

**URBAN POVERTY AND HEALTH: ANALYSIS OF
HEALTH CHALLENGES AND COPING AMONG
POOR HOUSEHOLDS**



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ADDIS ABABA

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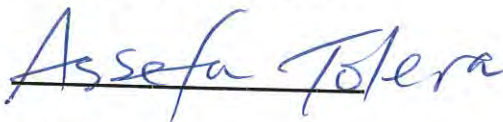
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To my beloved family;
Mekonnen, Yokabed, Raiy, Caleb and Misgana

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List of Acronyms

AIDS	Acquired Immuno Deficiency Syndrome
CSA	Central Statistics Authority
DHS	Demographic and Health Survey
EUHS	Ethiopian Urban Household survey
FGD	Focus Group Discussion
HIV	Human Immuno Virus
HICES	Household Income, Consumption, and Expenditure Survey
HSDP	Health Sector Development Programme
HSEP	Health Service Extension Programme
WHO	World Health Organization
WMS	Welfare Monitoring Survey
MOH	Ministry of Health
SDH	Social Determinants of Health Approach
SDPRP	Sustainable Development and Poverty Reduction Programme
UNFPA	United Nations Fund for Population
STI	Sexually Transmitted Illnesses

Glossary of Local Terms

Dabbo: Amharic term for bread.

Debal: Rent paying co-habitat in the same house.

Emnet: Prepared from ashes of incense smoked during church prayers; often used as remedies for various ailments.

Iddir: Neighborhood-based, traditional associations the primary function of which, is burying the dead and consoling the bereaved, and provision of financial support for covering expenses associated with burial ceremonies.

Injera: Pan cake like bread made from Teff flour.

Mahber: is a name given for an association, established by a group of Orthodox Christians who share the value of veneration of a certain saint or angel (whom they consider as personal guardian). They come together at the day of the particular angel/saint of the month to drink Tswa (literal meaning goblet).

Mitad: a flat clay pan for baking injera

Missir: Lentil, often used to make source for Injera

Shirro: Flour made from peas or chickpeas used to make source for Injera

Teff: Grain from which flour for Injera is made

Tela: Type of local liquor

Tej: Type of local liquor

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Annex I	In-depth interview questions
Annex II	Key informant interview questions
Annex III	Focus group discussion guides
Annex IV	Map of Addis Ababa

Abstract

The study focuses on the qualitative analysis of the dynamic linkage of poverty and health in the urban setting, with a particular reference to Akaki and Teklehaimanot areas in Addis Ababa. The findings strongly indicated that multi dimensional factors of poverty perpetuate illnesses that are communicable and recurrent, deterring livelihood activities and thus progressively intensifying poverty. The bidirectional linkage of poverty and health is found to be entrenched in livelihood, environmental, and psychosocial contexts in which people live and interact. Analysis of these contexts revealed that, insecure source of livelihood coupled with poor living environment significantly influence how people understand health, and thus their responses to health challenges. Although the two areas represent distinct features of inner city and outskirt, the poverty and health challenges faced by poor household were found to be similar in many ways among the two study areas. Poverty seems to affects all members of households, but health outcomes were found to be worse among women and younger children. The study also revealed how poverty shapes aspiration and people's life priorities significantly affecting people's disposition to health promoting activities. The study also attempted to gain insight into how people's coping strategies are shaped by various, household, community and institutional factors. Poor people were found to rationally make such choices, depending on who is sick, what illnesses, and attitude towards various measures including modern health care. People generally tended to be critical towards services provided in government facilities, though such complaints were minimal in Akaki where health care utilization is low. In the analysis of social capital, traditional social networks in which people belong were found to have both positive and negative impact on health promoting behaviour and coping with health challenges. In addition, the impact of non-government organizations on people's predisposition to cope with challenges of health and poverty were also assessed. The findings strongly indicate that most NGO actions have very little impact on enhancing people's capacity to cope with poverty in a sustainable manner. In fact the impacts of some NGO interventions were found to be detrimental to existing traditional coping mechanisms. The recommendations of the study revolve around its conclusion that serious consideration of these dynamic factors is imperative for health policy to be effective in addressing the soaring urban health problems.

Key words: Urban, Health, Poverty, Perception, Coping

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 General Background

Urbanization has been traditionally linked to development and development with human welfare. However in many third world countries reconciling the increasing level of urban population and the existing social services has become a growing challenge. The World Population Day marked in July 16, 2007 announced that for the first time in history, more people currently live in cities than rural areas, and much of this rapid increase is noted in the developing world particularly Africa and Asia (UNFPA, 2007). The event paused a major concern regarding poverty in cities of developing countries and the need to enable them exploit the opportunities offered by urbanization depicted by the following statement;

...In 2008 the world reaches an invisible but momentous milestone...more than half of its human population, 3.3 billion people will be living in urban areas, by 2030 this is expected to swell to almost 5 billion...many of the new urbanites will be poor, their future, the future of cities in developing countries, the future of humanity itself all depend very much on decisions made now in the preparation for this growth (UNFPA, 2007: 1).

Valahov et.al (2007) saw the current trends and threats of urbanization from three dimensions: more people moving into urban centers resulting in increased urban population; more poor people residing in slums with negative implications for healthy living and spatial conditions; and spread of cities again affecting human health and environment. As a result of such rapid urban growth that does not tally with social amenities, urban poverty is on the rise in many developing countries.

Urban poverty is a multi dimensional phenomenon characterized by lack of access to employment opportunities, adequate housing and social and health care services.

Health care is by and large one of the biggest challenges in urban areas. Many people in African cities live in slums characterized by unsanitary environment, sub-standard housing and overcrowded living conditions exposing them to poor health situations (Todaro, 2004). In addition to such increased exposure to health problems of the urban poor, research outputs revealed that household gender dynamics has differential impact in terms of vulnerability to illness, women being the primary victims (Masika, 1997; Narayan, 1999).

The impact of poverty on health outcomes, which is the main concern of this thesis, have long been well established in rural contexts where inadequate access to health service and information explain the situation. However, the categorical urban - rural comparison often obscures the real health situation in urban areas since average indicators are highly affected by inequalities within cities of developing countries.

The most striking fact, however, is that some health indicators in urban poor communities could even be worse due to multiple risks factors associated with overcrowded living situation, poor environmental sanitation and housing. Mboup (2003) and Montgomery (2004) argue that the urban poor are vulnerable to various health risks related to hazardous living and working conditions, malnutrition and lack of secured source of livelihood, and hence, some urban slum areas in African cities like Nairobi, face health risks that are as bad as remote rural areas and even worse in some cases. Despite this fact however, less attention has been paid to such disparity within urban centers and the peculiar nature of health risks faced by the urban poor. Intra-urban analysis of health and poverty therefore, could give a meaningful picture of experiences of poor people with health risks, illness and how they cope with them.

Similar to many developing countries, in Ethiopia too, such analysis of health issues in the urban context is not given much attention. This study attempted to get insight into the household dynamics surrounding the experience of people with health and poverty. Various dimensions of poverty perpetuating health risks including; source of livelihood, nutrition, family size, living condition and hygiene and sanitation are

examined. A psychosocial dimension, which tends to be neglected in many poverty studies, particularly how people's life goal and aspiration affect their endeavor for healthy life is also explored.

In the first chapter, the paper starts by introducing the topic, stating the research problem and the methods employed in the study. The second chapter gives a review of the link between health and poverty and a background of previous studies of urban poverty studies in Ethiopia, and particularly in Addis Ababa. Analysis of findings and discussions is presented in chapter three followed by conclusion and implications in chapter four.

1.2 Statement of the Problem

As indicated in the previous section, similar to many African countries, very little research attention has been paid to urban health issues in Ethiopia. This could be attributed to the fact that the majority of the population lives in rural areas and the common assumption that urban areas enjoy better health care access. This could clearly be observed in the context of the Ethiopian Health Sector Development Programme (HSDP) that is deliberately biased to rural areas with a major goal of increasing access to basic health services. However, the conceptual frameworks that informed the design of the programme and its evaluation do not appear to inculcate the urban perspective.

According to the World Bank (2005) urban poverty in Ethiopia is said to be on the rise and urbanization, despite its said benefits is posing potential threats in among which health is a critical concern. Yet, a significant proportion of urban poverty studies in Ethiopia dwell on income and/or consumption and the attention given to non-income dimensions like nutrition, education, health and social capital have been insignificant. Although National surveys like Demographic and Health (DHS) and Welfare Monitoring Survey (WMS) collect health related data in urban and rural localities, the evidence is not vigorous to inform urban health care strategy.

Studies often fail to establish much evidence on health impact of urban poverty, emanating from the traditional categorical comparisons of urban and rural areas that conceal the massive inequalities in cities like Addis Ababa and usually depict a flowery picture of the urban health status. Moreover, enquiry into poor people's experience and understanding of illness, which could have informed the urban health communication strategy, has rarely been made. This study is hoped to make a modest contribution in filling this lacunae.

1.3. Objectives

1.3.1. General

Considering the aforementioned gaps this study aims at gaining insight into the linkage between poverty and health based on experiences of poor people among selected neighborhoods of Addis Ababa.

1.3.2. Specific Objectives

The specific objectives included attempts to:

- Explore multidimensional aspects of poverty in the context of health
- Assess the common health problems prevalent in poor households and how these problems are distributed among family members (particular focus on health situation among women and children)
- Examine the interplay between poverty and health
- Understand how poverty experience shapes health perception and behavior
- Understand the gender face of poverty and ill-health
- Understand how poor people cope with health and poverty challenges, and factors affecting this process

1.4 Data and Methods

The study is conducted in two Kebles of Lideta and Akaki/Kality Sub cities through the use of qualitative research methods and employing various data collection techniques. The rationale behind the choice of method arose from the very objective of the study,

i.e understanding people' ongoing experience with challenges of ill-health and their perceptions as shaped by their poverty experience.

The practice of qualitative methods in poverty study is a recent phenomenon that is driven by the urge to understand underlying factors behind descriptive findings often given by surveys. These factors are rooted in people's routine lives, events, processes and the meanings drawn from such experiences that could be best exploited in qualitative methods that allow more open and flexible discussions. In the context of health studies as well, although standardized indicators are undoubtedly useful, such exercise should definitely take in to account people's own views and perceptions that actually shape their health behavior.

In light of this, the study acknowledges poverty as a specific and local experience to community, household and individual contexts, although poverty results from interplay of various macro and micro factors. Therefore, by targeting various groups and studying them in their local context, the study attempted to explore the dynamic link between health and poverty.

1.4.1 Data collection techniques

The research data was generated using the specific techniques including; review of literature and archival documents, in-depth interviews, key informant interviews, focus group discussions with various community groups and repeated on-site observation that are briefly described below.

Literature and documents review: The major objective of a literature review is to get understanding of what has been done regarding the research enquiry at hand. In initiating any research endeavor, this is an important stage where the research objective is refined and geared towards filling the gap left by previous studies (Mason, 2005). Thus, a review is not meant to be a summary of findings of other studies, but a critical attempt to build on previous works and dwell on the gap.

During this study, an extensive review of international and local publications of poverty and health studies was conducted, followed by an attempt to review the context in which health studies have been made in Ethiopia. A review of the policy environment that informed the existing health care system was also analyzed. Most importantly the highlights of the review were employed through out the study in an attempt to show how much the findings of this study contribute to filling the gap set in the problem statement.

In-depth Interview: In depth-interview is typically an informal, conversational dialogue between an interviewer and an interviewee on one to one basis. It is a commonly used qualitative technique characterized by mainly ‘talking with people’ guided by selected issue rather than asking structured questions (Mason, 2005; Silverman, 2005; Campbell .O, 1999; R.Ullin et.al, 2000). A typical feature of this technique is flexibility both in selecting the number of interviewee and in the process of interview. Since such interviews generate huge amount of data, collection and analysis is assumed to be time consuming. Although there is no as such a standardized range, a small sample size representing characteristics that are vital to the research, is often recommended. For instance Campbell O. et.al (1999) suggested 10-60 samples as an acceptable range for reproductive health research. Gubrim &David (2005) in their discussion about samples in qualitative research strongly remarked that ‘it is better to get much out small than small out of large’, emphasizing the value of depth in qualitative enquiry rather than the size covered.

In this study, fifteen in-depth interviews were conducted in each of the studied Kebeles of 05/06 (Akaki) and 11 (Teklehaiymanot). All in-depth interviews were conducted with female heads of households. The justification for this decision is, firstly women tend to be the caregivers for sick household members, particularly for children and spouses, and thus they could be considered as the best candidates to obtain complete information. Other studies also indicate that women’s level of awareness is a very strong determinant of child health since in most cases they are the closest care givers (World Bank, 2005). Secondly, the study had an interest to

uncover how this caring role affects experience of illness among women and their reproductive health experience. Although women were targeted for the reasons just stated, the in-depth interviews dealt with various issues and information that could be of use to infer about spouses, children and other members of households. In some cases, second time visits were necessary to set appointment for interview where necessary since the minimum interview session lasted for two hours.

Key Informants Interview: Key informant interview is basically an in-depth interview conducted with people in the study population who are knowledgeable about the issue of interest (Campbell O. et.al, 1999). In an individual case interview, the interest is more on personal experience and behavior, while in key informant interview the aim is to get information about various trends in the community, including beliefs and group practice. For successful interview with informants, creating rapport through repeated visits is important.

In this study informants were purposively selected so that they represent community, local administration and public health service. A total of six key informant interviews were done in both study sites with administrators, health care providers and Iddir leaders. The issues explored with these informants were mainly; social capital, community mobilization, role of NGOs and utilization of health care and information.

Focus group Discussions (FGDs): FGD is a technique used to generate insight into selected issues that could be better explored by interactive discussion. An ideal FGD group would contain 8-12 participants (R.Ullin et.al, 2000). In focus group discussions relative homogeneity of socio-economic and demographic characteristics is an advantage.

In this study, four FGDs were conducted in both study sites with separate groups of men and women with 10 -11 people participating in each group. The discussions mainly revolved around such issues like health risks and challenges they face, their

access and utilization of health service and information, and the impact of formal and informal institutions on their coping mechanism with health and poverty challenges.

On-site Observation: As interviews were conducted, various observations were regularly noted particularly on housing condition, assets, sanitation of the home and the surrounding environment, and situation of children that were valuable inputs in analyzing findings.

Selection of the study areas: The selection of the study localities is meant to facilitate understanding of characteristics of both inner city (represented by Teklehaimanot) and outskirts (represented by Akaki) areas of Addis Ababa. Households were purposively selected from the two Kebeles that are commonly known poor neighborhoods as indicated in the area profile. The relative homogeneity in each of the areas in terms of poverty situation has facilitated a purposive selection of studied households, although distinct criteria relevant to the study were employed. One major criterion was the existence of children under five years of age in the household, since the study has a special interest in assessing child health. An attempt was also made to balance the number of female headed households included.

1.5 Limitations

Although the study endeavoured to give a deeper insight into health situation in poor urban households it targeted only two kebles. In addition, a more complete picture of the intra-urban analysis of health disadvantage would be obtained by comparing poor neighbourhoods with other urban areas, that was not possible in this research due to temporal and resource constraints.

CHAPTER TWO

REVIEW OF LITERATURE

2.1 Poverty and Health: Exploring the Link

The relationship between poverty and ill-health is not simplistic; rather it is multi-dimensional and bidirectional such that poverty perpetuates vulnerability to ill-health, and ill-health reinforces poverty (DFID, 2005; Damen et.al, 2000). Poor people in developing countries experience higher morbidity levels, die younger (on average) and experience higher levels of child and maternal mortality (Montgomery, 2005). Ill health, therefore, is a frequent phenomenon in poor households causing a progressive decline in socio- economic status. In developing countries the major causes of mortality and morbidity are related with deprivation of basic capabilities. These deprivations are commonly characterized by inadequate nutrition, unsanitary environment, poor housing, lack of education and information and lack of proper health care.

Basic capabilities, according to Sen (1999), include; adequate nutrition, health, education, security, good relationship within household and community, enabling people to aspire and achieve better life. Deprivations of these capabilities are often inter-dependent affecting the ability to achieve an acceptable standard of living. This could be well illustrated by one aspect of capability deprivation, inadequate nutrition and its multidimensional impact in the lives of children. Child malnutrition, often considered as a core indicator of welfare, is defined to be “lack of macro nutrients (protein and calories) and micro nutrients (vitamins and mineral) that enable people to live a fully productive life” (World Bank, 2005a). Malnutrition increase and/or perpetuates vulnerability to recurring health problems that are mostly preventable or easily treatable, and their recurrence poses a great impact in the livelihood activities of people.

The effect of malnutrition particularly between the age of six and thirty six months, has been established to have a negative and irreversible impact on cognitive development of children affecting aptitude and achievement in school that would result in grade repetition and dropout, in addition to its effects on health status that often entails early mortality (World Bank, 2005a). Malnutrition also affects adults considerably diminishing physical energy to undertake work and ability to concentrate that could directly relate to one's performance. This is a simple illustration how deprivation of a single basic capability interlocks with health outcomes as well as livelihood opportunities.

Another example of inter-dependence of capability deprivations is depicted in a study conducted by Abay (2003) on how poverty affects health status and health care demand in Ethiopia. The study identified that poverty and lack of education reinforce the conditions of ill-health. It further states that the poor were more likely to fall ill and less likely to get treatment which increases the frequency and duration of illness. Lack of education also contributes to ill health condition among the poor by hampering predisposition to prevention of illness, seeking medical care, and choosing modern providers. According to the study, the effect of mothers' education on the decision to seek medical treatment was found to be ten times less for the poorest of the poor compared to other income groups.

