB	Regional Health Bureau
CHW:	Community Health Workers
FGDs	Focus Group Discussion
IDIs	In-depth Interviews
MCH:	Mother Child Healthcare
MSF:	Médecins Sans Frontières
SRS	Somali Regional State
SERO	Scientific Ethical Review Office
OCA:	Operational Centre Amsterdam
SGBV:	Sexual and Gender-Based Violence
TBA:	Traditional Birth Attendant
HEP:	Health Extension Program
HSTP	Health Sector Transformation Plan - Ethiopia
WHO	World Health Organisation

## 1. Background

Médecins Sans Frontières (MSF), Operational Centre Amsterdam (OCA) has been present in Dollo zone, Somali Regional State (SRS), since 2007, providing basic and reproductive healthcare to a population in remote living conditions suffering poverty, a lack of developed infrastructure, low education, poor food security, few livelihood opportunities and the ongoing effects of a protracted conflict and unstable conditions in the area.

Ethiopia has one of the highest maternal mortality ratios (MMRs) in the world (676 maternal deaths per 100,000 live births according to the 2011 Ethiopian Demographic Health Survey (EDHS)). This is generally associated with a lack of adequate access and continued under-utilization of 'modern' health services (USAID 2012). The EDH Surveys of 2000, 2005, and 2011 also showed that reproductive health coverage for women in general is very low but increasing(Onarheim et al. 2015), demonstrated for example by an increase in the number of health centres from 412 in 1997 to 2689 in 2010 (Yesuf et al. 2014)and the implementation of the Health Extension Worker Program(Carruth 2014). However, despite these efforts the country has struggled to improve its maternal health indicators (USAID 2012); maternal mortality has only decreased from 871 per 100, 000 live births in 2000 to 676 in 2011 (Yesuf et al. 2014).Significant disparities also exist in terms of health indicators and health services within Ethiopia(Shiferaw et al. 2015).

Even with the investments in primary healthcare infrastructure, staffing, and supplies in the Somali Region, since 2003 it remains underserved and few humanitarian agencies operate in the area. Reproductive health indicators are consistently amongst the lowest in Ethiopia, for example SRS has the second lowest percentage of skilled birth attendance in Ethiopia after Afar state, totalling 9% of births attended by a doctor, nurse or midwife in 2014, according to the Mini Demographic and Health Survey by the Ethiopian Central Statistical Agency. The same survey reported that 89.2% of births were attended by a TBA or family member(Central Statistical Agency, 2014).

The few existing health facilities in the Somali region are under-utilised by communities, particularly in terms of reproductive health services (Ministry of Health 2012). Low uptake is reported even in areas where services are geographically accessible and costs are reported to be low (Carruth 2014).

As a result, MSF and the SRS Bureau of Health (BOH) suspect that the health needs of the civilian population are not being adequately met, and aspects affecting access to healthcare are not well understood by healthcare providers. At the same time, comprehensive and in-depth analyses of the barriers to health service uptake in the Somali region are lacking, particularly with regard to reproductive health. Qualitative operational research exploring issues on barriers to healthcare from the perspectives of women and the knowledge and awareness of men living in the region has the potential to increase understanding and in turn help MSF/BOH to address the gaps in reproductive health provision by potentially 1) addressing access to services and 2) improving the quality of care by tailoring reproductive health services to the specific needs of the population.

Through previous and recent assessments on the topic the team are aware of anecdotal evidence suggesting a variety of reasons for poor utilisation of health care. Most recently, in March 2015, a series of informal focus groups discussions (FGDs) were carried out by the MSF team with local TBAs and women of child-bearing age, exploring reasons why women were reluctant to use reproductive

health services in one of the project sites, despite 24 hour availability of services. The main reasons given were that deliveries often take place at night, when women are reluctant to travel and that by the time there is an emergency it is often decided that it is too late to move to seek formal healthcare. Travel to a healthcare facility is widely seen as a means of last resort and often impractical or impossible, depending in part on the location of the nearest facility. In 2011 a project assessment showed among women interviewed concepts of wellbeing in pregnancy versus sickness as a reason to not seek or seek medical care. Men were also found to be an important but neglected commentator on women's health and wellbeing during pregnancy.

