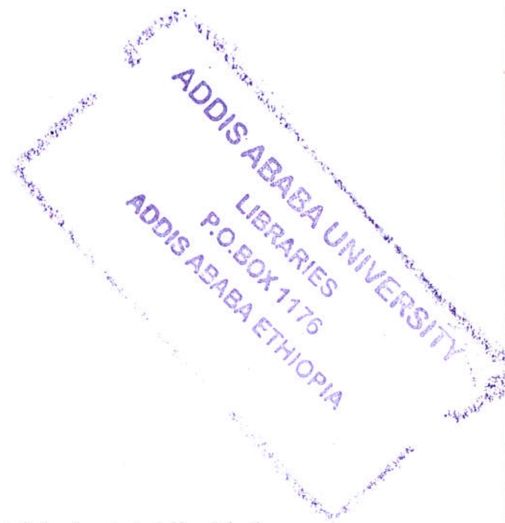
Title: Health Seeking Behavior among the 'Poorest of the Poor' in Addis Ababa: The Case of Gullele Sub City

By

Addisu Tegegne Bayle

Advisor: Mengistu Legesse (PhD)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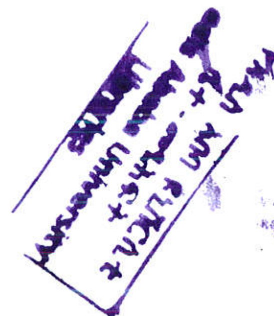

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Health Seeking Behavior among the 'Poorest of the Poor' in Addis Ababa: The Case of Gullele Sub City

Addisu Tegegne Bayle

Approved by:

Mengistu Legesse ____________ 09.09.2015

Advisor Signature

Hailemichael Tesfahun ____________

Internal Examiner Signature

Dr. Mohammed Hassen ____________

External Examiner Signature

Abstract

With unprecedented growth of urbanization, the issue of health and health seeking behavior (HSB) among the urban poor is spiraling. Taking prompt and appropriate health measures becomes unlikely to the urban poor due to the prevailing socioeconomic reality. Illuminating HSB of the Poorest of the Poor (PoP), who are under healthcare safety net, in Gullele Sub City of Addis Ababa was the objective of this study. To meet the objective, a mixed approach was employed. A total of 168 PoP who are eligible for fee waiver were surveyed through multistage cluster sampling. In addition, eight PoPs and six key informants which were selected through purposive sampling were interviewed. To analyze the quantitative data, Statistical Package for Social Sciences (SPSS) version 20 was used. Beyond descriptive statistics that was used to summarize the data, further statistical tests such as t test, one way ANOVA, Pearson's & Spearman's Correlation and Chi Square were employed to see differences and associations. 95 % confidence interval (CI) and 5% margin of error was considered during the statistical analysis. The qualitative data was analyzed thematically and integrated with the quantitative based on the similarity of themes. Accordingly, self-care, spiritual healing, traditional healer and trained allopathic are the major treatment alternatives of the PoP. It was also found that perception and attitude to health and healthcare correlated with seeking prompt healthcare among the PoP in the study area. A statistically significant difference in prompt healthcare utilization was found among the categories of sex, religion, religiosity and income, but insignificant for others. The healthcare safety net has brought a difference in HSB of the PoP. Generally, the perception and attitude of PoP to health and healthcare has an overriding role in shaping the HSB of the PoP. Though the fee waiver scheme has resulted in progress in the HSB of the PoP, the paradox behind low prompt utilization of healthcare has to be researched for evidence based practice.

Key words: *Attitude, Fee Waiver, Health Seeking behavior, Perception, Poorest of the Poor, and Urban Poor*

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Acronyms

AAFEDB	Addis Ababa Finance & Economic Development Bureau
ANOVA	Analysis of Variance
ART	Anti Retro-Viral Treatment
CI	Confidence Interval
EDHS	Ethiopian Demographic and Health Survey
ETB	Ethiopian Birr
FMOH	Federal Ministry of Health
HEW	Health Extension Workers
HSB	Healthcare Seeking Behavior
MoH	Ministry of Health
OLSA	Office of Labor and Social Affairs
PoP	Poorest of the Poor
SBM	Socio-Behavioral Model
SPSS	Statistical Package for Social Sciences
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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Introduction

Background of the Study

The issue of Health Seeking Behavior (HSB) emphasizes on the process and the action that people go through for the purpose of finding an appropriate remedy or to be healthy. It represents the sequence of remedial that individuals undertake to rectify perceived ill-health (Olenja, 2003). It is initiated with symptoms definition whereupon a strategy for treatment action is devised. HSB can be explained by people's health behavior as signs and symptoms by which the illness is recognized; presumed cause of the illness and prognosis established. These are in turn interpreted by individuals and/or significant others and on labeling the problem, proceed to address it appropriately through recommended therapies (p.61).

By 2030, according to the projections of the United nations Population Division, more people in the developing world will live in urban than rural areas and this demographic transformation will have profound implications on the health of urbanites, especially on the urban poor. It is common to see intra-urban health and HSB differences in most developing countries (Montgomery, 2009). To keep in touch the issue to Ethiopia, our context, until recently, much focus has been given on the rural populace while ignoring the urban dwellers. Though some efforts have been started since the recent past, urban dwellers remain suffering a host of problems, of which health is the major (Addis Ababa Finance & Economic Development Bureau (AAFEDB), 2010).

Poor are known for their excelled mortality rate particularly child mortality due to poor quality and quantity of water and sanitation, inadequate hygienic practice, poor ventilation dependence on hazardous cooking fuels; the transmission of disease among densely settled slum dwellers; and the city's highly monetized health system, which delays or prevents access to modern health services for the poor (Montgomery, 2009). Aside from unsanitary living conditions, the spiraling costs of hospitalization, medical consultation and medication prevent the urban poor from seeking health services. Moreover, the poor's misguided health practices and

their lack of knowledge and information on health promotion and disease-prevention contribute in worsening their health situation (Malanyaon, 1995).

The perception and attitude to health and healthcare has been found to be affected by socio-economic and psychological characteristics of an individual which means that the definition of ailment is not universal. Simply put, a rich person may identify a relatively minor indisposition as ailment and go for treatment, while the poor might perceive an ailment only when it is work disabling in nature. Their subsequent choice of service providers is often in conformity with their respective financial status (AAFEDB, 2010) which shows the HSB of the poor is quite different from their counterpart, rich. In the side of healthcare providers, they see poor clients who present themselves in a more debilitated condition than they would otherwise have been, having endured their illnesses until care could not be put off any longer. Health providers realize that the poor are likely to abandon prescribed medication to save on the costs of purchasing medicines, or economize by buying less than what was prescribed. They are not all that surprised when the poor fail to return as requested for follow-up visits (Montgomery, 2009). As per the study conducted by Ahmed (2005) on the healthcare choices of the poor, they tend to use self care, drug store, sales man (unqualified allopathic), traditional herbalists, paraprofessionals (semi qualified), and professional allopath (p.12).

According to AAFEDB (2010) the level of absolute poverty is approximated to constitute as 50% of the total households of Addis Ababa that in turn has an adverse influence on the health and HSB of the poor since poverty denies people from access to reliable health services and affordable medicines. To respond to the health needs of the poorest dwellers of the city, Addis Ababa Health Bureau has been enforcing the fee waiver policy. By establishing criteria of identifying the Poorest of the Poor (PoP), Addis Ababa Health Bureau has been furnishing health care safety net for the PoP. Simply put, this thesis addresses the following issues: first, it is interested to find out the perceptions and attitudes of the PoP towards health and healthcare, second, what seems the modern healthcare seeking behavior of the PoP, where do the PoP resort

to manage their illness and, finally, it underscores the implication of the fee waiver healthcare system on the health and HSB of the PoP in the study area.

Statement of the Problem

Poor health remains a leading problem among many countries' urban poor population (Malanyaon, 1995). The poor are extremely vulnerable in terms of their health needs and HSB. Evidences underscored the two way causal relationship between poverty and health: poverty breads ill health and ill health keeps poor people poor (World Bank, 1993, Wagstaff, 2001). Similarly, it is indicated that poverty will create ill health because it compels people to live in an environment that make them sick, without decent shelter, clean water or adequate sanitation. Poverty creates hunger, which in turn leaves people vulnerable to disease (WHO, World Bank & Voices of the poor, nd). As a matter of fact, as per the study conducted by Corno (2008), much of the African poor communities seeks medical care in traditional health sector or doesn't receive any health treatments. These all implies that poverty affects the HSB of the poor by deterring or delaying health care utilization or promotes use of less effective healthcare alternatives thereby adversely affecting the health status of the poor.

There have been several studies that were conducted on the issue of HSB in Ethiopia. To mention, Zewdie Birhanu et al. (2012) conducted a qualitative study concerning the HSB of women for cervical cancer in Ethiopia and pinpoint that the perceived benefits of modern treatment were very low. The finding indicated that women with cervical cancer were excluded from society and received poor emotional support and all these caused delays in seeking any health care. Traditional remedies were the most preferred treatment option for early stage of the disease. A more general study which was conducted by Anagaw Mebratie, et al (2013) on the healthcare seeking behavior in rural Ethiopia found out the existence of a strong preference for modern healthcare among study participants. In addition, the study also demonstrated variations across socioeconomic status by which the rich households two to three times more likely to seek modern care as compared to the poor households. This inequality also has an effect the choice of health care provider, and the timing of seeking care. Households in

the lowest consumption quintiles are generally more likely to resort to lower level care and postpone seeking care compared to better off households.

Fitsum Girma, Chali Jira & Belaineh Girma (2007) conducted a study on health services utilization and associated factors in Jimma zone and found that the utilization level was not satisfactory. Their finding revealed that sex, marital status, household income, socioeconomic status, presence of disabling health problem, presence of an illness episode, perceived transport cost, perceived treatment cost and distance to the nearest healthcare facility were found to be the major influential factors shaping healthcare utilization of the study participants. Similarly, Assesfa Amenu, Nash, Tefera Tamiru & Byass (2000) has also clearly articulated the patterns of HSB amongst leprosy patients in the former Shao province and found that 77% of the participants waited for longer than one year before going a leprosy clinic and during their first symptom, 68% of the cases went to traditional healer. An unpublished study by Suadiq Sufian Ali (2011) has also assessed the HSB of Dubti Wereda at community level and found out various determinant factors. CSA (2011) survey also show that only ten percent of women delivered in a health facility.

At this stage, it is straightforward to notice that the existing empirical researches resemble on the following issues. There were researches (Assesfa Amenu, Nash, Tefera Tamiru & Byass, 2000; Zewdie Birhanu et al, 2012) that focused on the HSB of people for a specific type of health concern as cancer and leprosy. Others (Fitsum Girma, Chali Jira & Belaineh Girma, 2007; Suadiq Sufian Ali, 2011) focused on the HSB and healthcare utilization of a specific geographic community. Some others also focused on the general healthcare seeking behavior of rural Ethiopia irrespective of their socioeconomic status (for example, Anagaw Mebratie et al, 2013) and still others (Karim et al., 2010) on maternal HSB for child illness.

Despite the existence of researches on HSB in our context, neither of them had an emphasis on urban poor populace though this section of the society is vulnerable to different kinds of health problems. There are also scant researches which underscored the factors that determine the HSB of the poorest urban dwellers. It is also important to note the absence of

empirical works which shows the rural-urban poor difference regarding their HSB. From the unstudied parts of the issue, this study was concerned with systematically articulating the HSB of the urban PoP living Addis Ababa which has not been addressed previously. Therefore, the study aimed at to find out the perception and attitudes of the PoP to their health and healthcare, when and where the PoP seek treatment since understanding the HSB could reduce delay to healthcare and inform lessons for evidence based practice to the attempts being done to better off the health status of the PoP. Simply put, this study could fill the limitation of the existing empirical works around the issue of HSB by enlightening the general HSB of the PoP residing in Gullele Sub City of Addis Ababa.

Objectives of the Study

General Objective of the study. The overall objective of the study was to investigate and understand the health Seeking Behavior (HSB) of the PoP (Poorest of the Poor) in Gullele Sub City, Addis Ababa.

Specific Objectives of the study. Up on the aforesaid general objective, the study had the following specifics:

Identify the treatment alternatives sought by the PoP to manage ill health;

Describe the perceptions of the PoP in the study area towards health and healthcare;

Determine the attitude of the PoP towards their health, healthcare providers and facilities

Describe the healthcare seeking behavior of the study participants in relation to various demographic and behavioral variables, and

Find out the relationship between the healthcare safety net program introduced by the FMoH and the HSB of the PoP in the study area.

Significance of the Study

Though the issue of HSB has a paramount role in health promotion and prevention, in Ethiopia, few studies (e. g. Assesfa Amenu, et al, 2000, Fitsum Girma, 2011; Suadiq Sufian Ali,

2011 & Zewdie Birhanu et al, 2012) have been conducted in addressing the issue and merely emphasized on the HSB of rural people, maternal and child health care, and on specific disease like HIV/AIDS, leprosy, and cervical cancer. None of them has an interest in articulating the HSB of the urban ultra-poor that is grappling with a multitude of health problems. Thus, it is the researcher's credence that this study can bridge the existing knowledge gap in the area by coming up with a new insight. The finding of this study could also contribute lessons to the better implementation of the existing fee waiver policy for the concerned bodies as Addis Ababa Health Bureau and Ministry of Health (MoH). Moreover, the PoP might be benefited from the findings of this study since the study could be used as inputs for policy reformulation which best serve the PoP.

This study is so vital in terms of clearly depicting the existing knowledge gaps in the area of HSB which calls for further research as; factors that shape the HSB of the PoP, the paradox between availability and healthcare utilization, and challenges and prospects of the existing fee waive scheme which is currently practicing. The study has also relevance for the Social Work education and practice in Ethiopia since it clearly highlights what expected and key intervention areas of Social Work to upgrade the conditions of the vulnerable, PoP.

This study had a meaningful significance for the researcher himself. As a novice researcher, it enables to advance his knowledge, skill and value spectrum in conducting Social Work research, and also let him to know more in the area of health social work in which the researcher has much pleased to conduct researches in the area by the future.

Definition of Concepts

Fee waiver. it is a right conferred to a household or individual that entitles the household/the individual to obtain health services in certain health facilities at no direct charge or at reduced price (FMoH, 2012).

Health seeking behavior. It is a state or decision making process of an individual or a household is actively seeking ways to alter his/her/their habits or environments to move toward a higher level of health and the decisions made encompass all available options.

Poorest of the Poor (PoP). Who is poor is difficult to define and the indicators that are used to measure are relative to contexts. But here in this research, the concept PoP, is used to represent those households/individuals identified as Poorest of the Poor through mechanisms put in place and eligible for fee waiver by FMoH (2012). The parameters are: individuals or households who earn less than minimum wage, households depending on petty trades and unable to meet their daily subsistence, orphaned children who have no financial support from relatives or no adequate pensions from parents, and those who are homeless. These people are termed as PoP, in the case of urban areas, and are eligible for healthcare services with fee waiver.

Urban poor. Are those urban dwellers experiencing a range of deprivations such as limited income to subsist themselves/their family, inadequate and insecure housing, high informal sector activities, few social protection mechanisms, less access to basic services, marginal geographic location, unhealthy and even violent environments (Muggah, 2012).

Perception. Perception is how you look, understood and apprehends the world around. In this study, perception is used in terms of how the PoP looks ailment, perceive causes of illness, perceived severity, perceived cue for treatment and perceived first line of action during illness episode.

Attitude. An attitude is a positive or negative evaluation or a judgment towards things, people, groups, and ideas (Bohner & Dickel, 2011)

Scope and Limitation of the Study

The study was conducted in Gullele Sub City of Addis Ababa. The issue of HSB is a broader concept by which all of the issues were not addressed by this research. The study was delimited to describing when, where and how do the PoP in the study area seek healthcare when they face health concerns. In addition, the study only incorporates those households who are beneficiary of the healthcare safety net program designed by FMoH. Moreover, the study highlighted the attitude and perception of the PoP to their health and healthcare and how these elements inform when and where to seek healthcare.

Research is not free from limitations. Though the researcher tried his best to minimize them, a number of issues are out of the reach of this study. Among the many limitations; this study focused on the HSB of the PoP in Gullele Sub City which doesn't show the reality in the other parts of the city, Addis Ababa. So, it is hardly possible to generalize the finding to the PoP of Addis Ababa since the reality might differ. In addition, the finding of this study can't represent the reality of the PoP in the rural setting which was out of the concern of this study.

The study illuminates the HSB of the ultra poor in Gullele Sub City of Addis Ababa. To address the issue, the researcher targeted those ultra poor which are already identified as PoP and are beneficiary of fee waiver for healthcare services. But, in the progress of the study, it was found that there was a problem in the process of identifying and making eligible the PoP for fee waive. There are some who were included in the scheme though they shouldn't and some others were not included, though they have to. As a result, to get a comprehensive and comparative understanding concerning the issue, it would have been fine if the perspective of those poor who are not included in the fee waiver scheme were included which is not the reality in this study.

The study has no ability to show the predicting factors that crucially shapes the HSB of the PoP in the study area. It can't show which variable to what extent predicts healthcare utilization that calls for a more sophisticated quantitative regression analysis. In addition, the researcher felt that the study was not holistic enough in gathering data from all healthcare options sought by the PoP especially the study didn't incorporate the perspectives of traditional healthcare providers and spiritual healers.

Review of Related Literatures

Introduction

This part tries to review the existing literatures related to the research question under scrutiny. It begins with conceptualizing HSB followed by discussing the interrelationship between poverty, health, and HSB. In addition, the existing empirical works on the different dimensions of HSB were reviewed. In this regard, how attitude and perception to health and healthcare shape on people's healthcare utilization, healthcare alternatives of the poor, and studies focused on the healthcare seeking behavior of the poor were reviewed. In this section, the researcher not merely attempts to review the existing knowledge, but also tried to include his reflection. At the end, policy issues in Ethiopian context and the conceptual framework of the study are included.

Conceptualizing HSB

HSB has been defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (Olenja, 2003, p.61). It represents a coherent picture of specific cultural features that affect people's health behavior. The explanatory model of a particular illness consists of signs and symptoms by which the illness is recognized; presumed cause of the illness and prognosis established. These are in turn interpreted by individuals and or significant others and on labeling the problem, proceed to address it appropriately through recommended therapies (Foster & Anderson, 1980 cited in Olenja, 2003). On the other hand, Tipping (2000) stated that healthcare seeking behavior is a decision making process for healthcare at the household level wherein the decisions made encompass all available options: public and private, modern and traditional. Tipping further notes that:

> Healthcare seeking behavior includes the decision not to take up available health services, wherein the use of home remedies or the decision to utilize no healthcare option at all may be exercised. Studies of HCSB incorporate, but are wider than, research on health services utilization. Utilization studies focus on the end point of the decision making process-the action ultimately taken-and often represent one type of healthcare provision (generally the public sector) and sector of the user population (usually those who can afford to access public health services). (p.6)

HSB is preceded by a decision making process that is further governed by individual and/or household behavior, community norms and expectations as well as provider related characteristics and behavior. The decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service (Tipping and Segall, 1995 as cited in Mackian, nd) and this makes the nature of care seeking not homogenous across different contexts (Olenja, 2003).

HSB studies acknowledge understanding human behavior is prerequisite to change behavior and improve health practices. Experts in health interventions and health policy became increasingly aware of human behavioral factors in quality health care provision. In order to respond to community perspectives and needs, health systems need to adapt their strategies, taking into account the findings from behavioral studies (Muela, Ribera & Nyamongo, 2003; p.3). HSB could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts. Consequently, as per Mackian (nd), health promotion programs, mostly, targeted on furnishing knowledge about causes of ill health and choices available, will go a long way towards promoting a change in individual

behavior, towards more beneficial health seeking behavior. However, on the other way round, it is indicated that individual should not be the exclusive target to promote good health rather health seeking behaviors have a more dynamic, collective, interactive element (p. 19).

Poverty, Health and HSB: Nexus

Literatures (Wagstaff, 2001; World Bank, 1993) indicate the two way causal relationship between poverty and health. Poverty breads ill health and ill health keeps poor people poor. The stark relationship between poverty and poor health could be explained as, in the least developed countries, life expectancy is just 49 years, and one in ten children do not reach their first birthday. In contrary, in high-income countries, the average life span is 77 years and the infant mortality rate is six per 1000 live births. Poverty creates ill-health because it forces people to live in environments that make them sick, without decent shelter, clean water or adequate sanitation. Poverty creates hunger, which in turn leaves people vulnerable to disease (WHO, World Bank & Voices of the poor, nd)

Direct and indirect treatment costs are among the most commonly mentioned obstacles to adequate HSB of the poor for obtaining prompt and adequate treatment, treatment compliance and access to preventive measures (Worrall, et al., 2003). Even if direct costs are affordable, or if medical services are free, indirect costs (for transport, special food, and 'under-the-counter 'fees) can limit access to treatment or lead patients to interrupt therapies (Abel-Smith & Rawal, 1992 cited in Muela, Ribera & Nyamongo, 2003).

A study conducted in ten Sub-Saharan African countries showed differences in anti-malarial treatments by socio-economic status (SES) (Wardlaw, 2003, cited by Worrall, et al., 2003), which favored the highest quartiles of SES groups. But even in a survey carried out in a rural poor society of South-eastern Tanzania, where SES seemed irrelevant, persons of the

relatively higher SES knew more danger signs and were more likely to bring their sick children to a health facility than those who were relatively poorer (Schellenberg et al., 2003 cited in Muela, Ribera and Nyamongo, 2003). It further indicates that treatment costs are not only an obstacle for adequate health-seeking of the poor; they also signify a higher burden for the poorer households compared to the more affluent. Even if the poor spend less or equal amounts on coping with illness, the percentage of the monthly or annual income is higher among the poor.

