JIMMA UNIVERSITY COLLEGE OF SOCIAL SCIENCES AND HUMANITIES DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

SOCIO-CULTURALAND HEALTH CARE FACILITY FACTORS AFFECTING HEALTH SEEKING BEHAVIOR AND THE UTILIZATION OF HEALTH CARE SERVICES

THE CASE OF SHEKI AND HOFFOLE KEBELES AT DEDO DISTRICT OF JIMMA ZONE, OROMIA REGION

BY:

ADEM KUNTI CHIKAKO

ADVISOR:

BISRAT TESFA (ASSIST.PROF. OF SOCIAL ANTHROPOLOGY)

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE DEGREE OF MASTERS IN SOCIAL ANTHROPOLOGY

JUNE, 2016

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Acknowledgements

I would like to express my deepest gratitude and heartfelt thanks to my thesis advisor, Mr. Bisrat Tesfa, (An Assist. Prof. in Social Anthropology) for his timely and scholarly help in reading and correcting this thesis. His corrections and critical remarks from the preparation of the proposal to the completion of the thesis were very useful and constructive. I am greatly indebted to my sources of information (cases and key informants) for providing relevant information and for their patience who offered their time to participate in this study during the time of interview. Special thanks also to the research assistants who participated in data collection.

I would also extend my sincere thanks to my wife Zemzem Jewaro with all our children for their consistent and unforgettable encouragement. Last, but not least, my special appreciation is to the school of graduate program of Jimma University for opening the field in master programme.

Abstract

Under the back ground, human health seeking and the resulting health service utilization is affected by multiple factors. The investigation of socio-cultural factors and health care institutional factors influencing health seeking behavior as well as health service utilization informs the health sectors at different levels. The objective was aimed to identify the social and health care institution facility factors affecting the health seeking behavior of the community in the utilization of health care service. The study was under taken in two Kebeles (Sheiki and Hoffole) of Dedo district located in Jimma Zone, Oromia Region.

Methodologically, purposively selected 5 case and 18 key informant community members were used as sources of information. In depth interview, case study, observation and document review were the standard method used for data collection. By its final result, individual, the family, illness characteristics; physical accessibility factors such as travel time from home to facility, availability and cost of transportation and condition of roads, and finally the delay in reaching an adequate health care facility factors include shortages of trained personnel; and competence of available personnel were variables which were influenced the health care service of the study area.

To sum up, in the conclusion, the social conditions in which people live and work can create or destroy individual's health. Lack of income, inappropriate and lack of access to health care systems, social, economic and environmental, cultural, health care facility were some of an influencing factors of health care service seeking behaviors of the community at the study area.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BPR	Business Process Re-engineering
CSA	Central Statistical Agency
EDHS	Ethiopia Demographic and Health Survey
EHNRI	Ethiopian Health and Nutrition Research Institute
EPI	Expanded Program on Immunization
EPRDF	Ethiopia People's Revolutionary Democratic Front
ESPS	Ethiopian Society of Population Studies.
FDRE	Federal Democratic Republic of Ethiopia
FMoH,	Federal Ministry of Health
HEP	Health Extension Program
HIV	Human Immune Virus
HSDP	Health Sector Development Plan
IEC	Information, Education and Communication
IRS	Indoor Residual Spraying
ITN	Insecticide-Treated Nets
JURERCCMHS	Jimma University Research Ethical Review Committee of College of Medicine and Health Sciences
MDG	Millennium Development Goal
PHCU	Primary Health Care Unit
RHBs	Regional Health Bureus
TB	Tubercle Bacillus
UHC	Universal Health Coverage
WHO	World Health Organization

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Chapter One

1. Introduction

1.1. Back ground of the study

Care seeking behavior is the process of care seeking by individuals for improving the perceived disease. The decision making for the treatment seeking is a dynamic and continual process which can be affected by various factors. These factors are divided to internal and external factors. Health care seeking behavior is the situation which is represented by treatment method choice. They include going to public hospital, health center, private hospital and self-treatment. This review engage and describing how the communities engage with services and what factors affect their health care seeking behavior service engagement.