Anecdotal reports from local staff report that many first time mothers see birth as an important rite of passage to motherhood and that although healthcare is appreciated the assisted delivery at birth by modern medical staff is seen to be unnecessary and are to somehow fail as a woman. Other beliefs include that TBAs are more knowledgeable and experienced, being older and trained in local knowledge and customs, whereas young BOH staff have been away to university and are perceived to have lost their links to the area (or are from other regions with different birth traditions). However no in-depth analysis of these or other barriers has taken place in the region.

Simkhada (2008) et al suggest key factors affecting reproductive health service uptake in developing countries (using the example of ANC) are: socio-demographic factors; availability of services; accessibility; affordability; characteristics of health services; and women's position in the household and society. Similarly, in the context of Ethiopia, Onarheim et al (2015) suggest that both 'push and pull factors' impact whether and when women make use of delivery-care services, including sociocultural factors, economic accessibility, perceived benefit from and need of services, and physical accessibility. Specifically considering utilization of sexual and reproductive services by young people, Muntean et al (Muntean et al. 2015). suggest the main barriers are related to limited sexual reproductive health (SRH) knowledge; lack of open discussion of sexual matters; low status of women; cultural and logistical barriers; competing priorities among community health professionals; limited resources for health facilities; and negative attitudes of providers towards unmarried youth. They observe that while antenatal needs of young married women are somewhat addressed, gaps exist in terms of services for unmarried youth, young men, rural youth and vulnerable groups.

It is clear that an understanding from the recipient of care is key if improvements to access are to be made (Gebrehiwot et al. 2012), and that a focus on contextualization of care is gaining pace in much of the public health and development literature on access to healthcare from around the world (Liambila and Kuria in Western Kenya (2014) and Das and Sarkar in rural India (2014)). The Somali region represents a particular historical, cultural and political context that necessitates dedicated study, and MSF, being placed as they are in SRS, may find that a focus on the context from the perception of patients and the local community can answer important questions about under-utilization and continuing high mortalities and morbidity rates in the region in relation to other regions of Ethiopia.

## **2. Rationale for proposed study**

A deeper understanding of the perspectives, knowledge and awareness of women living in the region with regard to pregnancy and child birth is essential to learn lessons and increase acceptability and effectiveness for reproductive health care services offered in the area.. How do

women and men perceive the options for reproductive health care? What are the gaps and needs? What are the barriers? and what may facilitate care?. In addition, inquiry with adult men with regard to their knowledge and awareness will help analyse the consistency of main findings through gathering opinions and suggestions at community level. This study therefore aims to describe the population's everyday experiences in SRS by exploring the enablers and barriers women face in accessing reproductive health care.

Key objective:

- To understand the reasons behind low utilisation of reproductive health care services in SRS from the perspectives of the local population.

Secondary objectives:

- To identify gaps and barriers for uptake of reproductive health services
- To identify what may help facilitate use of reproductive health services.

### **3. Methodology**

A qualitative, descriptive research design will be used, due to the exploratory nature of the subject. It will be conducted in two stages:

- 1) Literature review and mapping of current health policy with regard to reproductive health care in the region.
- 2)
  - Participant narrative in-depth interviews (IDIs) with female adults (will include pregnant women, new mothers and other women with an influence and understanding of the birth process)
  - Focus Group discussion, (FGDs) with male adults (will include males with knowledge on the topic of reproductive health and access to care, can include fathers, leaders)
  - Field notes and related observations

The choice of methodology will encourage rich text and reflective narratives from main participants in order to answer the research question, which looks at enablers and barriers to accessing reproductive healthcare in the region.

The researcher will document field notes during fieldwork, detailing insights and observations that develop over time and through repeated analysis of events, activities, and interactions. This aims to enhance understanding of data collected through in-depth interviews and FGDs increasing the robustness of results through contextualising the data. It will also highlight any discrepancies between what people say and what they actually do, so increasing the validity of the findings.

#### **3.2. Study site:**

This study will be conducted in Dollo Zone, Somali Regional State for one month.

#### **3.3. Sampling and recruitment strategy:**

Purposeful sampling will be applied, where the researcher will actively select informants that are seen to be most likely to provide insightful testimonies. Snowball sampling will support this, where subjects may recommend further potential candidates to the researcher. This is thought to be appropriate in the context, as pregnant women and mothers with infants under one are deemed likely to know of each other in the communities where the research will be carried out and allows for a more discrete and focused method of recruitment which can protect potentially vulnerable younger participants as people are generally known to others in a supportive context. Snowball sampling will also avoid a heavy reliance on the project to identify potential candidates, which would most likely lead exclusively to participants who already use Ministry of Health (MoH and MSF's health services).

