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THE STUDY OF ACCESS TO LOCAL HEALTH CARE IN ADDIS ABABA: PERCEPTIONS OF CITIZENS

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Abstract

Protecting the well-being of citizens becomes the focal governance agenda of Addis Ababa city administration particularly at the local level. Hence, increasing the degree of accessibility to health is fundamental to promote and maintain the well-being of the people. As a result, Addis Ababa city government has made substantial efforts to improve health accessibility. Among others, decentraliinging the health management to local governments was one. This study thus aimed to assess the perception of the respondents on access to health at sub-city and Wereda level. Hence, the study used descriptive and exploratory research methods.

Consequently, an open and closed-ended questionnaire was used to gather data from 385 sampled respondents. The findings show that access to health facilities and services has improved while the financial affordability is yet the primary concern of the people. Hence, the government must develop a comprehensive approach to further enhance the facilities and service accessibility at the local level.

Keywords: Addis Ababa, Access, Health, Perception, Wereda

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1. Introduction

Access to health care is fundamental in promoting and maintaining the well-being of the people because it impacts one's overall physical, social, and mental health status and quality of life. For this reason, it is a central concept in health policy and health service research. Despite its significance, the word access to health lacks a precise definition. Hence, some define access regarding entry into the use of the health care system. For instance, Gulliford et al., (2002) define access to health care as the absence of significant barriers to obtaining needed health care services. Others are interpreting as the freedom to use health services as well. For example, the World Health Organization (WHO) in 2007 defines as the ability of people to command appropriate health resources when needed. Moreover, According to Mcintyre, Thiede & Berch (2009), access to health refers to 'the empowerment of an individual to use health care and as a multidimensional concept based on the interaction (or degree of fit) between health care systems and individuals, households, and communities'.

So far there has been little disagreement about what constitutes in the dimensions of access to health care among individuals or organisations researching the area. For instance, Gulliford et al. (2002) have mentioned four aspects: service availability, utilisation of service, relevance and effectiveness, and equity. While, Thiede, Akweongo and McIntyre (2007) identified three dimensions of access: availability, affordability and acceptability. On the other hand, Peters et al. (2008) identified geographic accessibility, availability, financial accessibility, and acceptability as well. Therefore, this article considers the three dimensions, namely geographical accessibility, service availability, and economic affordability.

Addis Ababa city Administration endeavours to improve the accessibility of the people to primary health care and essential health services. One of the significant efforts was decentralising the management of health functions to local governments (the sub-city and *Wereda* level), especially since 2011. By the reform, the objective of this study is to assess the perception of the respondents on local health accessibility, since 2011. Thus, the research focuses on the opinion of the respondents because their satisfaction level is a key marker of local government's health delivery system performance.

2. Description of the study area

Addis Ababa, whose name means new flower, is the capital city of the Federal Democratic Republic of Ethiopia. The total area of the city is 540 square kilometres and has an altitude of 2,500 meters above the level of the Mediterranean Sea. Addis Ababa is considered as one of the 11 regional states in the country as well. It also has a broader role in economic, social, political and administrative perspectives. These often make a city that holds greater power than most other cities in Africa. Moreover, Addis Ababa is not only the economic centre of the nation where most financial and commercial institutions located but geographically as well. Furthermore, about 85 percent of the manufacturing industries found in the city. Currently, the city has approximately four million people, which is 30% of the country's urban population. Concerning the city's administrative structure, the city divided into ten sub-cities, and sub-cities further divided into 116 *Weredas.* One of the primary functions of these local authorities is health service delivery. In particular, the *Wereda* and the sub-city administration have the mandate of the primary health function.

3. Objective and Methods

The study aims to assess the respondents' perception of access to local health services in Addis Ababa. Hence, the study used descriptive and exploratory research methods. As such a multi-stage sampling technique was used to arrive at the required number of respondents. Firstly, the ten sub-cities categorised into three parts based on the numbers of their *Weredas*. Accordingly, *Yeka, Kirkos*, and *Gulele* selected from the first group, the second group, and third group respectively based on simple random sampling technique. Secondly, half (50%) of the *Weredas* selected from each sub-city, seven *Weredas*, six *Weredas*, and five *Weredas* from *Yeka, Kirkos*, and *Gulele* respectively thereby 18 *Weredas* in total. Finally, 385 households were selected based on online sample calculator software named CheckMarket formula. Hence, the open and close-ended questionnaire was administered to 385 randomly selected household respondents.