From literatures we can understand that, poverty hamper adequate treatment, and favor development of parasite resistance, illness recrudescence and prolongation, which ultimately increases direct, indirect and opportunity costs. Long duration or concentration of illness episodes in a household can lead to selling of all available assets and other coping strategies (as occasional work, child work, borrowing money, theft, sales of food stores and productive assets etc.), pushing the household into the vulnerability spiral. Illness can end up being extremely costly for the poor (Corbett, 1989 cited in Muela, Ribera and Nyamongo, 2003).

To sum up, as it is clearly underscored in various studies, the economic burden of illness can have a double impact on poor households. Firstly, it can have an impact on health if individuals see themselves forced to interrupt treatment since they lack finance, leading to increased vulnerability in terms of health. Secondly, when coping strategies lead to a process of impoverishment, a household is placed in a position of vulnerability in terms of material survival. In the worst case, both processes mutually reinforce each other, generating a spiral of double vulnerability and will create 'medical-poverty-trap'

Review of Empirical Works about HSB of the Poor

The focus of this part is reviewing the existing knowledge concerning the various treatment options that people use, especially the poor and how attitude and perception of

individuals is intermingled with HSB. It also incorporates the evidences of existing knowledge on whether there is a healthcare seeking behavior disparity across various predicting variables.

From literatures (e.g. Anagaw Mebratie et al, 2013; Gupta & Dasgupta, nd &World Bank, 1993), it is possible to understand that the poor, across the world, choose various types of healthcare alternatives. Like their counterpart, they do have a tendency to use self-care, professional allopathic, traditional healer, drug stores without prescriptions of physicals or if no option they would like to keep silent. Evidence (Gupta & Dasgupta, nd) conducted in urban Delhi revealed the preference for allopathic treatment across all socio-economic categories. But it found quite a different result concerning the healthcare seeking behavior of the poor. Firstly, government hospitals, which are meant for the use of less privileged households and are subsidized for that purpose, are mainly used by high and middle-income households. Twenty-six percent of high income and about 22 percent of middle income households used government hospitals as against 17 percent for low-income households. Secondly, the lower income households mainly use private clinics (80 percent), followed by middle and high-income households. Both of these results are completely opposite to what the government visualizes: the subsidized hospitals are being used more by those who can afford to pay, whereas the private sector is largely being used by those who are less able to afford its services.

In Ethiopia, though there is no empirical study on the HSB of the poor, yet, there are evidences that shows the preference of healthcare alternatives among the general population such as professional allopathic, traditional medicine (the use of herbs for addressing both physical and mental illness, the belief in the healing powers possessed by healers & holy water) and self care use are the major ones. The use of traditional medicine even reaches 90% (Africa Region Human Development, Ministry of Health Ethiopia &World Bank, 2004).

A more general study which was conducted by Anagaw Mebratie et al. (2013), on the healthcare seeking behavior in rural Ethiopia found out that there is a strong preference for modern healthcare. Education and religion of the households' heads, consumption and

geographical location are found to have an influence on the decision where to seek treatment. The study also demonstrated variations across socioeconomic status with households in the highest consumption quintile two to three times more likely to seek modern care as compared to households in the lowest quintiles. These socioeconomic inequalities are also found in the choice of health care provider, and the timing of seeking care. Households in the lowest consumption quintiles are generally more likely to resort to lower level care and postpone seeking care compared to better off households. it was also confirmed that households in the upper consumption quintile are three times more likely to seek care in a hospital compared to those in the poorest.

When we evaluate the existing empirical works, in Ethiopia, the studies (Anagaw Mebratie et al., Assesfa Amenu, et al, 2000, Fitsum Girma, 2011; Karim, 2010; Suadiq Sufian Ali, 2011 & Zewdie Birhanu et al., 2012) focused on the HSB of rural people, maternal healthcare seeking behavior for child illness, the HSB of a certain geographic community, etc. In addition, their interest was also merely on the individual's HSB towards a specific type of illness. The review of literatures noticed the scanty nature of empirical works on the health seeking behavior of the urban poor which invites for further research.

The perception, attitude, belief of illness and health has an important role in shaping the HSB of people. Health has often been perceived as a luxury good among the poor but not true in the case of rich (AAFEDB, 2010). People may possess imprecise and wrong perceptions about their health. Alam, Khanam & Hossain (nd) found that people are indifferent to their health needs, and in most cases, they defer or delay treatment by conscious choice when they are sick and need medical support. It is, therefore, important to understand how people perceive and view their health and health needs, and how and at what stage they decide to go to health providers for treatment or medical consultation and understanding the HSB could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies thereby to achieve the desired behavioral change. Perception of severity of illness was also found as a predictor for appropriate care but not prompt care (Sreeramareddy et al., 2006).

The existing literatures underscore a plethora of factors that determine the HSB of people. Illness type and severity, pre-existing lay beliefs about illness causation, the range and accessibility of therapeutic options available, and their perceived efficacy synergistically influence people from seeking health care (Helman 1995, Kleiman 1980 as cited in Syed Masud Ahmed, 2005). As study conducted in Timor-Leste by Anthony, Correia, Catherine, Ferreira and Pinto (2009) indicated that physical factors (long distance to health facilities discourage attendance), economic factors, socio-cultural factors, user-provider interaction, equipment and staffs of health facilities, medications, and referral are the underlining factors that either deter or initiate people to seek healthcare (p.29). The interplay of these factors are central in the final choice of a care seeking option as per their study.

Regarding the poor healthcare utilization, according to the study conducted by Montgomery (2009), the poor can be discouraged by the difficulties of finding affordable transport, inconvenient hours of operation at clinics or health centers, the frequent absence of key staff, and long waits to receive care. Education about causes, symptoms and treatments of illnesses as the key factor for success in behavioral change (Muela, Ribera &Nyamongo, 2003). A study conducted by Foster and Anderson (1980) noted that underutilization of modern health services is rarely due to the influence of local beliefs or an aversion of western medicine but rather depends on the cost and availability of those services. Whereas availability and physical access is important, it has become apparent that client perspectives on the quality of care and satisfaction on the service has also a role in shaping the HSB of the people (Olenja, 2003). Generally, as the existing empirical works indicates, it is important to note that health seeking behavior is a complex issue and no a single method may be used to explain or establish any pattern. Health seeking behavior is a reflection of different factors, which interact

synergistically to produce a pattern of care seeking but which remains fluid and therefore amenable to change.

Health Care Safety Net for Urban Poor in Ethiopia

The unprecedented pace of urbanization of the global population and its implications on health, security and development are raising concerns (Muggah, 2012, p.13). In the current running globe, the public health care delivery system becomes increasingly market-oriented and the urban poor find it difficult to access the health services and health safety net for the urban poor is increasingly threatened. The urban poor greatly increase their vulnerability to the changes in health care pattern and economic shocks that affect their revenue (Chap Sotharith, nd) and access of health care to urban poor has been a call in the world, especially in developing countries.

Weak infrastructure and limited distribution systems in low income countries complicate access to health services. Ethiopia is a poor country with weak health care systems and infrastructure. Due to various factors, as diversity of socio-economic environments, climates, and terrains among regions in Ethiopia, there exists uneven healthcare access (Chaya, 2007). WHO (2010) identified three major factors which limit universal coverage limited availability of health resources, over-reliance on direct payments at the time people need care, and (3) inefficient and inequitable use of resources. The limited availability of resources for health in Ethiopia is very clear. The total health spending in Ethiopia is very low and under financed though there are improvements. Cultural norms, distance to functioning health centers, and financial barriers were found to be the major causes for not seeking health services in health facilities (FMoH, 2010).

In the Ethiopian public health system, health facilities have been collecting revenue in the form of user fees for more than half a century. However, these fees have never been systematically revised and no longer reflect the cost of providing services, nor have the fees been adjusted based on the user's ability to pay for them. The health care financing strategy clearly stipulated that user fees needed to be revised to reflect the costs of delivering health care services, but also underscored that individuals should be charged according to their ability to pay. Cost sharing between the government and users was one of the principles of the health care financing strategy (FMOH, 2012).

The FMOH of Ethiopia developed a health care financing strategy in 1998 that was endorsed by the council of Ministers and became a very important policy document for introduction of health financing reforms. The healthcare financing policy incorporates a concept known to be fee waiver system which addressed the healthcare needs of the ultra poor (FMOH, FMoH, 2012).

A fee waiver is a right conferred to a household or individual that entitles the household/the individual to obtain health services in certain health facilities at no direct charge or at reduced price. One of the main purposes of the fee waiver system is to ensure equity in access to health services by increasing access of the poor to health services. Households/individuals identified as poor through mechanisms put in place for this purpose are eligible for fee waiver. They are who cannot afford to pay for health services and thus are provided waiver certificates from Woreda administration offices. These are persons who are identified as poor; street children and homeless citizens who can provide evidence from the bureau/office of labor and social affairs. The Bureau/Office of Labor and Social Affairs (OLSA) shall keep record of street and abandoned children who have no support. Displaced persons when they provide evidence from

Kebele administration, and disaster prevention and preparedness bureau; persons receiving 24 hours emergency care provided by health institutions, who cannot afford to pay for the service, and people with no third party accountable for them. These include: persons who are admitted to a health facility unconscious. Once the persons are out of the emergency care, they do not qualify for this; Persons who are receiving 24-hour emergency care are required to pay the payment for services rendered, if they are not holders of waiver certificate (FMOH, 2012).

Exemption system is the other health safety net in Ethiopia. Exempted health services refer to those services that are rendered free of charge to all irrespective of level of income by reason of them being of public health nature that widely affects the general public and improving the health seeking behavior of the society. The following are lists of currently exempted services: diagnosis, treatment and follow-up of TB; prenatal, delivery and postnatal services; family planning services; immunization of mothers and children against six child illnesses; HIV Voluntary Counseling and Testing (VCT); leprosy and fistula management; etc. (FMOH, 2012). Moreover, the recently proposed Community Based Health Insurance (CBHI) which is under pilot since 2011 is also the other policy document which could benefit the poor including the urban poor since it is also designed for the population engaged in informal sector and financed by contributions from members and subsidy from the government.

From the existing policies, it is straightforward to understand that, though there is no an independent policy which addresses the health needs of the urban poor in Ethiopia, there is a policy response which attempted to respond to the poor in general. But, given the magnitude of the problem among the urban poor, the healthcare safety net is inadequate and has a question of sustainability.

Conceptual Framework: Socio-Behavioral Model (SBM)

The SBM which is developed by Andersen (1995), identifies three categories of factors (predisposing, enabling and need factors) which influence HSB are grouped into logical sequence (Syed Masud Ahmed, 2005, p. 16). The model was specifically developed to investigate the use of biomedical health services. Later versions have extended the model to include other health care sectors, i.e. traditional medicine and domestic treatments (Muela, Ribera & Nyamongo, 2003).

Anderson (1995) explained the factor that shape HSB as follows. Predisposing factors include age, gender and religion. Availability of services, financial resources to purchase services, health insurance, and social network support are labeled as enabling factors, and under the need factors; the perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work or school, help from outside for caring .

The model centers specifically on treatment selection. It includes both material and structural factors which are barely taken into account by other models such as Health Belief Model. There have been a modification of the model and other factors were added to the Anderson's (1995) model: heath service system factors (policy, resources, and organizations); consumer satisfaction; health status outcomes as influenced by external environment (physical, political, economic) and personal health practices (diet, exercise, self-care, etc.). Finally, an emerging variant of the model emphasis the dynamic and recursive nature of health service use and portrays the multiple influence on health service use and subsequently, on health status (Muela, Ribera & Nyamongo, 2003)

Unlike others models which center around the individual characteristics, Anderson (1995) SBM seem quite holistic since it considers all the factors that were not been by others.

This study investigated the patterns of the HSB of the PoP in Gullele Sub City of Addis Ababa, under the broader umbrella of Anderson's model with some modifications. Obviously, the model postulated that HSB to be determined by a set of predisposing factors (age, gender and ethnicity), enabling factors (income & household poverty status and ability for out-of-pocket expenditure for healthcare) and health system factors (prevailing healthcare services available in the study community in the popular/folk, private and public sectors). These factors, directly or indirectly, influence perceived illness/need which converts individual's subjective perception of his/her state of health and the need for care into wish or demand for medical care and taking steps to get treatment (Andersen, 1995). This leads to have a specific HSB for the poor. Some policies, the fee waiver scheme, do have also an influence on the HSB of the ultra poor.

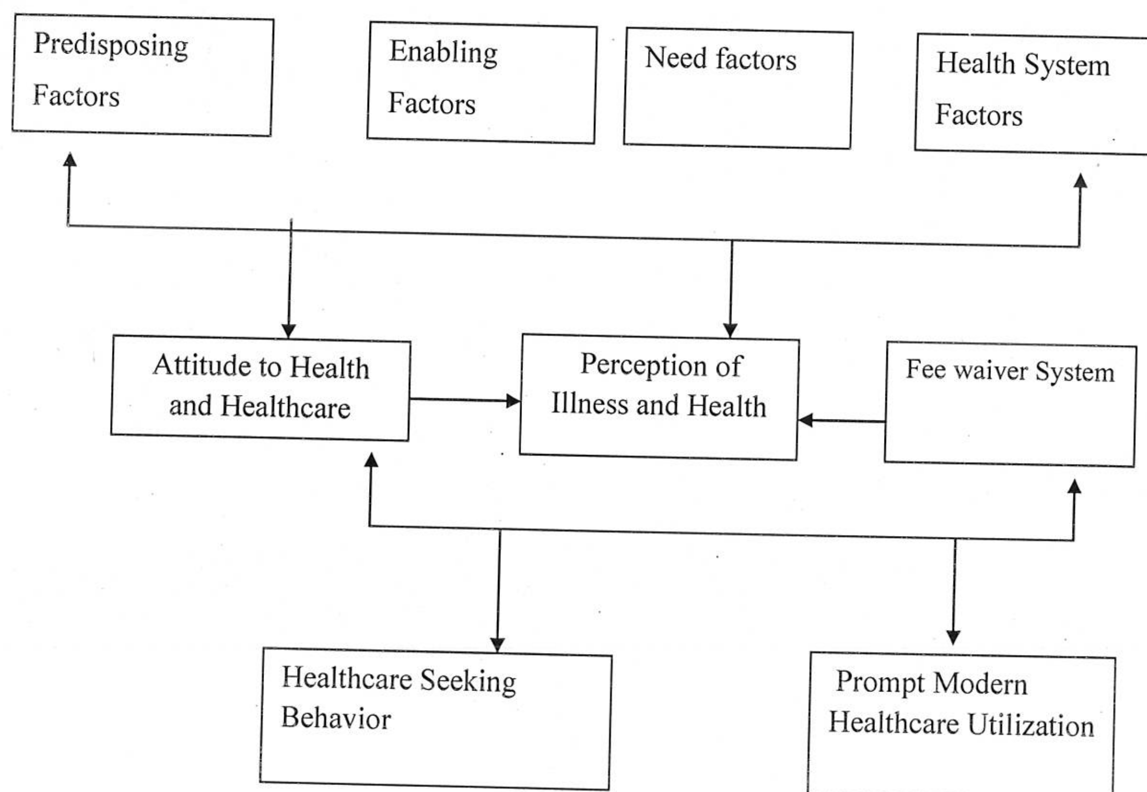

Figure 1: Conceptual Framework to understand HSB (Adopted from Anderson, 1995)

Research Method

Study Design

Certain types of social research problems call for specific approaches (Creswell, 2007). The study has followed a non-experimental study design. More specifically, the researcher found more imperative of using mixed approach because it could mitigate the disadvantage of the one by the other. A survey design provides a quantitative or numeric description of a population by studying a sample of that population. The quantitative one is important to know and minimize the error that the researcher commits and qualitative one is to have a rich data (Creswell, 2007). Therefore, through the quantitative approach, it was able to understand the perspective of the PoP towards their health and health care, the healthcare alternatives used and differences in prompt healthcare by demographic and behavioral variables and comparison in health decision of the PoP before and after their inclusion in the fee waiver system. On the other hand, the qualitative aspect was helpful to grasp thoughtful or in-depth insights concerning the HSB of PoP that supplemented the quantitative part of the study.

In terms of purpose, the study was descriptive by which an attempt made to came up with the clear picture of the issues under investigation. Considering the time dimension, cross-sectional study design was used through which an examination of the HSB of the PoP in the study area at the cross section of it at one time was made (Rubin & Babbie, 2011, p.148). Therefore, the researcher collected the data at a specified time (from February 11 to March 13, 2013) and analyzed to come up with a clear understanding of the HSB of the target population.

Study Population, Sample Size and Sampling Technique

Study population. Defining the study subjects is very important in conducting research (Creswell, 2007). The city of Addis Ababa has ten Sub Cities (administrative units of the city Addis Ababa) and the extent of poverty is quite relative across the Sub Cities, though it prevails in all. Of these, the study was conducted in Gullele sub city due to various reasons. From the exploratory interview that was made, it is in Gullele sub city by which more PoP exist. Relatively speaking, it is this Sub City which is used as a residential area for people having lower

socioeconomic status. In addition, there are also more NGOs working to address the health needs, sanitation and hygiene, of the poor in this Sub City (Personal communication, November 2012). Moreover, from the day to day exposure of the researcher, the researcher was initiated to entertain the issue in the Sub City. Above all, the researcher selected one Sub City for the purpose of manageability.

Gullele Sub City is one of the Sub Cities, located from northeast to north-west of Addis Ababa and is the fifth most populous Sub City having the total population of 267,381 with 129,239 male and 138,142 female (CSA, 2007). The Sub City is further divided in to ten *Wereda* (*an administrative structure which is lower than Sub City*) and each Wereda has its own health center except one of the Wereda's health center not yet functional.

As per FMoH (2012), households/individuals identified as PoP through mechanisms put in place are eligible for fee waiver (p. 26). It further explains that every Wereda/district has the responsibility to identify those people who are termed as POP by the parameters determined by the MoH and should have a bilateral agreement with the health centers found in each Woreda. It also underscore that if there is no any health center in that specific Wereda, the Wereda should have an agreement with the nearby health center found in another Wereda and hence those POP who are eligible will get the service in health centers which are not located in their Wereda in case there is no facility in theirs. Accordingly, the target population of this particular study was those heads of the household who are identified as POP and get medical service within the scheme of the fee waiver in Gullele Sub City in the year 2012/2013, excluding those PoP ineligible by revision.

Sample size. According to Cohen, Manion and Morrison (2007, p.107), "how big a sample must I obtain?" is how accurate do I want my results to be?" For them, sample size depends on the purpose of the study and the nature of the population under scrutiny. Calculating

and justifying sample size for a study can be an intimidating task for novice researchers. Nonetheless, it is one of the most important aspects of any study (Ali, 2012). An undersized study may result in a waste of resources due to their incapability to yield useful results. Therefore, sample size calculation is an important part of the study design to ensure validity, accuracy, reliability and scientific and ethical integrity of the study.

Harris (1985) stated that to see relationship and difference for a study involving six or more predictors, an absolute number of ten subjects per predictor is recommended and the equation to calculate the sample size is given by $n > 104 + m$ where n is the required sample size and m is the number of predictors. Accordingly, there were 16 predictors which were used for analysis in this study. Substituting the number of predictors in the above equation, the minimum sample size would be 120 and it was 168 PoP households that were included in the study which is more than ten participants per predictor. In addition, it is believed that the data which was collected from 168 survey participants is valid enough, accurate and enabled to see the difference and relationship of the predictors with the dependent variables since the study population is homogeneous, relatively speaking. By homogeneous, the study population is the PoP by the parameters of the MoH, living in low socioeconomic status. Most of them had large family size; their educational status was low, living in a deteriorated condition, and above all, they are homogeneous since they all are eligible for free healthcare. This was supported by Yount (2006) who stated the greater the variability in the population; the larger the sample needs to be.

Sampling technique. After determining the sample size by the procedure explained in the previous paragraph, the required samples were recruited by multistage cluster sampling. The reason of using multistage cluster sampling was the failure to get compiled sampling frame of the Sub City's PoP households and since multistage sampling is the right option to address large geographical area which is clustered. Of the total ten Weredas which are found at Gullele Sub

City, Wereda 03 and Wereda 06 were selected randomly. The Weredas were further divided in to either *Kebele* (*the lowest administrative structure of Addis Ababa previously*) or *zone* (*an administrative structure below Wereda*).

From Wereda 03, three Kebeles (08, 09 & 19) were selected since the list of the PoP exists by the previous governmental structure, Kebele. Similarly, as Wereda 06 was structured by Zones and the list prevailed in terms of Zone; three Zones (Zone 01, 02 & 05) were included. There are 1296 and 629 PoP in Wereda 03 and 06 respectively. After selecting totally six clusters (Kebele 08, 09 & 19 from Wereda 03 and Zone 01, 02 & 05 from Wereda 06), simple random sampling was conducted proportion to the size of each cluster (14% from each cluster was taken to reach the sample of 168). Accordingly, of the total 158 PoP (n=23), 290 PoP (n=41), 208 PoP (n=30), 301 PoP (n=43), 94 PoP (n=15), and 108 PoP (n=16) households which were found at Kebele 08, 09, 19 , Zone 01, 02 & 05 respectively, a sample of n which is within the parenthesis was taken from each cluster randomly. Hence, of the total 168 PoP included in the sample, 94 were from Wereda 03 and 74 were from Wereda 06.