Ethiopia has implemented successive Health Sector Development Plans (HSDPs) since 1997 in four phases. During this period, our country has made huge strides in improving access to health services and improvements in health outcomes. Ethiopia's health indicators have been remarkably improved from one of the worst in Sub-Saharan Africa to amongst the stand out performers in just two decades. The lives of millions of children have been saved, millions of new infections and death from communicable diseases such as HIV, malaria, and tuberculosis have been averted.

All this was done while building a health system that can sustain the gains over the long term. Despite the impressive progress made, Ethiopia still has high rates of morbidity and mortality from preventable causes. There is also disparity in uptake and coverage of high impact interventions amongst different regions and woredas. The quality of health care in terms of improving patient safety, effectiveness, and patient-centeredness, in both public and private facilities, is often inconsistent and unreliable.

The health sector transformation plan, in line with our country's second growth and transformation plan has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system. A focus in quality and equity requires a shift in the status quo to drive improvements at national scale over the next five years. (FMOH, 2015/16 - 2019/20).

The main goal of the health system is ensuring that everyone who needs health services (promotion, prevention, curative, rehabilitative and palliative services) is able to get them without undue hardship. Hence, Universal Health Coverage (UHC) needs to be a goal for Ethiopia's health sector in the coming decades. UHC has been defined as guaranteeing access to all necessary services for everyone while providing protection against financial risk. (ibid).

The National Health Policy has been used as an umbrella for the development of a 20-year comprehensive Health Sector Development Plans (HSDP I-IV) with four consecutive phases (5 year each) that have served as strategy for the implementation of the policy. Literatures report that the implementation of HSDPs has bought improvement of health service coverage through the construction of new health institutions and the availability of medium level health professionals especially Nurses and Health Officers since the inception of HSDP-I in 1997/8.

Promising results were also obtained in prevention and control of communicable diseases such as HIV, TB and malaria after the introduction of Health Extension Program(HEP) comprising 16 packages in the second phase(HSDP-II)(Zerhun ,Admasu,et al.,2014,(FDRE 2010). Though the evidence on institutional delivery and postnatal care is limited, HEP has improved access, coverage and utilization of family planning, antenatal care (ANC) and immunization services (ibid).

In 2010/11, over 73 percent of the total population had access to safe drinking water. Access to primary health care services and coverage of the Expanded Program on Immunization (EPI) were 92.1 percent and 74.5 percent, respectively. Estimated life expectancy at birth is 54 for males and 57 for females. Though these achievements are encouraging, Ethiopia's health sector is far from delivering what is required and the health status of the population is still poor. The low level of health service delivery is due partly to the low level of health sector financing. (FMOH 2010a).

The responsibility for health service delivery and regulation in Ethiopia comports with the decentralized federal arrangement of the country, per the 1995 Constitution. Responsibility of health policy, regulation, and service delivery is shared by the Federal Ministry of Health (FMOH), regional health bureaus and district health offices .Policy development is the responsibility of the FMOH. The implementation of policies, standards, and protocols as well as

the responsibility for service delivery at regional levels is mandated to regional health bureaus. (FMOH 2011).

When we come to Ethiopia's health delivery system, the FMOH has been implementing various activities, including the Business Process Re-engineering (BPR), to improve health service delivery in the country. Service delivery is under reorganization into a three-tier structure of specialized hospitals, general hospitals, and PHCUs. The structure of PHCUs in rural and urban areas will be quite different. With the aim of improving primary health care coverage of the rural population, the government has been implementing the HEP since the HSDP-II, delivering 16 packages of services11 at community and household levels. Although the HEP initially focused on rural settings, because most of the country's health problems are attributed to preventable infectious and communicable diseases, a 24-package urban HEP has been established. (FMOH 2012).

According to the 2010/11 public health sector report, there were 122 hospitals, 2,660 health centers, and 15,095 health posts in the country. In the three-tier system into which the government is reorganizing the health system, a PHCU will consist of five satellite health posts, one health center, and a primary hospital which are expected to serve 100,000 people. Each health post and health center is expected to serve 5,000 and 25,000 people, respectively. Furthermore, the secondary-level, general hospital, will serve 1 million people and the tertiary, specialized hospital, will serve 5 million. In addition, there were 63 hospitals (56 for profit and 7 for non-profit hospitals) and 4,088 clinics (lower, medium and higher level) owned by the private sector (ibid).