The questionnaire has three parts. The first part is about demographic characteristics, and the second part concerns the socio-economic characteristics of the respondents. The third part deals with the perception of respondents on local health service accessibility. The questionnaire first prepared in English and translated into Amharic for data collection and then into English for data analysis. Then, the gathered data were analysed using Statistical Package for Social Science

(SPSS) software version 20 and presented in Microsoft Excel 2011. SPSS was primarily used to manage and clear data easily as well as for descriptive statistics particularly frequencies. The data were performed using Microsoft Excel because the charts, graphs, and bar graphs in it are more attractive than in SPSS.

4. Background of the Respondents

The following table presents the demographic characteristics of the respondents. It accurately depicts respondents' sex, age, marital status, family numbers, and respondents' relationship with the household head.

Table 1: Demographic characteristics of the Respondents

		Frequency	Percent
Sex of respondents	Male	227	59
	Female	154	40
	No opinion	4	1
	Total	385	100
Age of respondents	Less than 18	3	0.8
	18-30 years	123	31.9
	31-45 years	208	54
	46-60 years	48	12.5
	Above 60 years	3	0.8
	Total	385	100
Marital status	Single	120	31.2
	Married	195	50.6
	Divorced	34	8.8
	Widowed	21	5.5
	No answer	15	3.9
	Total	385	100

Number of family members	1-2	93	24.2
	3-4	159	41.3
	5-6	101	26.2
	More than 6	32	8.3
	Total	385	100

Source: Own survey, 2017

As shown in table 1 above, of the 385 respondents, the majorities 227 (59%) are female while 154 (40%) are male. The remaining did not indicate their sex. Concerning their age, well above half of the respondents are between the ages of 31-45 years. About 32 % of the respondents are between 18-30 years of age. Respondents between the ages of 46-60 years are about 12 percent, whereas less than 18 years and above 60 years accounts less than one percent each.

About the marital status of the respondents, more than half of the respondents married, and 31 percent are single. Those who divorced are accounting for about nine percent. Five percent of them are widowed. The remaining did not indicate their status. More than 40 percent of the households have between three to four family members. Those who have between five to six family members are about 26 percent. About a quarter of the homes do have only one to two family members. The remaining that is less than 10 percent have more than six family members.

Table 2 below presents the socioeconomic characteristics of the respondents including their educational level, employment status and monthly income.

Table 2: Socio-economic characteristics of the Respondents

		Frequency	**Percent**
Educational level of respondents	No education	32	8.3
	Write and read	41	10.6
	Elementary school	44	11.4
	High school	89	23.1
	College	102	26.5
	University	77	20.0
	Total	385	100.0

Employment status of respondents	Self-employed	172	44.7
	Government employee	138	35.8
	Private sector employee	26	6.8
	Housewife	46	11.9
	Other	3	.8
	Total	385	100.0
Monthly income of households	Less than 1000 birr	82	21.3
	1001-2000 birr	50	13.0
	2001-3000 birr	101	26.2
	3001-4000 birr	57	14.8
	4001-5000 birr	51	13.2
	More than 5000 birr	44	11.4