For in depth interviews, participant selection will cover female participants 15 years and older as per World Health Organisation (WHO) definition of the reproductive age for women who are currently pregnant or are up to a maximum of 1 year post-pregnancy and women who may have influence and traditional knowledge of the birth process. The in depth interview will be organised and conducted sensitively in a private designated space convenient for each participant. Participation in the study will be voluntary and participants will be recruited using local knowledge with support from community representatives and programme staff. Through use of storytelling techniques participant reflections on relevant life memories and current experiences related to child birth and other aspects of sexual reproductive health are expected.

Men will be invited to participate in focus group discussions by engaging with the community directly and through community leaders and health workers enabling a space for explanation and dialogue to speak about the purpose of the research and allow for potential sensitivities to be addressed. The group discussions which will be organised in a neutral location where participants may hold their regular meetings, assembled to optimise comfort and privacy within the group. Full information about the purpose and uses of participants' contributions as well as clarification of how contributions will be shared with the moderators and others in the group will be provided. Participants need to be encouraged to keep confidential what they hear during the meeting and be reassured that data from the group will be anonymised using pseudonyms with care taken for quotes not to be traced back to individuals by the researcher. Male participation will not only result in gathering more diversity of opinion but also stimulate the possibility for them to become more involved in the topic, (Thaddeus, S and D Maine 1994).

All interviews will be recorded verbatim with informed verbal voluntary consent.

Analysis of data will begin as soon as the study starts and the number of participants will only be known when data saturation occurs; that is when new information is no longer being generated (Green & Thorogood, 2009). Previous experience of similar studies with a focus on one specific phenomenon has established sample size as up to +/- 12 potential interviews as a working figure for homogenous group selection (Guest, Bunce, and Johnson, 2006). In this instance 24 interviews with women will be conducted comprising: 1) adult clients attending ANC, who are pregnant or one year post delivery and 2) Women who may have influence and traditional knowledge of the birth process. In addition, 6 to 8 men will be asked to volunteer to participate in focus group discussions (FGD). Men who will be asked to participate: 1) fathers with pregnant wives or partners or fathers with young children; 2) older men in the community with traditional knowledge, experience and or influence on the birth process and 3) Men in current married or non-married partnerships.

#### Inclusion criteria

1. All adult clients 15 -49 years attending ANC or admitted in MCH will potentially be eligible
2. All adult women in the community who are currently pregnant or up to one year post-delivery
3. All women who may have influence and traditional knowledge of the birth process (include mothers, mother in laws and traditional birth attendants)
4. All adult men of different age ranges in the community who are willing to take part in a focus group discussion: married or in non-married partnerships; fathers with pregnant wives or partners or fathers with young children and older men in the community with traditional knowledge, experience of influence on the birth process

#### Exclusion criteria

1. Clients who do not consent to interview or those identified by MSF medics as too unwell to be interviewed
2. Community members who do not consent to interview

There is currently no other research project investigating the experiences of pregnant or recently pregnant women and therefore this population is not at risk of being over-selected.

### **3.4 Data collection and analysis:**

Data collection: comprises, In-depth interviews (IDIs); Focus group discussion (FGD); and field notes. The analysis approach is thematic, a method that identifies and analyses patterns in data (Braun and Clarke, 2006). A life story narrative guide (see annex 2) with initial open-ended question and guidance will be used to conduct in-depth interviews, using a narrative, story-telling approach (Bleakly 2005). A topic guide (annex 2) will be used to conduct the focus group discussions. Field notes will be taken and made throughout the fieldwork period.

Coding of data: open coding: - will be used where transcribed data will be broken into units of meaning to identify tentative codes. Axial coding will then be performed: - where codes are compared across the dataset to identify the relationships between them and to derive core codes. Selective coding will be then be undertaken whereby core codes will be repeatedly applied to transcripts (constant comparative analyses) toward the organic identification and development of latent patterns, themes, and negative cases. Exceptions will be looked at to test emerging themes and to analyse why these cases are different. A coding dictionary and analytic memos will be developed and scrutinized by minimum two team members to enhance inter-rater reliability and analytic credibility.