Ethiopia's HSDP-IV aims to improve the health workforce ratio from 0.7 per 1,000 to 1.7 per 1,000 population by the program's end in 2015, and the physician to population ratio from 1:37,996 to 1:5,500; this latter ratio is very low compared with the WHO standard of 1:10,000. According to the health sector report, though it is believed that there are enough nurses in the country, their deployment to the rural and hard to reach geographic areas is limited. Additionally, there is a need for an adequate number of nurse-midwives, and anesthesia professionals mainly to improve maternal and child health services.

The training and deployment of health extension workers have been a top priority on which the government has been working. The cumulative number of these workers has steadily increased during the previous years, from 2,737 in 2004/05 to 24,571 in 2007/08, and to 30,948 in 2010/11.

Furthermore, the Accelerated Health Officers Training Program, a bachelor's degree program that includes training on Basic Emergency Obstetric and Newborn Care and Comprehensive Emergency Obstetric and Newborn Care, is on schedule, producing many graduates every year since 2009. A two-year master's program to train health officers in emergency obstetric care was also initiated in several universities. (ibid).

By the end of HSDP-III in 2010, a total of 33,819 HEWs had been trained and deployed, reaching 89% of communities throughout Ethiopia. The country is close to its service provision goal of one HEW per 2,500 people. When HSDP-I, II and III compared and overviewed, the following points were some of its achievements. Within all these programs, there has been encouraging improvements in the coverage and utilization of the health service over the periods of implementation.

In HSDP-I and II, For example, the number of Health Centers has increased from 243 in 1996 to 412 in 2001 (70 % increase at the end of HSDP-I) and subsequently to 600 in 2004. The number of Health Posts increased from 76 in 1996/97 to 1,193 in 2001 and subsequently to 4,211 in 2004. Moreover, the number of Hospitals has increased from 87 in 1996 to 110 in 2001 and then to 131 in 2004. (FMoH: (HSDP-III) 2005/6-2009/10).

In terms of human resource development, the number of graduating health workers and their availability has improved over time, the most remarkable improvement being in Health Officers and Nurses. For instance, the total number of health workers has increased from 16,782 to 37,233 during the period of HSDP-I. This figure further increased to 45,860 by the year 2004 (a year before completion of HSDP-II). Moreover, around 2,800 Health Extension Workers (HEWs) were trained and deployed and 7,138 were admitted for training in 2004/5.During HSDP-I and II, contraceptive coverage improved from 4.0% to 25%; antenatal service from 5% to 42%; and postnatal service from 3.5% to 13.6%. Infectious and Communicable Disease prevention and control such as HIV/AIDS, malaria and tuberculosis are also showing encouraging signs of

improvement. (ibid).

On the other hand, HSDP-III is meant to serve as a comprehensive national plan and as a guiding framework for further regional and woreda detailed planning and implementation of the health sector development activities for the coming five years. The major goals of HSDP-III are improving maternal health, reducing child mortality and combating HIV/AIDS, malaria, TB and other diseases with the ultimate aim of improving the health status of the Ethiopian peoples and achieving the Millennium Development Goals (MDGs). (ibid).

1.2. Statement of the problem

The modern Ethiopian health system has a relatively short history. Moreover, it has been in constant change reflecting progress in the socioeconomic and political changes that took place during the last century particularly in the last two decades, in response to new health reform programs and policies launched locally to coincide with worldwide initiatives on health sector reforms. The significant gap in level of care and access to doctors and nurses and the advantages enjoyed by urban residents as compared to rural residents of the countryside.

According to the Federal Democratic Republic of Ethiopia Ministry of Health Sector Transformation Plan of 2015/16-2019/20 (2008-2012 EFY) report, though good trends are observed in health related MDGs, the number of citizens who are dying from preventable and avoidable causes is still high compared to the global average. According to the report, a considerable number of children and mothers are still dying due to failure to reach them with high impact interventions. For instance, the proportion of stunted children remains high with only a slight decline which exposes the nation to trans-generational consequences for intellectual and physical development. (FMoH, 2015/16-2019-/20).