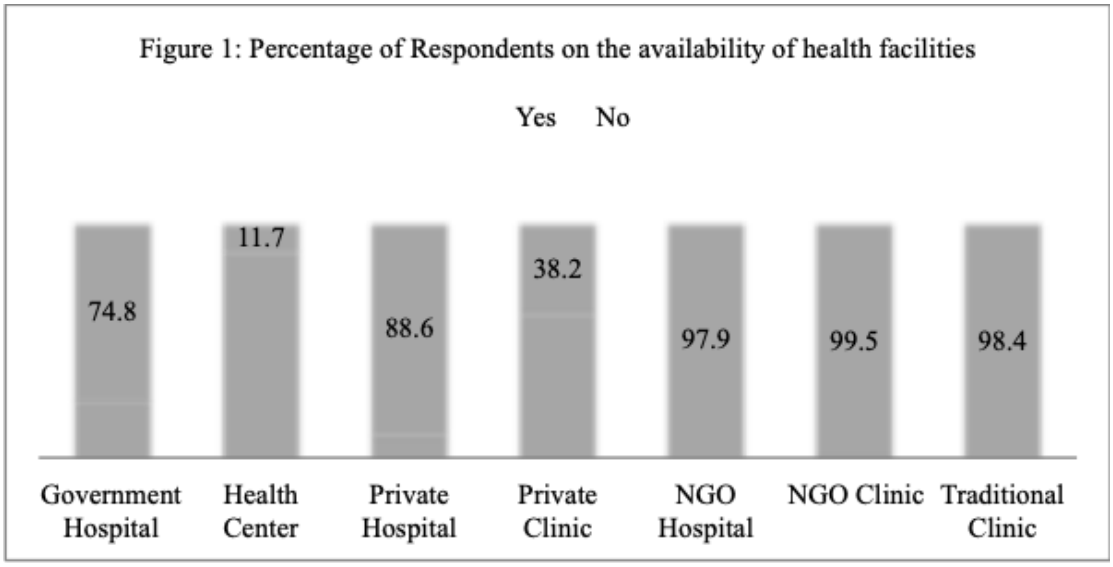
Source: Own survey, 2017

To the educational level of the respondents, as depicted in the table above, more than a quarter of the respondents have attended college, and 20 percent are university graduates. Those who are in high school and elementary school account for 23 percent and 11 percent respectively. More than 10 percent of the respondents can read and write whereas about eight percent of the respondents are illiterate. Concerning their employment status, fewer than 50% of the respondents are self-employed while about one-third of them are government employees. Less than 10% of respondents are Private sector-employees. Eleven percent of the respondents are housewives as well. The data also shows that about a quarter of the respondents earn 2001-3000 Birr. On the other hand, one-fifth of the households get a monthly income of less than 1000 Birr. Those who make between 3001-4000 Birr and 4001-5000 Birr account for 15 percent and 13 percent respectively.

5. Results

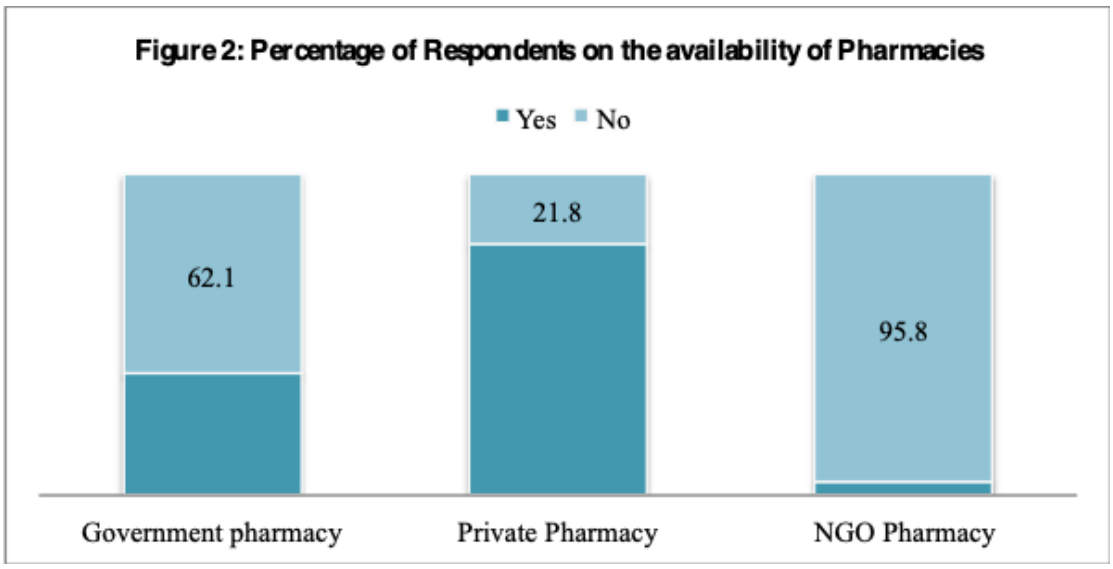
The first indicator to assess health accessibility is the availability of health facilities. Accordingly, the respondents were asked the question about which type of health facility they

have in their *Wereda*. As depicted in Figure 1 below, the predominant health facilities in the *Weredas* are Health Centers followed by Private clinics. Government hospitals and Private hospitals are other facilities that the respondents could access. NGO facilities and traditional clinics are merely available. This figure shows that most of the households could get health centres and private clinics while the accessibility of Hospitals is limited. Mainly, NGO Hospitals, NGO Clinics and Traditional Clinics are barely available.