On the other hand, for the qualitative part, purposive sampling technique was employed to select participants for in-depth interview (8 PoPs in the two Weredas) and key informants (6 informants). The key informants were health extension workers, officials and staffs of Addis Hiwot and Shiromeda health center (health centers found in Wereda 06 & Wereda 03 respectively). The number of participants was determined by the concept of data saturation. The selection of participants continued till data reaches at the optimum level. However, it was at the early stage that the data seems saturated and at that juncture I continued interviewing with the hope of obtaining a different idea.

Data Collection Methods, Development and Procedure

In this study, questionnaire and interview were used to elicit data from participants. Questionnaire was employed to collect evidences from the heads of the PoP households that are

included in the sample and a wide range of quantitative data regarding the PoPs' healthcare alternatives, view to their health and healthcare, and data which enabled to see whether there is significance difference in some health behavior/decision of the PoP after their inclusion in the fee waiver scheme were gathered. Closed ended questions having mutually exhaustive and exclusive categories that could measure the indicators of the HSB thereby gather information necessary to answer the research objectives were established. Likert Scale questions were constructed to measure the attitude of PoP to health, healthcare providers and public healthcare facilities, and religiosity of the PoP. By Likert Scale, brief statements were presented and the respondents were asked to what extent they agree or disagree with it (Rubbin & Babbie, 2011) and the concept would be measured by the composite of items.

In preparing the Likert scale question which measured attitude to health (6 items), healthcare providers (7 items) and public healthcare facilities (7 items), it was made equal positive and negative questions to know whether the participant duly responded to each questions or not (Vries-Schot, Pieper & Van Uden, 2011). The scale has five categories (strongly agree, agree, not sure, disagree and strongly disagree) and given a value 1 to 5 based on the nature of the questions. A scale, consisting of ten items, was used to measure religiosity of the PoP which was adopted from Vries-Schot, Pieper & Van Uden, 2011). The development of the questionnaire was not an easy task and was prepared after an exhaustive reading of the existing literatures both locally and abroad. In constructing the questions, technical or jargon terms, leading questions, double-barreled questions, derogatory terms and vague questions were avoided (Rubbin & Babbie, 2011, p.218).

In-depth interview was used to elicit more detailed data from research participants. In-depth interview is an ideal method to obtain detailed information on particular cultural beliefs and practices from the perspectives of the participant. It is through repeated face to face encounters between the researcher and the participant directed towards understanding perspectives on their lives, experiences, or situations as expressed in their own words (Kikwawila Study Group, 1994, p.10). In-depth interview was made with 8 PoP who are eligible

for fee waiver system and an in-depth and supportive understanding was generated concerning the attitude and perception of the PoP to health and healthcare, healthcare options and care seeking behavior, and the meaning that the fee waiver scheme had on the health and healthcare utilization behavior of the PoP.

Key informants interview was also the tool used to get qualitative data. According to Kikwawila Study Group (1994), the purpose of key informant's interview is to learn about people's view on the topic of interest, to learn their terminology, and judgments and to understand their perceptions and experiences. It is a kind of expert on some cultural, political or health aspects of the community beyond his or her own personal beliefs and behaviors. Hence, key informant interview was conducted with health extension workers (one from each Wereda), and officials and staffs of the health centers found in the study area, Addis Hiwot and Shiro Meda health centers (two from each health center). Through key informants interview, detailed data on when and where do the PoP seek healthcare, how the PoP perceive their health and the implication of the fee waive scheme on their HSB was gathered. So as to substantiate the primary date, empirical works, books and policy documents were consulted.

The English version of the questionnaire and the interview was translated to Amharic twice by two different individuals so as to validate its correct translation and piloted for fifteen respondents within the study population before actual data collection. Through the help of two individuals who knows much about the Weredas, the selected sample households were contacted. During the pretest, it was understood that most of the survey participants can't read and write and to enhance the quality of the data, the questionnaire was filled by the researcher. But, in the progress, eight households' heads were indifferent to be interviewed and were given the chance to fill the questionnaire by themselves. In relation to the interviews, two different interview guides for key informants and for the PoP were prepared in line with the objectives of the study. The PoP participated for in-depth interview were recruited with the help of Urban Health Extension Workers and some were selected while I was collecting the quantitative data. During

the interview process, a maximum of fifty minutes interview, tape recorder was employed after willingness obtained from the study participants and made the data collection simple.

With regard to offering incentives, although participation in research is technically voluntary, it is also the case that research participants should be compensated for their time and effort. Such compensation should vary depending on time, task complexity, and risk (Vanderstoep & Johnston, 2009, p.14). On the other end of the continuum, incentives are not always needed. Vanderstoep & Johnston summarized the condition as follows:

> There are situations where the researcher (s) is/are not going to pay incentives for participants. Whenever the community understudy is small and the researchers are known by the community, it would be easy to recruit participants who are going to be interviewed for free. In addition, when the researchers did not have sufficient funds to pay participants, the researchers shall recruit interviewees without offering any financial incentives. In such situations, researchers should make it clear to the participants that no incentive will be offered or granted. (p.15)

Hence, due to financial constraints the researcher didn't pay incentives for survey participants. But the individuals who facilitated to contact the participants were paid. In addition, compensation was paid for those PoP who participated in the in-depth interview for the time they wasted for an interview

Variables and Measurement

A multitude factors were considered in this study which could put an influence on HSB of the PoP. The factors which could have an association with HSB are attitudes towards healthcare and service providers, perception (perceived benefit, perceived severity, etc), religiosity, and other demographical variables (sex, age, income, etc) do have their own contribution in the type of healthcare alternative being used and to seek prompt healthcare. The variables and their measurement are described as follows.

Table A. Summary of the Variables, Indicators and Measurement

Variable	Indicators	Level of Measurement
Age of the head	Individual's age in years	Scale
Sex of the head	Individual's sex status	Nominal
Marital status	It is respondents nature of marital status	Nominal
Religion	The type of religious affiliation of respondents	Nominal
Education	Individual's level of formal education	Ordinal
Income	Average monthly income of individuals	Scale
Place of origin	Where do the origin of respondents belongs	Nominal
Religiosity	Individual's church attendance, religious commitments, abide with the dogma, ritual participation, etc	Scale
Household size	Members of the household who are living within the same roof	Scale
Attitude towards health and healthcare	The stand of respondents towards healthcare and healthcare providers that could be measured on Likert scale	Scale
Perception of severity	One's belief of how serious a condition and its consequences are; Specify and describe consequences of the risk and the condition	Nominal
Time of seeking treatment	By when respondents seek treatment after their first sign of symptoms	Ordinal
Interaction	Whether healthcare providers are friendly and empathic	Nominal
Type of illness	Whether the type of illness is acute or chronic	Nominal
Perceived causes of illness	The respondents perception and belief in understanding and interpreting the cause of illness	Nominal
Perceived benefits	The respondents perception on significance visiting healthcare institutions and professionals	Nominal

Data Quality Assurance

Reliability is concerned whether or not research findings would be repeated if another study conducted using the procedure or instrument (Ritchie & Lewis, 2003, p. 271). The instrument was piloted with 15 PoP and the reliability was checked through Cronbach Alpha procedure since it is important to estimate the internal consistency/reliability. The reliability coefficient r is expressed as a number ranging between 0 and 1.00, with r = 0 indicating no reliability, r = 1.00 indicating perfect reliability, r=0.90 and up indicating excellent reliability, r=0.80 - 0.89 good reliability, r=0.7-0.79 adequate reliability, and below 0.7 may have limited applicability (Robert, 1997). Accordingly, the reliability coefficient r for the scale that measured attitude towards healthcare providers, health and public healthcare facilities was r=0.705, r=0.812, and r= 0.848 respectively which all are greater than 0.7. For religiosity, the Cronbach alpha was 0.724 while to the items which measured health perception was 0. 667.

The validity of findings or data is traditionally understood as the correctness or precision of a research findings (Ritchie & Lewis, 2003, p, 275). In relation to the validity of the quantitative data, the instrument, content wise, was checked with the advisor. Each items of the questionnaire were commented by the advisor and some items were discarded since the items were either repeated or unrelated with what was intended to measure. In addition, the pilot study has also contributed to improve the quality of the questions, formats, scales and the language used thereby enhanced the validity of the data Robert (1997).

The quality of the qualitative data was assured by different mechanisms. Among others, building good rapport, clarifying the objective of the research to respondents, approaching friendly and getting trust, respecting the cultural values of the participants and staying long with interviewees were some of the procedures done to improve the trustworthiness of the data. Moreover, colleagues-check i.e. presenting the data to the colleague and understand what it mean Triangulating the data collected through different method of data collection were also utilized to confirm the trustworthiness of the data.

Method of Data Analysis

Obviously, the raw data has no meaning by itself unless it is arranged and analyzed properly. First, the quantitative data were cleaned, coded and entered into SPSS for windows version 20 and analyzed. Descriptive statistics was employed to summarize the sample characteristics. Keeping in mind the assumptions of each test, statistical tests as t-test, ANOVA, Pearson's Correlation Coefficient, Spearman Correlation and Chi-square were used to see differences and associations. For example, independent samples t test was used so as to see whether there is a statistically significance difference in the attitudes of males and females to their health and rural and urban origin. One way ANOVA was used to see the existence of a statistically significant difference in attitude to health across the categories of education. In addition, Pearson's and Spearmen's coefficient of correlation was used to see the relationship or association among variables in higher level of measurement while the equivalent non parametric test, Chi Square test, was used for lower level of measurement. Using these statistical tools, association among variables or differences among groups were seen.

Analyzing qualitative data is not a simple or quick task. Done properly; it is systematic and rigorous, and therefore labor-intensive and time-consuming (Pope, Ziebland & Mays, 2000). The analysis of the qualitative part has passed with a serious of tasks. After the collection of the data, the researcher transcribed the tape recorded data and immersed with raw data by listening tape records. Reading the transcripts and studying the notes, all of the key issues, concepts, and themes were identified and the raw data was rearranged according to the appropriate part of the thematic framework to which they relate. Subsequently, based on the similarity of the themes, it was integrated with the quantitative one.

Inclusion Criteria

In a research project, it is pertinent to set exclusion and inclusion criteria. During the survey, participants were expected to be the heads of the household. This was due to the fact that the heads are thought to have ample information concerning the members of the household. The

participants were those who are beneficiary by the scheme in the year 2012/2013 and, therefore, those who are not eligible for the specified year were excluded.

In the case of interview, the PoPs fulfilled the inclusion criteria set for survey participants and the Health Extension Workers who were interviewed were those who worked for more than two years in the area to get in-depth insight about the issue. Moreover, the staffs of the health centers included as a key informant were those who are working in the card section and officials of the health centers since they work in touch with the PoP and the policy.

Ethical Considerations

In the progress of research, researchers need to respect the participants and the sites for research (Creswell, 2007). Since the inception, there were situation considered assuming that it might put participants at risk during different stages of my research. Initially, after the approval of the proposal, a support letter was received from the school of Social Work which indicates who am I and what I was doing. The purpose of the research was clearly communicated to participants and let them know to withdraw if they get discomfort in the progress of their participation. In doing so, after giving the necessary information that enables the respondents to participate or withdraw, informed consent was obtained from them and at least oral agreement reached. In addition, I contacted individuals in authority in the research settings and created a smooth relationship before I begun the actual data collection. These created trust by approaching respondents friendly and doing all these, I achieved a maximum response rate.

During report writing, the researcher refrained from using a language that might disappoint the participants of the study and avoided his personal bias. Confidentiality and anonymity was ensured and hence it was impossible to know who said what without their consent. By and large, the interest of participants was given due place in the process and nothing was made that hurts the participants physically, socially, psychologically. Their dignity and privacy was highly maintained. The relationship between the researcher and the participants was based on mutual trust and they were not exploited and all the ethical concerns were respected duly throughout the process of the study.

Findings

Introduction

This part of the thesis presents the finding of the study obtained both from the quantitative and qualitative data collection methods and summarized within six sub-sections considering the objectives of the study. The first subsection is all about the socioeconomic and demographic characteristics of the participants followed by the healthcare alternatives that were used by the PoP. Third, the perception of the PoP towards health and healthcare was presented in a clear manner. The foci of the forth subsection is about the attitude of the PoP to their health, healthcare providers and public healthcare institutions. The fifth underscored the healthcare seeking behavior of the PoP and it relates healthcare seeking behavior with various socioeconomic and demographic characteristics of the research participants and behavioral variables. Lastly, it thoroughly presents the nexus between fee waiver system, and the health and HSB of the PoP. The researcher presented both the qualitative and the quantitative data under each subsections and didn't merely put the data but also interpreted meaningfully, what the data really meant. Hence, readers need to be clear that the result of the study, both the quantitative and qualitative, is presented concurrently. Generally, it is in this part, the basic research objectives are answered and discussed meaningfully in the subsequent part of the thesis in line with the existing empirical works.

Socioeconomic and Demographic Characteristics of the Research Participants

This subsection is interested in presenting the socioeconomic and demographic characteristics of the study participants as age, sex, educational status, major source of income, average monthly income, ethnicity, whether there is budgeting for healthcare in the household or not, etc. As it is clearly presented in the method section of the study, the study has followed a mixed approach. Accordingly, 168 PoP were surveyed, 8 PoP were interviewed and 6 key informants were interviewed from two Woredas, 03 and 06, of Gullele sub city. Table 1 and table 2 which are attached as an appendix clearly presented the quantitative and qualitative participants' socioeconomic and demographic background.

To begin, as depicted in table 1 attached in the appendix, of the total 168 surveyed households, 55.4% (93) of them were female headed and 44.6% (75) were male headed. In terms of age, the age of study participants falls between 19 and 83. The majority 67.2% (113) were within the age range of 40-70 and it is only 2 and 6 participants were within the age category of less than 25 and 70-85 respectively. The SPSS output indicates, of the total survey participants, 37. 5% (63), 32.1% (54) and 20.8% (35) were married, widowed and divorced respectively. The remaining 6.5% (11) were never married and 3% (5) were separated.

With respect to the religious affiliation of participants, 74.4% of the PoP were the followers of Orthodox Christianity. 22% were Muslim, 3% were Protestant and a single participant was Catholic. It is either the father (39.3%) or mother (48.2%) were the heads of the household. Some 12.5% of PoP households were led by grand parents, children, brother and aunt. In relation to the size of the household, it ranges from one to thirteen but the majority of the households have more than five members. The ethnic distribution of participants clearly depicts that the majority belongs to Amhara (35.1%) and Oromo (27.4). Whereas Tigre and Gamo represent 16.1% each, Siltie were 1.8 % and only a single individual was from Welayita ethnic group. In relation to the place of origin of the study participants, the majority, 76.8% of them were from rural while the remaining 23.2% had an urban origin. This, ultimately, informs the PoP in the study area are not from, they came to the city, Addis Ababa, either by migration or other sociopolitical scenarios.

As the SPSS output in Table 1 at the appendix indicates, the major source of income of the study participants were petty trade (15.5 %), daily labor (26.2%), pension (18.5%), employed somewhere (16.1%), relative support (8.3%), waiving (11.9%), renting property (1.2%), begging (1.2%) and 0.6% each earn from farming and other. From this, it is straight forward to understand that the study participants didn't engaged in a type of employment which worth much. Due to this effect, 76.8% (129) of the participants earn less than 500 Ethiopian Birr (ETB) per a month. The average monthly income of the study participants ranges from 100 to

1300 ETB with a mean of 431.5 ETB and Standard deviation of 155.9 is greater than the eligibility criteria considered to be said as a PoP in the study area. Parallel to this, neither of the participants had the experience to budget healthcare costs from what they earn.

Table 2 [in the appendix] tells more about the characteristics of the interviewed participants of the study. There were totally 14 individuals who participated for an in-depth interview (eight) and key informants (six) interview. More specifically, ten of the participants were female, of which five for each, i.e. as key informant and in-depth interview participant and the remaining four were male. The participants' age ranges from 27 to 83. Regarding their educational qualification, as presented in Table 2, the majority (five) of the PoP participated in the in-depth interview were illiterates while three of them can read and write. Three, two, and a single key informant were nurse, health officer and 12 completed respectively.

Alternatives of Healthcare of the PoP

The poor sought different healthcare options whenever they get health breaches and all of the surveyed and interviewed participants had the experience of visiting any type of healthcare. Consequently, all of the survey participants reported they had visited professional allopathic, 50% of them spiritual healing, 44.6% used self-medication, 14.3% visited traditional healers, and 1.8% bought medicines from pharmacy. From the data it is easy to grasp, though all the PoP had gone to modern healthcare facilities, the PoP had significantly used other healthcare alternatives concomitantly, alone or one after the other. It is possible to check table 3 in the appendix concerning the treatment options used by survey participants.

Correspondingly, the qualitative data showed that participants have a tendency of using different kinds of healthcare options, such as self care, professional allopathic, traditional healthcare and spiritual healing either concomitantly or alone. But most (five) of the interviewee

and all of the key informants conveyed that there is a tendency of utilizing home treatment and spiritual healing, holy water treatment, as a prime option. Similarly, an informant from Wereda 06 stated that seeking healthcare at professional allopathic is the last option by the PoP in the Wereda. She said:

> As the Wereda is the outskirt of the city, it is people having lower socioeconomic status are living in the area. Compared to people living in the heart of the city, the PoPs' attitude to their health is insignificant. Thus, the health concerns of the PoP are treated at home or waited expecting recovery as days in and out or seek holy water treatment if not recovered. If not yet recovered, at the end, they will seek from modern healthcare institution and hence to sought healthcare from professional allopathic is the last option of the PoP in the Wereda.

From the qualitative finding, it is evident that though the PoP are eligible for free healthcare services, they are not such motivated to look for healing from medical professionals that could be explained through diverse factors. Two beneficiaries reported that they used holly water concomitantly with the prescription of the medical professional and felt are suited. One participant said "physicians even do everything with the help of almighty, so no problem to take them parallel." On the other hand, there are also participants who said the treatment option depends on the type of illness. There are illness which could best resolved by professional allopathic as diarrheal disease, malaria, typhoid, etc. However, some chronic illnesses as cancer, hypertension and diabetic cases would be treated by traditional and spiritual healing. Unlike others, a single participant whose sero-status is HIV positive has a strong trust on professional allopathic. She explained the issue as:

> Nothing would escape from science, all health problems can be cured by physicians and nothing beyond them. For example, you can take my friends who thrown their Anti Retro-Viral Treatment (ART) and seek holy water treatment but they didn't recovered rather their immunity was compromised and some died. There are a lot of people who didn't get this chance, so we have to utilize the fruits of science.

With respect to the decision making power in the process of selecting the treatment options sought, the majority participants responded that it is the mother (43.5%) and father (31.5%) who has the power to decide on the treatment alternative to use. While 16.1% of the participants said all member of the household have equal voice in the process, the remaining 5.4%, 2.4%, and 1.2% of the participants revealed brother/sister/child, the household member who gets ill, and aunt respectively. From the data, it is straightforward that still heads of the household have the lions share in deciding crucial issues of the household, health issues in this case, without accommodating the voice of other members of the household. The detail data is presented in Table 4 of the appendix part.

The research participants were asked concerning the frequency of visiting modern healthcare institutions. 65.5% of them seek healthcare at health centers or hospitals once and more in six months, 27.4 % once in a year, 6.5 % once in the past five years, and a single participant had never visited in the past five years. Unlike the survey participants, the PoP who were interviewed, especially those who are diabetic and have hypertension case, regularly visit professional allopathic for medical follow up, even more than ten per a year. Literally, it could be possible to say that the PoP in the study area are vulnerable to health problems since the majority of the PoP had the experience of seeking healthcare in professional allopathic for once or more per a year.

Perception towards Health and Healthcare of the PoP

Health defined. People have different perception towards health and healthcare, and this will have direct impact on their health and HSB. As depicted in table 5 of the appendix, the definition or understanding of the survey participants to what health mean is different, nine diverse responses. For the majority, 31.1% and 36.8%, health mean the absence of disease or physical disconformities, and able to move and work respectively. For 15% mind remain fresh, 8.7% able to eat what one have, 2.7% having few children, 2.4% remaining clean, 1.8% looking good, 1.2% children play, and a single respondent said able to lead a peaceful life. From the data it is simple to notice that health is understood by the PoP in terms of the physical wellbeing.

An in depth understanding was generated from interview participants concerning the definition of health. A variety of definitions were forwarded by participants. Hence, health is to mean keeping oneself safe from everything that hurts your physique; a base for every spheres of human life, visiting healthcare before it gets severe, and others defined knowing one's status for every kind of health breaches and still a respondent defined it as a condition which is more than anything else. But, alike the quantitative finding, most of in depth interview participants understood health as the ability to move and work that could allow an individual to subsist oneself and one's family. For example, a PoP from Wereda 03 perceived health as follows:

> Simply put, health is a big wealth since without health nothing can be done. One can stand, move, work, help him/her and others, etc if and only if he/she is healthy enough. You may have much money but without health the money you have is nonsense. So, for me, health is a precious asset that everybody wishes and is an engine of human life.