Furthermore, from the same report, even though encouraging results are witnessed in diseases targeted for global elimination and eradication, incidences happen in some parts of the country, indicative of the need to persistently exert efforts in all parts of the country. In addition to the above idea, in terms of improving an access, although a remarkable progress has been made in improving access to primary health care units through massive expansion of health centers and health posts as well as deployment of low and mid-level health workforce. However, available per capita measures

of outpatient visits and hospital admission reports indicate low service utilization compared to the expansion of health facilities within accessible distance. (ibid).

Access and utilization of health care services is an important public health and policy issue in developing countries. However, through the degree varies the level of health care services is unsatisfactory in many country of the world. One study in rural Arizona minorities witnessed as this is a fact even in United States of America. The reasons identified include, lack of appropriate transportation to and from medical centers, low income, (poverty) and being uninsured, uneven distribution of medical services in the rural areas (only about 9 %) of physicians and 10 % of specialists practice in the rural communities), and closure of rural hospitals due to negative budgets leaving some rural communities with no hospital access (Allison 2005).

Similar studies has done in African countries reported that households' access and utilization of health care systems is highly influenced by economic, socio cultural, and health system related issues. For instance, community-based studies in Nigeria, Rwanda and Ghana indicated that the utilization of maternal health services particularly health facility delivery services remains low (Obasi 2013, Umurungi 2010 and Daniel 2013).

Multiple factors were pointed out as factors for underutilization of health services for antenatal and delivery purposes. As age increases, the residence is far from health care systems or rural women are more likely to deliver at home. Moreover, mothers' socio-economic status found to have strong correlation with institutional delivery in that women and partner with better education, professionals than women engaged in farming and daily labor, those women in households within the richer and richest wealth index and women with good health insurance coverage practiced a better institutional delivery. Cultural beliefs and ideas about pregnancy also had an influence on antenatal care use (Simkada B.et al., 2008).

As indicated above, different researchers have done many researches on health care issue in relating to social factors these affecting the societies' health care service such as of economic, cultural, and religious related factors but these researchers excluded the health care facilities as factors which has been affecting society's health care service seeking behavior which is one of the reason for community's delay in health care service seeking behaviors in the utilization of care service.

For instance, Fitsum, Challi, et.al (2011), study in Jimma zone indicates that factors like demographic, family income (economic), religion as some reasons for low levels of utilization among the community. However, they had omitting the issue of health care service facilities although these factors affecting the community's health care service seeking behavior.

Finally, these researchers in the similar way to the former researchers have also concluded their researches by recommending that health care service utilization level was not satisfactory at the study area. Thus, they recommend that the level of health service utilization should be improved by improving factors maintained earlier by other researchers without including health care facilities as factors.

In addition to what was mentioned earlier, another research which was done in Pakistan on the same topic of health seeking behavior and health service utilization concluded the factors determining the health care behaviors as physical, socio-economic, cultural and political contexts but excluding health care institution with its facility factors. (Babar T. Shaikh and Juanita Hatcher (2004).

Again, another research that was done by Simkhada, (2008) on the factors that affecting the utilization of antenatal care in developing countries showed that the main factors affecting the utilization of antenatal care in developing countries is mainly due to social, political and economic status of the given country. Similar to the above research studies, this researcher also suggested that adequate utilization of antenatal care cannot be achieved merely by establishing health centers; and women's overall (social, political and economic) status needs to be considered. (ibid).

Therefore, from these all reviewed literature, although health care service facility factors played its own role on individual's service seeking behavior, these researchers didn't take into account how health care service facilities has its own impact on individual's service seeking behavior in health care organization system.

But for the researcher, not only social factors but also health care service facilities played their role for individual's delay in health care seeking behavior. For instance, physical availability of health care institution, the way of reception and health care service visitor's psychological treatment in the health care institution, the issue of drug cost difference between different health care center which is now a days the serious matter of the community. Finally, what makes this study different from other studies is by the following points. When most of studies in health care

service tried to connect different social factors in relation to women (with reproductive health), the researcher's study was relating these factors from the whole communities aspect.