Poor people are often faced with shocks like chronic illness, loss of a household member or increased food price directly affecting their very survival. The ability of households to cope with impact of health-related shocks is severely constrained since illness directly affects livelihood performance. The impact therefore could be long-term reinforcing the illness-poverty trap. A common manifestation of the precarious health conditions of the poor is the relatively longer duration of illness. In one study, for example, the mean duration of illness for the poorest section of a sample population in Ethiopia is depicted to be 1.6 times longer than that of the richest

section (Asfaw 2003, cited in DIFID, 2005). This confirms with the recent report by UN-HABITAT (2006a), that revealed the urban poor die young due to hunger and malnutrition and infectious diseases among others.

Another dimension of long-term impact of poverty is social and psychological deprivation. Among persistently impoverished households, social capital aspects like family relationship may be eroded due to the stress caused by the need to sustain large family size, and the burden is more serious among women. Meron (2005) and Mulumebet (2002) found out that inability to meet basic needs causes stress and desperation robbing people's aspiration for better life. A research done by Akliu and Desalegn (2000) on how the poor perceive their own state, also identified that psychological factors like hopelessness, desperation and stress were strongly pronounced. This could be directly associated with the arising of conflict with in families which is an issue of interest in this study.

A study commissioned by DIFID (2005) in its discussion about health needs of the poor, argues that unless the poverty-ill health spiral is broken at a proper entry point, the poor remains in the trap and recovery might be difficult once human capital and livelihood opportunities are seriously affected. The study attempts to demonstrate the progressive mutual intensification of ill health and poverty in the model depicted below.

Figure 2.1 Bidirectional relationship of Poverty and ill-health- A detailed Model



Source: DFID, 2005

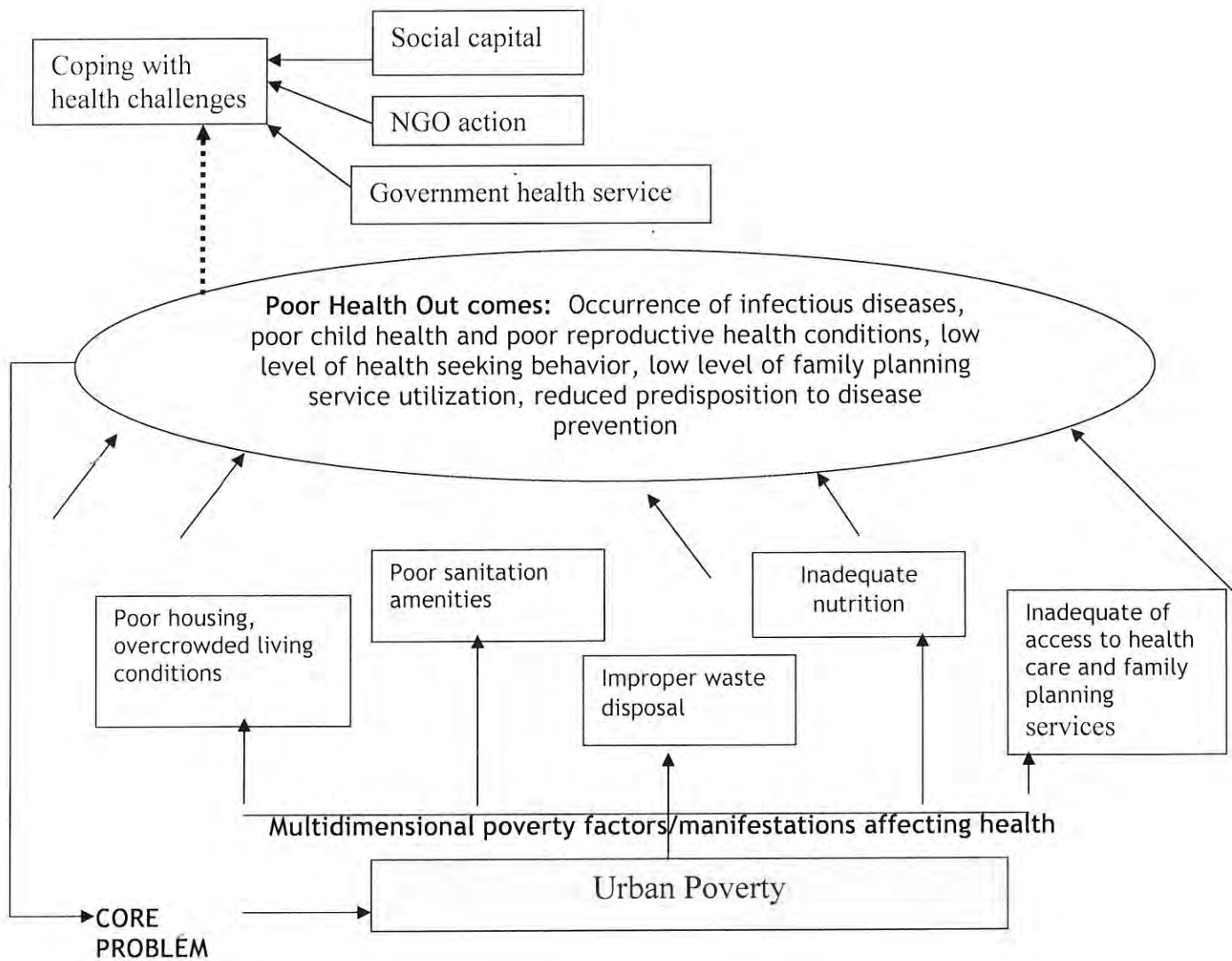
2.2 Conceptual Framework: Analysis of Health beyond the Biomedical Dimension

A progressive effort to put health in to the broad development agenda is marked by the various initiatives taken in the past few decades. The 1990 World Development Report defined poverty in terms of comprehensive issues like low consumption, low achievement in education and health. The report assumed a broad approach to poverty reduction by considering welfare dimensions beyond the economic domain. Health is one such major dimension significantly contributing to economic development and human welfare (Quentin and Jayasuriya, 2002).

The Millennium Development Goal (MDG) also endorsed health in a broader development context. The goals also pay attention on the urban poor giving particular focus on issues of housing, environmental sanitation, and preventable morbidity and mortality. Such initiatives were based on various frameworks that informed the analysis of health problems and strategies to tackle them. In the past two decades much focus has been made on the non-medical determinants of health and illness, which led to the development of the Social Determinants of Health Approach (SDH), which argues that the most dominant determinants of health are rooted in the social conditions in which people live and work (Valahov et.al (2007).

Ample evidence exists that improvements in health comes from improved socioeconomic position demonstrated in various dimensions of everyday life related to education, nutrition, housing, employment security, income, and social services. The return of translating such evidence in to policy action is high in terms of improving welfare conditions and enhancing development. This study takes multidimensional socioeconomic factors that are beyond the biomedical domain, in the analysis of urban poverty and health that actually informed the sketching of the operational model depicted below. The model is employed to reflect the study objectives and shape the analysis of findings as well.

Figure 2.2 Operational Model



2.3 Urban Averages: Hiding Spatial Disparities

In most health and poverty studies, attempts to elucidate poverty situations in urban setting using average measures of health indicators, has been a common trend. However, such measures are proved to blur the situation of the disadvantaged in urban areas since there is wide disparity within cities. Montgomery & C. Hewett (2004:3) described this fact as follows;

...the urban poor often face health risks that are nearly as bad as those seen in the countryside, and sometimes the risks are decidedly worse...If urban populations do have an advantage in health, relative to rural populations, then it seems that this advantage must be very unequally shared.

Similarly MBoup (2003) argues that national survey like DHS, by disaggregating data by urban-rural category portray a better demographic and health picture in cities, particularly in capital cities where inequality is usually the highest, hiding wide disparities in health status between the slum and non-slum parts of cities. In the same line of argument, Montgomery (2004) depicted the case of the slums of Nairobi, where rates of child mortality substantially exceeded those found elsewhere in the city and even the rural Kenya.

Satterhwalte (1997) also argues that urban poverty has tended to be underestimated in the past. He further elaborates on the concept of the “hidden income” which is explained as the advantage lower income households enjoy in getting better access to social services in comparison to their rural counterparts. Never the less, many people in cities of developing countries fail to meet basic needs related to health education, sanitation and housing, even if they might have income above poverty line. This is because although the income needed to avoid poverty varies from place to place, it is definitely higher in urban areas.

UN-HABITAT (2006) for the first time released report based on data of major cities disaggregated by urban poor, all urban and rural areas. The results were alarming in

that comparison of slums to rural areas and to higher-income city neighborhoods gave a clear evidence of the underestimation of urban poverty. The “urban penalty” faced by urban slum dwellers according to UN-HABITAT (2006b) is characterized by sub-standard housing, inadequate or non-existent essential services undermining the health, education and employment opportunities of slum dwellers. The report argued that, collated statistics on the living conditions of all urban households compared to rural ones, masks the grim conditions in which slum dwellers live and depicts a distorted picture that large proportion of the city population are better off than they are.

The precarious conditions of the urban poor are explained by various dimensions asserting the significance of intra urban analysis to properly understand the problem. For instance nutrition is a growing challenge in urban areas; rise in food prices determines how much and what types of food poor urban families eat. Many poor families will not have enough cash to buy sufficient food. When inflation hits essential commodities, poor urban families may have to spend 70 - 80% of their disposable income on buying food. In Ethiopia child malnutrition in slums and rural areas is 47 percent and 49 percent respectively compared to 27 percent in non-slum urban areas (UN-HABITAT, 2006b).

On the other hand, overcrowded and unsanitary living condition of slums is said to be more life threatening than living in a poor rural village. Children from the “highest” income groups in slums, have higher rates of diarrhea than children of the poorest rural families because they are exposed to contaminated water and food (MBoup, 2003). The report of UNHABITAT (2006b:1) also concludes that;

...as the locus of poverty moves to cities, the impoverished in urban slum settlements are as disadvantaged as, if not more so than, rural populations, particularly in the least-developed countries where there are high urban growth rates.

2.4. Health and Poverty in Ethiopia: An Overview

Ethiopia has one of poorest health status measured by all indicators compared to other low-income countries and even with in Sub Saharan Africa. According to the Ministry of Health (2005b), preventable infectious and communicable diseases account for about 60-80 % of the health problems in the country. The situation is highly associated with widespread poverty marked by nutritional deficiencies, low education levels (especially among women), inadequate access to clean water and sanitation facilities and poor access to health services. The proportion of population having access to any type of modern health care service is only 64% (MOH, 2006).

Maternal and child mortality rates are very high with rates of 871 per 100,000 live births and 140.1 per 1000 live births respectively (MOH, 2005a). Average life expectancy at birth is also relatively low at 54 and is expected to decline to 49.4 years if present HIV infection rates continue. Nutritional disorders rank among the top problems affecting the population in general and children and mothers in particular.

HIV and AIDS continues to be a threat for the country with 1.5 million living with the virus and about 1 million orphans whose education and livelihoods are severely threatened. Ninety one percent of the infections occur among the most productive age group, 15-49 putting a staggering impact on the poverty eradication efforts. The prevalence of HIV infection in urban areas (12.6%) is more than twice than rural areas (4.3%). The prevalence in Addis Ababa is the highest (15.6 %) (MOH, 2005b). Although efforts are directed to behavior change and mitigation of the impact, HIV and AIDS continues to be a major development threat in the coming decades due to its bidirectional link with poverty - poverty increasing vulnerability to HIV infection, and HIV infection intensifying poverty.

Young people constitute one third of the total population and face multitudes of reproductive health risks. The major reproductive health problems faced by the young population in the country are gender inequality, early marriage, female genital

cutting, unwanted pregnancy, closely spaced pregnancy, unsafe abortion, and Sexually Transmitted Infections (STIs) including HIV and AIDS (DHS, 2005).

Although urban health calamity is obscured by categorical urban-rural comparison as discussed in the previous section, some intra urban analysis indicates that the prevalence of illness among the urban poor is enormous related with malnutrition, overcrowded and unhygienic living conditions, poor housing and environmental sanitation (Mulumenbet, 2003; Meron, 2005; Girma, 2005; Daniel, 2005; Bevan, 2000).

2.5 The Policy Environment

In 1997/98 Ethiopia initiated a Health Sector Development Programme (HSDP) to implement a 20-year health strategy in five year rolling periods. The programme is strongly driven by decentralization of the health system with a goal of promoting access to basic health service. The first and second five years of the HSDP focused on health facility construction and human resource development at various levels, while the third five year period (2005/06 to 2009/10) is claimed to be committed to the achievement of MDGs (Millennium Development Goals) by aligning it with the SDPRP (Sustainable Development and Poverty Reduction Programme) (MOH, 2005a).

The third phase of the programme, which is currently running entails measurable targets revolving around maternal and child health, HIV and AIDS, malaria and TB, to be achieved by the end of the five years period. Health Service Extension Package (HSEP), a community based (household and kebele level) health intervention, is considered as the main strategy to avail primary health care services to all rural Kebeles by the end of 2008 (MOH, 2005b).

However, notwithstanding the fact that some aspects of the policy are said to be a little too ambitious, and the often admitted problems associated with implementation, the HSDP does not seem to pay adequate attention to address urban health problems other than suggesting “some sort of” HSEP to be adopted in urban areas (MOH, 2005a:20).

Based on the assumption that health care resources are skewed in favor of urban centers, HSEP is meant to improve access to health service particularly preventive interventions to the rural areas where the majority of the population resides. This assumption however seems to dwell on urban-rural comparison that resulting in hiding health inequalities and underestimation of urban health problems. Consequently the policy is observed to pay little attention to the increasing level of urban health problems perpetuated by poor living conditions and deteriorating environment.

Another flaw in approach related to understanding of people's access to health services is using distance as a sole measure, since utilization of health care service is determined by various factors. For instance, health care seeking behavior among urban poor may mostly be minimal, not only due to deprivation of capabilities, but also due to the fact that diseases related with unsanitary living condition are recurrent in nature and people tend to tolerate them.

The SDPRP has identified sectoral development as key strategy to realize poverty reduction and economic development mainly focusing on agricultural and rural development and food security, road and water development programs, and education and health sector development programs. In addition, unlike the HSDP, some consideration seems to be given to urban poverty in the SDPRP considering the fact that urban poverty has increased by about 11 percent while it declined by 4 percent in rural areas between 1995/96 and 1999/00. Urban poverty in turn is considered to negatively affect agricultural development by affecting the economic linkage (Abebe, 2002). Since the SDPRP embarks on a sector wide approach, one could expect the HSDP to take up these urban concerns and provide actionable deliberations to address the health needs of the urban poor, which is not the case.

Although the SDPRP proposed urban poverty reduction strategy stresses on expanding employment opportunities ((particularly focusing on strengthening skill development for self-employment and expansion of pro-poor micro-credit facilities), little is said

about the health needs of the urban poor. However, it should be noted that mere focus on augmentation of income, as Todaro (2004) rightly elucidated it, may not be a guarantee for improved health and education, unless the latter are targeted in their own right. Low life expectancy, child mortality and morbidity resulting from easily preventable illnesses like diarrhea pose persistent deprivation and reverse any gain in income.

This confirms the findings of Blakely et.al (2004) on the impact of socioeconomic status, particularly income, on risk factors and health status. The findings depicted that, although income is an important determinant of prevalence of health risk and thus health status, mere increment in income might not bring a desired effect in the reduction of disease burden. It should also be noted that persistent aspects of socioeconomic deprivation (lack of access to education, unsanitary environment and housing) may prevent the income gain from being realized and utilized in development. The study thus suggested that a poverty reduction strategy attempting to raise income levels, should be supplemented by appropriate public health policies to address broader environmental and housing needs.

In sum, in both SDPRP, as a national guide, and the HSDP as a sectoral programme, one could observe failure to picture the multidimensional face of poverty particularly in urban areas. It is evident that the SDPRP emphasized the income dimensions of poverty like employment and credit schemes, yet paying little attention to hazardous living conditions of the poor. The HSDP seems to lack the urban dimension of health care as well as emphasis on socioeconomic determinants of health that could only be understood based on analysis of characteristics like localities, age, gender and housing. It could therefore be plausibly assumed that the said shortcoming resulted, as Abbi, (2005) and AFRODAD (2005) argue, from a gap in utilizing multidisciplinary studies to inform such strategy papers, and failure to utilizing extensive endogenous research to inform its deliberations.

2.6 The Gloomy Picture of Urban Life in Ethiopia: Interplay of Capability Deprivations and Health Conditions

Many researchers agree that poverty studies in Ethiopia are generally limited and focused on rural rather than urban areas (Mekonnen, 1999; Shewaye, 2005; Abbi & Mackay, 2003 ; Abbi, 2005; Meron, 2005; World Bank, 2005). This could be attributed first and foremost to the fact that majority of the Ethiopian population (85%) lives and rural areas are dependent on the agriculture sector [particularly rain fed agriculture] where natural calamities could pose substantive threat to livelihood. Secondly there is a taken-for-granted belief whereby urban areas are generally associated with better living standards. This has obscured the real situation of the lives of the urban poor that has been exacerbated by high population growth, rural-urban migration and lack of adequate basic service.

There were however, periodic national household surveys allowing some urban rural comparisons initiated around the early 1990's with Welfare and Monitoring Survey (WMS) and Household Income, Consumption, and Expenditure Survey (HICES) by Central Statistics Authority (CSA). The other earliest attempts to examine urban poverty in Ethiopia was by Mekonnen (1999) using the 1994 Ethiopian Urban Household Survey (EUHS). The survey provided, among other things, information on the demographic and consumption behavior of selected households from seven urban centers of the country.

Abbi (2005) in his review of urban poverty studies in Ethiopia concluded that urban poverty is not sufficiently studied in the past and tended to be the concern of action oriented organizations like NGOs than academicians. He also identified lack of synergy among studies carried out by various actors that resulted in incomprehensive and fragmented evidence of poverty. However, the review discerned consistency of findings in key aspects of poverty despite the nature and the methods of employed in the studies under review. In most of the studies applying money metric measures of poverty (Kedir and Makay (2004), Drecon and Mekonnen (1999), factors underlying persistent urban poverty are related to insecure or no employment and thus low

income, high number of dependents, low level of education, meager asset ownership, and high food prices.