Perceived causes of illness by the PoP. The perception of the participants concerning the cause of illness accommodates a multiple response. Accordingly, from the survey

participants, as indicated in Table 6 of the appendix, 66.2% perceived that biogenic factors (heredity, infections, and environmental factors) as a cause and socioeconomic factors like alcoholism, being poor, and problems in the family accounts 28% of the responses. According to the participants, there are also some diseases which are caused by cultural and religious cause (3.6%) and 1.8% said they don't really know what causes illness. Similarly, the interview result generated diverse perceived factors of illness. Majority of them reported biogenic and social-economic factors as a cause of illness by highlighting hygiene problems as a prime biogenic factor. Poverty as a cause for ill health was raised by one interviewee. Participants also raised various social factors from their experience. A woman who had a hypertension case attributed her illness to the absence of peace in her family. She stated that:

> I do have a daughter living with mental illness who has been following medication at Amanuel specialized Mental Health Hospital though she is not witnessing progress. I always worry about her health and get angry since she nags with neighbor, by passer and her siblings. It is only with me that she has good relation and these all resulted in problem in my health and gets the hypertension.

A 78 years old participant also stated disagreement within family is the cause for falling him in hypertension. He said "after the death of my former wife, our children equally taken away all of the assets that I had and this upsets me which predisposes me for hypertensions.'' Another participant explained the cause of ill health by attaching it with her previous lived experience in terms of abuse and street life. She explained as:

> From my experience, some irresponsible individuals are the causes for the health problems of many of us. They deceived and brought us to Addis Ababa. After abusing us for a long, they will throw away to street life or look for to be employed as a housemaid-

which is another abuse. Such life, street which is risky and abuse as a housemaid can predispose individuals to different kinds of health concerns. Hence, irresponsible citizens who are bringing innocent youths like me to Addis Ababa through deception could lead to different kinds of health risks.

The case indicated above enlighten misinforming people from the countryside about urban way of life, abuse of housemaid, street life and associated risks of it could be mentioned as the a factor for exposing the PoP to ill health.

Perceived cues and types of health concerns of treatment. Participants were asked concerning the cue to seek medical help and 91.7 % (154) of them responded, it is due to physical signs as coughing, itching, loss of weight, headache, and various discomforts in their body that instigates them to seek healthcare. 5.4 % (9) seek medical help since they were advised by another person, and the remaining 3% (5) were because of their failure to discharge their usual responsibilities and routine health check. Consistent to the quantitative finding, almost all of the qualitative participants indicated that physical signs are the major cues that instigate them to seek healthcare treatment at different settings. The data illuminates that the different health promotion activities in mass media, printing and broadcasting media, do not address the poor. Moreover, it is also clear that it is physical signs that mostly instigates the PoP to modern healthcare.

Participants seek treatment for different types of health concerns. Half of the survey participants conveyed that they seek treatment for acute type of illness, 2.4% seek for chronic illness and 47.6% seek for all type of illness. Unlike the survey participants, most of the interviewed participants (5) stated that they sought treatment for chronic type of illness as diabetes and hypertension. The other sought for acute type of illness. From this we can

understand that chronic illnesses which are usually associated with the upper class society, are not the only concern of people living in the higher socioeconomic class, rather such problems also prevailed among the poor community, as per the finding informs.

Perceived time and first Line of action for treatment. Though almost all 99.4% (167) of the surveyed participants indicated the importance of seeking treatment in healthcare institutions, they were different with regard to perceived time that a person should seek medical care during illness. As depicted in table 8, 41.7%, 31.5%, and 25.6% revealed that the time to seek treatment depends on the type of illness, within 24 hours and when it gets sever respectively, where as the remaining 1.2% said after 24 hours. The qualitative information also revealed the same but explained in different way. It is when illness gets severe that a person should seek healthcare, otherwise seeking healthcare immediately considered as a luxury since there is a perception that illness is inevitable and could go away soon as times goes by itself.

The perception of participants towards what should be the first line of action during illness varied across survey participants. Consequently, the majority, 76.2% replied that it would be better if one seek help from medical professionals, while some 20.8% of the participants indicated to wait till the illness get severe. The other also recommend that to wait and see if conditions improved (1.2%), pray and expect a miracle (1.2%) and other (0.6%). Unlike With the same fashion, as per the qualitative evidence, most of (five)the participants said one should seek healthcare from professional medical personnel while some others (two) reported waiting to see if there is improvement by itself and if not visiting professional allopathic for severe illness. A single participant stated that holy water treatment is the perfect one and hence provide precedence for it. This indicates that though the PoPs' perceived first line of action was trained allopathic, in practice, there is a tendency of utilizing self care and spiritual healing primarily.

Perceived severity of illness and perceived interaction. The way participants perceive the severity of illness is quite different and is subjectively understood. The majority of the survey participants perceived the severity of illness when the person is bed ridden which accounts 39.9%, failed to walk (31.1%), illness prevents from routine activities (22.2%), fail to handle activities independently and thinking that illness may cause disability or other serious problems (3.1% each) and 0.7 % said when failed to eat.

Correspondingly, the qualitative aspect of the study revealed different understanding of severity of illness by the PoP. Half of the PoP, four of the eight, perceived it when someone is bed-ridden, two other said when physically deteriorated and can't move and still a single participant said the illness episode is considered sever when the person is going to die. Consistent to this idea, one key informant from Addis Hiwot Health center indicated that the understanding of the severity of illness by the poor section of the community is adversely affecting their sought of immediate healthcare. She underlined [the key informant] that the PoP will not seek healthcare till the illness episode prevents them from handling their usual chores. An illness episode which can bring an immense effect health is usually understood as silly and not concerned much. Another participant understood it when the person who is ill failed to restore in to the normal condition though he is taking the medication as prescribed.

Respondents were asked concerning the interaction that they have with healthcare providers. 91.1% of the participants reported that the healthcare providers are friendly and empathic and the remaining 8.9 % said not. Likewise, five of the interviewed PoP explained as they had promising interaction with the healthcare providers. Similarly, one key informant from Addis Hiwot health center added the appealing interaction of the clients and healthcare providers. She said "when there is no medicine prescribed in the pharmacy, pharmacists will

facilitate the mechanisms to change the prescribed medicine for substitutive." But two said while some are nice and dedicated to help clients, others are irresponsible, corrupted, unfair, disempowering and unreasonable in so many respects. One of the participants explained his concern regarding the misconduct of the healthcare providers as "the very reason that we visit healthcare institution is to get rid of our illness but sometimes it could be በእንቅርት ላይ ጆሮ ደግፍ ይሆናል፣ ከበሽታ በላይ በሽታ ገዝተን እንመለሳለን (an Amharic proverb to mean we are adding another problem on the existing one, illness on an illness)."

Table B . Statistical Summary of the Perception of Participants to Health and Healthcare

Issues	Yes		No		
	N	**%**	**N**	**%**	**Total**
I seem to get sick a little easier than other people since I am poor	87	51.8	81	48.2	168
My body seems to resist illness very well	78	46.4	90	53.6	168
Being healthy is to mean not being sick for a long	133	79.2	35	20.8	168
When I'm sick, I try to just keep going as usual	144	85.7	24	14.3	168
My health would be worse in the future than now	87	51.8	81	48.2	168
One should take previously prescribed medicine for an illness which seems similar to previous one	36	21.4	132	78.6	168
It is better to stop taking medicine even if the regimen prescribed has not been completed	21	12.5	147	87.5	168

Some questions which could evaluate the perception of the PoP to their health and healthcare were asked. To mention few, as clearly depicted in the above table, more than half of the survey participants, 87 (51.8%), perceived they are vulnerable to health problem since they are poor while 81 (48.2) did not. 78 (46.4%) feel that their body could resist illness very well and 133 (79.2%) understood healthy mean not being ill for a long time. The qualitative finding

revealed, on the nexus between poverty and ill health, there is significant relationship between them but putting health as a predicting factors than poverty determine health condition. Most of them except the key informants said health determines everything. Unlike the quantitative finding, the qualitative finding illuminate poverty never predisposes to health problems rather it is ill health that puts people in vicious circle of poverty. In line of this idea, a PoP from Wereda 03 indicated that health is more than any asset. He said "If you are healthy enough you can work, eat what you have and carry on life safely. When I was healthy, I used to work hard and pensioning me today. So, healthiness never let you to poverty." Similarly, 27 years old woman from Wereda 06 underscored ill health breads poverty than the reverse. In her own words:

> Previously, I was healthy and could carry 60 Kg banana from Taxi station to home, more than one Killo Meter, on my back for sell. But since I got health problem, I can't and puts my family for economic difficulties. Even living in poverty, your life style will never also let you to ill health. For example, if you were living in a narrow roof and you are healthy, you can work more and more so that you can earn much money and rent a room which accommodates your family thereby carry on your life with a full of contentment. Thus, if someone is not healthy, he is more likely to be thrown to poverty whereas being healthy enough can enable you to work and survive, and health is the foundation for other aspects of our life.

Unlike others, there was a participant who argued poorness never made them to be ill rather it is the rich who are mostly vulnerable to different types of diseases, especially, for chronic diseases. He said "most poor are happy than rich and are not vulnerable to disease, rather it is the rich that they are vulnerable to illness-ድሃ ያለውን ቆርጥሞ ያድራል፣ ጤነኛ ነው:: ሃብታም ግን ሃብታም ስለሆነ ብቻ ለተለያዩ በሽታዎች ይጋለጣል::" It is to mean the poor will carry on life eating what

he/she has but the rich is always exposed to varied types of illness. Another key finding was 144 (85.5%) of the participants reported that they try to keep as usual and handle their own activities though felt sick. It is also apparent to understand, from the table, 51.8% of the participants alleged that their health would be worse in the future than now. Moreover, while 78.6 % of the participants perceived that one should not take previously prescribed medicine for an illness which seems similar to the previous one, of all 168 participants, 87.5 % of them stated it is not good to discontinue taking medicine even if the regimen prescribed has not been completed.

The statements in the table above are believed to focus on the perception of participants in relation to their health and healthcare. Additional query that needs to be answered is that whether perceiving as the elements/issues listed in Table A could have any association to seek or not to seek immediate healthcare? Testing whether there is significant difference in seeking prompt healthcare, it was found that there is no statistically significant association between seeking prompt healthcare and each items mentioned ($p > 0.05$) in the table except for the item which says 'I seem to get sick a little easier than other people since I am poor' ($p=0.032 < 0.05$). It was 63.63 % who perceived so are likely to visit immediate healthcare. But to what extent perceiving so and to seek prompt healthcare relate? To this end, the Chi Square symmetric measure (phi value = 0.165) indicate that the relationship is weak.

Attitude of the PoP towards Health, Healthcare Providers and Institutions

Under this subsection, three main issues are presented. Both the qualitative and quantitative finding concerning the attitude of the PoP towards health, the attitude of the PoP towards healthcare providers and public healthcare facilities are concurrently presented. In addition, the relationship between some demographic characteristics with attitude of the PoP towards their health has also given due emphasis.

Table C Attitude of the PoP towards Health, Healthcare Provider and Public Facilities

Types of Attitude	N	Range	Minimum	Maximum	Mean		Std. Deviation
	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic
AHCP	168	24	9	33	26.45	.325	4.215
AH	168	20	10	30	21.40	.316	4.091
APHCI	168	20	7	27	17.44	.397	5.147

[Note. AHCP= Attitude towards Healthcare Providers, AH= Attitude towards health, APHCI= Attitude to public healthcare institutions]

The SPSS output, as presented in the above table, indicates the attitude of survey participants towards three entities; healthcare providers, their health, and public healthcare institutions. Accordingly, the mean attitude of participants to healthcare providers, their health, and public healthcare institutions is 26.45 (4.25 SD), 21.4 (4.09 SD) and 17.44 (5.14 SD) respectively. In addition, the minimum composite measure of attitude of the participants (out of 35) towards healthcare providers was 9 and the maximum was 33. While the minimum and the maximum attitude of participants to their health was 10 and 30, the attitude of participants to public healthcare institutions lays from 7 to 27 with a range of 20.

Sex, Place of origin, education, income and the attitude of PoP to health. The subsequent few pages attempted to see whether there is significant difference or association between the attitude of health and socioeconomic and demographic characteristics of the PoP.

Table D: Comparison of Participants' Attitude to Health by Sex

	Sex	N	Mean	Std. Deviation	Std. Error Mean	P value
Attitude to health	Male	75	21.68	4.205	.486	0.435
	Female	93	21.18	4.005	.415	

The independent samples t test result which compares the mean difference between male (21.68) and female (21.18) indicates that the attitude of the PoP towards their health is the same across categories of sex (p=0.435 > 0.05) with a 95% confidence level. This is to mean, there is no a statistically significant difference in the attitude of male and females to their health. In addition, as per the Chi Square test of association, place of origin has found no association with the attitude of participants to their health (p=0.594>0.05).

Table E: ANOVA Result of the Attitude of PoP towards their Health by Education

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	320.548	3	106.849	7.083	.000
Within Groups	2473.928	164	15.085		
Total	2794.476	167			

To see whether there is a statistically significant difference in the attitude of survey participants to their health across the different categories of education, one way ANOVA was used. The test result (F=7.083 & p=0.00 < 0.05 with the Df= 3) signifies that there is a statistically significant difference in the attitude of the PoP towards their health across their educational levels. Similarly, the Spearman's coefficient of correlation also indicates the existence of positive but weak relationship between education and the attitude of participants towards their health (r=0.307). In addition, to compare in pair among the categories of education, further statistical test was used, Post Hoc test. The following table presents the post hoc result concerning the attitude of respondents among the categories of education.

Table F: Post Hoc Tests: Multiple Comparisons of Attitude to Health and Educational Level

(I) Highest level of education attained	(J) Highest level of education attained	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Illiterate	Read and write	-1.360	.722	.239	-3.23	.51
	Elementary	-2.532*	.761	.006	-4.51	-.56
	High school	-6.300*	1.663	.001	-10.62	-1.98
Read and write	Illiterate	1.360	.722	.239	-.51	3.23
	Elementary	-1.172	.773	.430	-3.18	.83
	High school	-4.940*	1.668	.018	-9.27	-.61
Elementary	Illiterate	2.532*	.761	.006	.56	4.51
	Read and write	1.172	.773	.430	-.83	3.18
	High school	-3.768	1.686	.118	-8.14	.61
High school	Illiterate	6.300*	1.663	.001	1.98	10.62
	Read and write	4.940*	1.668	.018	.61	9.27
	Elementary	3.768	1.686	.118	-.61	8.14

*.The mean difference is significant at the 0.05 level.

Previously, it is proved the existence of a statistically significant difference in terms of the attitudes of health across the participants' educational level. But, there is an additional query that has to be answered, i.e. is there any statistically significant difference between each category? The Post Hoc test in the table above conveyed the comparison in the attitude of the PoP to health by their educational background. Accordingly, there is a statistically significant difference between illiterate versus elementary (p=0.006), read & write versus high school (p=0.018), and high school versus illiterate (p=0.01) regarding their attitude to health. But,

statistically insignificant difference in attitude of health between illiterate and read & write, read & write and elementary, and elementary and high school was observed.

The SPSS output of the one way ANOVA indicates that there is no statistically significant difference in the attitude to health across the different groups of religiosity (F=1.204 & p=0.31). In addition, Pearson's coefficient of correlation (r=-0.106) that was used to see the association between age and attitude to health indicates the two variables are negatively correlated, though weak. As individuals get older; the attitude to their health will decline. The following table summarizes the relationship between attitude to health and monthly income.

Table G. Correlations between Average Monthly income and Attitude towards health

	Correlation	AMHI	AH
	Pearson Correlation	1	.116
AHMI	Sig. (2-tailed)		.134
	N	168	168
AH	Pearson Correlation	.116	1
	Sig. (2-tailed)	.134	
N		168	168

[Note. AHMI= Average Household Monthly Income, AH=Attitude towards Health]

Pearson's correlation result that oscillates between 1 and -1 shows there was positive but weak (r=0.116) relationship between income and attitude of the PoP to their health. By positive and weak is to mean, as the income level of the PoP increase, their attitude towards their health is likely increase, but to some extent.

Table H. Summary of AHCP, AH and APHCI of survey Participants

Level of Attitude	Frequency (AHCP)	Percentage (AHCP)	Frequency (AH)	Percentage (AH)	Frequency (APHCI)	Percentage (AHCI)
SNA	4	2.4	4	2.4	44	26.2

NA	15	8.9	36	21.4	56	33.3
PA	102`	60.7	93	55.4	49	29.2
SPA	47	28	35	20.8	19	11.3
Total	**168**	**100**	**168**	**100**	**168**	**100**

[Note. AHCP= Attitude towards Healthcare Providers, AH= Attitude of respondents towards their health, APHCI= Attitude of respondents towards public healthcare institutions; SNA=Strong Negative Attitude, NA=Negative Attitude, PA=Positive Attitude and SPA=Strong Positive Attitude]

The predisposition of the PoP to their health, healthcare providers and facilities was recorded as strong negative attitude, negative attitude, positive attitude and strong positive attitude. Thus, as presented in the above table, table H, 4 (2.4%), 15 (8.9%), 102 (60.7%) and 47 (28%) had a strong negative attitude, negative attitude, positive attitude and strong positive attitude respectively to healthcare providers. This data indicates that, the majority, 88.7% of the participants had a favorable attitude to healthcare providers which would have an impact on the HSB of the poor. In addition, the table also demonstrates that positive (55.4%) and strong positive (20.8%) attitude towards their health. In relation to their attitude towards public healthcare institutions, while 59.5 % of the participants had strong and negative attitude, 40.5 % of them had strong and positive attitude.

Though it is not straightforward to determine the attitude of the PoP qualitatively, an in depth understanding about the attitude of the PoP to health, healthcare provider and healthcare facilities was generated. Accordingly, regarding the attitude of the PoP towards health, almost all of the interviewed participants indicated as they do have positive attitude to their health. Consistent to this idea, one participant said "I furnish due value to my health and this could be explained in terms of keeping my hygiene to protect myself from health concerns." In contrary,

an informant from Wereda 06 put that "since the people living around the area are dominantly beggars and lower socioeconomic status, they don't give much value for their health, health is not their priority." Another added that "if someone gets ill, he or she will not seek prompt care rather provides priority to his/her work or other matters which could be an indicator to their health is not favorable."

Unlike the survey participants who had negative attitude towards public healthcare institutions, the interviewed participants highlighted a positive feeling to public healthcare facilities and this is due to the fact the healthcare service in the government institutions is for free for the PoP. One of them stated that "public healthcare facilities are much better than the private ones and are mainly due to the fact it furnish service without charge or at least cost." On the other hand, one key informant stated that "the PoP usually misinformed each other as, mostly, there is no medicine and laboratory for fee waiver beneficiaries that resulted in devaluing public healthcare institutions and wish to visit private healthcare if they do have money." Similar to the quantitative finding, all except two of the interview participants had positive attitude to healthcare providers. In contrary to this, participants who had negative feeling to them said though there are some who are devoted to bring change on one's health positively, some others counteract.

Healthcare Seeking Behavior of the PoP

This subsection presented to what extent the study participants seek healthcare promptly. Various tests have been used to test the association between demographic characteristics and behavioral variables with healthcare seeking behavior. In addition, the qualitative data was included to substantiate the quantitative one.

Table I: Binomial Test of Healthcare Seeking Behavior of the PoP

Question		Category	N	Observed Prop.	Test Prop.	Exact Sig. (1-tailed)
Do you seek healthcare immediately your sickness?	Group 1	Yes	55	0.327	.003	.000
	Group 2	No	113	0.673		
				1.00		
	Total		**168**			

As the SPSS output indicates, of the total surveyed population, only 32.7% of them seek immediate healthcare, whereas, the majority, 67.3 % didn't. To compare this figure with the national standard (0.003) taken from the health development indicator of Ethiopia (2008) binomial chi square test was used. The binomial test indicates that there is significant difference in seeking immediate healthcare between the surveyed population and the national standard ($p=0.00 < 0.05$).

Demographic characteristics and healthcare seeking behavior of the poor.

Table J. Healthcare Seeking Behavior and Sex

Cross Tabulation			Sex		**Total**	**Pearson X^2 Correlation**
			Male	Female		
Do you seek healthcare immediately your sickness?	Yes	Count	18	37	55	0.033
		Expected Count	24.6	30.4	55	
		Residual	-6.6	6.6		
	No	Count	57	56	113	
		Expected Count	50.4	62.6	113	
		Residual	6.6	-6.6		
Total		Count	75	93	168	
		Expected Count	75.0	93.0	168	

The cross tabulation of sex and healthcare seeking indicates that of 75 male participants, 18 of them seek immediate healthcare while it is 37 out of 93 male participants who seek so. But, is there a statistically significant difference in prompt healthcare utilization between females and males? To compare the healthcare seeking behavior of females and males, Pearson Chi Square Correlation was used. From the test result ($p=0.33 < 0.05$), we can understand that there is difference in seeking prompt healthcare among female and male participants. Female are more likely to seek prompt healthcare than males but the extent of relationship is weak since (phi = -0.167). Test has been made to see whether there is a significant difference in seeking immediate healthcare among the categories of religious affiliation of the PoP. The test result informs the existence of a statistically significant difference in healthcare seeking behavior among Orthodox Christians, Muslims and Protestants ($p=0.007< 0.05$). But the difference is very small since phi=0.007 (refer Table 11 in the appendix for detail).

Education is presumed to have an association with healthcare seeking behavior. To confirm it, Chi Square test of independence was used. The SPSS output (Table 12) signified that there is no a statistically significant association between education and seeking prompt healthcare ($p=0.095 > 0.05$). The other demographic characteristic that was thought to have an association with healthcare seeking behavior was age of the heads of the household. The Chi Square test output signified that there is no a statistically significant association between age and seeking prompt healthcare ($p=0.657 > 0.05$). Similarly, there was no a statistically significant difference in immediate healthcare utilization across household size since the p value is greater than the significance level considered in this study.