Hence, the study includes not only social factors but also health care facility related factors are also reasons for the community's delay in health service seeking behavior in the health care service utilization system of the community.

1.3. Research Questions

- What are the socio-cultural factors affecting health care service seeking behavior and utilization of health services by the community in the study area?
- How are health care facility factors affecting health care service seeking behavior of the community in the study area?
- What are the socio-economic factors affecting health care service seeking behavior of the community in the study area?

1.4. Objective of the Study

1.4.1. General objective

The main objective of this study is to investigate the socio-cultural and health care service facility factors that are affecting health care seeking behavior and utilization of health services in in Sheki and Hoffolle kebeles of Dedo district, Oromia Region.

1.4.2. Specific objectives

- To assess the socio-cultural factors affecting community's health care seeking behavior and the utilization of health care service in the two kebeles.
- To investigate the economic factors affecting the health care seeking behavior and utilization of health services by the residents of the two kebeles.
- To assess how the accessibility factors affecting community's health care service seeking behavior of the community in the study area?
- To analyze how health care service facility factors are affecting the health care seeking behavior and utilization of health services by the residents of the two kebeles.
- To make inquiry on the measures needed to improve the health care seeking behavior and and utilization of health services in the two kebeles studied.

1.5. Significance of the study

From health care service point of view, the study explored valuable information on the factors influencing individual's health care seeking behavior and the utilization of health care service. Hence, the findings of this study will be an input for officials at different of the health sector to design the necessary mechanisms to improve community's health seeking behavior and utilization of health services.

In addition to an input, for instance, this study fill the gap and might be a reference point for policy makers in the Ministry of Health, as well as other key decision makers, civil society groups and interested international organizations on the implementation strategies health care service facility issues to improve problematic factors that can be seen in health care service institution and on the factors that enabled and inhibited care success across a meaningful range of health services from the social factors to service care facility factors at the health care center that directly or indirectly affecting an individual's health access and utilization trend of our society.

Finally, the study will also important for research academicians in order to take additional research having this study as their reference point along with development programs in the future.

1.6. Limitations of the study

The main limitation of this study was its dependence only on a qualitative research approach. It would have been good if it was complemented by a quantitative paradigm to explore feelings which could not be explained by qualitative analysis. Finally, this was a small scale study to fulfill a Master's degree study requirements so it had limitations in scope, size and analysis. Moreover, the researcher has both financial and time limitations in carrying out the research on a larger scale, even though a larger study would yield a better understanding of the problem.

1.7. Scope and delimitation of the study

To carry out this research work, it is necessary to delimit the scope of the study to the very manageable size. This is because of financial and time constraints Thus, geographically, this study was delimited to Sheki and Hoffole Keble at Dedo district of Jimma Zone.

1.8. Organization of the paper

The first chapter deals with back ground of the study, statement of the problem as well as the objective of the study. It also presents the research questions, significance of the study, delimitation/scope/ and the limitations of the study. The second chapter addresses the conceptual framework of the study and relevant anthropological literature that frames the theoretical orientation. The third chapter presents research methodology with different parts such as selection of the research site, study area and population, the study cases and key informants(as data sources) and sampling procedure, data gathering techniques/methods/ such as in-depth-interview and document analysis, and finally it addresses ethical consideration.

The fourth chapter presents data analysis and interpretation. Finally the fifth and the last chapter include summary, conclusion and recommendation of the thesis.

Chapter Two

2. Review of Related Literature

2.1. Conceptual Framework in Health Seeking Behavior

2.1.1. Understanding health seeking behavior

Care seeking behavior is the process of care seeking by individuals for improving the perceived disease. The decision making for the treatment seeking is a dynamic and continual process which can be affected with various factors. These factors are divided to internal and external factors. Health care seeking behavior is the situation which is represented by treatment method choice. They include going to public hospital, health center, private hospital and self-treatment. This review engage and describing how individuals (populations) engage with services and what factors affect their health care seeking behavior service engagement.(Sara MacKian: 2005)

Research into health care seeking behavior can provide insights into why some people opt out of certain services, why people are late in attending services and/or why some levels of health facilities are bypassed by intended users. These behaviors should be taken into account in organizing the provision of health care, thereby reacting to demand side considerations to maximize utilization and utility of health services to the people (ibid).