A panel study conducted in seven urban centers by Mekonnen (1999) attempted to point out important determinants in urban Ethiopia. The study revealed that prevalence of urban poverty was 46%. It also revealed that households face acute poverty mainly due to fluctuation of food prices, since significant proportion of expenditure (65%) of the urban poor is food related. Of all the food items grain was found out to affect the poor. Other relevant socioeconomic determinants of poverty that came out of the study were education, family size presence of elderly and young children.

An interesting attempt to concert qualitative and quantitative methods is depicted by Abbi and Mckay (2003) in their analysis of chronic poverty from a three years panel data collected from households in seven major urban centers. The qualitative aspect attempted to get subjective evaluation of welfare by asking how people's income, expenditure and living standard have changed over the three years period of the study.

The comparison between peoples' own evaluation of welfare and the quantitative analysis of welfare revealed a correspondence level of 33.5 (for expenditure), 40.3% (for income) and 42.8% (for standard of living). The researchers attributed such a wide discrepancy to the possibility that people might tend to be pessimistic. However, the fact that more correspondence is observed between the quantitative and the qualitative findings when people are worst off, than when they are better off, indicates a gap in the depth of the qualitative method employed in scrutinizing the issue.

Tesfaye (2006) did analysis of urban poverty in seven urban centers using the 1994 and 2000 household survey data conducted by Ethiopian Urban Household survey (EUHS). The study was basically a quantitative estimate of degree of deprivation of

urban residents on the basis of consumption and socioeconomic characteristics of households. The results showed urban poverty prevalence of 41% in 1994 and 43% in 2000. The poverty profile by household characteristics showed also that households headed by people of low education status, females, casual workers and unemployed people and households with large family size, constituted the poorer sections. .

Yet, as Bevan (2000) indicates the limitation income or consumption studies/surveys are subject to in describing the poor in a meaningful ways. It makes people passive and expecting to be “targeted” or “fit somewhere” which may be one reason why income tends to be underreported in many survey results. Bevan argues that disaggregating by various social and demographic context and applying various methods of enquiry, helps to identify people’s needs, aspirations, priorities in life, and obstacles they face.

Poverty studies employing such triangulated methods particularly analyzing important dimensions of poverty like health, housing and sanitation emerged only recently particularly with the Demographic and Health Survey (DHS). Major source of shock for urban areas according to WMS study conducted by CSA (2004) was illness of a household member (Urban 40% rural 24.8%) followed by famine (urban20% rural 28.1%) and death of head of household member (urban 16.4% rural 7.7). More shocks were due to drought, crop failure and livestock death, and flood for rural areas; while illness and death took the major share in urban areas. The report also identified urban coping mechanisms utilizing any family saving, dependency on food aid and sale of assets.

Driven by the participatory methods of the famous World Bank research “Voices of the Poor” the qualitative study conducted by Aklilu and Desalegn (2000) in ten rural and urban sites also revealed interesting findings. One finding is that poor people connect their situation with various aspects of their lives apart from income revolving around their children, environment, sanitation, health and education. Moreover, the study

recorded psychological and social strain poor people face, which failed to get attention in the previous studies.

Similarly, Belayneh (2005) conducted a Participatory Poverty Assessment (PPA) through 42 FGDs in 14 urban and rural villages mainly to understand how poverty is perceived by the poor. The finding categorized the perceptions of the study participant into four dimensions: denial of basic human rights, ignorance/lack of knowledge and information, unemployment, lack of access to basic services insufficient income and assets, and inadequate nutrition/shortage of food.

As regards studies that specifically focus on urban poverty, Heins et.al (2001) analysed the 1994 Ethiopian census data on infant and child mortality in urban Ethiopia basically focusing on Addis Ababa and other small towns. The study revealed that the education of mothers, fertility rate, the availability of a protected source of water and the improved sanitary conditions of households lead to lower levels of infant mortality rates. Housing conditions including number of persons per room was also reported to have direct bearing on survival of infants and children. Education of mothers was however, found to be the most important variable significantly influencing the health of infants and children. The study further indicated that infant mortality rate varied across educational status in urban areas of Ethiopia from 124 infant deaths (per 1,000 live births) for the illiterate to 48 for those with educational level of secondary and above (Heins et.al ,2001).

Analyzing the picture of poverty and inequality in Ethiopia, a World Bank study (2005b) revealed that poverty in general showed limited to no decline since 1992. According to the analysis, while urban poverty is observed to be on the rise there are signs of limited decline in rural poverty. The study suggested that any decline of poverty in rural areas could then be related to some improvement in access to services and infrastructure and women education rather than growth in agriculture.

The study also associates the fact that urban poverty has increased despite growth in the service sector due to increasing urban-rural migration, rather than population growth with in urban centers. For instance the DHS (2005) revealed that the Total Fertility Rate (TFR) for Addis Ababa is only 1.4 compared to the national 5.4% which is below the replacement level. Therefore, it can be concluded that increase in population come more from urban rural migration than natural increase. The other potential reason forwarded for rising urban poverty is policies that are deliberately biased towards rural areas resulting in neglect of urban poverty, which has become a potential threat resulting in increase of urban poverty and deteriorating conditions of health, environment and sanitation.

2.7 Poverty and Health in Addis Ababa

Addis Ababa is a primate city providing huge access to urban market, transport, communication, and skilled labor for various industries and social services like health and education for its residents. Tegene (1996) explains that although Addis Ababa caters better access to social services than any other place in Ethiopia, there is enormous inadequacy and disparity in infrastructure particularly housing and sanitation facilities. This is depicted by overcrowded living condition, poor quality of housing units, lack of adequate access to safe water and waste disposal.

In Addis Ababa most poor people are engaged in the informal sector generating very low income, they often work long hours in hazardous environment, eat poorly and live in poor houses, exposing them to the risk of illness. According to Tegene (1996) the poverty level in Addis Ababa is exacerbated by the in influx of unskilled and uneducated migrants who only join the urban poor and engage in casual work. Some of these activities according to Melakepaulos (1996) included peddling various items, assisting taxi drivers (Woyalas), scavenging for recyclable goods, production of local fuel materials from left over items, and subletting houses /room.

The factor predisposing poor people to recurrent ill conditions in Addis Ababa are mainly hunger and malnutrition, overcrowded living condition, poor housing and

unhygienic environment. In almost all the studies conducted in Addis Ababa, food poverty particularly related with sudden price rise was the main problem. Yassin (1997) in his assessment of selected parts of eastern Addis found out that over 60% of income of the poor is spent on food items that are particularly low quality and non-expensive. CSA (2004) also reported that 63.5 % of urban households experienced food shortage for 2-6 months prior to the survey period and 9.1% for 10-12 months.

Daniel (2001) in his assessment of poverty in twelve kebeles in central Addis Ababa concluded that food poverty is pervasive and majority of the poor households were female headed, large sized families and with housing of deteriorating quality and where basic facilities were inadequate. According to the World Bank Wellbeing Study (2005b) the substantial increase in urban poverty is attributed by the increase in Addis Ababa, where on poverty head count was 57% accounting 71 % of the urban poverty in the country that was mostly attributed to food prices.

According to the WMS report (2004) Addis Ababa has 91.2% coverage of toilette facilities and the lowest proportion (7 %) of population uses field and forest. About 64.2% of the population is said to have access to garbage vehicles or containers, while for 11.1 % waste disposal is no more than “throwing it away open field”. 82.4 % of the houses were made of wood and mud. Proportion of Addis Ababa residents who live in their own houses was 35.4 % while it was more than 92 % in rural areas (CSA, 2004).

Such average pictures however, do not portray the reality of the living condition of the poor. For instance, Daniel (2001) in his assessment of housing situation in Addis Ababa, concluded that that vast majority of the poor live in structurally poor houses where basic amenities are either lacking or inadequate. Million (1996) explained that the sanitation and housing problem of Addis Ababa is overwhelming resulting in high morbidity particularly in children.

Berhane (1996) states that the higher proportion of mortality and morbidity in urban areas is mostly water and excreta related, according to WHO (cited in Berhane, 1996)

about 30-50 illnesses could be caused by improper excreta disposal. Yet, he argues that provision of safe water supply in Addis Ababa will not reduce disease burden significantly unless it is supported by provision of proper waste disposal (particularly human excreta) and promotion of hygienic practices.

Aklilu and Desalegn (2000) in their qualitative studies in poor areas of Addis Ababa, discovered that most respondents described security as peaceful life, that was defined in terms of food, clothing shelter and employment opportunities. Poor people also mentioned diseases like AIDS, TB and typhoid make them insecure. Ill health was perceived as strong source of insecurity. The study generally found the trend that in people's own view well being has deteriorated over the preceding 10 years. They also noted hopelessness and despair among urban population, particularly the youth, are main factors leading them to undesirable and risky behavior.

Meron (2005) analyzed the gendered aspects of urban poverty in a qualitative study conducted in three kebeles of Addis Ababa. She indicated that the poor has multi dimensional definitions of poverty revolving around income, increased family size, ill health and unemployment. This study identified causes of poor ill-health to be malnutrition, unsanitary environment [attributed to] lack of latrine, drainage of waste and overcrowding. The common illnesses experienced by the poor people were Pneumonia, cough, common cold, TB, asthma, diarrhea, typhoid, skin infection and dysentery. Among children, cough, common cold and diarrhea were the most frequent diseases.

The DHS (2005) provides a range of information on various aspects of factors affecting health and health status particularly reproductive health by locality and demographic characteristics. Family planning utilization is a very strong indicator relevant to poverty analysis. Although overall total fertility shows the lowest rate in the country, various studies show that poor urban households tend to have higher fertility rates. Family planning utilization has a number of benefits in reducing malnutrition, child and maternal mortality, and nurturing a proper citizen.

Unmet need was described by women who say they want to space or limit the number of children but are not using any method for various reasons, and according to the DHS (2005) was 34 % of women of childbearing age has an unmet need of family planning. If all women use family planning methods, contraceptive prevalence rate in Ethiopia would have increased from 15 percent to 49 percent. Currently, only 31 percent of the demand for family planning is being met (DHS, 2005).

CHAPTER THREE

FINDINGS AND DISCUSSIONS

The findings discussed in the following sections are drawn from thirty household interviews, four focus group discussions and six key informant interviews conducted in the targeted kebeles. Employing a mix of various methods and units of analysis in the study is believed to have yielded a rich array of data that facilitated deeper understanding of the poverty and ill-health dynamics and elicited further areas of investigation as well.

The chapter begins by giving a brief profile of the area obtained from Addis Ababa City Administration, followed by analysis of multidimensional aspects of poverty in the studied areas. Following a description of health situation, findings on linkage of poverty and health, the core of the thesis, are discussed extensively. Finally, how the poor cope with health challenges are explored in the context of various factors.

3.1 Profile of the Study Areas

3.1.1 Teklehaimanot

Teklehaymanot area is located in Lideta sub city and comprises Kebeles 09/10, Kebele11 and Kebele14. These Kebeles form the core of the most deprived areas in Addis Ababa. The area is one of the most densely populated sections of Addis Ababa with about 76,058 in 2005, and having a density of 790 People/hectare of residential area. Over crowded living condition is characteristic in the area. Average family size in the area is 6.5 with a range of 1 to 23 members per household which is much greater than the average family size for Addis Ababa (Alemayehu & Birhanu, 2005a).

The livelihood of people living in the area is closely tied up with the famous grand market in Addis Ababa commonly known as Merkato. The number of people living in Teklehymanot increased as people engaged in retail markets and street vending in Merkato started squatter settlements in to the area. Its proximity to churches and

Mosques attracted beggars and disabled people as well. The area is also a common illegal market for auto spare parts and hiding place for burglars and criminals, which has given a bad image for the area (Alemayehu & Birhanu, 2005a).

According to the profile compiled by Alemayhu & Birhanu (2005a), there is one government health center, one NGO clinic and about four private clinics in the area serving at a proportion of 1 to 12,676 outpatients. There are about 39 iddirs, some are engaged in development activities like constructing common toilets and access roads besides their burial services.

3.1.2 Akaki Area

Akaki Beseka is an urban centre of recent origin. The establishment of the city was linked to the building of the Ethio-Djibuti railway station in the first quarter of the last century. The place is about 17.5 away kilometres from the centre of Addis and it was chosen as a site for several factories located in the outskirts of the city. The area is surrounded by semi-rural and rural areas characterized by an active pattern of movement of people to the urban area and settling in informal livelihood activities like selling local drinks which is a widespread business in the area. (Alemayehu & Birhanu, 2005b)

The settlement pattern of the area varies from one area to another based on the common livelihood patterns. There are kebeles in which the majority of the residents live by selling local drinks and petty trading, while other Kebeles engage in urban agriculture as a major source of livelihood. In places where the market and local drinks are concentrated, there is an overcrowded living settlement. (Alemayehu & Birhanu, 2005b)

Poor housing condition is one of the problems that exist in Akaki and it has a great impact on the health status of the community. Most of the houses are made of mud and are not maintained for a long time. Large numbers of people do not have access to toilet facilities. A household survey conducted in Kebele 05/06, the study area,

revealed that 40% of the houses are without pit latrines and residents use forests, rivers and open spaces wherever they are available. (Alemayehu & Birhanu, 2005b)

3.2 Multidimensional Aspects of Poverty

3.2.1 Demographic and socio-economic factors

Gender wise, all in-depth interviewees were conducted with female heads of households or female spouses of male heads of households based on the rationale described in the methodology section. Through the individual interviews, family information was collected, i.e. about male and female heads of households, other adult members, and older children and children under the age of five years. The age of interviewees ranged from 23 to 49 with an average age of 34 years. Out of the thirty interviewees, twenty one were married or live with regular partners with some sort of marital arrangement, while the rest of the interviewees head their households single-handedly because their spouses had either died or left them. Number of children per household ranged from 2 to 9 (average 4.7 children/household) with an average age of 4.9 years.

The FGD participants were made to represent similar socioeconomic and demographic characteristics so as to facilitate interactive inquiry of the issues selected during individual interviews. Discussion participants were also categorized based on gender to facilitate easy discussion. Key informant interviewees were selected based on their role as duty bearers in both formal and informal institutions.

Regarding education status, very few women (including their spouses) had any form of formal education in Akaki, while in Teklehaimanot area attainment of primary education was much better. Ownership of selected household asset was assessed in both areas of the study. In Akaki sub city very few households have radio sets and kerosene stove and none have television sets. Some households had poorly carpentered, small to medium sized, beds with straw mattresses and old blankets

which they share among two to five members, though majority of members sleep on the floor.

In Teklehaimanot more households had radio and television sets and kerosene stoves, as well as relatively better ownership of beds and blankets (although still the many members sleep on the floor). Interestingly, two households in Teklehaimanot had DVD players. This might be explained firstly, by the proximity of the area to the main market, Markato, which might have provided better opportunity to engage in various informal jobs and thus relatively better income. Secondly, the bunch of electronic shops in the area might have shaped preference in purchasing household items.

Still, the researcher finds it puzzling to find DVD sets (purchased at average price of 300-450 Birr) in such impoverished households. One such case was a family of five members who live in a one roomed house making paper bags for the nearby shops, as their main source of livelihood. They share one bed for three while two children sleep on the floor. The roof leaks during winter often spoiling the bags they prepared affecting their daily sell. When the interviewee explained the rationale for purchasing DVD, she said 'it is not because we have extra money that we bought this, but because we do not want our children to be inferior to others' (*Terfon sayhon lijochachin kesewe endayansu new yegezanew*) The common price to rent a VCD movie is one Birr, and it is so common to hear young adults including children talk about serial movies like 'Prison Break' and '24'. Leisure and spending preference seem to be constructed around such movies among children of Teklehaimanot.

In fact, one key informant asserted that DVD player is a common status symbol in the area to the extent that people might be willing to go on empty stomachs and buy one. Similar to this, a living room closet (*Buffe*) seems to have such symbol in both study areas. It is one of the primary choices of items to purchase, especially when one family member is working abroad in the Arab countries and sending remittances, or whenever they get into a credit scheme. People express these as lasting assets (*zelaki Nibret*) which during interviews they often mentioned as the most valuable assets

they have in their houses. This could also be explained by Sen's (1999) discussion about social exclusion among the poor. He discussed that the poor find it difficult to take part in their surrounding and be part of the accepted social life, which might induce the drive to purchase modern equipments that carries such symbols.

3.2.2 Low paying and insecure source of Livelihood: A Drive of Household Poverty

Most of the interviewees including their spouses (except two spouses who had regular jobs working as security guard and factory worker) were engaged in informal jobs generating very low income. In Akaki, the dominant source of livelihood is day labor as there are a lot of new construction projects in the outskirts, in addition to baking bread as input for brewing local beverage (*Tella*), retailing vegetables and other food items at road sides (*Gulit*), washing clothes for pay, and selling firewood and charcoal. A more diversified source of income particularly related to petty trade was observed in Teklehaiymanot area. These activities mainly included embroidery, preparing paper bags for kiosks and waste collection in addition to those activities mentioned in Akaki. This could very well be attributed to the existence of diverse opportunity to create linkage with the surrounding businesses in Merkato.

Respondents were asked whether their own or their spouses' source of livelihood has changed for the better in the past six months. The response of the vast majority indicated that their lives did not change for the better, while for some it became even worse. Almost all the women were getting in and out of various informal jobs during the period. The most common reasons given for this were related with pregnancy and child care. For most of them it is difficult to leave very young children behind while engaging in different activities. The only option for some of them was to engage in something that could be undertaken around the home area, while for others it was to wait till their children are grown enough to be carried around or to be taken care of by older siblings. This tallies with one of the strongest findings of 'Voices of the Poor', a qualitative study conducted by World Bank (1999) in 47 countries, that explained how mothers of young children are torn apart between child and home care on one hand, and earning income on the other.