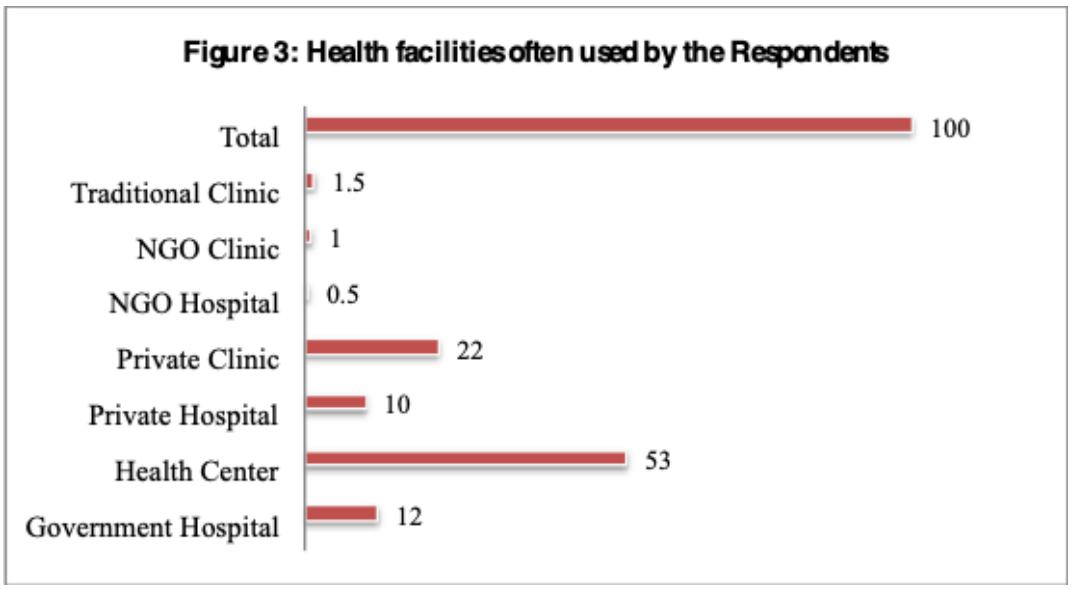
Source: Own survey, 2017

The other indicator of physical accessibility is the availability of pharmacies since people get the prescribed and on counter medicines from them. Hence, the availability of these facilities is essential to secure better health service delivery. Accordingly, the respondents were asked whether these facilities are available or not in their respective *Wereda*. The response showed that the Private pharmacies are open in most areas and about two-thirds of the respondents also accessible to Government pharmacies. Only less than five percent of the respondents said that they have NGO pharmacies in their *Weredas*. This shows majorities of the households can access private pharmacies than government-owned pharmacies.



Source: Own survey, 2017

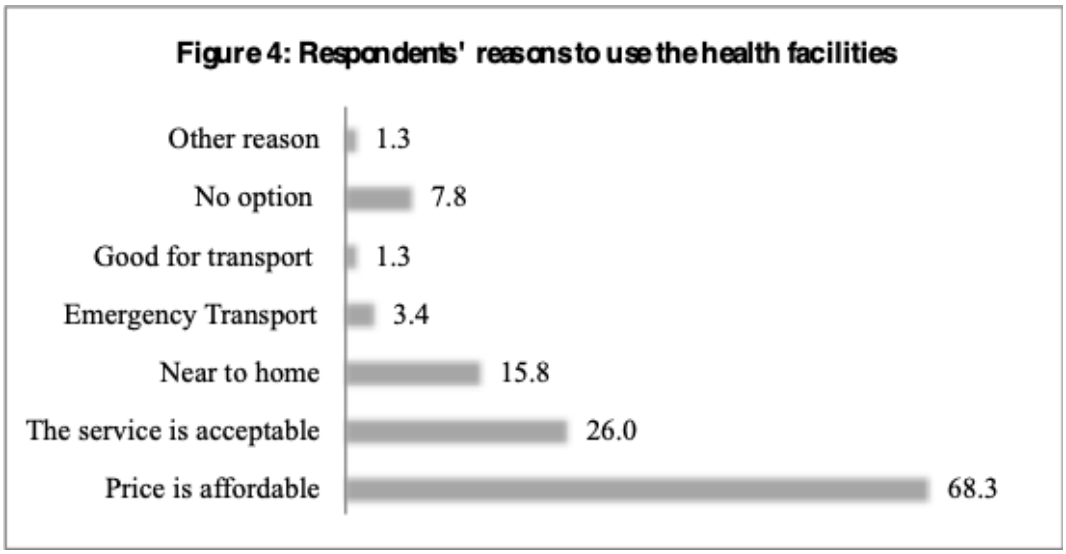
As shown in the figure below, more than half of the respondents are using Health Centers. Private Clinics, Government Hospitals and Private Hospitals are used by 22 percent, 13 percent, and 10 percent respectively. Only one percent of the respondents use NGO Clinic while fewer than 5% used NGO Hospital and traditional clinics.