Health seeking behavior is not just a one off isolated event. It is part and parcel of a person's, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural and experiential factors. The process of responding to 'illness' or seeking care involves multiple steps (Uzma et al, 1999).

Furthermore, Rahman (2000) demonstrates that a woman's decision to attend a particular health care facility is the composite result of personal need, social forces, the actions of health care providers, the location of services, the unofficial practices of doctors, and in some contexts has very little to do with physical facilities at a particular service point. Although, it is difficult to identify which determinants are most influential in the decision making to utilize health care but existing knowledge suggests that culture, economics, access, perceptions, health knowledge and literacy, belief in efficacy, age, gender and social roles are all among the extensive list of factors

influencing both the choice to seek health care and the assessment of which health care option to utilize for prevention and treatment of illness (Rebhan, D.P., 2008).

Models of health care seeking behavior are complex and dynamic. People do not seek one source of care, and differ in their behaviors according to who is affected and what diseases are experienced. Behavior is also affected by beliefs of causation behind certain diseases, such as evil eye, infection or accident. Furthermore, the decision to seek care is mediated by opportunities to seek care, especially concerning time and cost. These decisions are not isolated to individuals but are embedded in a broader household and social organizational decision process and the capacity to allow seeking of care.

This paper seeks to collect and review available literature and evidence, to understand the socio-cultural and health care facility affecting factors at the study area. It is hoped that understanding population health care seeking behavior and the affecting factors will allow a better appreciation of how the study area population react with the concept of health, health care service provided and interacts with health service providers. Research into health care seeking behavior can provide insights into why some people opt out of certain services, why people are late in attending services and/or why some levels of health facilities are bypassed by intended users.

These behaviors should be taken into account in organizing the provision of health care, thereby reacting to demand side considerations to maximize utilization and utility of health services to the people. According to Altman, B.B.A., (2008), studies on health care seeking behavior can open opportunities to respond with strategies promoting a more desirable interaction between populations and health systems, and efficiency in meeting public health goals. Utilization patterns give an indication of current preferences amongst people already deciding to seek care.

These data shows where populations, given options available to them, feel they receive services most suited to them in terms of cost, convenience, quality and acceptability. Utilization patterns can help inform where a target population already goes for health management, allowing services and referral to be built up and to maximize their impact. They can also indicate where they do not go and where services may be downgraded (ibid).

As a result, researchers, practitioners, educators and policymakers regularly confront questions regarding the extent to which people have access to health care, the quality of this care and the nature of how, where, when and why people utilize (or do not utilize) existing health care resources. The implications of these more recent initiatives suggest a sustained collaborative effort that spans the health care system, research, business, the media and participatory community action.

2.1.2. The Conceptual Framework: The Three Phases of Delay in Health Care Seeking Service.

Many literatures clearly indicated that while distance and cost are major obstacles in the decision to seek care, concerning the health care facility factors, there is evidence that people often consider the quality of care more important than cost. These three factors: distance, cost and quality-alone do not give a full understanding of decision-making process. Their salience as obstacles is ultimately defined by illness-related factors, such as severity. Differential use of health services is also shaped by such variables as gender and socioeconomic status. Patients who make a timely decision to seek care can still experience delay, because the accessibility of health services is an acute problem in the developing world (Pergamon: 1994).

For instance, in rural areas, a woman with an obstetric emergency may find the closest facility equipped only for basic treatments and education, and she may have no way to reach a regional center where resources exist. Finally, arriving at the facility may not lead to the immediate commencement of treatment. Shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, become documentable contributors to maternal deaths. From the clinical literature that about 75% of maternal deaths result from direct obstetric causes, such as hemorrhage, obstructed labor. Infection, toxemia and unsafe abortion (ibid).

From the same literature that a majority of these deaths could have been prevented with timely medical treatment. Delay, therefore, emerges as the pertinent factor contributing to maternal deaths. For instance, Hospital based investigators of maternal mortality have long bemoaned patients' delay in coming for care. However, to blame the patient for the delay would be simplistic.