Life is very difficult. When I give birth to my fourth child, I could not go here and there to work. I had to stay home and look after the children; they are all under five years. Where can I leave them? Their father may not work sometimes, he is a daily laborer. Oftentimes we don't have enough to eat. It is only when my kids grow up that I can work...

Alem, age 33, Akaki

The second common reason given for switching between various informal jobs is increase in cost of inputs particularly food items like; teff, cereals, and oil. This is particularly relevant among those who were engaged in selling food related items; *Injera* (Ethiopian bread made from teff), *kolo* (roasted barley sometimes mixed with sorghum) and *pasty* (a kind of bread of Arabic origin fried with oil).

I am selling Kollo (roasted barley), but the price for barley has increased, I am not sure what I should do. If I increase the price of the Kollo, people won't buy me, I can't blame them because cost of living has become sky-rocketed (Nuro semay geba). My husband sells used clothes, there are times when he sells nothing the whole day. It is very difficult to get something for supper during such times.

Abebech, age 35, Teklehaimanot

I used to sell Injera before, and we used to eat some from what I sell. But I could not afford to buy Teff any more. The price has gone up unbelievably. Now I am selling fresh corn (Bekolo eshet). I don't know what I will be doing when the Bekolo season is over.

A woman from Akaki

In the same manner, most respondents said that their spouses have been in and out of different jobs, and in some cases stayed unemployed for weeks and even months. This has greatly affected their ability to meet the most basic needs like, food, health care needs, education of children, and paying bills for services such as electric power and water. The impact of unemployment among men is often worse than women, as

women were found to have wider opportunities to engage in various informal and less paying jobs like washing cloths and baking Injera. In addition, unemployment among men may often be a source of conflict in many households, due to their failure to fulfill the socially expected role of a bread winner. (Discussed under 3.5)

In responding how income and living condition has been in the past six months, most of them responded that income has more or less remained the same or changed negatively but living condition has deteriorated particularly because of the rise in food price resulting in literal inability to feed the family members.

3.2.3 Housing and Sanitation Amenities

3.2.3.1 Housing

About half of the interviewees live in government rentals while the remaining half live in private rentals. Almost all of the houses in both study areas are constructed from mud with poorly maintained and deteriorating structure. The mud wall in most houses has crumbled and the inner wood and holes are visible here and there, covered by card board in some cases. The roof usually had no ceiling (*kornis*) or the ceiling is made of old grain sacs or plastics sheets. Majority of the houses have leaking roofs during the rainy season making the earth floor muddy.

Although poor housing is a common phenomenon in both study areas, there are distinct housing characteristics observed among the studied areas. In Teklehaimanot, severe shortage of housing facilities is noted characterized by unimaginably overcrowded living conditions, even if most of them earn relatively better income than those in Akaki. In most cases there is only single, small, unventilated roomed house that could even be touched by stretching one's hands to the sides, and whenever there is an extra room the quality is so poor that it can rarely be used as a functional living or bed room. Understandably, there is no separate sleeping area for many households, and in considerable cases, about three to five people sleep in one bed while other family members sleep on layers of grain sacs or some sort of mats thrown on the floor.

Very few households have shared cooking area (common kitchen in the form of a shade, hardly better than open air); while for many households cooking takes place in the living area. In some houses sleeping area are built as a flat layer closer to the roof (*Kot*). The inner walls are mostly unpainted, in some cases painted white with lime (*Norra*), others are half-covered with old magazine papers. It is also common to see pictures of famous foreign singers, actors and football players. The floor is usually earthed while in some cases it is covered by plastics.

On the other hand, in Akaki, since located at the outskirts, there is lower level of overcrowded condition, and it is very common to find houses with backyards (which are often used for disposing household and human waste) The houses are also in deteriorated status, with poor sanitation and waste disposal facilities. The wall are often unpainted, the floors are earthed and periodically painted with cow dung. Although the characteristic of poor housing is shared among the two areas, one could clearly observe higher urban influence in Teklehaimanot area just by looking at such housing characteristics.

It could be noted that the deteriorated housing condition observed in both study areas decidedly increases people's exposure to various infectious diseases. Household members particularly children in the study area are certainly vulnerable to various such illnesses because of unhygienic and overcrowded living conditions. This is also confirmed by a study conducted by Heins et.al (2001) on infant and child mortality in Ethiopia, with particular emphasis in Addis Ababa. In its assessment of the impact of socio-demographic and housing factors on child health from the 1994 census, the study strongly concluded that housing environment in which children grow has a significant impact on their health.

One important housing aspect affecting health condition is overcrowded living condition. The study revealed that level of crowdedness is worse in impoverished urban pocket as represented particularly by Tekelehaimanot, worsening the level of

associated vulnerability to illnesses. A study by Kumie et.al (2006), discussed that overcrowded living condition results in high level of exposure to communicable diseases, mainly parasitical and respiratory diseases. Indoor pollutions particularly due to dust from earthed floor as well as smoke resulting from cooking in unventilated living rooms area accounts for huge proportion of respiratory illnesses and mortality among children (Kumie 2006; Heins et.al 2001). Heins et.al (2001) also found out that the level of infant mortality is found to be higher for those housing units where wood and charcoal are used for cooking, and those which did not have kitchen at all. In the studied households, the majority do not have separate kitchens and cooking often takes place in the living area which in most cases is a single room. This could very well explain the recurrent prevalence of respiratory conditions among adults and children revealed in the studied households.

Another interesting finding about poor housing condition is its psychological dimension i.e. the impact on people's outlook about themselves, motivation to change their lives and their living environment. Most interviewees expressed psychological impact of deteriorated home environment in different ways. They associated deteriorating living environment with their helplessness to improve their lives and health situation. It was noted that impact of poor housing goes beyond poor physical structure and unsanitary amenities. People feel awkward, sub-human and pessimistic towards their future when they speak about their houses and their surrounding environment. Interviewees mentioned housing situation back and forth when they talked about their poverty. They explained their housing situation as typical of their incapability and hopelessness.

You are looking at my house, five of us live in this room, it leaks, and we sleep water-soaked during rainy seasons. Living in this environment, how could I improve my life (ezih wist nore min sew ehonalehu), I cannot even make my home a bit pleasant place to stay. Whenever I come home after a long tiring day, I sigh in distress...

Birhan, age 34, Teklehayimant

It was also found in Teklehaimanot, that small size of houses define where children play or spend most of the time, since they would 'mess up' the house if they stay in for too long, as noted by interviewees. So in most cases, they are obliged to play on filthy area for long hours.

3.2.3.2 Sanitation Amenities

Sanitation amenities were found to be in worst conditions in both areas. Almost all the interviewed households buy water from government owned water pipes in Akaki while in Tekehaimanot most of them buy from privately owned water pipe paying 0.15 to 0.20 birr/ bucket. Regarding waste disposal practice, solid waste is mainly disposed in a river or open fields in Akaki. Waste containers are also used in both study areas that usually spill over creating nuisance and bad odor. Liquid waste is mostly damped indiscriminately and/or in sewers.

In assessing access to proper excreta disposal, it was found out that in both study areas there is severe lack of latrines. In Akaki, very few households have access even to shared latrines, and most of them use backyards of their houses, nearby bush, an open area near the railway, and during the evenings they use the nearby sewers. Interviewees mentioned that they do not visit often the existing public latrines because they are far; for instance people do not go to the latrines just for urination. It is not practical for children to use the public latrines, so they use buckets in the house and it is disposed in the nearby sewer. It is also common and observable for children to defecate in the open field around the neighborhood. As observed in Teklehaimanot, shared latrines and public latrines are in the worst condition imaginable, and small in number. The major means of disposing human excreta is to put it in a bucket and dispose it in the sewers. Despite the observable bad condition, one interviewee remarked that the area is now cleaner since the sewers are built.

Understandably, the poor sanitation situation of the housing environment perpetuates vulnerability to communicable illnesses. Although piped water is relatively accessible in the study areas, it could reasonably be argued that the chance of contamination of

water is high given the poor sanitation with in the houses as well as the outside environment (since pipes are often located outside the house and shared in neighborhoods).

The link between housing and environmental sanitation and health has been established by many studies. According to Tsehay (1997), about 30-50 illnesses could be caused by improper excreta disposal. She also discussed that the higher proportion of mortality and morbidity in Addis Ababa as in many urban areas is often water and excreta related. One of the major arguments of the study is that provision of safe water supply in Addis Ababa will not reduce disease burden significantly unless it is supported by provision of proper waste disposal (particularly human excreta) and promotion of hygienic practices. Similarly, the study by Heins et.al (2001) revealed that out of selected housing characteristics (like type of floor, sources of drinking water, types of kitchen, type of toilet and density as measured by persons per room), toilette facilities strongly explain infant and child mortality, In another study, Million (1996) explained that the sanitation and housing problem of Addis Ababa is overwhelming resulting in high morbidity particularly among children. It could also be observed that despite the lower level of crowdedness noted in Akaki, there is almost equally overwhelming level of poor health in the area, which could be explained by the worst sanitation conditions in both areas.



Teklehaiymanot

Teklehaiymanot

Akaki

Some views of the study area

3.3. Health Situation

In assessing health situation among the studied households, information was collected about commonly encountered illnesses by different family members. The analysis of health problems was drawn both from disease encounter in two months prior to interview as well as the time when the interview was conducted. The study revealed that majority of the interviewees and their families encountered various health problems in the past two months. Children under the age of five were found to be most affected by infectious disease. It was also noted that women get sick frequently with different diseases particularly reproductive health problems mainly related with child birth, while among men illness is usually associated with physical labor for which they rarely seek health advice.

The table below shows the type of illness faced by different members of the family in two month period prior to interview. There were more or less similar trend in both study areas in terms of type of diseases encountered and distribution among members of households. The most frequently mentioned illnesses in both areas were however, respiratory conditions (*bbird*) among adults and cough/cold and diarrhea among children.



Table 3.1. Summary of types of illness faced by members of interviewed households in two months period prior to interview¹

Area	Type of illness faced by the interviewee (Female)	Type of illness faced by spouse of the interviewee (male)	Type of illness faced by children of the interviewee
Akaki	Headache, Diarrhea, eye problem, TB stomachache Gynecological problems	Pain in the leg Chest problem	Cold/ cough, diarrhea, intestinal parasites, throat infection/tonsillitis
Tekleha imanot	Headache, Diarrhea, lung problem, TB, cough/cold, ear problem	mental problem, intestinal infection, Asthma	Cold/ cough, bloody diarrhea, throat infection/tonsillitis, stomachache and ear problem

Recency was also considered in analyzing experience of illness among households. In most of the households, it was found out that there were persons who were sick at the time of the interview, mostly children and women. The common types of illnesses included stomachache, diarrhea, cough/chest problem, leg pain, and AIDS (in two cases as far as we could know).

The most characteristic description given about encounter of these illnesses is that, the above mentioned health problems are highly recurrent and circulating among members. This is often described as ‘living with cough’, ‘coughing since birth’ ‘cough/diarrhea does not go away and ‘the children get sick turn by turn’.

¹ Note that health problems/diseases are reported as termed by respondents.

Many researches have established that the type and the recurrent nature of illnesses among the urban poor is attributed to overcrowded living condition, poor housing and sanitation and inadequate nutrition (World Bank (2005); Montgomery (2003); Mulumebet (2002); Meron (2005). As explained in the previous sections, recurrent respiratory illnesses is said to be strongly associated with indoor pollution resulting from cooking in poorly ventilated living areas, in addition to unsanitary and overcrowded living environment (Kumie 2006; Heins et.al 2001).

3.3.1 Child Health

In both study areas it was found out that in all of the households, one or more children had been sick within two months prior to the interview. Common illnesses experienced by children under the age of five years during this period were described as cough/cold, stomachache, diarrhea, fever, sore throat and lung problems.

A typical finding about childhood illnesses in both areas is the recurrent nature of illnesses and how parents feel about it. Interviewees expressed that repeated visits to health institution make them feel mortified when they take children to the same clinic for same illnesses. The first reason is the feeling of being labeled as 'visiting with out much reason' especially when they are non-payers. Secondly, the prescriptive advice they receive from health workers makes them feel blunt as one woman in Teklehaymanot recounted:

...last week my son had sore throat and I took him to the health center. After three days his brother got sick. I felt so ashamed to take him, since I have been taking them many times during the month. What would they say about me? So I decided to share this syrup for both of them, now you can see that they are getting better, the fever has also subsided. In fact, when one is sick it is so common for the others to get sick, but I take only one of them, and they share the medicine. Last time, the doctor told me not to let them play on dirty area, which he said is the cause. Where can I keep them, even if I tell

them they won't listen, where would they play? If I let them stay in this little room, they'll mess things up and drive me crazy...

Aberash, age 41, Teklehaymanot

In addition to describing health problems, other related issues like nutrition, education and child labor were explored in the study. In assessing nutrition conditions, for obvious reasons, the need for adequate amount of food for children is often emphasized by interviewees than its balanced nature. This was strongly raised especially in the context of increasing demand of children for food and other basic needs as they grow up and particularly in relation to the current increase in food price.

...my three kids have grown up now, they won't be satisfied with small amount of food any more. Each one of them eats at least half Injera...

Almaz, age 37, from Akaki

During interviews, it was commonly observed that when children ask for food they often were given coins to buy sweetened ice bar (*jelati*), candy and in some cases a piece of bread. In Akaki, an interviewee was trying to keep out her children now and then during the interview, when she finally shouted '*if you think we are eating, we are not*'. One could observe how inadequacy of food has affected children even by looking at them.

A record of types of food consumed by children under the age of five years on the day prior the interview was collected. The finding showed that in all the households, separate food was not prepared for children, and that they mostly ate food prepared from cereals and teff (*injera, dabbo*) with sauce made from pulses (*shiro, misr*). No single interviewee mentioned that their children ate fruits, vegetables, meat and milk in any form. Interestingly, breastfeeding is found to be very common among all the interviewees, it was found out that children are breastfed for a minimum of three years. Despite the known benefits of breast feeding in prevention of childhood

illnesses, children in both areas are experiencing recurrent infectious disease, which could only be explained by housing and environmental factors.

School enrollment among children of school-age was assessed; in Akaki there were a number of children of school age especially in large sized families, who were not yet enrolled in primary school. Many dropouts were also found in both study areas, most of whom quitted school around eighth grade. The reasons given were various and mainly related with poverty (lack of financial capacity to send them to school, the need to put children to work, and low school performance). One key informant in Akaki mentioned that when children get in eighth grade, literally they will be told that they had received 'enough education' and it is time to work. Young children often engage in the most common job, i.e daily labor. (Mostly loading and unloading goods and material on and from trucks, and manual works at construction sites). In such conditions, young girls are said to be exposed to various sexual abuses, which could be one factor for high level of teenage pregnancy and unsafe abortion mentioned to exist in the area.

In the same manner, in Teklehaimanot, it was revealed that children start working around the age of fourteen years, often while they are still at school. At this age, they are often expected to at least cover their meals (if not give money to the parents) and come home just to spend the night. It is found to be usual for them to drop school sooner when they start working; it is also revealed that many of these children engage in robbery of various kinds and activities like drug abuse, unsafe sex that are risky to their health.

The last issue explored regarding children was, interviewees' perception of their children's future. Interviewees were asked whether they look forward to a better future for their children. All the interviewees expressed that they worry about their children and their welfare especially if they are not there to provide for them. There is a general emphasis on education as a vital factor for the success of children. However, this seems to be drawn from a common belief that the 'educated gets

employed' (*ketemaru yalfilachewal*) but not founded on what is happening on the ground to realize that.

Overall assessment of situation of children was generally shocking as depicted by how people described the level of poverty and the difficulty in raising children. It was explicit that often time they are faced with a moral question of whether to send children to school, feed them, or send them to work.

A male FGD participant in Akaki said (with tears in his eyes)

...I earn 80.00 Birr per month. I am not in apposition to send my children to school anymore because I can't afford to pay the registration fee, buy them exercise books and school uniforms. I can't do all these. I don't have problem with uniforms, since they go to school in two shifts, they used to share one. But, what about the rest of the things they need? ...and above all what would they eat?

The situation of children is indescribably poor exposing them to various health problems. It was noted that children who drop out of school are likely to engage in risky behaviors, and in the case of young girls exposure to sexual abuse is increased.

3.3.2 Women's Reproductive Health

The general health problems commonly encountered by women in the study areas are presented in the previous discussions. In this section, reproductive health issues particularly family planning service utilization and women's vulnerability to HIV and AIDS were assessed both in individual interviews and FGDs. Another reproductive health issues that strongly came out during FGDs was lack of adequate rest and nutrition after child birth. The common tradition for women after delivery is to rest for about forty days to two months and have good foods that are meant to maintain the body (*metares*). The participants however, mentioned that this is not possible among most of them for various reasons including; the need to start working soon after delivery, lack of money to buy the variety of foods needed, and usually there is no one to help around home. The women associated this situation with almost all ill-

health conditions they face even after many years of delivery. They described that a woman who has not had adequate care after delivery, would have weak and painful back, weak bones, get sick frequently, her uterus prolapses (goes out), and will not have energy to work.

3.3.2.1 Utilization of family planning services

Interviewees were asked about their knowledge and benefits of family planning methods and the factors underlying the predisposition to use family planning methods. A gap was observed in knowledge of family planning methods in both areas, though it was more pronounced in Akaki. The most frequently mentioned methods were pills and injectables in Akaki, while in Teklehaimanot each respondent identified at least three and at most six contraceptive methods including; injectables, oral contraceptive, loop, condom, Norplant, tubal ligation and abstinence.