Source: Own survey, 2017

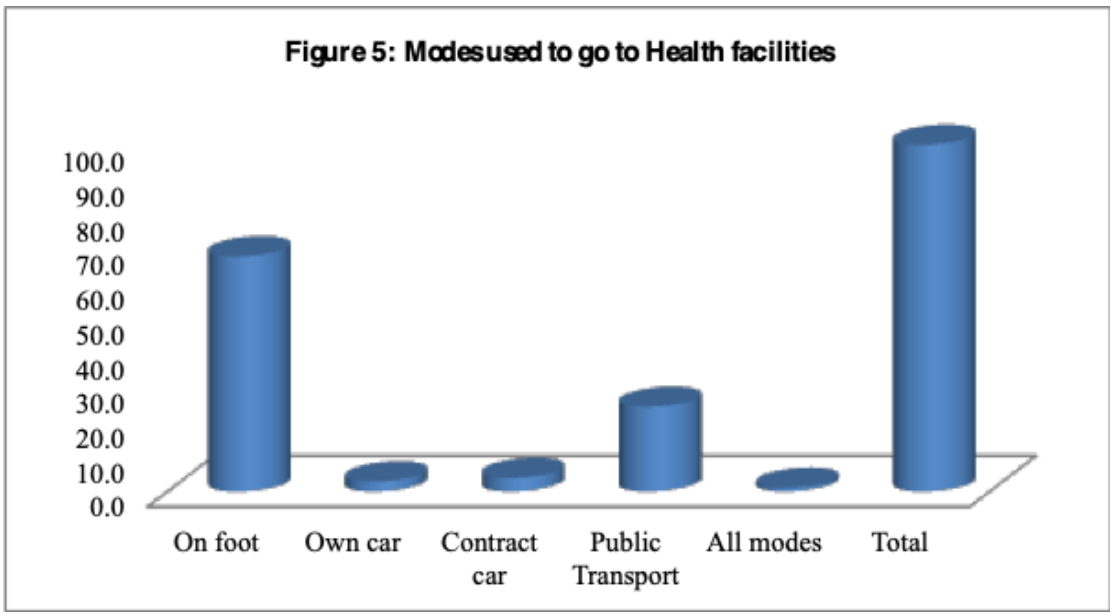
There are various justifications behind to use or not to use a particular health institution. Thus, the figure below shows why respondents preferred to visit. Accordingly, the respondents primarily choose the facility they often used because of affordability. They also prefer the facilities due to service acceptability and vicinity. Only about three percent of the respondents

chose the facilities because they provide emergency (ambulance) service. The rest attributed to transportation and proximity of the health institutions to their home. The remaining, 8 percent are forced to use the facilities because they have no other option in their neighbourhood. This data shows that affordability is a big concern for the households to choose the health facilities.



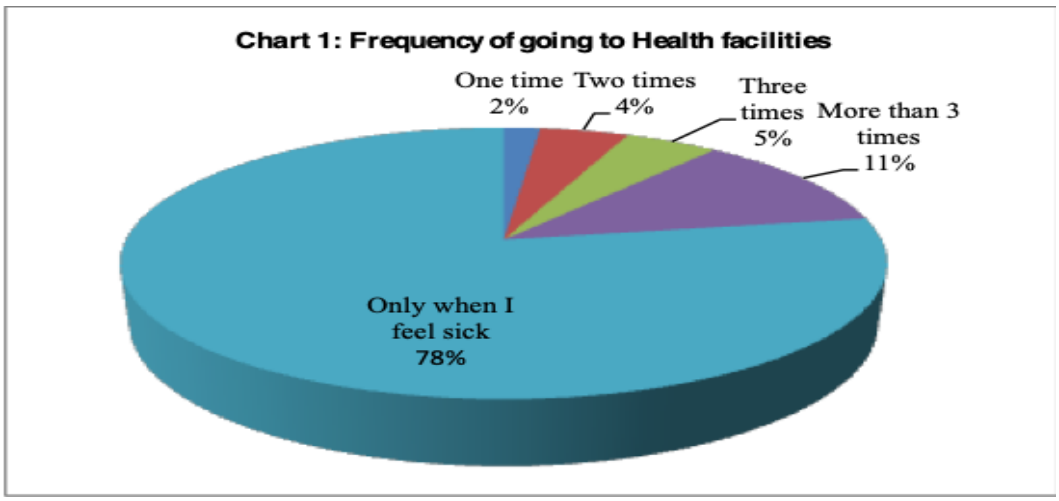
Source: Own survey, 2017

With regards to transportation, significant numbers of the users (68 percent) often go to the facilities on foot. About 24 percent of them use public transport. Four percent, three percent, and one percent of the respondents use contract car, their car, and all modes based on the situation respectively. This figure shows that the majority of the health facilities might be accessible on foot since they are available at a reasonable distance. And significant numbers of people also use public transport where the health facilities are not accessible on foot. On the other hand, more than 95 percent of the respondents have no their car. Service acceptability and short the distance to home are important reasons to choose the health facilities as well.