Data Analysis: will start concurrent to data collection to inform probing with subsequent interviews and FGDs. We will use grounded theory approach, so that emergent codes and themes are based in the data derived from interviews and FGDs and checked with reflexive practice to ensure against the insertion of preconceived assumptions. An inductive process of developing theory or concepts emerging from participant accounts as well as exploring and testing pre-existing ideas will be used. Participant responses from individual interviews will be compared with other data sources, such as FGDs and field notes where convergent themes will be identified. In this way we will be looking for points of agreement or difference between the perspectives and accounts drawn from the interviews and group discussions; i.e. to what extent the different accounts or data sets agree or contradict with each other or if certain conflicts emerge. Selected anonymised narratives or case

studies will be drawn out to ensure the individual 'stories' are not lost and to explore how the themes interrelate in particular cases. The text generated from focus groups with men through an iterative process may enrich or add to deeper understanding provided by individual interviews with women. We will compare findings to other studies through a secondary literature review.

### **3.5 Interview Language:**

A field study investigator will conduct the interviews in Somali, the local language, unless there are participants who can and want to speak English. All interviews will be carefully transcribed from the recorded interview and remain verbatim, to include all pauses, hesitations, laughter etc. Transcriptions conducted in Somali will be translated by two locally trained translators to ensure translation checks can be made, one at project site for quality control purposes and one via a professional translation service. They will be supervised to work with terms of reference including respect towards all parties involved in the study; confidentiality of all translation will be maintained; neutrality and accuracy when translating; confirming no conflict of interest and to inform on local idioms and traditions that will help understand better the context and communication. A confidentiality agreement will be signed by both translators.

### **3.6 Limitations:**

The findings of this study will be descriptive, but as with a qualitative study, results may not be generalizable to the whole of Somali Regional State. In qualitative research there is always the risk of researcher bias and lack of methodological rigour, but this will be minimised as much as possible through careful auditing of the research process and ensuring adequate experience in qualitative research.

### **3.7 Data Validation:**

As mentioned in the methodology data is being collected from a variety of sources in order to compare and strengthen related conclusions. Validation will be established by including deviating cases and testing emerging theories, instead of only selecting examples which reiterate desirable points (Green & Thorogood, 2009). Reflection of the role of the researcher as a confounding factor will be considered throughout the analysis, acknowledging the potential for bias. Documentation of research process will include a clear account of procedures used as an audit trail that can be easily followed. Triangulation will take place by searching for convergence among the different sources of information gathered to form themes or categories within the analysis which will add to the validation.

### **3.8 Data protection and management:**

After the interview and discussions we will ensure that all the data collected (digital files, survey forms, paper notes, audio recordings, interview and discussion transcriptions) is managed respectfully and confidentially and will exclusively be used for the purpose of this study and the project. Details of participants recorded with their express consent in order to ensure feedback of findings will be stored confidentially and securely (password protected) in one location and used only for the purpose intended. The names of interviewees, their identification codes, transcripts,

and audio recordings will be stored with password protection on the PI's computer. Secure back-ups will be made according to the project's data security standards in the event that the PI's computer is lost, stolen, or broken. Audio recordings will be destroyed once translated and checked. Anonymous transcripts and field notes for audit purposes will be destroyed after five years and/or two years post publication. Electronic data will be deleted from the hard drive and paper documents will be shredded by the MSF UK Programmes Unit.

#### **4. Ethical Considerations**

##### **4.1 Social Value:**

This project has a number of potential benefits.

##### Project Level benefits:

Better programmatic understanding of barriers to reproductive healthcare and the general pressures related to SRS context from the perspective of women eligible to use services.

##### Community Level Benefits:

For findings to improve accessibility of health and quality of care

For findings to raise awareness of issues related to the provision of reproductive health in SRS context

##### Wider Benefits:

Research findings and analysis may influence a wider institutional and academic discourse, embedding access to health issues in a more nuanced understanding of socio political aspects that continue to drive barriers to reproductive healthcare in similar contexts.

##### **4.2 Potential Risks:**

The study will be carried out in collaboration and with permissions of the Regional, Zonal, District and Kebele administration Offices, and in partnership with Bureau of Health. If participants feel distressed by talking about any difficult or sensitive experiences during the interview or questions on health issues do arise, as the research is taking place alongside the medical programme the patients can be linked efficiently to the necessary support. The study should not substantially interfere with routine programmatic activities although it will require the support of the project team in terms of input into participant selection, and ensuring confidential space for the interviews. Remuneration for participants is anticipated and will be as per MSF standard. It is not foreseen that respondents will receive financial compensation in exchange for participation. However, non-monetary tokens such as a soap kit or equivalent and transport fees will be included and is referred to in the information sheet and the form used to guide the consent process.