Alike the quantitative result, the qualitative result indicated the absence of difference in prompt healthcare seeking behavior among the PoP across household size. But one key

informant from Addis Hiwot Health center reported that prompt healthcare seeking behavior among the PoP, sometimes, decline as household size of the PoP increase since there is a fixed frequency of visiting healthcare for free. In her own words:

> A PoP is allowed to get healthcare service for free for four visits per a year. In the fifth and sixth visit, he/she is expected to pay 15% of the cost of the service. For seventh and more visits, the PoP has to pay 50 % of the service. In addition, if the household size is two and more, ten visit (all the visits by each member of the household added) is the maximum per a year. Otherwise, for the next two visits (11th & 12th) visits, they would pay 15 % and for the 13th and more, they have to pay 50% of the service. Hence, as the size of the household and the frequency of illness in the household increases, the likelihood to seek healthcare will be adversely impacted since the PoP are liable to be charged.

Chi Square test of association between place of origin and healthcare seeking behavior depict that there is no association between them. It was also found the absence of a statistically significant difference in healthcare seeking behavior among the married, never married, widowed, divorced and separated ($p=0.186 > 0.05$). Similarly, the statistical summary that shows the relationship between monthly income and immediate healthcare behavior demonstrates that there is no a statistically significant association between them, having the significance level of 0.282.

Attitude to Health, Healthcare Facilities and Providers and Healthcare Seeking Behavior

Chi square test of independence was used to analyze the relationship between immediate healthcare seeking behavior and the attitude of the research participants towards healthcare providers, their health, and public healthcare facilities. Accordingly, while attitude towards

health (p= 0.00 < 0.05) and attitude towards public health facilities (p=0.009 < 0.05) had shown relationship with healthcare seeking behavior, attitude towards healthcare providers had no relationship since p=0.707 which is greater than the margin of error assumed in this study. The extent of the relationship between attitude to health and healthcare seeking behavior explained by eta = 0.709 which is strong. Therefore, the data revealed that the favorable or positive attitude that the PoP have to their health, the more probability to seek immediate healthcare.

Perceived Benefit and Healthcare Seeking Behavior

Of all the survey participants, it was only a single individual who perceived that seeking healthcare institutions is not important at all and this individual's attitude to health, healthcare providers and seeking immediate healthcare was minimal. Otherwise, all perceived that it is important to seek healthcare from healthcare institutions. Correspondingly, almost all of the qualitative participants perceived they could best benefited from visiting healthcare facilities. But one key informant put the reverse. She stated that "the perceived benefit that the PoP place for healthcare facilities is insignificant and is adversely influencing their healthcare seeking behavior timely".

Perceived Severity of Illness and Healthcare Seeking Behavior

As it has been presented previously, survey participants perceived the severity of illness differently. To mention they perceived an illness is severe when an individual is bed ridden (39.9%), failed to walk (31.1%), illness prevents from routine activities (22.2%), fail to handle activities independently and thinking that illness may cause disability or other serious problems (3.1% each) and 0.7 % said when failed to eat. Do perceiving severity of an illness as such had any relation with the PoP's sought for healthcare was the other query that needs to be answered. Accordingly, the chi square test of association result from the SPSS revealed that, except with

perceiving as bed ridden, others have no association with seeking immediate healthcare. The Chi square test result indicated that there is significant association between perceiving illness as sever when bed ridden and seeking immediate healthcare (refer table 10 & 12 in the appendix for detail).

As indicated in table 12, the statistical summary that tests the relationships between perceiving the severity of illness when the person gets bed ridden and seeking immediate health care indicates there is significant difference in seeking immediate healthcare among those who perceived so and not since the significance level is 0.00 which is less than 0.05. The symmetric measure shows to what extent the two variables are related. To this end, the phi statistics (-0.395) shows there is strong association between perceiving the severity of illness as bed ridden and to sought prompt healthcare. Literally, it is to mean that the PoP who perceived the severity of illness as bed ridden are less likely to seek immediate healthcare while those who didn't perceive as such are more likely to seek prompt healthcare.

The qualitative evidence also confirmed the same. Most of the qualitative participants indicated that someone could be said severely ill when he/she is bed ridden or can't move which could potentially deteriorates their prompt healthcare. Similarly, one key informant from Wereda 06 health center, Addis Hiwot health center, said "people around here [Wereda 06] perceive illness as minor and it is when the urban health extension worker visit home to home and refer them that the PoP seek healthcare." The PoP do not see mild illness as it can endanger their life. From the data we can understand that the PoP understood an illness as severe when it reaches on the stage that can hurt them much and difficult for restoration.

As the cross tabulation indicates in table 9, of all 15 participants who reported that healthcare providers are not friendly and empathetic, 12 of them do not seek immediate

healthcare when they get ill. To test whether the difference is statistically significant, the Chi Square test statistic shows the absence of significant difference in seeking immediate healthcare among the participant who said healthcare providers are friendly and emphatic and who didn't ($p= 0.27 > 0.05$). Regarding the qualitative participants, most of them narrated that healthcare provider has friendly approach during treatment. A story from a 78 years old man, the order from some healthcare providers to buy medicine out-of-pocket is understood positively and shows a sign of trust ship between the two parties. He said:

> Healthcare providers are so interactive and attempt to help me their best. Sometimes, they recommend buying medicine and using laboratory out-of-pocket, but I perceive it positively. I believe, had it been the medicine, they would not disallow us because it is nothing that the healthcare providers going to cost.

A 30 years old woman shares the idea but stated quite differently. She stated:

> Generally healthcare providers are good enough, but sometimes they insisted us to buy medicine from our pocket, though it prevails. At that moment, if I can, I'll buy it. If I have no the cash, I will keep silent and is mandatory to do so though the illness could hurt me. This will never prohibit me not to seek treatment and will not bored since I feel that the medicine will prevail another time and that moment will never happen again.

As depicted in table 13, the ten items that were prepared to measure the religiosity of participants indicates that the mean of religiosity participants was 35.02 (SD=5.616) with a minimum of 13 and maximum of 49. After preparing three cut points (20, 30, & 40), the distribution was categorized as very weak, weak, religious, and very religious. Accordingly, more than 72% of the participants are religious and very religious. Is there any association between of religiosity and the option of healthcare that participants sought? The Chi Square test

of independence was computed to see whether there is any relation between the type of healthcare options and the level of religiosity. Consequently, it has been found that there is no significant association between the type of treatment options that the PoP sought and religiosity having all p values greater than 0.05. Do religious people immediately seek treatment? The subsequent tables focused on this issue.

Table K. Association between Religiosity and Healthcare Seeking Behavior

Do you seek healthcare immediately your sickness?		Religiosity of respondents				Total	Pearson x^2 Correlation
		Very Weak	Weak	Religious	Very Religious		
Yes	Count	2	2	41	10	55	0.015
	Expected Count	1.0	8.5	38.0	7.5	55	
	Residual	1.0	-6.5	3.0	2.5		
No	Count	1	24	75	13	113	
	Expected Count	2.0	17.5	78.0	15.5	13	
	Residual	-1.0	6.5	-3.0	-2.5		
Total	Count	3	26	116	23	168	
	Expected Count	3.0	26.0	116.0	23.0	168	

To check the association between healthcare utilization and religiosity, Chi Square test of independence was used. As table K tells, there is statistically significant association to seek prompt healthcare and the religious levels (among very weak, weak, religious, very religious) of

the PoP in the study area (p=0.015 < 0.05). The test statistics Phi and Cramer's value (0.25) depicts that the association between religious level and immediate healthcare sought is moderate.

Fee Waiver, Health and HSB of the PoP

The last inquiry of this thesis was to investigate the relationship between the fee waiver system that has been applied by MoH and its meaning on the health and healthcare seeking behavior of the poor in the study area. More specifically, the sub-section attempted to look thoroughly the following issues: What is new on the health and healthcare seeking behavior of the PoP since their inclusion in the fee waiver system? Is there any difference in some health behaviors before and after their inclusion? What was the decision that the PoP used to make before their inclusion and what is the view of the PoP on the existing practice of the fee waiver system?

Table L: Descriptive Statistics on Fee Waiver, Health and HSB of the PoP

A	N	%		**Response**	N (%)	B	N (%)
Much worse	3	1.8	Do you think that your HSB improved AFW?	**Yes**	153 (91.1)	Poor	6(3.6)
Somewhat Worse	2	2				No change	9(5.3)
No change	66	39.3				Improved	100(59.5)
				No	15 (8.9)		
Somewhat better	66	39.3					
						Very Improved	53(31.5)
Much Better	31	18.5					
Total	168	100		**Total**	168 (100%)	**Total**	168 (100%)

Note. A= Health Status After fee waiver system, B= Health seeking behavior after Fee Waiver system, AFW= After Fee Waiver System

The table above, table L, summarizes what looks like the health and healthcare seeking behavior of the PoP after the inclusion of the PoP in the fee waiver system. About 97 (57.8 %) of the participants reported that there is an incredible change in their health after their inclusion with in the scheme. Parallel to this, 91.1% of the participants said that their HSB has been improved favorably since their inclusion in the fee waiver system. As it is previously indicated, though 91.1 % of the respondents have reported progress in their HSB, in practice, it is only 55 (32.7%) of the participants who seek immediate healthcare. The qualitative evidence also indicates the same. Most of the PoP put their health and sought for healthcare has been improved significantly as of their inclusion. A PoP from Wereda 03 explained the positive contribution of the scheme on his health and healthcare as follows:

> My health is getting improved after my inclusion in the system. I feel better since I am not bed ridden and came to talk to you because I am okay. Regarding my healthcare seeking behavior, the scheme brought significant improvement in my sought for healthcare. I used to visit healthcare rarely due to financial constraint, but I start to visit healthcare keenly as of my inclusion.

A 56 years old woman also shares the idea that the system brought a striking outcome on her health and healthcare utilization. She explained the issue as:

> My inclusion contributed much to be healthy and started to follow up my health seriously. I made a surgery three times, get cured from my health concerns and my motivation to seek healthcare promptly has been increased significantly. And I feel that hadn't been included in the scheme, I would die. Thanks God and government!

The key informants at the two Weredas indicated that though the HSB of the PoP has been improved as of their inclusion, in practice, it is not possible to say the PoP seek immediate healthcare during sickness. In support of this idea, a health extension Worker from Wereda 06 explained for the question 'do the HSB of the PoP increased after their inclusion?' as:

> Absolutely not! Everybody is eager to be included in the scheme, both poor and rich. Their strong keen is to have the fee waiver certificate that makes them eligible for fee waiver. But after they got the certificate, their sought for prompt healthcare don't increased. They all need their inclusion to use the scheme when they face sever conditions and their illness get sever since seeking modern healthcare is their last option among these people.

In the same way, another informant provided a slightly different idea (from the PoP) regarding the aftermath of fee waiver on the healthcare seeking behavior of the PoP. Putting what she said in her own words:

> It is difficult to say the healthcare seeking behavior of the PoP either increased or decreased. Most of the people residing in this Wereda are mobile and when we move home to home for health education, we [urban health extension workers] rarely came across the person that we met before. So for me, I am afraid to say the healthcare seeking behavior of the poor is either after fee waiver gets introduced in the area.

Generally, from the findings of both the quantitative and qualitative data one can easily understand that the scheme has brought progress on the health and HSB of the PoP. But, still, the data reveals the prompt healthcare seeking behavior is low.

Decision on health issues before inclusion in the Scheme. The quantitative part of the study came up with a variety decisions that the PoP mostly overtook whenever they face health concerns starting from transferring other expenses for medical treatment to ignoring illness episode. The coming table clearly summarizes the issue.

Table M. Decisions Used to Take BFWS by the PoP

What you Used to do during Illness Episode BFWS (MR)?	Responses	
	N	Percent
Professional allopathic through transferring other expenses for medical treatment	115	43.4%
Seek help from my social network	17	6.4%
Seek treatment from traditional healers since it is less costly	16	6.0%
Praying	56	21.1%
Taking medicines from pharmacies	12	4.5%
Seek help from NGOs for medical service	2	0.8%
Ignoring the symptoms	43	16.2%
Fee waiver User	4	1.5%
Total	**265**	**100.0%**

BFWS= Before Fee Waiver System, MR=Multiple Response

Table M demonstrates the decisions that participants used to take before their inclusion in the fee waiver system. Accordingly, the majority, 115 (43.3%) reported they used to transfer other expenses for medical treatment followed by spiritual healing as praying and holly water (21.1%). The remaining responded that seeking help from social network (6.4%), traditional healer (6%), pharmacies (4.5%), has been fee waiver user since earlier (1.5%), and seeking help from NGOs (0.8%).

Correspondingly, the qualitative participants used to decide, dominantly, either ignoring the symptom or seeking healthcare out-of-pocket if they had money before their inclusion in the scheme. A 30 years old woman stated her decision used to take as "before my inclusion, I used to

visit healthcare out-of-pocket and if I had no money, I keep silent. But after I included in the scheme, I start to experience a remarkable progress in my health and healthcare seeking behavior." Similarly, a 27 years old woman explained the scheme as follows:

> The scheme is significant from so many perspectives. If you are sick, it is possible to get served freely, at least bed service for severe illness let alone medicine, laboratory and other expenses. Before my inclusion, mostly I ignore the symptom and rarely used to visit treatment in health centers. Even after my inclusion, occasionally, the physicians order to buy medicine from pocket and at that instance, either I will buy if I have or pray in front of God to bring blessing since God will never leave us. I remember the moment that I lost my first child. My child was extremely sick and admitted at the hospital. The doctor repeatedly requested me to buy medicine from pocket but I did have nothing at that juncture and my child passes away (overwhelmed with deep sorrow &...crying).

Health decisions of the PoP before and after the scheme: Comparison. Participants were asked to make a comparison on some health decisions before and after their inclusion. They were asked to compare what looks like their healthcare sought, using home and traditional healthcare and worry to their health before and after the introduction of the scheme. The following table summarizes the issue in detail.

Table N. Two related Samples test of the PoP

Statements	Before FWS		After FWS		Wilcoxon (TRST) P-value
	Yes=N(%)	**No=N(%)**	**Yes=N(%)**	**No=N(%)**	
A	133(79.2)	35(20.8)	109(64.9)	59 (35.1)	0.00
B	155 (92.9)	12 (7.1)	137 (81.5)	31(18.5)	0.00
C	89 (53)	79 (47)	28 (16.7)	140 (83.3)	0.00
D	95 (56.5)	73(43.5)	15 (8.9)	153 (91.1)	0.00
E	35(20.8)	133(79.2)	55 (32.7)	113(67.3)	0.00
F	136 (81)	32 (19)	140 (83.3)	28 (16.7)	0.248

[Note. FWS= Fee waiver system, TRST=Two-Related- Samples Test, A= I wait to seek treatment till my illness get sever, B= I seek treatment as per the type of illness, C= I seek treatment at home or traditional than going modern health facilities, D= I don't like to visit health facilities though I know that my illness is hurting me, E= I go to health facilities promptly when I get sick & F= I worry much to my health]

Table N depicts the distribution of survey participants in some important health decisions before and after their inclusion in the fee waiver system and attempts to compare between two. To mention some, about 20.8% used to seek prompt healthcare before their inclusion and increased to 32.7% after the introduction of fee waiver system. The Wilcoxon test (sig. =0.00) also informs the prevalence of a statistically significant difference in seeking immediate healthcare before and after intervention within the study participants.

With respect to seeking treatment at home or traditional health, for 53% of the participants traditional and homeopathic treatment was the prime healthcare option before their inclusion in the fee waiver scheme and reduced to 16% after inclusion. To know whether these figures (53% & 16%) have a statistically significant difference, Wilcoxon test was used. The tests statistics indicates that there is a statistically significant difference in seeking treatment at home and traditional healer before and after the introduction of fee waiver system ($p = 0.00 < 0.05$). Literally from the data, one can understand that the likelihood of visiting traditional healer and using home treatment has been diminished as of the commencement of fee waiver system. In other words, the PoP in the study area are somewhat instigated to visit modern healthcare after their inclusion in the healthcare safety net.

From the data, it is simple to understand that the value that participants furnish to their health had also enhanced. Previously, about 95 (56.5%) of the survey participants were indifferent to visit modern healthcare facilities though they know that their illness could hurt

them. But after inclusion, the figure declined to 8.9%. The Wilcoxon test statistic also confirms that there is a statistically significant difference in having an interest to visit healthcare before and after the introduction of the fee waiver scheme. Factually, it is possible to say that the PoP who used to dislike visiting healthcare facilities though their illness is hurting them has been decreasing as of the beginning of the fee waiver scheme. In relation to ones worry to health, while 80% of the participant used to worry much concerning their health before their inclusion, the figure increased to 83.3% after inclusion in the fee waiver system and the two related sample test depict that there is no statistically significant difference regarding their worry to health before and after the commencement of fee waiver system to the PoP in the study area.

Views of the PoP to the Fee Waiver System

Survey participants were asked their opinion concerning the fee waiver scheme. The table below summarized the reflection of the PoP towards the healthcare safety net that they are benefiting out of it.

Table O. PoP's View on the Fee Waiver System

Responses	A	B	C
Yes	58 (34.5%)	102 (60.7%)	41 (24.4%)
No	110 (65.5%)	66 (39.3%)	127 (75.6%)
Total	**168 (100%)**	**168 (100%)**	**168 (100%)**

Note. A= Physicians don't treat us equally as those clients who are paying out-of-pocket-healthcare; B= The scheme is not adequate enough; & C= The healthcare providers disempowered me due to the fact that they notice as I am privileged for fee waiver.

The table above depicts the views of the PoP on the fee waiver system. 110 (65.5%) of the participants reported healthcare providers didn't treat as like as those who are using the service out-of-pocket and the remaining 34.5 % said the healthcare providers treat clients irrespective of who they are. Regarding the adequacy of the service, the majority, 102 (60.7%) of

the participants felt that the scheme is not adequate enough and the remaining 66 (39.3%) thought that the service is adequate. 127 (75.6%) of the participants reported that the healthcare providers didn't disempowered them due to the mere reason of knowing they are privileged for fee waiver but the remaining 41(24.4%) reported the reverse.

The qualitative part of the study engendered an in depth perspective regarding the view of the PoP to the fee waiver system. The interview result with the PoP indicate the scheme is somehow inadequate because there are instances whereby the PoP are requested to use out-of-pocket for healthcare especially for medicine and laboratory. This was also repeatedly raised by the key informants. In addition, most of the key informants stated that there was a problem in identifying the PoP and making eligible for the service. To this regard, one health extension worker who worked at Wereda 06 for more than three years emphasis the identification of the PoP has a problem. She said:

> The Committee who recruited the PoP was not in accord with the parameters given. For me, the process had a problem. There are households who included in the fee waiver system even though they should not and vis-à-vis. The Committee didn't visit home to home. But we [health extension workers] know who is poor and not. There were people who are included though they rent home and better living condition. In the reverse, the chance was given to the other people. Generally, for me, it is not possible to say that the system is best benefiting the PoP.

Generally, from the data it is understood that the process of identifying the PoP had a trouble. This could because of the failure to meaningfully interpret the parameters issued by the MoH. This is really diverting the very intent of the scheme though measures to correct the problems are being done through revision.

Discussion

Introduction

The focus of this part of the thesis is relating the finding of the study with existing knowledge. More specifically, it attempted to compare the finding of the study with previous researches related the issue. But, due to the existence of scanty empirical works on HSB of the poor in Ethiopian context, the findings of the study was, utmost, discussed in line with works which were done abroad. An attempt was also made to link the findings of study with the tenets of the model used as a conceptual frame work. Moreover, the researcher has also incorporated his personal reflection considering the finding of this study and others too. Accordingly, alternatives of healthcare of the PoP, perception towards health and healthcare of the PoP, attitude of the PoP towards health and healthcare, healthcare seeking behavior of the PoP, and the relationship between fee waiver and HSB of the PoP are discussed thoroughly.

Alternatives of Healthcare of the PoP

People are likely to use various types of healthcare options to resolve their health problem. For Alam, Khanam & Hossain (2000), relevant issues in the process of solving health problems are: What is the process of decision making? Where to go? Are there any preferences? Is it possible to discern any pattern in the choice for health services? An understanding of these issues could play a pivotal role since the use of different health services depends on it. In this study, HSB of the PoP in light of the issues raised above was uncovered.

As per the quantitative study conducted by Diop, Seshamani & Mulenga (1998), 34 percent of the survey participants used self-medication only. The prevalence of self care does not vary much by demographic characteristics of the individual or the socioeconomic characteristics

of the household (p.14). Similarly, but in different way, I found that 44.6% of the study participant used self care but concurrently with other healthcare options in my study. In addition, the study also confirmed that there is no significant difference in seeking self medication across demographic characteristics of the study participants.

Unlike the research findings (Gupta & Dasgupta, nd and Diop, Seshamani & Mulenga, 1998), in this study, spiritual healing is the second most preference of healthcare alternative. It is 50% of the participants who are experienced in using spiritual healing either alone or concurrently with other healthcare options. Surprisingly, some of the study participants had also the interest to use spiritual treatment, especially holly water treatment, for chronic illness and professional allopathic for treating acute illness which makes this study quite different from the studies mentioned above.

A study conducted by Gupta & Dasgupta (nd) revealed that irrespective of all socioeconomic categories in `the study, allopathic treatment was preferred. A more general study conducted by Anagaw Mebratie et al (2013) on the healthcare seeking behavior in rural Ethiopia found out that there is a strong preference for modern healthcare. Keeping in touch the issue to this study, the situation is quite different. Though the PoP had a preference for allopathic treatment during illness episode occurred, they were indifferent in utilizing professional allopathic alone rather they are likely to utilize other types alongside, as self-care, traditional healer, spiritual healing or buying medicine from pharmacy without the prescription of a physician. In contrary to the studies (Anagaw Mebratie et al, 2013 & Gupta & Dasgupta, nd) which highlighted allopathic treatment as the prime preference, the qualitative evidence of the study produced that the PoP are likely to use one option after the other and found that allopathic treatment was given the last precedence. It is after self care and visiting spiritual healthcare, and when these options are not bringing recovery or the illness gets severe that they sought modern

healthcare. So, the pattern of seeking healthcare, as per the qualitative fact, is self-care, spiritual healing and then to professional allopathic.