Source: Own survey, 2017

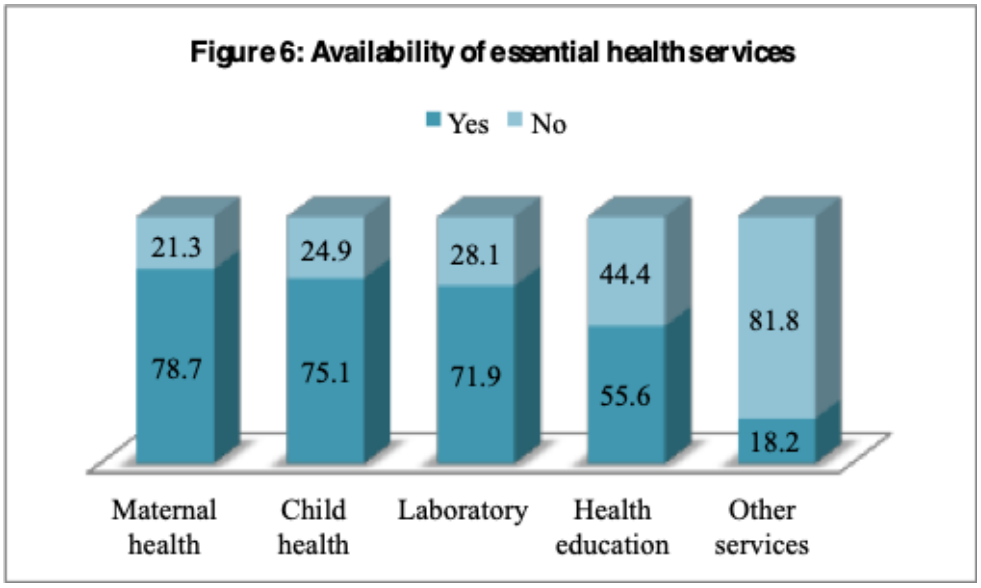
78% of those who asked indicated that only when they feel sick visited the health facilities. About 11 percent of them use more than three times a year. Whereas, fewer than 5% of the respondents use three times, two times, and one time per year. The respondents are primarily visiting the health facilities to get treatment when they ever need medical care; while immunisation and family planning are other purposes of attending health institutions. Only less than 10 percent of the respondents go to the health facilities for regular examination. This figure shows that substantial numbers of people go to health facilities only when they feel sick or get an injury. Their awareness of the prevention of diseases or a regular checkup is limited.



Source: Own survey, 2017

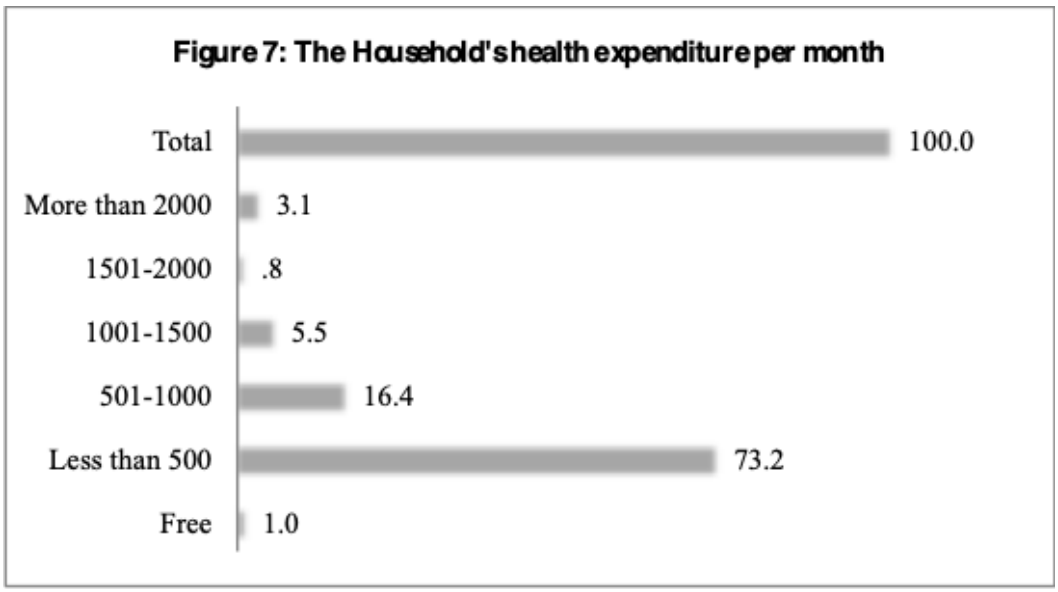
The other dimension of health accessibility is the availability of health services in health

