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The Urban Poor and Health Seeking Behavior: The Healthcare Seeking Behavior of the 'Poorest of the Poor' in Addis Ababa, Ethiopia

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Abstract

With unprecedented growth of urbanization, the issue of health and health seeking behavior (HSB) among the urban poor is spiralling. Taking prompt and appropriate health measures becomes unlikely to the urban poor due to the prevailing socioeconomic reality. Illuminating Healthcare seeking behaviour 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 analyse 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 Correlation and Chi Square were employed to see differences and associations. 95

Index terms— fee waiver, healthcare seeking behavior, poorest of the poor, and urban poor.

1 Introduction

a) Background and Justification of the study oor 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. Poor are known for their excelled mortality rate 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 Author ? ?: Jimma University, Ethiopia. e-mail: addisu34@gmail.com conditions, the spiralling 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 diseaseprevention contribute in worsening their health situation (Malanyaon, 1995).

Evidences underscored the two way causal relationship between poverty and health: poverty breads ill health and ill health keeps poor people poor (World **??**ank, 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 district at community level and found out various determinant factors. CSA (2011) survey also showed 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 when and where the PoP seek treatment during ailment and describe the healthcare seeking behaviour of the PoP across different socioeconomic and demographic characteristics of the PoP in Addis Ababa, specifically in Gullele Sub City.

2 b) Objectives of the Study

The study has the following specific objectives Identify the treatment alternatives sought by the PoP to manage ill health Describe the healthcare seeking behaviour of the study participants in relation to various demographic and behavioural variables

3 c) 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 researchers tried 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 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.

4 d) Definition of Concepts

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).

5 II. Research Methods and Design a) Study Population, Sample Size and Sampling Technique

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.

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 in Ethiopia which is lower than Sub City) and each Wereda has its own health centre except one of the Wereda's health

centre 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 centres found in each Woreda. It also underscore that if there is no any health centre in that specific Wereda, the Wereda should have an agreement with the nearby health centre found in another Wereda and hence those POP who are eligible will get the service in health centres 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.

6 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. 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 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). 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 centre (health centres 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.

7 b) 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. 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.

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 (Kikwawila Study Group, 1994, p.10). In-depth interview was made with 8 PoP who are eligible for fee waiver system and an indepth 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. 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 centre). 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.

8 c) 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 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.

9 d) Analytical approach

Obviously, the raw data has no meaning by itself unless it is arranged and analysed properly. First, the quantitative data were cleaned, coded and entered into SPSS for windows version 20 and analysed. 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. Using these statistical tools, association among variables or differences among groups were seen.

Analysing qualitative data is not a simple or quick task. Done properly; it is systematic and rigorous, and therefore labour-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.

10 e) 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, Addis Ababa University; 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, individuals in authority were contacted and created a smooth relationship before the researchers begun the actual data collection. These created trust by approaching respondents friendly and doing all these, a maximum response rate was achieved.

11 III. Findings

This part of the article presents the finding of the study obtained both from the quantitative and qualitative data collection methods. 168 PoP were surveyed, 8 PoP were interviewed and 6 key informants were interviewed from two districts, 03 and 06, of Gullele sub city (see the appendix for the details). The researchers presented both the qualitative and the quantitative data together 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 in relation to the existing empirical works.

12 a) 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. The upcoming table clearly depicts 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.

13 Volume XIV Issue VI Version I

Similarly, an informant from district 06 stated that seeking healthcare at professional allopathic is the last option by the PoP in the district. She said:

As the district 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 district.

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 research participants were asked concerning the frequency of visiting modern healthcare institutions. 65.5% of them seek healthcare at health centres 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 Volume XIV Issue VI Version I ??008) 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).

14 c) Relationship between Demographic characteristics & healthcare seeking behavior Table 3 : Healthcare Seeking Behavior and Sex

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).

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 centre reported that prompt healthcare seeking behavior among the PoP, sometimes, decline as household size of the PoP increase since there is a fixed 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.

With ten items, the religiosity of participants was measured and found out that 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 table focused on this issue.

15 Table 4 : Association between Religiosity and Healthcare Seeking Behavior

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.

16 IV. Discussion

In this part of the research, an attempt was made to relate and compare the finding of the study with existing knowledge and the tenets of the model used as a conceptual frame work. 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.

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, Volume XIV Issue VI Version I 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, it was 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 selfcare, 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.

In relation to socioeconomic characteristic, age, sex, maritalstatus, 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.

17 V. Conclusion and Implications of the Study a) Conclusion

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 overthe-counter drugs is not as such used among the PoP in study area.

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.

18 b) Implications of the Study

Education is believed to have a paramount role to bring a progressive behavioural 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.

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 centres 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 favour 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 centre and community. 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-bio psychosocial and spiritual model.

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.

Figure 1:

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%

Figure 2:

[1]The Urban Poor and Health Seeking Behavior: the Healthcare Seeking Behavior of the 'Poorest of the Poor' in Addis Ababa, Ethiopia

[2]© 2014 Global Journals Inc. (US)

[3]© 2014 Global Journals Inc. (US)The Urban Poor and Health Seeking Behavior: the Healthcare Seeking Behavior of the 'Poorest of the Poor' in Addis Ababa, Ethiopia

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**			

18

Figure 3: - 18 (

Figure 4:

1

Figure 5: Table 1 :

2

Figure 6: Table 2 :

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