Most Individual interviewees as well as FGD participants viewed family planning not only as beneficial, but also as a pressing need from the point of view of their poverty and incapability to provide for their children. The difficulty they face to provide basic needs for their children is felt very strongly among both male and female study participants. In fact the need for family planning seems to be strongly perceived next to the basic ones. They explained the need to limit the number of children in terms of lack of jobs, increasing cost of raising children, and increasing cost of living.

I don't want to have another child at all, it is just to make your self and the children suffer. I can't even feed my children three times a day, our poverty has worsened even from what it was six months ago... I don't know what will happen next to the existing one's, let alone think of having another baby. I did not think of all these when I had them, now I live in desperation...I don't even know what to feed them, they demand more food as they grow...

A woman from Akaki

Although FGD participants discussed family planning mainly in the context of marriage/established relationship, they revealed that teenage pregnancy and unsafe abortion are common phenomena in both the study areas. In fact, in three households, there were teenage girls who gave birth and are living with their parents.

The majority of interviewees asserted that they would like to limit or space child birth, indicating a strong basis for using family planning method. Never the less, very few women are currently using any form of modern family planning method, a condition commonly known as unmet need of family planning. The findings of this study therefore confirms the results of the DHS (2005), which revealed that in Ethiopia, only 31 percent of the demand for family planning is being met, while 78% of women and 76% of men prefer to space or limit the number of their children. According to this study, the contraceptive prevalence rate in Ethiopia would have increased from 15 % to 49 %, if these unmet needs were met.

On the other hand most study participants are found to be harboring a lot of misconceptions and misinformation about the side effects of the methods. This could explain why the majority of the women have used a family planning method at some point in the past but have discontinued. The major reasons given for discontinuing in both areas is side effects about family planning methods. The most common misconceived side effects were nerve pain, weakness and encountering serious problem if they take it without food, and accumulation of pills in the stomach and eventual bursting.

Often time, misconceptions were found to be learned from peers, although some participants explained serious health problem they encountered after they started to take contraceptives. For instance a male FGD participant in Akaki recounted that he took his wife to the health center where she was given a method. She gained a lot of weight and got seriously sick. When he took her back and she was given another method, her illness worsened and she was referred to a hospital where she was told

she had diabetes and hypertension. She finally discontinued the method and they recently had their sixth child.

Birinesh, age 36, from Teklehaymanot also recounted her unpleasant experience as,

It has been so difficult to raise my two children. So I started to take pills, but I forgot to take one day and I got pregnant with this baby. Before the pills, they gave me an injection, and it messed up my health. My period would last for 25 days, and I got all drained by the injection and weighed 42 Kg by then. After that I stopped it and I changed to the pill, but I failed.

While side effects could happen, it seems that a lot of stories, actual ones and misconceptions surrounding them seem to spread fast and exaggeratedly. There seems to be a lot overstatement about side effects in the community particularly in Akaki, which definitely implicates on the quality of existing health service and information delivery. Amazingly, religion related reasons were never mentioned which used to be considered as one major barrier for family planning in the past. This could be an indication of how poverty has dictated people's perception and the needs they perceive and prioritize. Unfortunately the majority are not benefiting from the service for the mentioned reasons that could have been solved with appropriate communication and service delivery strategies.

It was also noted that among those interviewees with larger family size frequent conflict occurs, severely affecting sense of betterment for future (detailed in section 3.4.2) Regular utilization family planning method in such households was found to be actually low. This could have resulted from desperation and feeling that they do not have a future that they believe they can change or improve by doing so.

As noted in the literature review of health related policies in the country, this could be a typical illustration that access and even affordability (for instance family planning service is free in government institutions) may not always mean people use

the health services around them even if they have massive needs. In this regard two arguments could be raised concerning both sides of beneficiaries and the health service. First, services do not seem approachable/inviting for people to go back and request information whenever side effects arise, since in most cases people never returned before they decide to discontinue. Second, outreach activities for community based discussion and delivery are almost non-existent even for services like family planning that could have been well handled through such schemes.

3.3.2.2 Women and HIV and AIDS

In both study areas the participants talked about HIV and AIDS whenever they talk about health and disease prevention. In discussing HIV prevention however, a tendency to overemphasis on avoiding contact with used razor blades and needles is observed. It might not be plausible to argue that they are not aware of heterosexual transmission of HIV, which accounts for over 95% of means of transmission in Africa. However it was clearly evident that sexual transmission of HIV is not the first thing that comes to their mind when discussing it, which is a point of juncture for reviewing HIV and AIDS communication. People were likely to talk about sexual transmission only when probed by issues like relationships and marriage.

The study attempted to explore how the interviewees perceived vulnerability of women to HIV/AIDS. Most of them perceived that women are more vulnerable to HIV infection for different reasons which they associated with their own experiences and observation in their locality. Two women in Teklehaimanot explained that they are living with HIV/AIDS.

BOX 3.1 The major reasons mentioned for increased vulnerability of women for HIV/AIDS

- women may get infected from their husbands particularly those who drink alcohol,
- women are recipient of the fluid of the man during sexual intercourse,
- women could be raped,

- women get easily deceived and led into sexual affair,
- women engage in sex work in order to earn income,
- women are responsible for caring for family members sick with AIDS. They described this, mostly from their own observation of how women are exposed in their locality.

When asked what they could do at their level to minimize their vulnerability to HIV, generally the responses were that they could not have much control to address the problem, while few mentioned HIV testing. They related the situation to their impoverished state and obstacles that hinder them from preventing themselves.

Hirut, age 27 from Teklehaymanot described her own situation;

Yes, a woman is more vulnerable than a man. I would often stay at home, look after my kids, wash people's cloths, and see how I fill up the day's requirements. My husband stays out, when he comes drunk, in the evenings, how could I know where he has been? How could I know I have not get the virus until now? There is no way I know. I should try my best to fulfill what he needs so that he won't see another woman.

Men FGDs revealed when and how men engage in risky behavior particularly when drunk;

There are a lot of Areke houses (local liquor houses) around this area, it is a very good business. Especially on Saturdays which is a market day for us, men come from the nearby rural areas, drink Areke and often spend the night there. You know that when a man drinks, he cannot control himself. The prostitutes (except those who recently came from rural areas) usually do not agree to have sex without condoms even if the men want to add money. They are far better in protecting themselves than other young women who would

easily say okay for sex with out condoms; that is why you see a lot of them having babies in the neighborhood....

Alemu, age 43, Akaki

3.4 Poverty and Health: The Interplay

3.4.1 The Construct of Health and Poverty among the Poor

According to Booth et.al, (2006), assessment of people's own experience is imperative in the analysis of poverty for three major reasons. First, it enables to get a wider range of indicators of deprivation, by understanding how people are affected and what their priorities are. Second, analysis of causes of poverty could be more robust when it is informed by the people's own explanation, since processes of impoverishment could better be traced. Third, for policy interventions to be effective in enhancing existing coping strategies an understanding of people's own account is important.

In light of this, the following sections attempt to look at the interviewees' own perception about the health and poverty dynamics. Interviewees were first asked about their own understanding of poverty, its cause and how it affects their life. Then what they understand by good health and bad health status is explored, followed by assessment of their understanding of health risks surrounding their lives as related to health outcomes. Finally, their experience of illness and treatment as shaped by the above mentioned factors among others is assessed.

BOX 3.2. Excerpts of own description of poverty

Akaki

- Lack of job and/or inadequate income
- Inability to feed your children
- Inability to buy *teff* and eat 'good food'
- Working in hungry stomachs

- Lack of own house
- Children not going to school or dropped out because of inability to support their education or because they had to work
- Children do not wear good clothes; do not sleep on clean bed
- Living under a leaking roof
- No television and telephone

Tekelhaimanot

- Lack of jobs
- Not having income that is proportional to expenses for basic needs
- Not being able to do what you want to do or to be what you want to be
- Not being able to go to school or to send your children to school
- Not having some one to support you
- Inability to get proper treatment during illness
- Inability to pay rent, and living with the fear of eviction from houses
- Worrying about where to get food items for the next meal from
- Living under leaking roofs and battered walls, with no toilettes and no kitchen
- Living in a congested, overcrowded rooms
- Inability to buy soaps to wash clothes
- Being sub-human (*Ke sew betach mehon*)

3.4.1.1 Own Description of Poverty Experience

As summarized in Box 1 the interviewees described the multidimensional aspects of poverty and its manifestation in their own lives, often with a very strong emphasis on food poverty. The rise in the price of food (particularly grain, cereals and Teff) is strongly felt among all the households and is confirmed across all the study participants in the focus group discussion and interviews with informants. The

participants talked in terms of price of grain per tin (equivalent of a kilogram) since they were not able to buy in large quantities.

Teff has now become 6 birr per tin and beans/peas 5-6 birr/tin. The difference from last year, even from six months ago is incomprehensible. We used to eat Injera as a staple food. These days, putting your mitad (a flat clay pan for baking injera) on fire and getting yourself to bake a bunch of Injera is a matter of luxury. If we find the money we buy one or two injera, if not we eat anything that is available; it could be boiled potato left from my vegetable retail, roasted barley (Kolo) or boiled wheat and sorghum(Nifro), anything that could be bought on daily basis.

Sifra, age 37, Akaki

Respondents were asked to what extent the recent subsidized wheat distribution has improved their household food consumption. Almost all of the participants mentioned that it was a reasonable price, but their major problem is that they are not able to generate forty-five birr at one point in time to buy the twenty five kilogram of wheat they are entitled to. Therefore they often give their ration cards to retailers who would receive the entitled amount and sell them the quantity they can afford with the same subsidized rate.

BOX 3.3 Summary of own explanations given for poverty

In theoretical terms, responses from all the study participants about cause of poverty could be categorized in two categories of causes designated as acute poverty and long-term poverty.

Acute poverty: is characterized by a sudden exacerbation/worsening of living condition due to increasing price of 'everything' particularly food items. The consequence is acutely felt in all the households literally described as inability to feed themselves and their children. Therefore households resort to ad hoc mechanisms to respond to the situation; these included drawing children out of school

and engage them to work 'anything', drastic decrease in quality and quantity of food intake, and in some cases begging.

Long-term poverty: is described as an impoverished situation into which they were born and are living in. The causal description for this is found to be dominantly fatalistic although some other important factors as lack of education lack of regular/secured jobs, and large number of children are identified as well.

When the interviewees talked about the causes of poverty there was a distinct difference in the definition of poverty and their responses to it. Responses from the vast majority indicated the prevalence of acute poverty, which is mainly characterized by a question of survival, is all about the struggle to meet the daily food needs of family members. Acute poverty has visibly affected their health, physical strength to work, and children's schooling. As indicated in the literature section, other studies confirm that food poverty is the most prominent characteristic of urban poverty. According to the World Bank Wellbeing Study in Ethiopia (2005) the substantial increase in urban poverty is mostly attributed by high food prices.

I often have nothing to give my children when they come from school, and they usually come very hungry since they eat very little before they go. If I have some bread, I would give it to them, if not I would tell them to sleep so that their hunger will pass, and may be in the evening I could fix something for them. I don't mind not eating if I manage to give them something. But, from day to day, I get easily tired when I work, due to the hunger.

Gete, age 39, Akaki

It is worth noting that women are almost always most affected by acute poverty since they prioritize feeding their children and husbands and would eat for themselves from the leftover, if any. This is culturally ascribed and is practiced even in under normal conditions. The Amharic saying "yeset misawa mekenetua" (literally "a woman's lunch is her belt") may best describe this phenomenon. The impact of such acute or

long term food deprivation has multiple health impacts implicating on economic activity.

Most interviewees also talked about their experiences of deprivation as longstanding and intergenerational phenomena, which could be categorized as long-term poverty. In this regard they stressed that deprivation of opportunities, particularly education, hindered their ability to secure decent jobs and lead a poverty-free life. However, although they forwarded structural explanations to their impoverished state, there is a strong tendency to mingle fatalism in explaining their situation, which seems to negatively affect their future aspirations and goals.

Poverty means several bad things, my house is so scruffy, my health is poor, I often do not have enough to fill our stomachs, eating 'good' food is unthinkable. We are not educated so cannot find good jobs and lead a decent life. But, even if I live in such a misery, I hope that it will pass, it is good to be thankful, if I worry too much I may go crazy. So I try not to bother, you see if I have a birr I buy bread for breakfast, if I have few coins, then Kollo, if not we don't eat, that is it, what difference would I make if I worry? God knows for the lunch, what we eat will depend on what I earn during the day. Despite my hard work, life does not get better; it just does not go beyond our stomachs. Look at this plastic bag, this is the cloth we put last week to wash, I could not manage to buy a bar of soap, so we are wearing it again. This got worse with my new baby, our poverty got double. Had I not had these children, I would have gone out with some men and earned something like others! You want me to talking about my poverty....what can I tell you and what not? Poverty robs you off your dignity, even look at your work now, you are asking us all this, and we are telling you everything because we are poor. Who would even spare time and speak to you if you go to the rich?...you'll listen and you'll soon forget...

Selam, age 30, Teklehayimanot

For me poverty means, something you won't change weather you strive to or not, weather you work hard or not, (bilefam balefam nuro yaw new) life just does not change, 'it is from hand to mouth' we are meant to be poor and will remain poor.

Tsehay, age 33, Akaki

3.4.1.2 Poverty Shaping Health Perception

The way interviewees described good health and disease (summarized in box 4 below) indicates their perception of the link between poverty and health and the degree to which their perception is shaped by the precarious life situation they are in. Almost all of the study participants generally associated 'being sick' with 'inability to work' and described it as 'staying at home' (*bet mewal*). Among all the study groups (in-depth Interviewees, FGD participants and key informants) the physical, social and psychological aspects of illness and pain were strongly discussed in the context of livelihood activities. Generally there is a tendency to view health as instrumental to work and earn a living rather than as a fundamental need to be met in its own right.

The interviewees were also asked whether they think poor people are more exposed to health problems than better off people. Majority of the interviewees stated that poor people are more vulnerable to health problems mainly because they cannot afford 'good' medical care/ go to private clinic or buy medicines private pharmacies¹, as opposed to the better off. Very few interviewees (most of them from Teklehamanot) raised other issues that are decisive to health like inability to afford better diet, better houses, and clean clothes and toilettes contribute to ill health conditions among the poor.

Generally, much attention seems to be paid to illness thus curative care than preventive aspects, and the major socio-economic and environmental factors that predispose the poor to health risks, tended to be neglected. This attitude results in

¹ Please not that medicines are much cheaper in government facilities but most prescribed medicines are usually unavailable. On the other hand almost all medicines may be available in private pharmacies, but the price is unaffordable by the poor.

lack of focus on what people can do to avoid illnesses, adversely affecting preventive activities.

Some interviewees do not understand why the poor are particularly vulnerable to diseases and hold an attitude that they are equally affected (*beshitana mot lemanim ayikerim*) while few mentioned that it is in fact among the well-off that diseases like hypertension and diabetes are common. They termed these disease as 'diseases of the rich' (*ye habtam beshita*) associated with sedentary life style (sitting all day long and not having much to work).

BOX 3.4. Excerpts of description of good and bad health status

A person having GOOD health status is described as

Akaki

- One who does not stay at home, engaged in some work (*bet yemayiwil*)
- Able to work and wear better clothes
- Able to work without feeling sick (*serto yemigeba*)
- Happy
- Free of HIV
- Able bodied
- Has hands and legs (*ejina egir yalew*)
- One whose sight is not impaired

Teklehayimanot

- Free from addiction,
- Not engaging in work which is hazardous to health,
- Able to engage in whatever work one wants, not having any diseases,
- Happy

A person having BAD health status is described as

Akaki

- Who is not able to work
- Who is unhappy
- Has HIV or is sick of AIDS

- Has lung problem
- Has sight impairment
- Is not able bodied
- Does not have money to meet basic needs

Teklehayimanot

- Unable to move around and work
- Suffer from recurrent illness,
- Have a mental disorder
- Have headache

BOX 3.5 Are the poor more vulnerable to health problems than the better off? How?

Akaki

Most of the respondents in Akaki responded from the point of view of what the well-off have and what they have not in relation to the latter's exposure to diseases, or to their capability to get treatments when they are sick

The well off:

- Are able to go to hospitals and private clinics when they are sick and get 'good' treatment
- Eat good food and resist disease
- Live in clean houses and large compounds where their kids can play
- Have clean toilets
- Wear washed and clean clothes

Teklehaimanot

The description was given from the point of view of the poor explaining the situations that expose them to diseases

- The poor work on activities or areas that are hazardous to their health
- The poor do not get adequate and well balanced food, and they work beyond their physical capacity/expend more energy than they get from food intake

- The poor are not able to keep clean, may not have money to buy water for washing, live in overcrowded living condition, lack toilets and separate kitchens and such conditions expose them to diseases.
- When you are poor you worry about what to work, what to feed to your children and it makes you anxious, irritable and angry...this by itself makes you sick of headache

3.4.2 Psychosocial Factors Related to Poverty and Health

3.4.2.1 Intra Household Conflict

In this study attempts were made to explore psychosocial factors affecting health and healthy behavior and how people perceive these phenomena. Accordingly, events of quarrel/conflict that occurred in the households in the month prior to the time of the interview were assessed. It was found out that in the vast majority of households there were repeated events of conflict. Majority of the quarrel/conflict was with a spouse, and/or children who do not want to go to school, are not working or happen to have 'difficult' behavior. In some cases conflict occurred with other adults living in the same house/rent paying co-habitat (*debal*, in Amharic) and/or with neighbors.