Another point to note is that, as per the research done in urban Delhi, poorer households don't rely much on traditional healers; nor are they relying much on the charitable facilities. Private hospitals are also completely out of reach of the poorer people (Gupta & Dasgupta, nd). But in this study, though the PoP in the study area had also the experience of visiting traditional healers including spiritual healing, unlike Gupta & Dasguptas' finding, the PoP had also relay on the modern healthcare [public] since they get the service for free. Generally, from this and other findings, it is possible to say that the poor incline various types of healthcare alternatives as professional allopathic, traditional healer or self-care but the way the use is quite different. For example, in the case of this study, it is after the trial of other healthcare alternatives that the poor seek treatment from professional allopathic. And they [the PoP] mostly use the treatment of professional allopathic parallel to other options.

Perception of the PoP to Health and Healthcare

It is important to know how people interpret their health, its relation to physique and living conditions before designing any program or intervention for encouraging people to use different healthcare facilities. It is also pertinent enough to understand the mindset regarding how people look at health problems, when, how, and where they go for treatment (Alam, Khanam & Hossain, 2000).

Health definition. To understand healthcare seeking behavior, it is necessary to find out how people look at different types of diseases. It is also important to have a clear knowledge of how people define and perceive disease (Alam, Khanam & Hossain, 2000). A qualitative study conducted by Alam, Khanam & Hossain revealed that health was perceived in terms of the absence of different diseases. The diseases range from simple body ache or headache to

serious diseases such as jaundice, typhoid and gastric (2000, p.12). In line with this, this study also yields the same. Both the qualitative and the quantitative finding revealed the definition given to health deemed to the physical health- the absence of disease or disconformities in one's body. It is almost 68% of the surveyed participants that they define health being the absence of disease and physical disconformities. Unlike this, there are also participants who perceived health from the perspective of social and mental wellbeing which is consistent to the definition of health by the WHO as health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. To this respect, 15% said mind remain fresh, 8.7% able to eat what one have, 2.7% having few children, 2.4% remaining clean, 1.8% looking good, 1.2% children play, and a single respondent said able to lead a peaceful life. Generally, from the evidence, it is vivid to understand that health is, dominantly, conceptualized from one dimension, physical/biological health, which is to mean absence of disease or physical disconformities whereby a person is able to toil to make a living. Other aspects of health are not given due place among the PoP.

Perception of severity illness: According to Anderson's model which is used as a conceptual framework indicates that perceived severity of illness has an impact on the HSB of individuals (Pillay, 1993). Evidence from Western Nepal indicated that the perception of severity of illness for child illness by mothers was a predictor for appropriate care but not prompt care (Sreeramareddy et al., 2006). Similarly, a research in Bangladish showed that people are indifferent to take any medicine unless it became serious. Mild sickness was considered normal, tolerable and could be cured by self-medication or just by staying at home. In severe sickness, medical support becomes necessary (Alam, Khanam & Hossain, 2000). My study discerned various cues of perceiving as an individual's illness is severe as when the person is bed ridden,

failed to walk, prevented from routine activities, fail to handle activities independently and thinking that illness may cause disability or other serious problems. Consistent to Alam, Khanam & Hossains' (2000) finding, done on the HSB of urban population in Bangladish, the study found that the PoP don't seek prompt healthcare since they felt that they would be okay as day in or day out or through home treatment. So, the subjective understanding of the seriousness of illness has a strong influence on the prompt healthcare utilization of the PoP.

Types and causes of illness. Diop, Seshamani & Mulenga (1998) found out that 43% of the study participants used modern health services for acute illness as headaches, diarrhea, etc. and 51 % of them seek modern healthcare for chronic illness (p. 14). Consistently, the finding of my study revealed that while only 2.4 of the participants used for chronic illness, half and 47% of the participant sought healthcare for acute, and both chronic and acute types of illness respectively. The qualitative aspect of the study indicated that while half of the participants reported they seek for acute, the other half for chronic especially for diabetes and hypertension. From this, we can understand that chronic illnesses which are usually associated with the upper class society, are not the only the concern of people living in the higher socioeconomic class, rather such diseases also prevailed among the poor community.

As per Mackian (nd), health promotion programs on the causes of illness are an essential tool to bring behavioral change. In this study the majority of the participants had a conception that ill health happen due to biogenic factors (66.2%). By biogenic, it meant infections, environments factors as hygiene problems and pollution, manmade and natural disasters and heredity could be the main causes of illness. In addition, participants also attribute the causes of illness to various socio-cultural and economic factors like alcoholism, being poor, and absence of peace within the family. Though they were insignificant, still there are participants who don't

really know the cause of ill health and calls for more intervention to promote their health and seek healthcare timely which is consistent with Mackian (nd).

Perceived vulnerability and poverty. Empirical works (Gupta & Dasgupta, nd, Tipping's, 1994, Wardlaw, 2003) indicate the existence of relationship between being poor and vulnerability to ill health. A study conducted in urban Delhi disclosed that the high and middle income households have a lower probability of falling sick than the low income households (Gupta & Dasgupta, nd) and the poor are more vulnerable. The PoP in this study are also vulnerable to varied illness and even more than half (51.8%) of the surveyed PoP perceived that their socioeconomic status [living in poverty] exposed them to different kinds of health problems. Inconsistent to this, Tipping's (1994) work in rural Vietnam indicated no marked differences in the prevalence of illness comparing poor and non poor.

There were also PoP who perceived that poorness never let the poor to ill health rather it is the rich who are mostly vulnerable to different types of diseases due to their life style, especially, for chronic diseases. So, the PoP had also a mentality of attaching some diseases as a disease of the rich and will not be contracted by these diseases.

Attitude towards health, Healthcare Providers and Public Healthcare Facilities and HSB

Health beliefs and attitudes about medical care, physicians and disease has an influence on the health seeking behavior of people. For example, those families that believes in the efficacy of medical treatment will seek care sooner and more often (Pillay, 1993). In this regard, the attitude of an individual towards health and physicians has a link with the HSB of individuals.

The Chi Square test was used so as to analyze the relationship between immediate healthcare seeking behavior and the attitude of the research participants towards healthcare

providers, their health, and public health institutions. Accordingly, consistent to the Anderson's model and what was said by Pillay (1993), attitude towards health has a significant relationship with seeking prompt healthcare. This could be explained as people starts to avoid letting illness interfere; feel health as the base for other aspects of life; more interested to consult healthcare providers, and pleased to visit health care facility, undoubtedly, the likelihood of visiting prompt healthcare would significantly increase.

A study conducted by Diop, Seshamani and Mulenga revealed that people think good treatment is not available at a government hospital. It is the private ones who provide a full pledged treatment for patients (1998, p. 15). Unlike this, the study generated an opposite finding. It revealed, almost 60% of the quantitative participants had a positive attitude towards public healthcare facilities. Meaning, participants had a conception that public health facilities are as good as the private ones; prefer the public than the private though the cost is the same; don't seek treatment at public as a result of the existence of free service, public health facilities are clean enough, have no long waiting time and have the necessary medical equipments. On the other hand, 40 % of the quantitative participants had a negative attitude towards public healthcare facilities which informs that they didn't get the elements that are mentioned before. This is also explained by the Anderson's model by which attitude of people toward health facilities has an impact on their health seeking behavior. But, unlike the model, the study revealed that there is no significant association between seeking healthcare and attitude towards healthcare providers.

Age was negatively associated with evaluation of one's health. The evidence indicated that the elderly persons have an attitude that they are no more useful to their society and said "nobody values an old person." Meaning as individual's age gets older, the attitude that they have towards to their age decline (Waweru, Kaabiru, Mbithi, & Some, 2003). Similarly, the

Pearson's correlation result shows that there is a negative correlation between age and attitude of people, though very weak (r=-0.106). The figure indicates that as the age of participants' increases, their attitude to their health is likely to decline. In addition, the attitude to health has also a positive association with the income of participants though weak (r=0.1) which is to mean as the monthly income of participants increase, their attitude towards their health too. The attitude of participants towards health varies across the different levels of education which is similar to the model used as a conceptual framework. From this we can understand that education could enable people to furnish due vale to their health.

Healthcare Seeking behavior and Socioeconomic Characteristic

Age, sex, marital status, education, occupation, etc were explained as factors that shape the health seeking behavior of people (Pillay, 1993). Similarly, Diop, Seshamani, & Mulenga (1998) revealed that socioeconomic characteristics of the household could affect the use of the modern health sector. Sick individuals who are members of households headed by a male have a higher probability of entering the modern health sector (p. 14). Inconsistent to this, this study has found females are more interested to visit immediate healthcare than males.

The study also found out that there was no marked difference in seeking immediate healthcare across the different educational categories which is inconsistent with what was found by Diop, Seshamani, & Mulenga (1998). Their empirical evidence indicate that while sick persons from households headed by individuals with no schooling or with a primary level of education have a comparable likelihood of entering the modern health sector, those from households headed by individuals with secondary level of education or higher have a significantly higher probability of entering the modern health sector (p.14). On the other hand, there was a study which illuminated maternal education has no any association with seeking

immediate healthcare for child illness (Sreeramareddy, Shankar, Sreekumaran, Subba, Joshi, & Ramachandran, 2006).

A study conducted by Waweru, Kaabiru, Mbithi, and Some (2003) disclosed with advancing age, the proportion of those seeking health care reduced. Likewise, Diop, Seshamani, & Mulenga (1998), age operates as a variable affecting the likelihood of entering the modern health sector for curative care. Children and youngster do have more likelihood of seeking entering the modern health sector than people who are above the age of 65 years old. But in this research, healthcare seeking behavior has no a difference across the age of the research participants, though the study incorporates people from the age of 19 to 83. In addition, a study conducted in urban Delhi indicated that a higher household size has a negative relationship with probability of falling sick and lower probability of seeking healthcare (Gupta & Dasgupta, nd). Meaning, people having more household in urban Delhi were more vulnerable to ill health and their motivation to take an aversive health action was insignificant. But, unlike the case in urban Delhi, this study, the quantitative of course, depicted the existence of insignificance difference in the healthcare seeking behavior of the PoP having different household size. Hence, from this we can understand that the size of the household has no association with the likelihood of the PoP to seek prompt healthcare. But as the qualitative evidence informs household size has a detrimental relation with household healthcare seeking behavior, in some instances.

In relation to religiosity and healthcare seeking behavior, it is assumed that the more the religious, the more to seek spiritual healthcare and delay to seek immediate modern healthcare system. Consistently, the study verified the existence of a statistically marked difference in healthcare seeking behavior [professional allopathic] across the level of religiosity was observed among the participants of the study. Client-provider interaction is recognized as playing a

major role in health seeking behavior. An essential factor in determining whether a person seeking health care, complies with treatment and maintains a relationship with the health facility and/or provider is client satisfaction (Olenja, 2003) by which the sound client provider interaction, the better treatment process and seeking healthcare. But the finding of this study completely contradicts with Olenja (2003). Both the qualitative and the quantitative data disclosed that the interaction that they have with the service providers has nothing to do with their care seeking behavior. For example, from the qualitative data, it is possible to understand that providers sometimes disempowered them and even prohibit them from getting medicine and as a result they [the PoP] nag with them. Though they noticed that they are mistreating them against their right, they will never hesitate to visit healthcare by another time.

Health expenditure and budget is one of the indicators of HSB. A study from urban Delhi verified that there is no much difference in health care expenditure among low, middle, and high-income households contributed almost equally to total health expenditure (Gupta & Dasgupta, nd). But in this study, most of the health expenditure of the PoP is covered by the government except when the PoP are requested to buy medicine out of their pocket, rare though. Moreover, all of the PoP in the study didn't budget healthcare costs in either their monthly or yearly expenditure.

Fee waiver and Healthcare Seeking Behaviour

There are two arguments concerning the relationship between the existence of free health care and HSB. While some put it as it enhances once HSB, the other argued the reverse. Direct and indirect treatment costs are among the most commonly mentioned obstacles to adequate HSB of the poor (Worrall, et al., 2003). On the other hand, even if direct costs are affordable, or if medical services are free, indirect costs (for transport, special food, and 'under-the-counter

'fees) can limit access to treatment or lead patients to interrupt therapies (Muela, Ribera & Nyamongo, 2003). In addition, Foster and Anderson (1980) noted that underutilization of modern health services is rarely due to the influence of local beliefs rather depends on the cost of the service especially for the poor. It is generally assumed that interventions for the poor will enhance their material and social capacities to prevent ill health, and to seek appropriate and timely care (Ahmed, Adams, Chowdhury & Bhuiya, nd). Anderson's model which guides this study also put income and policy related issues as an enabling factors.

On the other way, Diop, Seshamani, & Mulenga (1998) noted that fees in the modern health sector and household income have a low effect on the probability of entering the sector. It is distance from the healthcare facility that determines most. Therefore, fee service or insurance might not be able to guarantee true access to needed care for people unless the comprehensive health care provider networks are designed to cover more types of services, be more convenient and have more accessible health care providers.

In the case of this study, the evidences portray the same with the existing literatures. There were PoP who felt the introduction of the scheme has a positive association with their health and HSB. The scheme has played a significant progress in their health because the PoP have got treatment for free and recovered from their illness which is consistent with (Ahmed, Adams, Chowdhury & Bhuiya , nd & Diop, Seshamani & Mulenga, 1998). In this regard, 91.1% of the quantitative participants revealed the improvement of their HSB since their inclusion. This is also consistent enough with Anderson's model which underscores medical aid as one of the enabling factors that is explained in the conceptual framework of the study (Pillay, 1993). In contrary, there were also PoP who claimed that the fee waiver scheme has insignificant influence on their health and HSB which is in harmony with (Diop, Seshamani & Mulenga (1998).

From the findings, we can also be aware of that though the PoP alleged an immense positive contribution of the scheme on their HSB, practically; their prompt healthcare utilization is very low. It is only 55 from 168 PoP that seek immediate healthcare when they get ill. Hence, relatively speaking, the HSB of the PoP had shown progress as of the implementation of the scheme. But, given the existence of free healthcare, the prompt modern healthcare seeking behavior is minimal.

The PoP used to take various measures to as to avert their health concerns. But of all their actions, the PoP dominantly used to transfer other expenses to cover healthcare cost and spiritual healing as a major one. Manipulating their social network, seeking treatment from traditional healers and taking medicine from pharmacy were also used as a solution. Above all, significant portion of the participants revealed that they were forced to ignore the symptoms (16.2%), as last options which used to threaten their health immensely. Here, possibly to say, the scheme is playing a significant role on the health and HSB of the poor and is the right policy response to the health needs of the poor section of the society. This could be explained in terms of the findings that were obtained from the comparison of some health behaviors before and after the inclusion of the PoP. As the Wilcoxon test of comparison revealed, there was a statistically significant difference [meaning progress] in terms of visiting healthcare promptly, waiting to seek treatment till illness gets severe, seeking treatment based on the type of illness, and seeking treatment at modern health care than at home or traditional healthcare.

Conclusion and Implications of the Study

This part of the thesis has two basic sub-sections. The first sub section is concerned with the conclusion and the second is all about the implications of the study to various entities. Both were articulated based on the evidences obtained from the study.

Conclusion

After looking the findings of the study scrutiny, the subsequent concluding remarks were made.

The PoP in the study area used diverse healthcare options including modern healthcare that they can use for free. From the qualitative and quantitative evidence it is possible to paint the healthcare seeking options of the study participants. As it is clearly presented in the result and discussion section, the PoP are indifferent in utilizing professional allopathic immediately especially for mild illnesses rather they were keen to use self-care or ignore the symptom. It is when the illness episode gets severe that they sought the help of professional allopathic. The PoP in the study area, therefore, are not interested to opt for trained allopathic immediately to respond to their sickness rather they seek for other options or ignoring the symptoms and it is at the last stage that the PoP seek help from trained allopathic. Moreover, using over-the-counter drugs is not as such used among the PoP in study area.

As the findings of the study disclosed, participants don't seek prompt healthcare. An illness episode which can bring an immense effect on their health is usually understood as silly and not concerned much. The PoP are more likely interested to maintain their usual activities though they are sick. The PoP in the study area perceived illness as sever and should be treated by the professional allopathic when the person is bed ridden, couldn't work and move or the illness disallow from doing day to day activities. Therefore, to seek healthcare when illness gets

severe seems a normative action among the study participants. From this, we can say that the perception that the PoP had towards the severity of illness had negatively influenced the quick healthcare utilization of the PoP among the study area.

It has been envisaged that peoples' attitude towards their health would have a strong association to seek immediate healthcare. It was confirmed that as the PoP have a positive attitude towards their health, they would start to give due value to their health issues, more likely to consult doctors, interested to worry to their health and ultimately keen to visit immediate healthcare. Thus, from this it is possible deduce that attitude towards health plays a prominent role to seek prompt healthcare among the PoP.

Vividly, intervention has a power to bring progress in human behavior. The commencement of the fee waiver scheme has brought progress in some of the health decisions of the PoP. There is progress in healthcare seeking behavior, providing due value to one's health, change in health care alternative etc. Though there is improvement in the healthcare seeking behavior of the PoP, given the existence of free healthcare service, prompt modern healthcare is still minimal among the PoP.

Socio demographic factors are believed to have an effect on prompt healthcare seeking behavior (Diop, Seshamani, & Mulenga, 1998; Pillay, 1993). Socio demographic characteristic like education, marital status, age, household size, religious affiliation and place of origin has no any association with prompt healthcare utilization among the PoP in the study area. Though the extent varies, religiosity, sex and income of the PoP has a relationship with seeking immediate healthcare among the PoP.

The Ministry of Health has outlined parameters that could enable to identify the PoP both in the urban and rural setting which could be interpreted in to contexts. Accordingly, Gullele Sub

city has drawn the criteria in to its situation and has been benefitting the PoP through fee waiver scheme. But, the process of identifying the beneficiaries in the study area has a problem and the criteria set by the MoH to identify the PoP have not been interpreted duly.

Implications of the Study

This part of the thesis is concerned with the implication behind the findings of the study from various perspectives. In particular, it illuminates the undertone of the study findings in three major areas. These are: what are the implications of the study to Social Work education and practice in Ethiopia, as an infant profession in the country? What are the implications for policy and practice in the area? And what it implies for further research? These issues are incorporated in detail subsequently.

Implication for policy and practice. Ethiopia has gone through with healthcare financing since the recent past so as to best serve citizens. There are schemes which are known to be exempted healthcare and fee waiver system, while the first benefits all irrespective of their economic status, the second targeted the poor section of the society. Dominantly, the cost is covered by donor agencies and partly by the government which raises the question of sustainability and financial burden. Moreover, the scheme is also creating a dependency syndrome on the psyche of the PoP. Whenever the PoP ordered to use out-of-pocket, they hesitate. Therefore, there has to be a policy response that could create self-reliance, for example, a special health insurance system that could best embrace the poorest thereby moving away from free healthcare care service eventually.

Countries use various healthcare safety nets for the lower socioeconomic section of their citizens. But from experience and empirical researches (Ahmed, et al, nd & Diop, Seshamani, and Mulenga, 1998), it is possible to learn that the existence of such healthcare insurances and

other schemes never be a guarantee to be used by the poor. Rather, there are other structural, socio-cultural and psychological states of affairs that condition benefiting out of the scheme. The same is true in this particular study. The people who are named to be eligible for the scheme are not using the system effectively. Thus, for the effective implementation of the policy, a lot has to be done at the grass root level especially on the perception and attitude of the PoP to health and healthcare.

Education is believed to have a paramount role to bring a progressive behavioral change especially formal education has an association with the attitude of one's health and is an input to bring progress on one's health status. Educating the PoP about the causes of diseases, mechanisms of preventing illness, health extension, etc would advance their attitude to their health in a positive direction thereby the likelihood of doing a prompt action on their health problems will be improved. Formal education is, however, a long-term investment, as an alternative and in the short term, therefore, a special health literacy program that targets the PoP has to be applied if an authentic change in the health status of the PoP is needed.

Poverty and health problems are interrelated; one breads the other. Though the health needs are properly addressed through the fee waiver system, the other dimension of their life, living in poverty trap, had not been attempted to curtail which in turn puts them in to health problems. If the intention is to bring a remarkable progress in the health and HSB of the PoP, it would be better if holistic intervention made in these vulnerable sections of the society in an integrated manner. In addition, it was found the existence of problems in properly identifying fee waiver beneficiaries. The PoP are not identified in accord with the parameters of the MoH. Therefore, here, it needs to rethink the organization and management of the service system. MoH

should help and monitor the process of the identifying the PoP at the grass root for the better off implementation of the Policy.

Implication for social work education and practice. It is apparent that addressing the bio-psycho social and spiritual needs of clients is important for the progress of clients. It was observed the absence of Social Worker at the health centers and community which could best help clients holistically. They [the PoP] are treated one dimension of their health and other parts are not given due emphasis. Thus, Social Work, a profession which claims standing in favor of the vulnerable, the PoP in this case, has to produce more Social Workers which could boost the rejuvenation process of the poor, even at diploma and certificate level that could be hired as a social worker in each health center and community. The schools of Social Work education in Ethiopia, mainly the school in Addis Ababa University, need to uphold the issue to be designed as a policy and show the way of its implementation. Moreover, the biomedical model has dominated the process in the health setting. Therefore, Social Wok practice in the health setting has to challenge the biomedical model and need to advocate for the contemporary model in the area-biopsychosocial and spiritual model.