We view delay as having three phases: Phase I delay, Phase II delay and Phase III delay. Phase I delay is delay in deciding to seek care on the part of' the individual, the family, or both. Examples of factors that shape the decision to seek care include the actors involved in decision-making (individual. spouse, relative, family); the status of women; illness characteristics; distance from the health facility; financial and opportunity costs; previous experience with the health care system; and perceived quality of care. Phase II delay is delay in reaching an adequate health care facility.

Examples include physical accessibility factors, such as distribution of facilities, travel time from home to facility, availability and cost of transportation and condition of roads. Finally, phase III delay is a delay in receiving adequate care at the facility. Here, relevant factors include adequacy of the referral system; shortages of supplies, equipment, and trained personnel; and competence of available personnel (ibid).

2.1.3. Researcher's Approach to the topic

Health promotion programmes worldwide have long been premised on the idea that providing 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, there is growing recognition, in both developed and developing countries, that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behavior. An abundance of descriptive studies on health seeking behavior, highlighting similar and unique factors, demonstrate the complexity of influences on an individual's behavior at a given time and place. (Sara MacKian (2005).

2.1.4. Health Seeking Behaviors: two approaches

Researchers have long been interested in what facilitates the use of health services, and what influences people to behave differently in relation to their health. There has been abundance of studies addressing particular aspects of this debate, carried out in many different countries. For instance, according to Tipping and Segall (1995), firstly there are studies which emphasizes the 'end point' (utilization of the formal system, or health care seeking behavior); secondly, there are those which emphasizes the 'process' (illness response, or health seeking behavior).

Studies demonstrate that 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. In mapping out the factors behind such patterns, there are two broad trends. There are studies which categorize the types of barriers or determinants which lie between patients and services. In this approach, there are as many categorizations and variations in terminology as there are studies, but they tend to fall under the divisions of geographical, social, economic, cultural and organizational factors. (Ibid).

Table 1: An illustration of categorization of health care seeking factors across studies

Author	Geographical	Social	Economic	Cultural	Organisational
Kloos (1990)	**Geographical**	**Socio-economic**		**Cultural**	
Yesudian (1988)		**Demographic**	**Economic**	**Cultural**	**Organisational**
Leslie (1989)			**User factors**		**Service factors**
Anderson (1995)	**Environmental**	**Predisposing and enabling factors**			**Health system**

Source: *Taken from a review of health seeking behavior: problems and prospects. University of Manchester Health systems Development Programme, 2005, UK.*

These categorizations can be further broken down to illustrate the types of measures frequently used. These are grouped under reoccurring determinants in **Table 2**, and placed into key spheres of influence: informal, infrastructure and formal.

Table 2: Breaking down determinants of health care seeking behavior.

Category	**Determinant**	**Details**	**Sphere**
Cultural	Status of women		
Social	Age and sex	Education level Maternal occupation Marital status Economic status	Cultural propriety' (informal)
Socioeconomic	Age and sex		
Economic	Costs of care	Treatment Travel Time	Physical
	Type and severity of illness		
Geographical	Distance and physical access		infrastructure
Organizational	Perceived quality	Standard of drugs Standard of equipment Competence of staff Attitudes of staff Interpersonal process	Technical Staffing Interpersonal (formal)

Source: *Taken from a review of health seeking behavior: problems and prospects. University of Manchester Health systems Development Programme 2005, UK.*

The view is often that the desired health care seeking behavior is for an individual to respond to an illness episode by seeking first and foremost help from a trained allopathic doctor, in a formally recognized health care setting. Yet a consistent finding in many studies is that, for some illnesses, people will chose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities (Ahmed et al, 2001).

2.1.5. Health seeking behaviors: the process of illness response

The second body of work, rooted especially in psychology, looks at health seeking behaviors more generally; drawing out the factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviors or their use of medical care and treatment. Thus whilst in the former literature health care seeking behavior is conceptualized as a 'sequence of remedial actions' taken to rectify 'perceived ill-health'(Ahmed et al, 2000), in the second approach the latter part of the definition, responding specifically to perceived ill-health, may be dropped, as a wider perspective on affirmative, health promoting behaviors is adopted.