BOX 3.6. The major reasons for conflict with in the households are found to be:

- Burden to meet the needs of large number of children
- When Children ask for food
- When the husband beats the children,
- When the husband does not work
- When the husband does not bring in enough income, and comes home drunk
- When the children refused to go to school
- When the children refused to work

Most of the interviewees narrated vividly how such events usually start, how they deal with it and how they think it affects their health and perceptions about their future. Most of them describe a peaceful day when their husbands do not get drunk, come early in the evening, and come with some money, which otherwise happen to be the major sources of conflict between spouses/partners. In Akaki particularly drinking *Tej* (and buying for each other) is a common practice among men even during the day time. The Men FGD was purposely scheduled for morning time, still it was learnt that some participants had some *Tej* before the discussion.

I and my husband used to quarrel quite often. It starts when he comes home staying out all day selling used cloths and tells me that he has not sold any thing, or he gives me 2 birr. I cannot work since my children are very small. What would I buy the children with two birr? These days we had not quarreled because he got sick, with some mental problem and had gone to his mother's place in the rural area.

A woman from Teklehaimanot

Another important psychosocial factor behind conflict is the perception attached with a non-working male spouse. In line with the culturally ascribed gender roles in the society, men are almost always perceived as the bread winners of the household, while women's role is limited to responsibilities of managing the home. It is therefore socially expected that a man should engage in income earning activities, while it is acceptable for women to stay home and undertake household chores. This is however not the case in most of the studied households since the poor are not able to secure adequate income unless both are working. As the same time it is often difficult to secure their jobs and could be jobless at any time. It is found that the job insecurity is worse among men than women, since the latter are often engaged in a range of less paying jobs, like baking Injera, washing, etc. Indeed Meron (2005), in her study of urban poverty in selected areas of Addis Ababa, discovered that women are earning the bulk of household income, since they have a range of choices among various

informal works. The social and psychological impact of this situation on men is also noted to exacerbate with this situation.

Most of the interviewees asserted that, in a situation where women are engaged in income earning activities, there is continuous conflict initiated from both sides. First of all it is very difficult for the women to accept the fact that they are 'feeding' their husbands not just because of the burden, but the social expectation described above. Secondly, apart from bearing the household workload, the women engage in jobs that are tiring and risky for health. They earn very little income and often find it difficult to even feed the family. Thirdly, they are exposed to various physical and sexual harassment when they are working very early in the morning or very late in the evening, sell bread and kollo on the streets and work at people's houses. In addition, some women expressed that their spouses might think they cheat on them when they work away from home. These situations added with the 'misbehaviors' of spouses or children (described previously as causes of quarrel), usually become sources of desperation and irritability easily igniting up conflict.

The view of men was obtained from FGDs conducted in both study areas. The group included men who are currently jobless or had experienced it in the past. During the discussion it was revealed that men find it difficult to cope with the psychological impact of being unemployed. They described that the pain of sending children to bed on empty stomach and failure to provide for them is unbearable. They often shout and quarrel when children ask for food even though they know the woman cannot do anything about it. Apart from such actual lack of income, the feeling of 'waiting from the woman's hand' (being dependent on a woman) is devastating for them. Therefore, they deal with this situation by spending most of their time in local liquor houses (*Tej Bet and Tela Bet*) with their friends squandering every penny that comes around or what they take from their spouses.

The women interviewees were asked how such conflicts affect their health. Almost all of them stated that they are frequently affected by problems like headache and

gastritis; two women said they believe that such situation is the cause for their hypertension. Some of them said that they feel very weak and drained after such confrontations. Regarding psychological impact, the women went beyond the physical domain and described life as 'bitter' and nothing good could come up in the future because of these discordant relationships. It seems like such repetitive quarrel/conflict has drained out all possible positive outlook for life and the motivation to change which is crucial for promoting a healthy life. The women were also asked how they deal with such events. The responses were they feel angry, shouting, crying, or beating the children, followed by a state of depression in most of the cases. Some women deal with it by keeping silent until their spouses stop shouting at them or beating them, which occurs often times.

From these findings, it could be observed that conflict within these families affects health in two major ways; by creating directly exposing them to some stress related health problems and by adversely affecting their motivation to betterment. In fact the latter could significantly erode the minimum possible pursuit of a healthy life. In addition, it is important to note here that, while both men and women equally suffer from the poverty related psychological problems, women are additionally rendered victims of physical abuse, due to women's subordinate social status ascribed in the society.

3.4.2.2 Life Priorities and Aspiration: What Matters is What is Happening Today

Prevention of illness and promotion of healthy behavior requires people's aspirations towards and prioritization of healthy issues in their world outlook and the attempt to practice these in their everyday life activities. On the other hand, it could be argued that it is only when people have some value for their future, a purpose or aim in life, that they care about what is happening to, and around them today, which would guide their future behavior related to health and prevention of illness accordingly. In this context, interviewees were asked what their priorities in life are, if and what they think beyond today, if they have any confidence that they can make tomorrow a better day, and if they are striving to achieve that.

All the interviewees expressed that their precedence is to get their daily subsistence and they feel that they are not in a position to think beyond today, while very few of them said they think and plan beyond today. For those few women whose spouses have some form of regular income, the priority is covering the cost of basic needs through out the month, and finding other jobs to supplement income. For the majority of the interviewees fully engaged in the informal work, life is full of 'uncertainty and anxiety' as they described it by many factors including; insecurity of jobs, increase in food price, increase in house rent, fear of eviction, illness of any family member among others. Therefore the common drive is to run here and there to make ends meet, of which daily bread is the major one.

Currently, life for me is miserable; I don't even have enough to feed my children. How and what could I think of tomorrow? For me nothing goes beyond the day, not what I earn, not what I think. Even if I want to, what would I think of, except how I start and end the day?

Alemesh, age 29, Teklehaimanot

When asked weather they think/believe they could make tomorrow a better day, there was some sort of bewilderment among the majority. In fact this was the most strange question they encountered during the interview. Most of them confessed that they have never thought about such things before. Almost all of the interviewees had fatalistic views, as they do not think that they are as such responsible, nor do they think that their actions are decisive for their future. Mostly their responses to such questions are characterized by leaving it to fate often described as *egzer yakal* (God knows) with an expression that often seems equivalent to 'I don't know' than a reflection of faith.

Their ideas for a better tomorrow are generally pessimistic and betterment is far and something that is beyond their control. If they at all think of a better tomorrow, it is within the bounds of wishes expressed in statements such as "when our children

achieve some schooling and find jobs they may help us”, or “if I could manage to send my children to Arab countries, our lives would change”, etc. Generally, they tend to associate a better tomorrow with some unexpected wishful event, something that is not dependent on what they are doing today.

Interviewees were asked if and what they actually are doing to achieve what they say they are aspiring to. Their responses showed that, by and large, not much is happening in their daily lives, that is geared towards betterment, other than striving to fix the next meal, the next rent or the next school fee. The majority of the interviewees consider better life as something far and difficult to attain. When asked if they have regular saving meant for improving/sustaining their livelihood, most of them stated that they save about two to six birr per month, which is meant to cover some inevitable costs like Iddir contribution and rent.

However, most interviewees expressed some practical expectations that they do not as such associate with betterment. This includes their hope to move around and engage in one or more jobs once their under five children have grown. Currently they spend most of their time working around home since they have to look after their children. They also expect older children (above 13 or 14 years) to engage in work and bring in some money to support the household income.

A qualitative study of poverty conducted in both rural and urban areas by Aklilu and Desalegn (2000), revealed that the poor strongly express dismal views about their future. These expressions include; ‘life is from hand to mouth’, ‘we live only for today’, ‘it is a life of no thought for tomorrow’ and ‘we envy the dead’. Other expressions of hopelessness and desperation cited in the study also include; ‘we are between life and death’, ‘we are waiting to die while seated’, ‘we are full of debt’, and ‘we’ve neither dreams nor imaginations’. Similarly, Meron (2005) and Mulumebet (2002) found out that inability to meet basic needs causes stress and desperation robbing people’s aspiration for better life. It could be rightly argued that the negative impact of such disposition on health is enormous as future aspiration has a

major role in affecting current health related decisions people make. A study by Campbell (2003) reveals how promotion of prevention programmes is difficult among the poor as described in the following statements;

The pathways along which social disadvantages impacts on health are many and complex. Apart from the direct effects of socio-economic deprivation on health, members of marginalized groups often lack the material or symbolic resources to deal with health-damaging stress...people who lack the power to shape their life course in significant ways-through poverty/and or through low social status- are less likely to believe that they can take control of their lives and thus less likely to engage in health-promoting behaviors.

3.5 How do the poor cope with health risks and problems?

3.5.1 Preventive Health Practice in the Context of Poverty

As described in the previous sections, it was found out that majority of the study participants more or less perceived various health risks associated with poverty. In discussing own response, most participants expressed prevention of illnesses as generally keeping oneself away from diseases, not leaving foods without the lids on, not eating food which has been left open, washing hands before eating, washing dishes children use, personal hygiene, cleaning the living environment, going to a medical center when one is sick, and not using needles and razor blades other people have used in order to prevent HIV infection. Although such statements were mentioned by the study participants back and forth, much emphasis is made about getting treatment during illnesses. The interviewees were also asked to mention any preventable health problem they knew. Every interviewee mentioned a minimum of two and a maximum of four preventable diseases. These include typhoid, HIV and AIDS, tuberculosis, common cold/cough, eye problem, skin diseases, diarrhea, intestinal parasites and headache.

It could be noted that the level of knowledge about basic prevention practice among the study participants seems considerable. However, when asked about their practice the responses from the majority of individual interviewees as well as group discussants were tagged by statements like 'we do what we can' which seems to carry an implicit message of 'although it might not bring much change'. This situation tallies very well with the psychological impact of poor housing on people's motivation to change. It is not feasible for such household members to improve a deteriorating living environment, which results in eroded motivation and sense of helplessness as far as change is concerned.

Therefore, one may not dare to argue that these people failed to translate their knowledge into practice, which is a commonly given reason to problematic communication efforts. In this case however, the level of poverty seems to dictate

how people respond to health risks and diseases as it is evident that they are deprived of the most basic facilities that they need to lead and maintain a healthy life.

3.5.1.2 Utilization of Health Information

Relevance and utilization of health information is explored among four FGDs carried out in the two areas. The male discussants mentioned that they usually get health related information from the radio, while women get information from the health center. Most women discussants also confirmed that they get most of the information from the health center when they go for various reasons since they do not have time for listening to the radio. They also mentioned some periodic neighborhood/home to home health education given by Keble.

In assessing how the health messages were relevant they were asked some of the topics they got information about. The women discussion group revealed that they do not often remember much of what has been said at the health center, it was difficult for them to mention any distinct topic except issues about child care in some cases. When asked why, they mentioned that their minds are not free at all, they will be thinking about how long they will be waiting at the clinic, whether the drugs will be available, or how much income they lose when they stayed there instead of being at work, what food to give their children when they go back home, etc.

However, when prompted by the discussion facilitators about some common topics like HIV and AIDS, they said, they hear about that everywhere outside the health center. The other issue mentioned by the facilitator was family planning, and the responses obtained were that most women get information about family planning from outside, particularly neighbors and relatives. For almost all of those who have ever used any form of modern contraceptive, they got the first information from their own social network that convinced them to seek the service. Interestingly, they get the information along with all sorts of misconceptions. This was also confirmed in the individual in-depth interviews as the most frequently mentioned reason for not using

or discontinuing a family planning method, even when having a strong need for using it.

The discussion participants were also asked what they think of the way messages are given, their appeal and practicability to their situation. They expressed no complaint about the health education, probably because they think that everything that comes from a health professional is correct. Rather, they repeatedly resorted to mentioning their dissatisfaction about the service (discussed under section 3.4). They associated the limited applicability of messages with their own personal problem of concentration, or inability to apply the messages because of their poverty, that could signify that messages are not given with an emphasis on what could be done at the local level.

Key informants from the nearby health facility were interviewed about health service and information they deliver. Informants mentioned that communicable diseases are the most common diseases treated in the facilities. The informants emphasized that people find it difficult to prevent diseases because of their overcrowded living environment and poor sanitation. The informants explained that health education sessions on different topics are regularly held in the health center, but admitted that community based discussions are important.

These findings could then suggest that people capture health information, (whether they have it complete or not) when they think it concerns them and when they are able to relate it with their lives like in the case of family planning. Otherwise, for interviewees life is all about priorities, and the first one is food, and health issue comes first or even second only when illness occurs hindering them from earning income and when they seek curative care. For them what matters is what happens today, not what may happen tomorrow if they did or did not do something. This is the vital factor many health education or behavior change strategies miss out. People will be disposed to act only when they personally perceive and appreciate the problem and the relevance of the action. For instance, the discussions revealed that whenever

they hear and look at the health and socioeconomic benefit of family planning they seek the services, although sustained utilization is affected by the dynamics of many factors as discussed in the previous section.

The last issue explored was about the style/method of health education they prefer. The participants gave strong emphasis for education sessions where they get a chance to express their side of the story. In fact some participants said the FGD was a case in point, where they could share their problems, because outsiders (like the discussion facilitators) could only get the half picture of the problem. Participants mentioned that no one could best comprehend and prioritize their problem as they do because they live in it, except that they are incapable of solving it.

3.5.2 The Course and Rationale of Measures Taken During Illness

The interviewees stated that they take various measures during illness that seem to follow some “rational” stage and also varies across members of the household. The first response to illness is leave it to subside by it self, followed by use of traditional or religious remedies, and lastly visiting health facilities.

In both study areas, the tendency to visit health institutions is generally less for both male and female adults unless the disease worsens, although interviewees Teklehaimanot area are relatively better in visiting health facilities, especially for children. The decision for such response to visit or not to visit a health facility seems to be rationally made for different reasons, of which recurrent nature of illnesses that tends to be lived with, and the acute nature of illness among children might be the leading ones.

Government health centers are often preferred, because the service is cheaper or free for some poor people declared as such by the kebele. However, they listed a number of complaints about the service they get; the most frequent ones were long waiting hours, incomplete laboratory services, and improper behavior of service providers (sometimes particularly discriminatory for non-payers), health workers not

conducting physical examinations but prescribing drugs only by listening to what the patient (or parents, in case of little children) have to say, and most of all, unavailability of drugs. It was also observed that complaints were strongly dependent on the out come of the most recent visit, and people tended to associate a good service with getting medicines that “cure” than with any other factor.

Interestingly, most of these complaints came from interviewees in Teklehaimanot areas that could obviously be explained by the relatively frequent visit they made. Often times, they talked about specific services (pharmacy, laboratory, health workers) rather than wholly about the health center as was the case in Akaki, who seem to distant themselves from health facilities. For instance, when an interviewee in Teklehaymanot, talked about unsatisfactory treatment in the health center, she might explain it in terms of irresponsible health worker, who failed to properly diagnose the disease or ordered a medicine that does not cure, so they opt to a different facility. However, a woman in Akaki, may conclude that the health center (or the modern health care) is does not help and the traditional one is better.

During illness there is a general tendency of self treatment either by traditional means (herbs, spiced tea, coffee ...), religious (*Emnet, Tebel*) or buying drugs (mostly anti pains) unless the illness gets worse. It was also found out that most women are not likely to take rest when they are sick. Even when they are unable to attend their work outside home, they will often carry out the household chores since they are expected to feed the family unless it is impossible for them to work, children are also found to help around in some households.

In assessing illness at the time of interview, most interviewees and their young children were found to suffer with some infectious diseases illnesses that are communicable. The duration of their sickness was found to range from three days to a year. Concerning the measures they took, few adults visited the health center in both areas. However, more children in Teklehaiymanot were taken to the health facility than in Akaki. For those children who were taken to the health facility, the prescribed

drug was not available in most cases, so they were given home treatment, while two cases were taken to private clinics in Teklehaimant.

3.5.3 The Role of Social Capital in Coping with Health Challenges

Under social capital, the role of traditional social institutions and networks in generating support at times of need and community action to maintain healthy environment were assessed. In both study areas, it was observed that people attach a strong value to such type of social groupings like *Iddir*, *Mahber* and *Tswa*.

Iddirs are neighborhood-based, traditional associations the primary function of which, is burying the dead and consoling the bereaved, and provision of financial support for covering expenses associated with burial ceremonies. Membership to an *iddir* does not require any criterion except being a resident of the specific locality and willingness to pay the monthly contributions, which usually is affordable to most people. In some of the main urban centers of Ethiopia, *iddirs* are expanding their activities from simply being that of providing support during bereavement, towards promoting a broad range of development initiatives collaborating with government and non-government. These initiatives include: provision of micro-credit, education on HIV and AIDS, and giving nutritional and other support to people living with HIV/AIDS.

Traditionally, *Mahber* is a name given for an association, established by a group of Orthodox Christians who share the value of veneration of a certain saint or angel (whom they consider as personal guardian) and who come together at the day of the particular angel/saint of the month. Every member prepares a feast once in a year or more, depending on the number of members, and his house will be the venue of the get-together for that month. Members of a *Mahiber* consider themselves as brothers and sisters and in principle should support each other at times of need. It is therefore a quasi religious association, the social aspect of which may often be much stronger than the religious. However, these days, it has become common to come across other equally informal associations, especially associations of people with consangual

relationships with the same name. In general *Mahiber* or *Tswa* are less formal in terms of structure and level of organization.

In assessing the role of social capital in health, two issues were predominantly explored during FGDs, support system during illness and the role in group action. In spite of the above described growing importance of *Iddirs*, FGD participants in both study areas mentioned that *Iddir* membership helps only during death of a relative and not for illness, there is an indirect way of helping in which members contribute by their own initiative to assist a sick *Iddir* member. Yet participants gave a strong value for help during death since they considered inability to hold formal burial ceremony for a dead relative is culturally the worst thing one could face. However, interviewees stressed that they would like *Iddirs* to do more than that and extend their supports to diversified problems including illness or other difficulties. It could therefore be assumed that the *Iddirs* in the study localities are not yet among those working in partnership with development actors, as is the case in many urban *Iddirs*. Discussants stressed that they rather generate more support from *Mahber* and *Tswa*, most enjoyed institutions by members, where they are closer to each other and enjoyed the regular meeting sessions where they share their stories, news and information. Meron (2005) asserted the same in her study that poor women enjoy the time they meet at their *Mahber* and *Tswa*.