Implications for research. This study invites a number of issues as a research question. As it is reviewed by the researcher, there were scant local researches which highlight the patterns and predominant factors shaping the HSB of the urban poor in Ethiopia. Therefore, the study calls for further researches to focus in these areas to fill the knowledge gap thereby can generate or reveal indigenous knowledge which could best inform the practice in the area. In addition, as the fee waiver scheme is being implemented in the rural and urban settings, it would be better if researches conducted to reveal out a comparative analysis on the HSB of the urban PoP and its

counterpart since the socio-cultural conditions of the two settings, urban and rural, are quite different.

To the best of the researcher of this study, an attempt was made to review the studies that are already conducted about the implementation of the fee waiver system in Ethiopia. But it was found that there are no researches in this regard. Therefore, this study invites future researches to give attention regarding the effectiveness, challenges and prospects of the scheme for the well-off implementation of the scheme. In addition, this study was conducted in urban setting, Addis Ababa, even in one sub city. This informs a country wide research to be done on the issue especially the rural setting, rural PoP, since the majority of the Ethiopian population lives in the rural part of Ethiopia. Moreover, for evidence based practice, the reason behind the gender inequality in seeking prompt healthcare utilization needs future research.

It is lucid that residing in a poverty trap could potentially contribute to different type of health problems, especially to communicable disease. Therefore, it is important if evidences are revealed concerning the predominant diseases that mostly affect the PoP and the healthcare seeking behavior of the PoP to specific types of illness has to be verified. In addition, still traditional healing is significantly being used by the PoP as a solution for their health problem and needs future research regarding their effectiveness of course.

It is generally assumed that policy interventions, as fee waiver schemes, on the poor will enhance their material and social capacities to prevent ill health, and to seek appropriate and timely care. The study confirmed that the prompt modern healthcare seeking behavior of the PoP is low even though availability and affordability of healthcare are not a question since the PoP are eligible free healthcare. Thus, researches have to be done to justify this irony.

References

Addis Ababa Finance & Economic Development Bureau (2010). *Urban development indicators*. Addis Ababa, Ethiopia.

Ahmed, S. M. (2005). Exploring the health seeking behavior of disadvantaged populations in rural Bangladish (published Master's thesis). Stockholm: Karolinska University press.

Ahmed, S., Alayne M., Adams, Chowdhury, M. & Bhuiya, A. (nd). Changing health-seeking behavior in Matlab, Bangladesh: do development interventions matter? Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12917272

Alam, N., Khanam, R. & Shahed Hossain, S. (2000). Healthcare-Seeking Behavior and BCC Needs for Urban Population: A Qualitative Study. Jahangirnagar University, Savar, Dhaka. Retrieved from http://www.icddrb.org/what-we-do/publications/doc_download/1

Ali, S. (2012) Sample Size Calculation and Sampling Techniques. *Learning research. Retrieved from http://ecommons.aku.edu/cgi/viewcontent.cgi?article=1012&con.*

Anagaw Mebratie, Poel, E., Zelalem Debebe, Degnet Abebaw, Getnet Alemu & Bedi, A., (2013). Self-reported health care seeking behavior in rural Ethiopia: Evidence from clinical vignette. *Working Paper, No.551.* Retrieved from http://repub.eur.nl/res/pub/38648/wp551.pdf

Andersen (1995). Revisiting the behavioral model and access to medical care: Does it matter? *Journal of Health and Social Behavior, 36, 1.* Retrived From http://globalhealth.stanford.edu/resources/Revisiting_Behavi.

Assesfa Amenu, Nash, J., Tefera Tamiru, & Byass, P. (2000). Patterns of health seeking behavior amongst leprosy patients in the former Shao province. *Ethiop. J. Health Dev.14(1):43-47.*

Bakeera, K., Wamala, S., Galea, S., State, A., Peterson, S., and Pariyo, G. (2009).Community

perceptions and factors influencing utilization of health services in Uganda. *International Journal for Equity in Health.* Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2717964/

Bohner, G., and N. Dickel. 2011. Attitudes and attitude change. *Annual Review of Psychology* 62:391–417. DOI: 10.1146/annurev.psych.121208.131609

Carpetta, P. (2003). *Social research: theory, methods and techniques*. London, Thousand auks & New Delhi: Sage Publications.

Chaya, N. (2007). Poor access to health services: Ways Ethiopia is overcoming it. *Research Commentary (Volume 2.).* Accessed on Nov. 25, 2012 from http://populationaction.org/wp-content/uploads/2012/01/Health.

Cohen, L., Manion, L. & Morrison, K. (2007). *Research methods in education* (6th ed.), UK: Routledge.

Corno, L. (2008). Switching (or not) health seeking behavior: evidence from rural Tanzania. Bocconi University. Retrived from http://www.csae.ox.ac.uk/conferences/2007-EDiA-LaWBiDC/paper

Creswell, J. W. (2007). *Qualitative inquiry research design*. Thousand, London, Oaks, New Delhi: Sage publications.

CSA (2011). *Ethiopia demographic and health survey*: *preliminary report.* Addis Ababa, Ethiopia.

CSA (2007). Population and housing census of Ethiopia. Addis Ababa, Ethiopia.

Diop, F., Seshamani, V., and Mulenga, C. (1998). Household Health Seeking Behavior in

Zambia. Maryland: Abt Associates Inc. Retrieved From http://www.phrplus.org/Pubs/te20fin.pdf

Enquobahrie Asmamaw (2004). *Understanding poverty: the Ethiopian context (a paper presented at the Gambia AAPAM Roundtable conference*, Banjul, Gambia. Retrieved from http://unpan1.un.org/intradoc/groups/public/documents/aapam/

Fitsum Girma, Chali Jira & Belaineh Girma (2007). Health services utilization and associated factors in Jimma zone, south west Ethiopia. *Ethiop. J. Health. Sci. (Suppl 1):85-94.* Retrived from http://www.ejhs.ju.edu.et/admin/Volume-21-Num5/HSUAF.pdf

FMOH (2012). *Implementation manual for healthcare financing reforms final document* Addis Ababa, Ethiopia.

FMoH (2011). *Health Sector Development Program IV 2010/11 – 2014/15.Final Draft.* Addis Ababa, Ethiopia.

Foster, *G.*, & Anderson, B. (1980). American Anthropologist, 82: 145–147. doi: 10.1525/aa.1980.82.1.02a00300

Gupta, I., and Dasgupta, P. (nd). Health-seeking Behavior in urban Delhi: An Exploratory Study. *World Health and Population. Vol. 3, No.2.* doi:10.12927.whp..17580.

Harris, R. J. (1985). *A primer of multivariate statistics* (2nd ed.). New York: Academic Press

Karim, A., Wuleta Betemariam, Samuel Yalew, Hibret Alemu, Carnell, M. & Yared Mekonnen (2010). Programmatic correlates of maternal healthcare seeking behaviors in Ethiopia. *Ethiop. J. Health Dev. Special Issue 1:92-99.*

Kikwawila Study Group (1994).Qualitative Research Methods: Teaching materials from a TDR workshop. Retrived from http://www.gfmer.ch/SRH-Course-2012/research-methodology/pdf

Malanyaon, O. (1995). Health seeking behavior of urban poor communities. *Discussion paper series no. 95-13*. Philippine Institute for development studies. Retrived from http://www3.pids.gov.ph/ris/dps/pidsdps9513.pdf

Montgomery, M., R. (2009). Urban poverty and health in developing Countries. Population Bulletins *Vol. 64, No.2.* Stony Brook University. Retrieved from http://www.popcouncil.org/pdfs/wp/184.pdf

Muela, S. H., Ribera, J. M., & Nyamongo, I. (2003). Health seeking behavior and the health system response. *DCPP Working Paper No. 14.* Swiss Tropical Institute, Universitat Autònoma de Barcelona, and University of Nairobi. Retrived from http://www.dcp2.org/file/29/wp14.pdf

Muggah, R. (2012). Researching the urban dilemma: urbanization, poverty and violence. from http://www.idrc.ca/EN/Programs/Social_and_Economic_Policy/Go.

Olenja, J. (2003 ed.). Health seeking behavior in context. *East African medical journal.* University of Nairobi. Retrieved on Dec 12, 2012 from http://www.uonbi.ac.ke/departments/staff_profile.php?id=8656

Pillay, B. (1993).A study of the relation between health attitudes, values and Beliefs and help-seeking behaviour among black patients attending a general Hospital. PhD dissertation. Retrieved from http://hdl.handle.net/10413/312

Pope, C., Ziebland, S. and Mays, N. (2000).Qualitative research in health care: Analyzing qualitative data: *Education and Debate.* Retrieved from http://www.ascellon.com/WorkArea/linkit.aspx?LinkIdentifier

Ritchie, J. and Lewis, J. (2003). *Qualitative Research Practice: A guide for social science students and researchers.* London: SAGE Publications.

Robert, T., M. (1997). *Measurement and evaluation in psychology and education* (6th ed.). New Jersey: Prentice-Hall, Inc.

Rubin, A. & Babbie, E. (2011). *Research method for social work* (7th ed.). Canada: Linda Schreiber.

Sotharith, C. (nd). Urban Poverty and Social Safety Net in Cambodia. Retrieved from http://yataisuo.cass.cn/UploadFile/200591723544269.pdf

Sreeramareddy, C., Shankar, R., Sreekumaran, B., Subba, S., Joshi, H. and Ramachandran, U. (2006). Care seeking behavior for childhood illness- a questionnaire survey in western Nepal. doi:10.1186/1472-698X-6-7

Suadiq Sufian Ali (2011). *Health seeking behavior of Afar people* (unpublished Master's thesis), Department of Sociology, Addis Ababa University..

Tipping, G. (2000). Healthcare seeking behavior in Asian Transitional Economies: a literature review and annotated bibliography. Brighton: Sussex BN 1 9RE. Retrieved from http://www.ids.ac.uk/files/DB17.pdf

USAID (2012). Health care financing reform in Ethiopia: improving quality and equity. Hailu Zelelew: Author. Retrieved from http://www.healthsystems2020.org/files/85865_file_Ethiopia_H

Vanderstoep S. & Johnson, D. (2009). *Research methods for everyday life: blending qualitative and quantitative approaches*. San Francisco: Jossey-Bass.

Vries-Schot, M., Pieper, J. & Van Uden, M. (2011). Mature religiosity scale validity of a new questionnaire. *European Journal of Mental Health.* 7 (2012) 57–71 DOI: 10.5708/EJMH.7.2012.1.3

Wagstaff, A. (2001). Poverty and health: CMH Working Paper Series, Paper No. WG1 5,

March, Cambridge and Geneva. Retrieved from http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2001/03/20/000094946_01030305572311/Rendered/PDF/multi_page.pdf

Wamai, R. (2009). Reviewing Ethiopia's Health System Development. *International Medical community 52(4): 279–286.* Retrieved from http://www.med.or.jp/english/journal/pdf/2009_04/279_286.pdf

Waweru, L. M., Kaabiru, E. W., Mbithi, J. N., and Some, E. S. (2003). Health status and health seeking behavior of the elderly persons in Dagoretti Division, Nairobi. *East African Medical Journal Vol. 80 No. 2.* Retrieved from http://www.ajol.info/index.php/eamj/article/download/8647/1916

WHO (2011). Addressing health of the urban poor in South-East Asia Region: challenges and opportunities. New Delhi: Mahatma Gandhi Marg.

WHO, World Bank & Voices of the poor (nd). Dying for Change: poor people's experience of *health and ill-health.* Retrieved from http://www.who.int/hdp/publications/dying_change.pdf.

World Bank (2005). Ethiopia: *A Country Status Report Poverty*, Volume 2, Main *on Health and Report.* Washington, DC. Retrieved from https://openknowledge.worldbank.org/handle/10986/8687

Worrall, E., Basu, S. & Hanson, K. (2003). The relationship between socio-economic status and malaria: a review of the literature. Background paper for "Ensuring that malaria control interventions reach the poor". Retrived from http://siteresources.worldbank.org/INTMALARIA/Resources/SESM...

Yount, R. (2006). Populations and sampling. Retrieved from

http://www.napce.org/documents/research-design-yount/07_Samp

Zewdie Birhanu, Alemseged Abdissa, Tefera Belachew, Amare Deribew, Hailemariam Segni, Vivien, T., Kim, M., & Fiona, M., R.(2012). Health seeking behavior for cervical cancer in Ethiopia: a qualitative study. *International Journal for Equity in Health.* ISSN 1475-9276. Retrieved from http://www.equityhealthj.com/content/11/1/83

Zwi, A. B., Blignault, I., Glazebrook, D., Correia, V., Bateman Steel, C.R., Ferreira, E. & Pinto, B.M. (2009). Timor-Leste healthcare seeking behavior study. The University of New South Wales, Sydney. Retrieved from http://www.sphcm.med.unsw.edu.au/SPHCMWeb.nsf/page/Timor-Leste

Appendix I: SPSS Output Tables

Table 1: Socioeconomic and Demographic Characteristics of Survey Participants

Socio-demographic characteristics		Frequency	Percent	Socio-demographic characteristics		Frequency	percent
Sex	Male	75	44.6	**Origin**	Rural	129	76.8
	Female	93	55.4		Urban	39	23.2
Age	<25	2	1.2	**Household size**	<3	31	18.45
	26-40	47	27.97		4-6	89	52.97
	41-55	54	32.14		7-9	42	25
	56-70	59	35.1		>10	6	3.6
	71-85	6	3.6		Total	168	100
Level of Education	Illiterate	60	35.7	**Religion**	Orthodox	125	74.4
	Read and write	56	33.3		Muslim	37	22.0
	Primary	46	27.4		Protestant	5	3.0
	High school	6	3.6		Catholic	1	0.6
					Total	168	100
Head of the household	Mother	81	48.2	**Ethnicity**	Amhara	59	35.1
	Father	66	39.3		Oromo	46	27.4
	Grand parent	4	2.4		Tigre	27	16.1
	Child	11	6.5		Gamo	27	16.1
	Brother	5	3		Gurage	5	3.0
	Aunt	1	0.6		Welayita	1	0.6
					Siltie	3	1.8
Average Monthly Income	100-300	48	28.6	**Major Source of Income**	Petty trade	26	15.5
	301-500	81	48.2		Daily Labor	44	26.2
	501-700	35	20.8		Pension	31	18.5
	701-900	3	1.8		Employed	27	16.1
	>900	1	0.6		Renting property	2	1.2
Marital Status	Never married	11	6.5				
	Married	63	37.5		Farming	1	0.6
	Widowed	54	32.1		Waiving	20	11.9
	Divorced	35	20.8		Relative support	14	8.3
	Separated	5	3.0		Begging	2	1.2
	Total	168	100		Other	1	0.6

Table 2. Socioeconomic and Demographic details of the Qualitative participants'

Participants	Sex	Age	Educational Background	Sources of income	Religion	Ethnicity	Household size
KI-1	Female	30	Nurse	UHEW	NA**	NA**	NA**
KI-2	Female	27	Nurse	UHEW	NA**	NA**	NA**
KI-3	Female	27	Nurse	UHEW	NA**	NA**	NA**
KI-4	Male	45	Health officer	Official	NA*	NA**	NA**
KI-5	Female	34	Health officer	Official	NA*	NA**	NA**
KI-6	Female	29	12 completed	Card Section	NA*	NA**	NA**
IDI-1	Male	78	Illiterate	Farmer	OC	Amhara	3
IDI-2	Female	56	Read & write	Petty trade	OC	Amhara	4
IDI-3	Male	42	Read & write	Daily laborer	OC	Oromo	6
IDI-4	Female	30	Illiterate	Housewife	OC	Amhara	5
IDI-5	Female	27	Illiterate	Petty trade	OC	Amhara	3
IDI-6	Female	38	Read & write	Petty trade	OC	Gurage	4
IDI-7	Male	50	Illiterate	Waiver	OC	Gamo	2
IDI-8	Female	29	Illiterate	Daily laborer	OC	Gamo	3

[Note. ** NA=Not Applicable: Collecting some basic information from key participants was exempted. IDI= In-depth Interview, KI=Key Informant, OC=Orthodox Christian, UHEW= Urban Health Extension Worker]

Table 3. Healthcare Alternatives of the PoP

Healthcare alternatives: Multiple Response	N	Responses Percent	Percent of Cases
Self-medication	75	21.2%	44.6%
Spiritual healing	84	23.7%	50.0%
Traditional Healer	24	6.8%	14.3%
Pharmacy	3	0.8%	1.8%
Professional Allopathic	168	47.5%	100.0%
Total	354	100.0%	210.7%

Table 4. Decision Power for Healthcare Options by Respondents

Who decides?	Frequency	Percent
Mother	73	43.5
Father	53	31.5
All do have equal power	27	16.1
The household member who gets ill	4	2.4
Brother/sister/child	9	5.4
Aunt	2	1.2
Total	168	100.0

Table 5: the Definition of Health by the PoP (MR)

Definition of Health by the PoP	Responses N	Responses Percent	Percent of Cases
Absence of disease	104	31.1%	61.9%
Able to work/move	123	36.8%	73.2%
Remaining clean	8	2.4%	4.8%
Few children	9	2.7%	5.4%
children play	4	1.2%	2.4%
Look good	6	1.8%	3.6%
Mind remain fresh	50	15.0%	29.8%
Able to eat what one have	29	8.7%	17.3%
peaceful life	1	0.3%	0.6%
Total	**334**	**100.0%**	**198.8%**

Table 6: Perceived Causes of Illness by the PoP (MR)

Perceived Causes Of Illness (MR)	Responses N	Responses %	Percent of Cases
Biogenic	147	66.2%	88.0%
Cultural/religious	8	3.6%	4.8%
Socioeconomic	63	28.4%	37.7%
I don't know	4	1.8%	2.4%
Total	222	100%	132.9%

Table 7: Types of Health Problem and Perceived Cue/Prompt for Seeking Medical Help

Illness Types	Perceived cue/prompt for treatment					Total
	Physical signs	advice by another person	Inability to cope with normal responsibilities	Routine health check	Other	
Chronic	4	0	0	0	0	4
Acute	73	8	1	1	1	84
For all Types	77	1	1	0	0	80

Table 8. Time to Seek Treatment and First Line of Action during Illness Episode

Perceived Time to Seek Treatment	**Frequency**	**Percent**	**Perceived first line of action during**	**Frequency**	**Percent**
Within 24 hours	53	31.5	Seek immediate help from medical professionals	128	76.2
After 24 hours	1	0.6	Wait and see if condition improves	2	1.2
When it get sever	43	25.6	Pray and expect a miracle	2	1.2
Depends on the type of illness	70	41.7	Wait till it gets sever	35	20.8
Other	1	.6	Other	1	.6
Total	168	100.0	Total	168	100

Table 9. Perceived Client-providers interaction and Perceived benefit of healthcare

Responses	Do you think that the healthcare providers are friendly and empathetic?		Do you think that seeking treatment in healthcare institutions is important?	
	Frequency	Percent	Frequency	Percent
Yes	153	91.1	167	99.4
No	15	8.9	1	.6
Total	168	100.0	168	100.0

Table 10: Perception of Severity of Illness by the PoP (MR)

Perception of the severity of illness	Responses		Percent of Cases
	N	Percent	
When illness prevents from routine activities	65	22.2%	38.9%
When failed to walk	91	31.1%	54.5%
When the person fail to handle activities independently and seek the help of others	9	3.1%	5.4%
When the person is bed-ridden	117	39.9%	70.1%
When I thought that the illness can cause disability or other sever problems	9	3.1%	5.4%
Failed to eat	2	0.7%	1.2%
Total	**293**	**100.0%**	**175.4%**

Table 11. Chi-square Test of Association between Religious Affiliation and Prompt Healthcare Seeking Behavior

Chi-Square Tests	Value	Df	Sig.	Symmetric Measures		Value	Sig.
Pearson Chi-Square	12.07	3	.007		Phi	.268	.007
Likelihood Ratio	13.88	3	.003	Nominal by Nominal			
Linear-by-Linear Association	.690	1	.406	Valid cases		168	
Valid Cases	168						

Table 12: Chi-Square Tests of Perceiving the Severity of Illness Bed Ridden And Prompt Healthcare

	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. 1
Pearson Chi-Square	26.159	1	.000		
Continuity Correction	24.362	1	.000		
Likelihood Ratio	25.407	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear	26.003	1	.000		
N of Valid Cases	168				

Table 13. Descriptive Statistics of Religiously of the PoP (When Recoded)

Religiosity of respondents	Frequency	Percent	Valid Percent	Cumulative Percent
Very Weak	3	1.8	1.8	1.8
Weak	26	15.5	15.5	17.3
Religious	116	69.0	69.0	86.3
Very Religious	23	13.7	13.7	100.0
Total	168	100.0	100.0	

Appendix II: Questionnaire

PART I. Socioeconomic Details (Please indicate your answers in the space/box provided in the each of the questions.)