facilities. The presence of a range of packages in the health institutions contributes once the well-being of the society. Hence, more than three-fourths of the respondents witnessed that services related to maternal (mothers) and child health is available. Moreover, the availability of laboratory service and health educations have also confirmed by well over 75% and more than half (55%) of the respondents respectively. Eighteen percent of the respondents have said there are other services (such as free counselling on nutrition and proper food handling). This data shows that vast numbers of the population could get essential services, but there are people still cannot access the services.



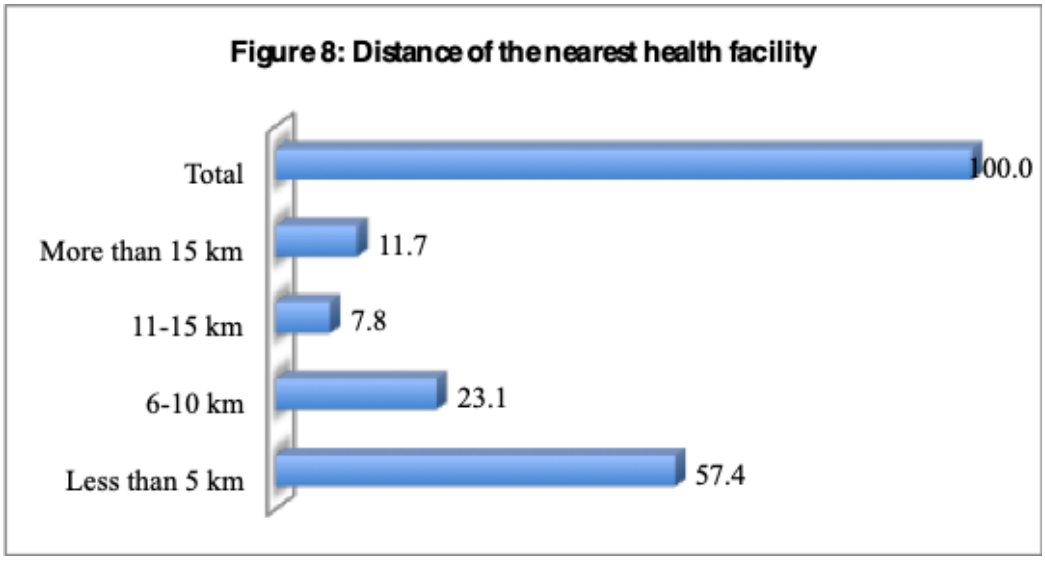
Source: Own survey, 2017

Financial affordability is also another attribute of health accessibility. With this regard, the respondents asked about their monthly expenditure on health. Hence, as depicted in figure 6 below, more than three-fourths of the respondents would incur 500 Birr per month to get the health services. About 16 percent of the respondents spent 501-1000 Birr. Those who spend between 1001-1500, 1501-2000, and more than 2000 are fewer than 10 percent. Only one percent of the respondents are the user of cost waivers (free service). The data reveals that well over 70% of the respondents spend less than 500 birr. However, average monthly expenditure of the respondents exceeds 20 percent of their monthly income since majorities earn less than 3000 as was mentioned in their monthly income data. Nevertheless, insignificant numbers of people are getting services for free.



Source: Own survey, 2017

Concerning distance of the health facilities from their home, about 60 percent of the respondents would get health facilities within 5 km. About 20 percent of them can access it within the range of 6 and 10 km. 10 percent of the users must travel more than 15 km to get the facility. Similarly, the remaining must go about 11-15 km to access the facilities. The data shows as well, residents in *Gulele* Sub-city would get health facilities within 5km than *Kirkos* and *Yeka* Sub-cities. However, significant numbers of the population still do not access health facilities within a reasonable distance in all the three sub-cities.