With the intention to know the nature and extent initiatives from within the community for the purpose of health related group actions such as cleaning their environments, FGD discussants were asked relevant questions. The participants revealed that group action by community's own initiation is almost non-existent. In fact what they understand by group action is something led by NGOs or the Kebele for some assistance or credit. In fact, one participant remarked as 'what would we do if we gather by ourselves; even today we came because you called us'. They explained that people are not interested in group activities unless they get something personally. The FGD itself was considered one of such events both by the local administration as well as the community.

They asserted that they participate in group activities like mass cleaning, only when some sort of fines and coercion are involved, especially by their Iddirs than the local administration. Iddir informants also mentioned that mobilizing community for such action is not their prime objective, unless it is directed from the Keble or NGOs, for which they are often summoned to coordinate.

In addition discussants depicted that there exists a very strong informal sanction hindering the predisposition for self initiation. A person who would bring up an idea would be labeled and even ostracized as meddling in something “that does not concern them”. Any activity seems to be considered relevant as far as it carries benefits that can be consumed at personal level. One FGD participant said;

It is difficult to initiate by ourselves to organize our labor to undertake a group activity like cleaning up our environment. We have so many unemployed young people who sit around all day; they could do a lot of things. But when you bring up an idea of gathering, contributing and doing something for the whole community, you will be labeled as having the luxury of time and money to be concerned about others, engaging in something that should be undertaken by the government and trying to impress authorities. I remember a woman was beaten because she asked people to contribute one birr for cleaning up this place.

3.5.4 The Role of NGOs in Poor People’s Coping with Poverty and Health challenge

Apart from perceptions towards and utilization of government health facilities, NGO interventions in poverty and health were also assessed through individual and key informant interviews. In both areas there are NGOs that are operating in areas related with poverty and/or health. The study participants also discussed the impact of NGOs whose operation in the area terminated.

Most of the household interviewees at some point have been receiving aid, while some are still receiving support of various kinds from NGOs. These included, school fee and uniforms for children, wheat and oil, medical support and money in some cases. Interviewees were asked about the significance and impact of such support in their lives. Amazingly the responses were similar across interviewees and study areas, described as 'better than non ' (*keminim yishalal*). They considered the support just as an input to what they strive for everyday - their subsistence. They affirmed that there is no much lasting impact and it "stops when it stops".

However, all key informant interviews particularly *Iddir* leaders and the Kebele representative revealed the limitation of NGO action in their areas. The informants admitted that most of the interventions by NGOs are aimed at providing temporary assistance for targeted individuals or households, which in fact is quiet accepted by the community although there is no much impact in reducing poverty. In addition, the key informants all agreed that most NGO interventions target very much limited number groups of people, so the impact and coverage in reducing poverty is doubted.

In fact, according to the key informants in most cases people see how they fit themselves in the targeting criteria and receive what ever is available. In Teklehaimanot, the informants mentioned a case with one NGO that used to be engaged in providing food and other supports to households with children under five years of age. They pointed out that there developed a trend among the target group to have another baby when their children grew out of the eligibility age limit. The trend of receiving temporary aid is noted to be extensive in both areas to the extent that this research endeavor was considered as one of such support activities and data collection was challenged when it was understood otherwise.

One key informant in Akaki mentioned a particular NGO action considered as a sustainable contribution towards healthy communities. The action of the said NGO included; building a number of public toilettes, health posts, maintaining houses of the elderly, and building common kitchens for poor households and engaging poor

women in income generating activities. Talking about NGOs engaged in such sustainable actions like income generation, they mentioned that a critical problem is mainly follow up of beneficiaries. People usually attend training on income generation activities, but when they receive the start up money, they usually spend it on their immediate needs. The fact that assistance is misdirected to temporary benefits is hampering achievement of sustainable improvement in health and livelihood.

The key informants also talked about the weakness from the community's side as well. They explained that most people do not value sustainable actions as they do for a monthly food ration that will not change their lives. According to them, this is the main reason why community utilities like toilets, roads and parks are poorly cared for. In addition, when some NGO gives grants for group entrepreneurship, people do not want to work together. They mentioned of a lot of businesses, like mills, cereal shops, and construction input firms, which failed very quickly. The other important factor, mentioned is, when people start to get some income through the income generating schemes, there is a tendency to resort to extravagance especially spending a lot on food items, rather than saving and improving their business. This could also be attributed to the attitude created among people, as NGOs bring money on their behalf but they give them very little.

One informant in Akaki said

'...when people get such money they will immediately shift from eating kollo to meat and teff, so they quickly get bankrupt, all this is a problem of follow up on the NGOs' side'

The role of NGOs in both areas may not be neatly categorized in terms of their beneficial value. In fact, it elicits a moral choice of giving out medicines, feeding people or sending children to school today, or enabling/empowering people to achieve these by themselves tomorrow.

Another important growing trend raised by a key informant from Kebele administration is how NGOs in both areas are involving with the surrounding formal and traditional institutions. Disapprovingly, they spoke about events of NGO meetings with *iddirs* leaders and other community partners, where perdiems are paid and even in relatively increased amounts for leader since they are thought to have 'mobilizing' role in the community. In fact the recent trend is that NGOs see *iddr* as the cornerstone of emerging civil society, and symbolize the common dogma of 'stakeholder participation'.

With all due regard to participation, it is imperative to be critical about appropriateness of the process as well as sustainability of the impact. In this regard then, there are a lot of questions a reasonable person could ask as far as such NGO actions are concerned. What is the point of feeding people for a year and leave them? Where is the basis for genuine action while community participation is corrupted with perdiems? In fact, the longer impact of this process could pose a potential threat to the sense of cohesion and voluntarism existent within in such community associations, apart from nurturing the sense of dependence among the community. In the famous World Bank report on qualitative poverty study conducted in 47 countries, Narayan (1999) argues that the biggest weakness of NGOs is they generally do not enhance the capacity for self governance. The report also mentioned that the reach of NGOs is very much limited to few targets questioning the wider impact despite their efforts.

A similar attitude is also noted among some local administration staff, during one informal discussion about life, one Kebele worker recounted as

We are paid with very low salaries; still I am in a much better position than the others...I work in a section where there are a lot of workshops, and I get some perdiems...

CHAPTER FOUR

CONCLUSION AND IMPLICATIONS

4.1 Conclusion

The study attempted to explore the relation and dynamism of urban poverty and health, as well as socially determined perceptions and behaviour of the poor in selected neighbourhoods of Addis Ababa. The study revealed that the impact of poverty on health is driven by multi-pronged and interlocking sets of factors that could be well analysed beyond the income domain. Ranging from the physical environment to psychological aspects, these factors were found to have huge role in posing particular exposure to diseases among the poor, and mothers and young children were found to be most affected. These factors are also central in shaping how meanings of health and illness are constructed among the poor and hence their response to illness and predisposition to preventive practice.

Insecure and source of livelihood among the urban poor has impacts beyond low levels of income fundamentally affecting people's aspirations in life and their receptiveness to change. For the urban poor, life is a matter of daily struggle. This is a formidable barrier for people's predisposition to disease prevention that is often neglected by health communication strategies. The physical environment in which the poor live and work is the source of constant exposure to diseases often coupled with psychological dimensions affecting their motivation to better life. Such psychosocial factors affecting healthy life exist both in the household dynamics and the external social life surrounding the poor. Conflict within families is found to be one major factor influencing healthy attitudes and behaviour.

Coping with challenges of health and poverty is shaped by various factors that could be analyzed at personal, community and institutional levels. Initiation for health related action among the community is found to be severely constrained among the poor by massive capability deprivation at personal level. Such initiation seems to be

sanctioned by prioritization of and focus on the struggle for survival and the immediate purpose of one's own perceived gain or lose that the action may entail.

The health care service has a huge role affecting how people cope with health challenges. Although in both study areas health services are accessible at affordable price, people were not benefiting much from the system, clearly indicating that access cannot be exclusively measured by distance. The static health delivery system has constrained the opportunity for community based interventions like family planning and treatment of diarrhoeal diseases among children. We are living in an era where urban poverty poses eminent threat to wellbeing. In cities like Addis Ababa, where overcrowded urban pockets are common, the health threats are manifold. Health communication strategies existent in the studied areas are way behind addressing the problem, and need to escalate to outreach and interactive methods. It is heartbreaking to observe the consequences of unmet needs of family planning that could have been massively curbed through appropriate communication and approachable services.

Another dimension of coping is traditional social network like Iddir that were found to be characterized by trust and solidarity and thus more influential than any other formal institution. This indicates that channelling development activities through traditional social institutions, which is increasingly gaining popularity among some NGOs, is an approach worth the attention of all concerned development actors. Moreover since these institutions are not originally development oriented, any attempt to involve them calls for careful analysis of the context in which they operate.

The attempt of NGOs to work with these associations in the areas is a case in point, in its unintended consequence of depleting the inherent coping mechanism of these associations, since most assistance schemes are directed to achieve immediate objective than lasting capacity. It could be observed that providing temporary aid only

reproduces poverty often with long persisting dependency syndrome, rather than reducing it.

4.2 Implications on Research and Policy

As attempted to show in the preceding chapters the study revealed that the link between poverty and health is intrinsic and calls for a change in approach both in terms of researching urban poverty as well as in designing policy. In light of the study findings the following points are believed to be of vital importance that deserve adequate attention.

Poverty reduction efforts need to consider health improvement as a major precursor of urban development. Attempts to address poverty need to assume a concerted approach to tackle the multidimensional deprivations explored in this study. Health improvement in this sense would then mean addressing various factors that are beyond the biomedical domain; creating sustainable jobs, improving working and living environment are prominent in bringing up sustainable and multiple benefits.

The national health strategy needs to be reviewed taking the dynamics of health and poverty in urban areas into consideration. Looking into urban health inequalities would entail analysis of health problems beyond health service access and development of a robust urban health strategy.

Health communication strategy needs to adopt interactive methods that engage the community. 'Throwing' health messages at people in static health facilities, won't take us any where unless the poor themselves play their part. In this regard, a system of Community Health Extension Workers (CHEWs) needs to be established with in communities of urban areas who would engage in creating interactive discussion and counselling about various health issues (family planning, child health, nutrition...) relevant at household level. In such a way, preventive practice needs to be enhanced as a primary goal of healthcare, while improving the curative service in the same manner.

A more rigorous system of monitoring and evaluation need to be designed for NGO actions in an effort to direct their resources to sustainable actions that can draw people out of dependence and enhance self-governance.

Finally more research needs to be carried out in the area of intra urban analysis of health inequalities and how these translate in to deliverable urban health actions

Reference

- Abay Asfaw (2003) How Poverty Affects the Health Status and The Health Care Demand Behavior of Houeholds? The Case of Rural Ethiopia.
- Abbi M.Kedir (2005) Understanding Urban Chronic Poverty: Crossing the Qualitative & Quantitative Divide. CPRC Working Paper 53 Chronic Poverty Research Center. Leicester. U.K
- Abbi M. Kedir & Andrew McKay (2003) Chronic Poverty in Urban Ethiopia: Panel Data Evidence. Paper Prepared for International Conference on Staying Poor: Chronic Poverty and Development Policy, hosted by Institute for Development policy and management, University of Manchester, UK 7-9 April 2003
- Abebe H. Gabriel (2002) "The PRSP Process in Ethiopia." Paper Presented at the Second Meeting of the African Learning Group, on the Poverty Reduction Strategy Papers, Brussels, ECA, November 2002 18-21.
- Aberra Kumie, Tegegne Gebre Egziabher and Helmut Kloos (2005) 'Housing and Health' in Yemane Berhane, Damen Haile Mariam & Helmut Kloos (eds) Epidemiology and Ecology of Health and Disease in Ethiopia. Addis Ababa: Shama Books
- AFRODAD (2005). The Impact of Poverty Reduction and Growth Facility on Social Services in Ethiopia. Study Report. First Draft Accessible at <http://www.afrodad.org/downloads/publications/Ethiopian%20Study.pdf>
- Akililu Kidanu & Dessalegn Rahmto (2000) Listening to the Poor: A Study Based on Selected Rural & Urban Sites in Ethiopia: FSS Discussion Paper NO.3. Image Printing Press. ADDIS ABABA
- Alemayehu Shewarega & Birhanu Habtu (2005a) Teklehaymanot Development Plan Renewal Project for Addis Ababa City Administration. Unpublished Document.

- Alemayehu Shewarega & Birhanu Habtu (2005a) Akaki Development Plan Renewal Project for Addis Ababa City Administration. Unpublished Document.
- Belayneh Begajo (2005) Local Perspectives on Poverty and Development in Alemayehu Seyoum etal (eds) Proceedings of the Second International Conference on the Ethiopian Economy VOL III PP 263-284
- Bevan Philippa (2000) Poverty in Ethiopia: Discussion Paper Prepared for DFID: Final Draft. University of Bath
- Blakely Tony, Simon Hales, Alistair Woodward (2004) Poverty: Assessing the Distribution of Health Risks by Socioeconomic Position at National & Local Levels. (WHO Environmental Burden of Disease Series, No 10. Geneva, World Health Organization
- Booth David, Melissa Leach & Alison Tierney (2006). Experience Poverty in Africa: Perspectives from Anthropology. Q-Squared Working Paper No. 25. Accessible at http://www.q-squared.ca/pdf/Q2_WP25_Booth_%20et.al.pdf
- Central Statistical Authority (2004) Welfare Monitoring Survey 2004: Analytical Report. *Statistical Bulletin 339-A*
- Central Statistical Agency (2005) Ethiopia Demographic & Health Survey (DHS).
- Campbell Catherine (2003) 'Letting Them Die' Why HIV/AIDS Prevention Programs Fail. Bloomington. Indiana.
- Damen Haile etal (2005) 'Health and Poverty Reduction' in Yemane Berhane, Damen Haile Mariam & Helmut Kloos (eds) Epidemiology and Ecology of Health and Disease in Ethiopia. Addis Ababa: Shama Books
- Daniel Gebretsadik (2001) Urban Poverty and the Housing Condition of the Poor in Addis Ababa: A Case Study of Selected Kebeles in Central Addis Ababa. M.A Thesis School of Graduate Studies, Addis Ababa University. (Unpublished)

Daniel Kassahun (2005) Some Aspects of the Charcoal Economy and its Impact on Poverty and the Environment in 'Issues in Urban Poverty: Two Selected papers. FSS Studies on Poverty No.5'. United Printers, Addis Ababa

Department of Economic & Social Affairs of the United Nations (2006) Fighting Urban Poverty: Which Participatory Approaches? Accessible at <http://unpan1.un.org/intradoc/groups/public/documents/UN/UNPAN024789.pdf>

DFID (2005) Health & Poverty Linkages: Perspectives of the Chronically Poor. Working Paper 1. Paper Presented on workshop on Meeting the Health Related Needs of the Very Poor. DFID Workshop 14th and 15th February.

Dercon Stephan & Mekonnen Tadesse (1999) A Comparison of Poverty in Rural and Urban Ethiopia in in *Ethiopian Journal of Economics* Volume VIII No 1 Special Issue Poverty & Poverty Determinants in Ethiopia. PP 83-98 A Publication of The Ethiopian Economic Association.

Girma Seifu (1997) Poverty in Addis Ababa: A Comparison of Female and Male Headed Households. M.A Thesis in Economics, Faculty of Business & Economics Addis Ababa University. (Unpublished)

Gubrim Jay & David Silverman: Doing Qualitative Research (2nd ed), Florida

Heins Frank, Mekonen Tesfaye Paolo Valente (2001) Infant and Child Mortality in Urban Ethiopia: With Special Reference to Socio-Demographic and Housing Conditions in Urban Areas and Addis Ababa. Accessible at http://www.irpps.cnr.it/etiopia/pdf/Infant_and_Child_Mortality.PDF

Jayasuria & Quentin (2002) World Development 2003. Dynamic Development in Sustainable World: Background Paper Explaining Country Efficiency in Improving Health & Education Indicators: The Role of Urbanization. Accessible

at http://siteresources.worldbank.org/INTURBANPOVERTY/Resources/Eff_WDR2003.pdf

Masika Rachel, Arjan de Haan & Sally Baden (1997) *Urbanization & Urban Poverty: A Gender Analysis: Report Prepared for the Gender Equality Unit of SIDA.* Accessible at www.ids.ac.uk/bridge PDF

Mason Jennifer (2005) *Qualitative Researching*, SAGE Publication, London

Mboup Gora (2003) *Social Indicators in Urban Context: Urban Poverty and Health Study in Sub-Saharan Africa* Rational, Methodology and Instruments.* Expert Group Meeting on Setting the Scope of Social Statistics. United Nations Statistics Division

Mekonnen Tadesse (1999) *Determinants & Dynamics of Urban Poverty in Ethiopia in Ethiopian Journal of Economics* Volume VIII No 1 Special Issue Poverty & Poverty Determinants in Ethiopia. PP 61-81 A Publication of The Ethiopian Economic Association.

Melake Selam Paulos (1997) *Some Aspects of the Survival Strategies of Poor Inhabitants of the City of Addis Ababa* in Tegegne G/Egziabher & Daniel Solomon (eds) *Urban and Regional Development Planning & Implementation in Ethiopia.* Proceedings of the National Conference on Urban & Regional Development Planning and Implementation in Ethiopia held between Feb 7- Feb 10 1996.