1. Sex 1= Male 2= Female ☐	2. Age__________
3. Marital status 1= Never married 2= Married 3= Widowed 4= Divorced 5= Separated ☐	4. Religious affiliation 1= Orthodox Christian 2= Muslim 3= Catholic 4= Protestant 5= Others (specify_________) ☐
5. Who is the head of the household? 1= Mother 2= Father 3=Grand parent 4= Child 5= Other (specify________) ☐	6. House hold size _______ 7. Ethnicity 1= Amhara 2= Oromo 3= Tigre 4= = other (specify________) ☐
8. Major sources of income 1= Petty trade 2= Daily Labor 3= Pension 4=Employed 5=Renting Property (House) 6=Farming 7=Waiving 8=Relative support 9= Begging 10=others (specify___________) ☐	9. Highest level of education attained 1=Illiterate 2=Read and write 3=Elementary 4=High school 5=College and above ☐ 10. Place of birth/Origin 1= rural 2= urban ☐
11. Household income per a month (on average)_____________ 12. Does your household include health care costs in your monthly/annual expenditures? 1= Yes 2= No ☐	13. If 'yes': Average Household expenditure for health and health care annually: ________

PART II. Questions Regarding Treatment options

14. Do you visit health centers or any other alternative immediately after your first symptom?
1=Yes
2=No

15. Options sought when you and your household get ill	1= Self medication 2= Spiritual healing 3= Traditional healer 4=Drug stores (pharmacies) 5= Professional allopathic 6= Ignore the symptom 7=Other(Specify_______________)
16. Have you ever used anything other than that given to you by a medical professional to treat illness? 1= Yes 2= No	
17. If 'yes' for Q. 18, which type of treatment options you have used? 1= Self medication 2= Spiritual healing 3= Traditional healer 4=Drug stores (pharmacies) 5= Other(Specify_______________)	
18. How often do you generally seek health care at a health center or hospital? 1= twice per a year 2= Once per year 3= Once in past 5 years 4= Never in past 5 years 5=Never in the future even	
19. Who decides the treatment option sought when one of the member of the household get sick? 1= The mother 2= The father 3= All do have equal power in the process 4= The household member who gets ill 5= Other (specify) 20. Do you seek healthcare immediately your sickness? 1= Yes 2= No	

PART III. Health Perceptions Questions

General perception (Please put your answers in the box provided in each questions)

21. What does health mean for you? (Multiple responses is possible)

1= Absence of disease
2= Able to work/move
3= Remaining clean
4= Few children
5= Children can play
6= Looks good
7= Mind remains fresh
8= Able to eat what one have
9= other (specify_________)

22. Perceived causes of illness(Multiple responses is possible)
    1= Biogenic (heredity, infection, environmental pollution)
    2= Cultural/religious
    3= Socioeconomic
    4= other (Specify__________)
23. Perceived cue/prompt before seeking medical help(Multiple responses is possible)
    1= Physical signs
    2= Advice by another person
    3= Inability to cope with normal responsibilities
    4= Routine health check
    5= due to mass media campaign
    6= Others______________
24. For what type of health problem you seek treatment? (Multiple responses is possible)
    1= Chronic
    2= Acute
    3= For all type of illness
    4= I don't seek at all
25. When do you think that a person should seek medical care?
    1= within 24 hours
    2= after 24 hours
    3= When it get sever
    4= It depends on the type of illness
    5= I don't seek whenever
    6= Other Specify -----------------
26. Do you think that seeking treatment in healthcare institutions is important?
    1=Yes
    2=No
27. Do you think that the healthcare providers are friendly and empathetic?
    1=Yes
    2= No
28. What do you think should be the first line of action when someone gets ill?
    1= Seek immediate help from medical professionals
    2= Wait and see if condition improves
    3= Pray and expect a miracle
    4= Seek help from traditional healer
    5= Wait till it gets sever
    6= other (specify__________)
29. How do you perceive the severity of an illness?

1. When illness prevents from routine activities
2. When failed to walk
3. When the person fail to handle activities independently and seek the help of others
4. When the person is bed-ridden
5. When I thought that the illness can cause disability or other sever problems
6. Other specify_______________

Perception Towards Health and Healthcare

30. Please read each of the following statements, and then respond to each statement by saying either true or false.

Item	True	False
1. I seem to get sick a little easier than other people since I am poor		
2. My body seems to resist illness very well		
3. Being healthy is to mean not being sick for a long time		
4. When I'm sick, I try to just keep going as usual		
5. I think my health will be worse in the future than it is now		
6. I worry about my health more than other people worry about their health		
7. One should take previously prescribed medicine for an illness which seems similar to the previous one		
8. It is better to stop taking medicine even if the regimen prescribed has not been completed		

Part IV: Attitude towards healthcare providers, health and healthcare institutions

Dear respondent! Read each of the following statements that states your attitude towards healthcare and healthcare providers and rate your stand by saying strongly agree (5), agree (4), neutral (3), disagree (2) and strongly disagree (5). Please encircle the numbers which represents your affiliation towards each of the statements.

31. **Attitude towards healthcare providers**

1. Healthcare providers are not always correct				
1	2	3	4	5

Strongly agree	Agree	Neutral	disagree	Strongly disagree
2. The healthcare providers are friendly and empathetic				
5	4	3	2	1
Strongly agree	Agree	Neutral	Disagree	Strongly disagree
3. I feel that doctors simply prescribe medicine than providing a holistic treatment				
1	2	3	4	5
Strongly agree	Agree	Neutral	disagree	Strongly disagree
4. Healthcare providers are helpful to improve patients health				
5	4	3	2	1
Strongly agree	Agree	Neutral	Disagree	Strongly disagree
5. Healthcare providers are corruptive				
1	2	3	4	5
Strongly agree	Agree	Neutral	disagree	Strongly disagree
6. The health care providers don't not ensure confidentiality and privacy				
1	2	3	4	5
Strongly agree	Agree	Neutral	disagree	Strongly disagree
7. The health care providers took more time to examine and listening my concerns				
5	4	3	2	1
Strongly agree	Agree	Neutral	Disagree	Strongly disagree

For researcher only
Sum total=

32. Attitude towards Health

1. I try to avoid letting illness interfere with my life				
5	4	3	2	1
Strongly agree	Agree	Neutral	Disagree	Strongly disagree
2. Health is the base for other aspects of life				
5	4	3	2	1
Strongly agree	Agree	Neutral	Disagree	Strongly disagree
3. It is only the ill that that should consult healthcare providers				
1	2	3	4	5

Strongly agree Agree Neutral disagree Strongly disagree
4. I don't like to go to the healthcare institutions 1 2 3 4 5 Strongly agree Agree Neutral disagree Strongly disagree
5. Getting sick sometimes is part of a life 1 2 3 4 5 Strongly agree Agree Neutral disagree Strongly disagree
6. If I get sick, I seek treatment immediately 5 4 3 2 1 Strongly agree Agree Neutral Disagree Strongly disagree

For researcher only Sum total=

33. Attitude towards Healthcare Institutions

1. Public health facilities are as good as the private ones 5 4 3 2 1 Strongly agree Agree Neutral Disagree Strongly disagree
2. I would prefer a private than the public one if costs are the same 1 2 3 4 5 Strongly agree Agree Neutral disagree Strongly disagree
3. I visit public health facilities since the service is for free 1 2 3 4 5 Strongly agree Agree Neutral disagree Strongly disagree
4. Public health facilities don't have the necessary medical equipments 1 2 3 4 5 Strongly agree Agree Neutral disagree Strongly disagree
5. Public health facilities are not clean enough 1 2 3 4 5 Strongly agree Agree Neutral disagree Strongly disagree
6. Public health facilities have long waiting time 1 2 3 4 5 Strongly Agree Agree Neutral disagree Strongly disagree

For researcher only Sum total=

34. The following statements attempt to measure your religiosity. Please indicate to what extent you agree or disagree with the following statements by encircling the alternatives given.

HEALTH SEEKING BEHAVIOUR AMONG URBAN POOR

1. Although I believe in my religion, many other things are more important in life. 1 Strongly agree · 2 Agree · 3 Neutral · 4 disagree · 5 Strongly disagree
2. I rarely attend the religious festivity of my religion 1 Strongly agree · 2 Agree · 3 Neutral · 4 disagree · 5 Strongly disagree
3. I always fast as per the expectation of my religion 5 Strongly agree · 4 Agree · 3 Neutral · 2 Disagree · 1 Strongly disagree
4. My beliefs in God give meaning to my life's joys and sorrows. 5 Strongly agree · 4 Agree · 3 Neutral · 2 Disagree · 1 Strongly disagree
5. I rarely read the bible or other religious literatures 1 Strongly agree · 2 Agree · 3 Neutral · 4 disagree · 5 Strongly disagree
6. I am trying to fulfill my God-given purpose in life 5 Strongly agree · 4 Agree · 3 Neutral · 2 Disagree · 1 Strongly disagree
7. My whole approach to life is based on my religion. 5 Strongly agree · 4 Agree · 3 Neutral · 2 Disagree · 1 Strongly disagree
8. I feel that religious healing is not as effective as any other healings 1 Strongly agree · 2 Agree · 3 Neutral · 4 disagree · 5 Strongly disagree
9. My religious beliefs makes me not to have trust on physicians and healthcare system 5 Strongly agree · 4 Agree · 3 Neutral · 2 Disagree · 1 Strongly disagree
10. I feel that I am knowledgeable concerning the dogma of my religion 5 Strongly agree · 4 Agree · 3 Neutral · 2 Disagree · 1 Strongly disagree

PART V. Question regarding the Fee waiver

35. Answer every question by marking the answer as indicated. After your inclusion in the fee waiver scheme, how would you rate your health, in general, now?

    5= Much better now than my inclusion

    4= Somewhat better now than my inclusion

    3= About the same as before my inclusion

    2= Somewhat worse now than my inclusion

    1= Much worse now than my inclusion

36. Do you think that your healthcare seeking behavior has improved favorably after your inclusion in the scheme of fee waiver?

    1= Yes

    2= No

37. If 'yes', in general, what would you say on your healthcare seeking behavior after your inclusion in the fee waiver system?

    5 = Very improved

    4= improved

    3= No change at all

    2= Poor

    1= Very poor

38. What would you do if you get ill before your inclusion in the fee waiver scheme?

    1= I will transfer other expenses for medical treatment

    2= Seek help from my social network

    3= Seek treatment from traditional healers since it is less costly

    4= Praying

    5= Taking medicines from pharmacies

    6= Seek help from NGOs for medical service

    7= Ignoring the symptoms

    8= other (specify______________)

39. Dear respondent! Read each of the following statements and respond your stand by saying either 'Yes' or 'No'. You can use this × to indicate your response.

Items	Yes (1)	No (2)
1. Physicians don't treat as equally as those clients who are paying out-of-pocket- healthcare		
2. The fee waiver scheme is not adequate enough		
3. The fee waiver system has no any implication on our sought for modern medical facilities		
4. The healthcare providers disempowered me due to the fact that they notice as I am privileged for fee waiver		

40. The following statements attempt to describe your perception, attitude, towards health, ill health and healthcare before and after your inclusion in the fee waiver system. You are kindly requested to respond by saying yes or no for both, before and after their inclusion (use × to indicate your affiliation).

Items	**Before your inclusion in fee waiver**		**After your inclusion in fee waiver**	
	Yes (1)	No (2)	Yes (1)	No (2)
1. I go to health facilities promptly when I get sick				
2. I wait to seek treatment till my illness get sever				
3. I seek treatment as per the type of illness				
4. I seek treatment at home or traditional than going modern health facilities				
5. I don't like to visit health facilities though I know that my illness is hurting me				
6. I worry much to my health				

Appendix III: Interview Guide with POP

Exploring Participants' background:

1. Tell me your biographical information including age, household size, religion, ethnicity, education, major source of income, average monthly income
2. Duration of living in Addis Ababa?
3. When did you included in the Fee waiver scheme?

Focus area		**Specific questions**	**Probes**
Perception and attitude towards health and healthcare	Perception	What does health mean for you? For what kinds of health problems do you seek health care? What is the perceived cue/prompt before seeking medical? Is there any relationship between being poor and vulnerability to ill health? If yes, how? Would you explain in detail how illnesses happen? How do you define the severity of disease? What are the benefits of visiting healthcare? What do you think should be the first line of action when someone gets ill?	Acute/chronic? Communicable/non communicable? Why? What? How? Physical signs, advice by another person, inability to cope with normal responsibilities, Routine health check or mass media campaign? Why?
	Attitude	-What is your attitude towards health? -What is your attitude towards healthcare providers? -what is your attitude towards the service provision public health facilities? How do you compare it with the private ones?	-Ones wariness and taking precaution, consulting medical personnel about ones health, visiting healthcare institutions??? -Negative/positive? Client-providers interaction, corruption, empathy, Explain in detail?

		-In terms of cost, service, equipments and staffs, neatness, waiting time, etc?
Medical options sought for treatment	- How are disease treated socially in your community? -What kind of healthcare option do you seek when you get ill? Why? -Do you use any kind of complementary medicine? If yes, what and why?	
Fee waiver system and health seeking behavior	Would you explain the implication that the fee waiver scheme has on your health and HSB? -What measures you used to take before your inclusion in the fee waiver scheme? -How do you explain your interaction with healthcare providers in relation to being beneficiary in the fee waiver system?	Probe on before and after their inclusion regarding health attitude?, perception?, and healthcare seeking behavior? Seeking care promptly, using other care options, worrying to one's health, etc? Is the service adequate enough? Why? Any comment that has to be improved on the waiver scheme?

Appendix IV. Interview Guide for Key Informants

1. Tell me your Position, educational qualification and work experience
2. How do the PoP perceive health and healthcare? How health defined? Perceived severity? Perceived cue?
3. How are disease treated socially in the ultra poor community?
4. What are the treatment alternatives that the ultra poor use dominantly? Why?

5. How do you explain the attitude of the ultra poor towards their health and healthcare? Why?
6. What is your view regarding the healthcare seeking behavior of the ultra poor? Why?
7. How do you explain the impact of the fee waiver scheme on the health and HSB of the PoP?
8. How do you see the health and HSB of the PoP before and after the fee waiver system?
9. What are the challenges with the implementation of the scheme on the poor community?

Appendix V: Informed Consent for Survey Participants

I am Addisu Tegegn, post graduate student from Addis Ababa University, School of Social Work. I am doing my thesis on the health seeking behavior of the 'Poorest of the Poor' (PoP) in Gullele Sub City of Addis Ababa. The objective of the study is to understand the health seeking behavior of the PoP in Gullele Sub City. More specifically, it targets on determining and describing the attitude and perception of the PoP towards health and healthcare, identifying the choices of healthcare, their utilization, and the meaning that the fee waiver system has on the health and healthcare seeking behavior of the poorest sections of the Sub City's populace. The finding of the study will contribute much for policy makers, practitioners and future researchers. Therefore, your participation has a due place for the success of the study.

You, as a resident in *Wereda* 03 or 06 of Gullele Sub City, are selected randomly as a participant. Your name will not be disclosed in any kind of documentation and the information you give is anonymous. It would be kept in secret and be used only for the consumption of academic purpose. There is no expected risk of participating in study beyond losing up to 20 minutes of your time and you have the right to quite at any stages of the process if you feel risky. If you have any question in the progress, feel free to ask and you have also the right not to respond for the question you feel discomfort.

Generally, understanding the objectives of the study, hopefully you are quite positive to work for and collaborate for the success of the study. Putting your signature is not as such a mandatory since you can also assure your informed consent orally.

Date______________________ **Signature of the Participant**______________________

Appendix VI: Amharic Version of the informed Consent for Survey

እኔ አዲሱ ተገኘ በአዲስ አበባ ዩንቨርስቲ ሶሻልወርክ ት/ቤት ማስተርስ ተማሪ ስሆን የመመረቂያ ጹሁፌን የድህ ድሃ የተባሉ የህብረተሰብ ክፍሎች የጤና አገልግሎት የመፈለግ ባህሪቸው ምን እንደሚመስል እያጠነሁ እገኛለሁ፡፡ የጥናቱ ዋና አላማም ድሀ የህብረተሰብ ክፍሎች የጤናና ጤና አገልግሎት ፍላጎትን ማወቅ ነው፡፡

ይህ ጥናት ድሆች ስለጤናቸው፣ ጤና አገልግሎት፤ እና የጤና ተቋማት ያላቸውን አመለካከት፣ አስተሳሰብ እና የጤና እክል ሲያጋጥማቸው የሚወስዷቸውን መፍትሄዎች በጥልቀት ለመዳሰስ ይሞክራል፡፡ ከዚህም የሚገኘው መረጃ በዘርፉ ለሚሰሩ አካላት፣ ተመራማሪዎችና ፖሊሲ ቀራጮች እንደ ግብዐት ሊጠቅም ይችላል፡፡ ስለሆነም የርሰዎ ምላሽ ለጥናቱ ስኬታማነት እጅጉን ስለሚጠቅም ከዚህ በታች የተዘረዘሩትን ጥያቄዎች እንዲመልሱልኝ እጠይቃለሁ፡፡

ምላሽዎ ፍጹም ሚስጥራዊነቱ የተጠበቀ ሲሆን የጥናቱ ሪፖረት ሲቀርብም ማንነቶ ፍጹም አይገለጽም፡፡በጥናቱ በመሳተፈዎ አንዳቺም ጉዳት የማይኖረው ሲሆን በተጨማሪም በማንኛውም ጊዜ ተሳትፎዎን የማቋረጥና ጥያቄ የማቅረብ መብት አለዎት፡፡ በጥናቱ ለመሳተፍ ፍቃደኛ ስለሆኑ እያመሰገንኩ ከታች ፊርመዎትን የማስቀመጥም ሆነ ያለማስቀመጥ መብት አለዎት፡፡

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Appendix VII: Informed Consent for Interview Participants

I am Addisu Tegegn, post graduate student from Addis Ababa University, School of Social Work. I am doing my thesis on the health seeking behavior of the 'Poorest of the Poor' (PoP) in Gullele Sub City of Addis Ababa. The objective of the study is to understand the health seeking behavior of the PoP in Gullele Sub City. More specifically, it targets on determining and describing the attitude and perception of the PoP towards health and healthcare, identifying the choices of healthcare, their utilization, and the meaning that the fee waiver system has on the health and healthcare seeking behavior of the poorest sections of the Sub City's populace. The finding of the study will contribute much for policy makers, practitioners and future researchers. Therefore, your participation has a due place for the success of the study.

You are selected as a participant to share your understanding about the issue understudy. Your name will not be disclosed in any kind of documentation and the information you give is anonymous. It would be kept in secret and be used only for the consumption of academic purpose. There is no expected risk of participating in study beyond losing up to 50 minutes of your time and you have the right to quite at any stages of the process if you feel risky. If you have any question in the progress, feel free to ask and you have also the right not to respond for the question you feel discomfort.

Generally, understanding the objectives of the study, hopefully you are quite positive to work for and collaborate for the success of the study. Based on you consent; I am interested to tape record. Putting your signature is not as such a mandatory since you can also assure your informed consent orally.

Date____________________ **Signature of the Participant**____________________

Appendix VIII. The Amharic Version of the Informed Consent for the Interview

እኔ አዲሱ ተገኘ በአዲስ አበባ ዩንቨርስቲ ሶሻልወርክ ት/ቤት ማስተርስ ተማሪ ስሆን የመመረቂያ ጸሁፌን የድሀ ድሃ የተባሉ የህብረተሰብ ክፍሎች የጤና አገልግሎት የመፈለግ ባህሪቸው ምን እንደሚመስል እያጠነሁ እገኛለሁ:: የጥናቱ ዋና አላማም ድሀ የህብረተሰብ ክፍሎች የጤናና ጤና አገልግሎት ፍላጎትን ማወቅ ነው:: ይህ ጥናት ድሆች ስለጤናቸው፣ ጤና አገልግሎት፤ እና የጤና ተቋማት ያላቸውን አመለካከት፣ አስተሳሰብ እና የጤና እክል ሲያጋጥማቸው የሚወስዷቸውን መፍትሄዎች በጥልቀት ለመዳሰስ ይሞክራል::

ከዚህም የሚገኘው መረጃ በዘርፉ ለሚሰሩ አካላት፣ ተመራማሪዎችና ፖሊሲ ቀራጮች እንደ ግብዐት ሊጠቅም ይችላል:: ስለሆነም የርሰዎ ምላሽ ለጥናቱ ስኬታማነት እጅጉን ስለሚጠቅም ከዚህ በታች የተዘረዘሩትን ጥያቄዎች እንዲመልሱልኝ እጠይቃለሁ:: ምላሽዎ ፍጹም ሚስጥራዊነቱ የተጠበቀ ሲሆን የጥናቱ ሪፖረት ሲቀርብም ማንነቶ ፍጹም አይገለጽም:: በጥናቱ በመሳተፈዎ አንዳቹም ጉዳት የማይኖረው ሲሆን በተጨማሪም በማንኛውም ጊዜ ተሳትፎዎን የማቋረጥና ጥያቄ የማቅረብ መብት አለዎት:: ለምሰበሰበው መረጃ ጥራትና ታአማኒነት ሲባል ፍቃዋደዎ ከሆነ መቅረጸ ድምጽ መጠቀም የምፈልግ ሲሆን ጥናቱ ከተገባዳደ በኋላ የሚደመሰስ ይሆናል::ቃለመጠይቃቹን እስከ 50 ደቂቃ ሊደርስ ይችላል:: በጥናቱ ለመሳተፍ ፍቃደኛ ስለሆኑ እያመሰገንኩ ከታች ፊርመዎትን የማስቀመጥም ሆነ ያለማስቀመጥ መብት አለዎት::

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HEALTH SEEKING BEHAVIOUR AMONG URBAN POOR

Declaration

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

Name: ______________________________

Signature: ______________________________

Place: ______________________________

Date of Submission: ______________________________

This thesis has been submitted for examination with my approval as a university advisor.

Name: ______________________________

Signature: ______________________________