The main burden to interviewees will be the time taken for the interview. We have communicated with relevant authorities from the outset in order to ensure correct permission, courtesy, and access to the population. The research team will be especially mindful of privacy and choice of environments to ensure participants of in depth interviews and focus group discussions feel comfortable with them. Information generated through the interviews and focus group discussion



will be kept private and confidential by the investigators. With regard to the FGD we will request members to maintain confidentiality of the group's discussion. We will request this at two stages: via informed verbal consent with each individual member of the group immediately prior to carrying out the discussion using a form to guide the consent process; and afterward once all individuals in the group have consented, ground rules toward respect and confidentiality within the group will be addressed again at the beginning and end of the discussion. In the context of the FGD, the researchers take into account that ultimately it can only be up to the group itself to respect the confidentiality of what is said in the discussion (Tolich, M. 2004).

We will be mindful to maintain a strategy for anonymisation of data which keeps confidential names, places and other identifying features across data sets, interview transcripts and field notes. We acknowledge the potential challenges presented in doing this, such as a well-known event occurring within a location that may be easy for others to recognise in research reports. In such a case any specific data referring to the event will be decontextualized where possible or omitted.

There are no current security restrictions but it is acknowledged that the project operates in an area that may experience security risk due to ongoing protracted conflict. Local project security rules will be adhered to as per MSF policy. If the study had to be stopped prematurely further discussion with the local authority and security office for the Regional, Zonal, District and Kebele administration Offices with possible options of continuation of the survey at a later date or in another location will be sought. All participants and stakeholders will be informed and feedback of preliminary findings communicated when available. The data collected will be stored on the computer server securely. The potential for disclosure will be discussed with participants during the consent procedure. There may be a potential need for disclosure should any information be revealed during the course of an interview or discussion which might indicate risk or harm to the participant (i.e. concerns that would require response of a medical or legal nature). In circumstances of health risk or harm (both physical and psychological) it will be necessary to discuss with the participant beforehand the need to disclose such information.

Examples of this for health would be a notifiable disease endemic in the area of study for example polio or measles. This duty of disclosure is made explicit in the form to guide the consent process and information note for participants.

It is not mandatory for the researcher to report cases of violence or abuse which are punishable with less than life imprisonment. Local advice to the research team is that it is considered for the victim to notify a case to concerned government body or legal entity. It is universal that no third party will report on behalf of such complaints arising from a personal relationship. For such cases medical and psychological care and support is in place. Based on the cases of rape life imprisonment can be given (in case of enhanced punishment for concurrence) where the raping is related to illegal restraint; or abduction of the victim, or where a communicable disease has been transmitted to the victim. Such cases will be reported to the senior management of the Médecins Sans Frontières programme and a supportive approach will be taken with the participant's needs and interest as central. This is made explicit in the form to guide the consent process and information note for participants.

### **4.3 Respect for Recruited Participants and Study Communities:**

Community participation in the study will be achieved through engaging with them directly. When the research team is present in the study location to ensure that potential participants are aware of their rights with regard to the research process, we will seek local community leaders, local groups and health workers to help identify key members that are known to be trusted by the community and have some insight into principles that need to be discussed such as voluntary participation and consent. We will offer to such individuals a non-monetary token of compensation such as a soap kit or equivalent and transport fees will be included as needed. A summary of study findings will be made available to participants and the community by the researchers, where an opportunity will be taken to discuss the findings. As described in section 5.3 dissemination plan, it is possible to prepare summary points and share with the stakeholders by organizing dissemination workshops for zonal stakeholders.

### **4.4 Informed Consent and confidentiality:**

Information will be provided separately to all individual participants both those approached for individual interviews and the FGDs. For this particular study, verbal consent is sought as written consent itself is known locally to reduce participation in research due to the fear of legal consequences for the signatory.

Potential candidates will be informed about the purpose of the study verbally and through a written information sheet. It will be explained clearly, using language the participant is able to understand, stating that participation is voluntary and for potential participants there will be no repercussions for non-participation and that the respondent can change their mind at any time to participate, with the choice to not answer any particular question asked during the interview or to withdraw from the interview at any point.