Meron Assefa (2005) *Gender Dimensions of Urban Poverty in Ethiopia: The Case of Three Kebeles in Addis Ababa* in 'Issues in Urban Poverty: Two Selected papers. FSS Studies on Poverty No.5'. United Printers, Addis Ababa

Million Desalegn (1997) *Social Equity, Urban Poor and Vulnerable Groups in in Tegegne G/Egziabher & Daniel Solomon (eds) Urban and Regional Development Planning & Implementation in Ethiopia.* Proceedings of the National Conference on Urban

- & Regional Development Planning and Implementation in Ethiopia held between Feb 7- Feb 10 1996.
- Ministry of Health (1993) Health Policy of the Transitional Government of Ethiopia. Addis Ababa. Artistic Printing Press.
- Ministry of Health (2005a) Health Sector Strategic Plan (HSDP-III) 2005/2006-2009/10. (Unpublished)
- Ministry of Health (2005b) Essential Health Service Package for Ethiopia. (Unpublished)
- Ministry of Health (2006) Health and Health Related Indicators. Addis Ababa. Eth-CANA Publishers
- Montgomery Mark & Paul C. Hewett (2004) Urban Poverty & Health in Developing Countries: Household and Neighborhood Effects
- Montgomery Mark (2004) The Place of Urban Poor in the Cairo Program of Action and the Millennium Development Goals: Paper Presented at the Seminar on the Relevance of Population Aspects for the Achievement of the Millennium Development Goals, New York, 17-19 November 2004 Population Division, Department of Economic and Social Affairs, United Nations.
- Mulumbet Zenebe (2002) An Analysis of Household Poverty from Gender Perspective: A study based on Two Kebeles in Addis Ababa in Meheret Ayenew (ed) Poverty and Poverty Policy in Ethiopia, Proceedings of the Workshop Organized by Forum For Social Studies on 8 March 2002
- Narayan Deepa et al (1999) Can Anyone Hear us? Voices from 47 Countries. Washington DC, World Bank Publications
- Satterthwaite David (1997) Urban Poverty: Reconsidering its Scale and Nature in *IDS Bulletin Vol 28 No 2*

- Sen, Amartya (1999) *Development as Freedom*. Oxford. Oxford University Press
- Shewaye, T (2002) A Review of Institutional Capacities to Address Urban Poverty in Ethiopia in Meheret, Ayenew (eds) *Poverty and Poverty Policy in Ethiopia*. FSS Special Issue Consultation Papers on Poverty No 7. Addis Ababa: Graphic Printers.
- Tegegne G/Egziabher (1997) *Decentralized Urbanization: An Urban Development Strategy for Ethiopia* in Tegegne G/Egziabher & Daniel Solomon (eds) *Urban and Regional Development Planning & Implementation in Ethiopia*. Proceedings of the National Conference on Urban & Regional Development Planning and Implementation in Ethiopia held between Feb 7- Feb 10 1996.
- Tesfaye Alemayehu (2006). *The Analysis of Urban Poverty in Ethiopia: The University of Sydney*. Australia
- Todaro, Michel and Stephen Q. Smith (2004) *Economic Development*. Singapore. Pearson Education Pte. Ltd.
- Tsehay Berhane (1997) 'The Role of Sanitation in Disease Prevention and Control in Urban Environment' in Tegegne G/Egziabher & Daniel Solomon (eds) *Urban and Regional Development Planning & Implementation in Ethiopia*. Proceedings of the National Conference on Urban & Regional Development Planning and Implementation in Ethiopia held between Feb 7- Feb 10 1996.
- Ulin R, et.al (2002) *Qualitative Methods: A Field Guide for Applied Research in Sexual & Reproductive Health*. North Carolina, Family Health International.
- UNFPA (2007) *State of the World Population 2007: Unleashing the Potential of Urban Growth*. Accessible at <http://www.unfpa.org/swp/2007/presskit/pdf/>
- UN-HABITAT (2006b). *The Urban Penalty: Location Location Location*. Accessible <http://www.unhabitat.org/>

UN-HABITAT (2006a). The Urban Penalty: The Poor Die Young. Accessible <http://www.unhabitat.org/>

Vlahov David et.al (2007) Urban as a Determinant of Health. *Journal of Urban Health*.
Bulletin of the New York Academy of Medicine.

World Bank (2005a) Ethiopia: A Country Status Report on Health and Poverty in Two Volumes) Volume II: Main Report. Washington, DC

World Bank (2005b) Wellbeing and Poverty in Ethiopia: The Role of Agriculture and Agency. Washington DC

Yassin Worku (1997) Poverty in Addis Ababa: A Case Study of Selected Kebeles In Eastern Addis Ababa. M.A thesis School of Graduate Studies, Addis Ababa University. (Unpublished)

Annex I

Structured and semi-structured In-depth interview questions: Heads of households (female heads; this does not necessarily mean female headed households)

Ps. Note: Gray shaded questions are core analytic issues requiring a deeper dialogue

Sub city _____

Kebele _____

House number _____

1. Socio demographic characteristics

1. Age
2. Is your husband/partner alive?
3. What is the age of husband/partner?
4. What is your current source of income?
5. What is your husband/partner's current source of income?
6. Has your source of livelihood changed in the past 6 months? How many times? From what to what? How about overall income in the past 6 months? (Negatively change, positively changed)
7. Has your partner's source of livelihood changed in the past 6 months? How many times? Which ones?
8. Number of own children, List their age
9. Number of children other than own (relatives, orphans..), List their age
10. Number of any other adults living with you _____
11. So the total family size of your household is? _____ (point of crosscheck for the above!)
12. Do any of your children work? How many of them work? Which age? Are the children who work are your own children or children other than own? (make sure they don't sense that you judge them)

13. What kind of work do they engage in?
14. Total income from all sources (from all family members)?
15. How long have you lived in Addis?
16. How many old dependents are there in the family? Is it extended family?

2. Education

1. Own level of education (last completed grade)
2. Husband partner's level of education
3. Do all your children (school aged children) of your own go to school?
4. If no why? Are there drop outs? How many? At which grade for what reason?
5. Do all children (school aged) other than your own go to school? If no why? Are there drop outs? How many? At which grade for what reason?
6. How often do children study?
7. How do children spend their leisure?

3. Asset ownership (if you can observe good; if not ask!)

1. Radio
2. TV
3. Kerosene stove
4. Blanket
5. Bed
6. Others_____

4. Housing (Note your observations as well)

1. Type of ownership: owned, private rental, public housing, squatter no rent, squatter rent paid
2. Location: Proximity to hazardous area (waste, factory waste...)

3. Durability: made from permanent or non-permanent material, type of floor
4. Sufficient living area: number of rooms, availability of separate cooking area, number of people sleeping on one bed

5. Water and sanitation facilities

1. Access to clean water: (private/group access to piped water)
2. How do you dispose household waste? (waste bin, just dumping, river...)
3. Access to proper excreta disposal: What kind of toilette do you have access to? public, private, shared in neighborhood toilette____,

6. Own perception of health and poverty

1. In your own view how do you describe poverty? How is poverty manifested in your household?
2. What do you think is the cause of YOUR poverty?
3. How do you describe good health status? How do you describe bad health status?
4. Do you think poor people are more exposed to health problems? how?
5. How are the rich any better than you in terms of their health?
6. How do you describe your own state of health? Your children's? Your spouse?
7. What do you think are the necessary conditions for better health?
8. WITH YOUR CURRENT STATUS OF LIVING what can you do to improve/ maintain better health situation for your family?
9. What do you understand by 'prevention of illnesses'? What preventable illnesses do you know? (Let them list spontaneously! These could be; skin diseases, eye diseases, intestinal disease like typhoid, diarrhea, respiratory diseases...)

10. What things have you done in the past 6 months to prevent yourself and your family members (particularly children) from illness?
11. What things have you done to improve the status of your housing? (It could be plastic flooring, painting, cleaning...)
12. What do you understand by personal hygiene? How often do you Bath? Your spouse? Your children? How often do you wash cloths?
13. What do you understand by environmental sanitation? What things have you done in the past two months to improve sanitation of your home, compound surrounding...? (when you ask this, relate it with their environment)

7. Experience of illness and treatment

1. What are the most frequent illnesses faced by members of your household in the past 2 months? (Yourself and your spouse and any other adult in your household?)
2. When you YOURSELF (women HHH) are sick what measure do you take?
3. When you YOURSELF (women HHH) are sick who helps around home?
4. When do you think (for which illnesses) a sick person should visit a health facility?
5. Where do you usually seek treatment for you? your family? Why? (Government hospitals, health centers, private, NGOs)

Illness and treatment history of 2 month

Ps. Fill the table for all members of the household who were sick in the past two months

Person	Age	Type of illness in the past 6 months	Taken to health facility	Home treatment	Religious	Left untreated
Male HHH						
Female HHH						
Own Son/s						
Own Daughter/s						
Children other than own						
Any other adult						
Other						
Other						
Other						
Other						

6. Is there a sick person at home CURRENTLY? Who? What illness? For how long was he/she were sick? What measure was taken?
7. How long do you walk to the nearest affordable health facility? (in minute)
8. Which health facility is the most affordable? (gov., NGO or private health facility)
9. What was the average consultation fee (ye card), average investigation fee (laboratory) and average treatment fee (medicine) you paid the last time you went to a health facility? Was it a gov., NGO or private health facility?
4. Do you have any dissatisfaction in using the most affordable health facility? (Probes: staff manners, availability of adequate laboratory service, availability of drugs.....)

8. Psychosocial factors/ Aspiration and motivation for better life

1. How many times was there quarrel/conflict in the household in the past month? Was it with your spouse? Children? Other?
2. What was the main reason for the quarrel?
3. How do you deal with such events?
4. What impact do these events have on you? (Probe: your aspiration for a better tomorrow) Do you think this would have an impact on your health? How?
5. What is your life priority? (Probe: is it to fill the day's requirement like food, is it to make tomorrow a better day? Do you think beyond today? What do you think)
6. Do you consider tomorrow as better? Why?
7. Do you have the confidence that you are capable to make a better future for you and your family? If yes what is your capability (strength)? If no, why?
8. Do you strive to make your future better? To get out of poverty? If yes, what things do you do? If No, why not?

9. Do you save regularly? How much do you save?
10. Have you ever received aid of any form? For how long? Do you think it has helped you in any way? If yes in what way? If No, why? WHAT could be done differently to make it useful?
11. Have you ever thought about the future of your children? What do you think it will be? What do you do to make their future better than yours?

9. Social capital

1. In how many informal associations are you a member? Which type of associations? (iddr, equb, tsiwa, mahiber...)
2. How much is your monthly contribution?
3. What benefit do you get out of these generally?
4. Are these networks helpful during illness? How?

10. Child health

1. Have any of your children under 1 and under 5 years died in the past 2 years?
2. Are all children under 2 years fully immunized?
3. How long did you breastfeed children under 5?
4. Common illness experienced by children under 5 years in the past 6 months and measures taken (Please make sure it filled in the table above)
5. If left untreated, why?
6. Complete list of food children under 5 ate the day before interview (breakfast, lunch, dinner and any snack including drinks) do you children eat differently?

11. Maternal health and Sexual and reproductive health issues

1. Total number of pregnancies
2. Total number of children born alive
3. Number of abortion, number of induced abortion
4. Place of delivery of the last pregnancy
5. Have you followed antenatal care during the last pregnancy?
6. Do you know about family planning methods? Which methods do you know?

7. What benefits of family planning do you know? Do you think it relates with health of women and children? How?
8. Do you want to have any more children?
9. If yes to Q3, do you think you can afford to raise any more children?
10. If No to Q3, have you ever used family planning methods? If no, why?
11. Who decides when to have a baby, number of children... in your family?
What is your role?
12. Have you ever contracted sexually transmitted illnesses? What did you do?
13. DO you think women are more vulnerable to HIV/AIDS? How?
14. What can be done (at family levels like yours) to reduce this vulnerability?

12. Health information

1. Where do you USAULLY get health information?
2. How often do you hear health messages?
3. Which ones do you find relevant? If it is not relevant, why?
4. Do you apply these messages into your situation? Can you give me an example? If you can't apply it, why?
5. Do you think knowing about health and prevention of illnesses would help you to have better life?
6. If you think it helps, which methods of education would work for you? (Probe: community discussion, media, home to home...)
7. What could be your role in the health education process? How could you participate in the process?

Annex II

Focus group discussion guides: Women/men of reproductive age group

1. FGD Guides: women (25-49)

- What are the common health problems faced by women of your age?
- How do you decide when to have children?
- Exposure to Sexually transmitted illnesses and treatment.
- Do feel you are particularly vulnerable to HIV/AIDS? Why?
- Social capital
- Health information

2. FGD Guides: Men (25-49)

- Perceptions about family planning, its benefits
- Attitude towards women's role in deciding number of children
- How do men spend leisure time?
- Risky behavior (drinking, unsafe sex...)
- Exposure to Sexually transmitted illnesses and treatment.
- Risk perception of HIV/AIDS
- Social capital
- Health information

Annex III

Key informant interview

1. Head/ representative of a health center

1. What are the frequent illnesses in this area?
2. How do you carry out health education sessions? Contents, community-based, center-based, individual based...
3. How do you think are people responding to the health education that you are giving?
4. How do you think people perceive the service you give?
5. What are your challenges in addressing preventable illnesses in this area?

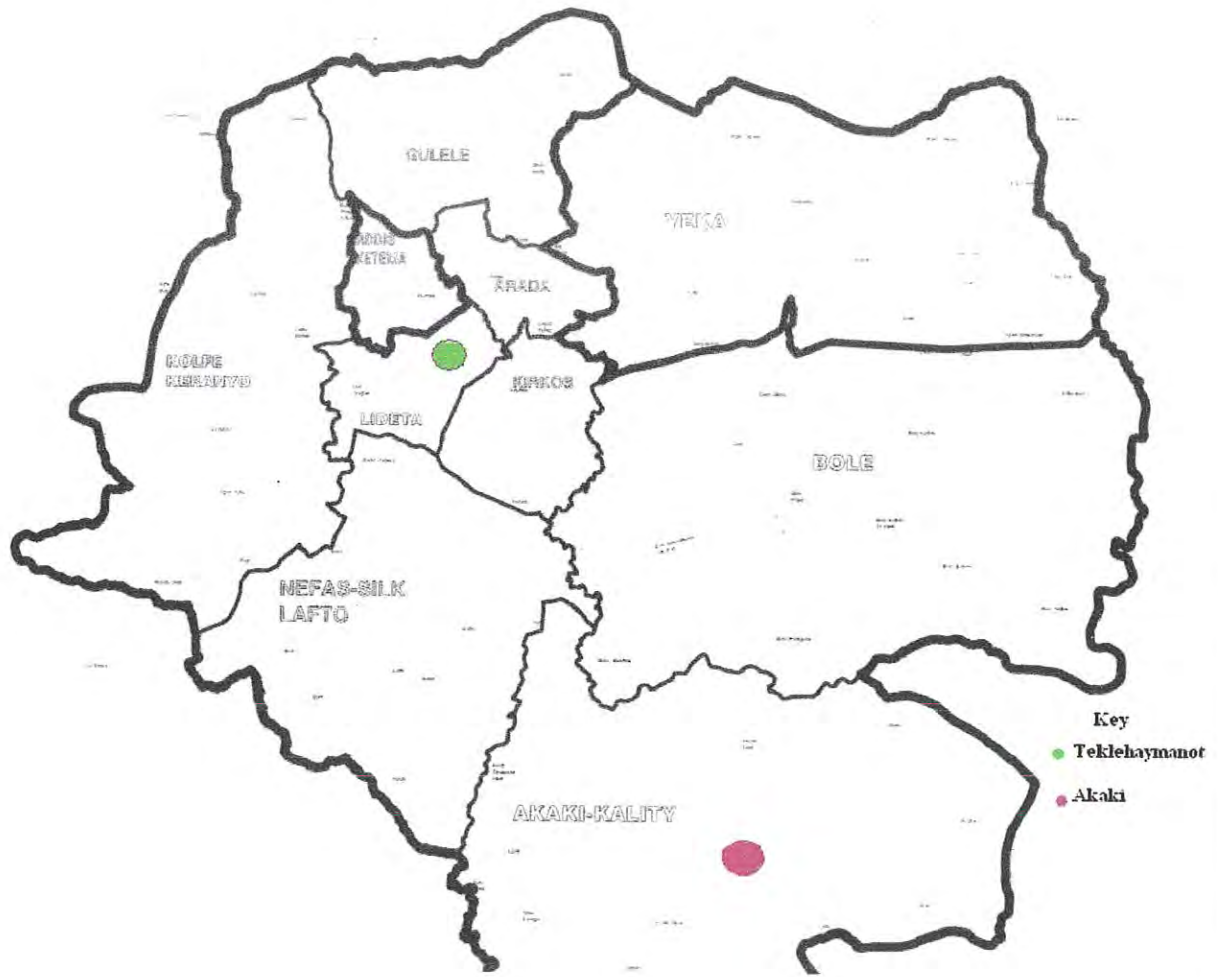
2. Keble Administration

1. What has been the role of NGOs in this area? How many have been operating? For how long?
2. What has been the change they brought in poverty reduction, in health?
3. If no much impact, how could it improve?
4. How do you mobilize people for group action like mass cleaning? What have been your challenges? How do you deal with it?

3. Iddir Leaders

1. What is the biggest challenge in poverty and health in this area?
2. How do you mobilize/convince people for any group action/support?
3. What is your challenge in mobilizing people in the past six months/recently? How did you deal with it?

MAP OF ADDIS ABABA



Declaration

I the undersigned, declare that this is my original work which has not been presented for a degree in this or any, other university, and that all sources of materials used for the thesis have been fully acknowledged.

Name: Hanna Woldemeskel

Signature:  _____

Date of Submission August, 2007

Name of Advisor: Tegegn Geberegiabher (Dr)

Signature _____

Date _____