Source: Own survey, 2017

6. Discussion

The availability of appropriate and required facilities at the right place is a primary concern in ensuring access to health for the communities, which includes issues like location and distance of health care facilities, and transportation options. Where the essential and appropriate health facilities are available, the possibility to promote and maintain health, prevent and manage disease, reduce unnecessary disability and premature death, and the degree of achieving health equity to all people is high. With this regard, the collected data shows that residents in *Gulele* sub-city could get the health facilities within 5km than *Kirkos* and *Yeka* Sub-cities. However, significant numbers of the population in all Sub-cities still do not access within this range. For instance, the researcher observed that there is no health center in *Wereda* 1 and *Wereda* 7 in *Kirkos* sub-city. Similarly, private clinics are also concentrated in some areas and sparse in others. For instance, in *Yeka* Sub-city, there are many private clinics in *Wereda* 8 whereas few in *Wereda* 11. Likewise, in *Kirkos* Sub-city, there is a concentration of private clinics in *Werda* 4, *Wereda* 5, and *Wereda* 7.

On the other the hand, the role of traditional clinics and NGOs barely exist in the local health delivery system. NGO clinics found only in four *Weredas*: *Wereda* 5 & *Wereda* 7 (*Gulele* sub-city); *Wereda* 4 (*Yeka* sub-city); and *Wereda* 4 (*Kirkos* sub-city). This figure shows that substantial numbers of the people in Addis Ababa do not access health facilities nearby to their homes. This fact attributed by either lack of a mandate to establish a health center or lack of commitment on the side of local authorities. These, in turn, inhibit their capacity to facilitate investment in health sectors investment at the local level by different stakeholders. There is as well a gap in integrating health services among the providers, especially in enhancing the roles of NGOs and traditional clinics. Therefore, the local administrations must put rigorous efforts to improve the accessibility of health facilities.

Nowadays, pharmacies play a significant role in dispensing medications and ensuring patient safety. They also advise, educate and consult people on drugs and related issues. Hence, they play an indispensable role in improving access to health. Accordingly, the respondents asked whether they have pharmacies in their local area. The data revealed that private pharmacies are available in all surveyed *Weredas* despite their numbers. Therefore, the substantial amount of respondents able to access government pharmacies that usually located in the compound of

health centers. However, few health centers are not providing proper pharmacy services, primarily due to the lack of buildings and essential drugs that directly affects the health delivery system. Therefore, the local government administration, health offices and concerned organisations are required to make sure the availability of medicines and drugs.

Availability of the facilities is not enough by itself unless appropriate and required services are there at the right time. The study, therefore, assessed the perception of the respondents on the availability of essential services. The result shows that high numbers of the population can access essential services such as maternal health, child health, and laboratory service and health education. However, considerable amounts of the community do not access the services due to organisational and personal barriers. Organisational barriers are often related to weak data management system, reluctance of health professionals, weak referral system and long waiting time in the health facilities.

On the other hand, personal barriers include lack of information and knowledge, personal beliefs and attitudes related to socio-cultural and religious background, and language barrier. Due to this reason, about 80 percent of the population visit the health facilities only when they feel sick or get an accident rather than for regular checkup. Lack of awareness about the benefits of disease prevention might be one of the reasons. Therefore, it is critical in designing a comprehensive approach that tackles these barriers to improve peoples' access to health.

Health care affordability is crucial for the society for utilising the service not only to get help whenever they are sick but for a regular checkup. Hence, the respondents asked, and more than three-fourths of them indicated that they often prefer health institutions that can provide the service at less price. Moreover, the data pointed out that majority of the respondents expend less than 500 birr. However, the average monthly expenditure of the respondents exceeds 20 percent of their monthly income since majorities earn less than 3000 as was mentioned in their monthly income data. Nevertheless, tiny numbers of people are getting free service. This data shows that people are very anxious about the prices of the service. That is why the majorities are using health centers since the costs they incurred are affordable relative to their counterparts (private clinics). However, health centers are still not accessible as per the perception of the respondents

especially for patients who need to visit the centers for medical help regularly. Hence, the government must take a comprehensive and sustainable measurement in providing affordable health services to the people like putting the designed community-based health insurance into reality.

7. Conclusion

The data revealed that the high number of people in Addis Ababa could access the health facilities and pharmacies within 5 km in their *Wereda*. However, considerable amounts of the people still do not get the facilities within this range. Furthermore, it is noteworthy to acknowledge the achievements made on the improvement of access to essential health service, still, there are problems related to critical medicines. The affordability issue is another challenge in accessing local health services in spite of its improvements as well.

Therefore, the government must take comprehensive measures in addressing the problems. Especially through empowering offices such as Health, and Food, Medicines and Health Care Administration and Control at *Wereda* level to avoid thievery in pharmacies. It is also imperative to strengthening health center governing boards to make sure the community involvement. Enhancing collaboration between health facilities and other stakeholders is also very vital in improving the local health accessibility in Addis Ababa.

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