Voluntary informed verbal consent, will be obtained after the information sheet has been understood and immediately prior to interviews or discussions taking place using a form to guide the consent process.

Verbal consent will be sought by the field study investigator in the local language by way of an easily administered verbal consent procedure (see annex 1 part 2 for each age group both for IDIs and FGDs).

The verbal consent procedure will clarify that refusal to take part or withdraw from discussion or interview involves no penalty or loss of services. All data will be anonymized and care will be taken to ensure any quotes presented in the final report cannot be linked to individuals or places other than the study area itself.

Consent for marriage in Ethiopia is 18 years unless with judicial permission it can be younger<sup>1</sup>, for those women 15, 16 or 17 years old who may volunteer to be interviewed we will seek the consent of the husband in the absence of the parent or guardian as advised by the EPHI-SERO in Ethiopia.

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<sup>1</sup> <http://www.refworld.org/pdfid/4c0ccc052.pdf>

Alongside the consent of the husband or parent/guardian, assent from the young person will be included as part of the consent, meaning there is a signal that the young person is willing to take part in an individual interview.

In summary:

- Information sheet in a language understood by the participant is read aloud and or explained to the participants and acknowledged as understood
- The participants will consent verbally to two parts: one for the interview or discussion to take place the second for the interview to be recorded
- In case of younger participants 15, 16 and 17 years of age, permission of the parents, legal guardians or in their absence husband will be sought
- Alongside parental or legal guardian consent assent from the young person will be included as part of the consent, meaning there is a signal that they are willing to take part
- The investigator obtaining consent will record and date this on the verbal consent guide stating that the research study has been described and questions answered by or on behalf of the participant. Ensuring the participant is competent to consent and understood what they were consenting to.
- The above record will be witnessed by a person known and chosen by the participant.

Prior to the interviews, time will be taken to put participants at ease creating an environment whereby the participant feels confident and in control of the conversation. It is acknowledged that the personal interaction between participant and researcher is crucial to data gathering and therefore the researcher's reflexivity on their role as the researcher in terms of a balanced interaction is important to avoid undermining of trust. Due to the exploratory nature of qualitative research it will not be known beforehand what information may come into the conversation during the interview and therefore sensitive information will be managed by stopping the interview if the patient indicates it is too difficult for them to continue, and ensuring appropriate support is available for the participant. Opportunity will also be taken to follow up on such cases if deemed appropriate with the existing services available.

Each respondent will be given a code, corresponding to the time they were interviewed so that they can only be identified by the researcher. A master list of names of study participants both IDIs and FGDs with their identification codes will be securely kept and stored by the principal investigator.

#### **4.7 Independent Review:**

This protocol has been submitted to the Ethiopian Ethics Review Board and the MSF Ethics Review Board

### **5. Study Implementation**

#### **5.1 Collaborative partnership:**

This study represents collaboration between the Ministry of Health of Ethiopia and Médecins Sans Frontières. Within Médecins sans Frontières, the co-investigators are based in the Operational Centre in Amsterdam (The Netherlands), and UK Programmes in London (UK).

## **5.2 Timeline:**

This study will be conducted over a four month period between November 2016 and February 2017 (comprising of approximately one month preparation, one month data collection in the study site and one month data analysis and write-up). Dissemination is aimed to take place in March 2017.

## **5.3 Dissemination plan:**

A paper will be produced highlighting key study findings and their relevance to programming, including any recommendations that emerge for policy purposes. These will be distributed to MSF field contacts and coordination teams. Findings will be shared and discussed with relevant contacts from the MoH in Ethiopia. A summary of study findings will also be made available to participants, through field team members and/or the principal investigator. If possible a meeting will be held with community members to discuss the emergent findings and to gain their feedback and thoughts on these. A study manuscript will be produced and submitted for publication in a peer reviewed scientific journal. Discussions will be held with the MoH, MSF field contacts and coordination teams regarding implementation of study findings to future programme activities.

## **5.4 Resources:**

The field study investigators will carry out all interviews with training and supervision provided by the principal investigator. Identification of initial participants will be done with the help of the MSF team in MCH or outreach locations. The funding for the field study investigator's, tape recorder and the principal investigator are covered within project costs.

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