A number of 'social cognition models' (Conner and Norman, 1996a) have been developed in this tradition, to predict possible behavior patterns. These are based on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care and personality (Conner and Norman, 1996b). The underlying assumption is that behavior is best understood in terms of an individual's perception of their social environment.

Another model assumption linked to that those who believe they have control over their health are more likely to engage in health promoting behaviors (Normand and Bennett, 1996). The 'health locus of control' construct is therefore utilized to assess the relationship between an individual's actions and experience from previous outcomes. The most popular of these is 'the multidimensional health locus of control measure' (Wallston, 1992).

2.1.6. Theories and models about health care seeking behavior and health service utilization

A theory is a set of interrelated concepts, constructs, and propositions that present a systematic view of a domain of study for the purpose of explaining and predicting phenomena. A model, on the other hand, is a heuristic device for organizing components of a domain of phenomena to show relationships between the parts and the outcome of interest. Scholars from different disciplines distinguish between theories and conceptual models in contrasting ways; however, common distinctions emphasize the degree of generality, formalization, coherence, and causality involved.

Theories tend to encompass broad classes of phenomena, while models are applied to more narrowly defined domains, have less formalization, and make more tentative claims about causality. For example, the social ecology of health model draws on general systems and social science theories, but it is a model and not a theory. It organizes component factors according to levels of influence on health and uses the heuristic device of the iceberg-type figure to depict the relationship between deep structural factors, intermediate factors, and individual factors (Coreil, J. (2008).

2.1.7. Intrapersonal-Level Models

A large number of health behavior models fall within the intrapersonal level of influence because they emphasize cognitive and behavioral factors and are often referred to as cognitive models.
The term cognitive model comes from the root word cognition, which denotes the process of knowing or perceiving. Thus, cognitive models focus on people’s knowledge, attitudes, and perceptions about a topic. As noted previously, much of the early work on health behavior emphasized individuals’ understanding of the factors involved in producing a healthy or unhealthy outcome. Over the years, more specific constructs have been identified to denote more narrowly defined cognitions, such as expectancies and intentions (ibid).

2.1.8. The Health Belief Model

This earliest health belief model (Janz, Champion, & Stretcher, 2002) depicted in **Figure 1.**

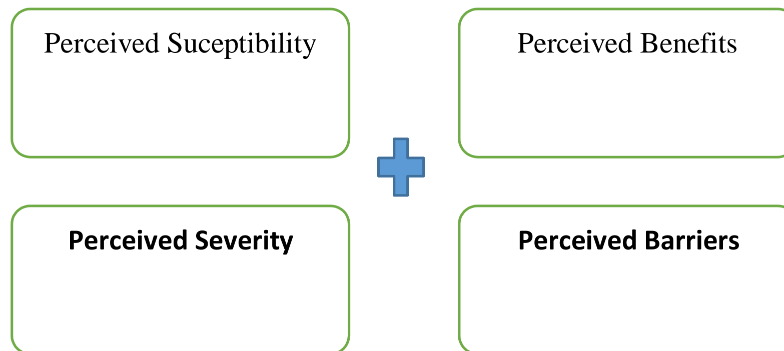


Figure 1: Health Belief Model

Source*: Coreil, J. (2008). Social Science Contributions to Public Health: Overview.*

The model posits that the decision to take action to protect one's health is determined by four factors: (1) whether people consider themselves susceptible to the condition (perceived susceptibility), (2) whether the condition is perceived as having serious personal consequences (perceived severity), (3) whether a specific action is expected to reduce the risk of getting the condition or the consequences of it (perceived benefits), and (4) whether the perceived benefits of the action outweigh the subjective costs or barriers to taking action (perceived barriers).

According to this model, for example, a middle-aged woman in good health may think that she has a very low chance of getting the flu because she hasn't had a bout in many years (susceptibility), and her recollection of the last episode is that it was not that debilitating (severity). She has doubts that the generic flu shot actually protects someone from acquiring the infection (benefit), and she would have to take time off work and drive across town to get one (barrier). In this scenario, the woman's "decisional balance" would probably lead her to decide not to get the immunization.

In contrast, another middle-aged woman with a family history of breast cancer might consider herself at risk for the disease (susceptibility), which she fears as a "death sentence" because several of her relatives have died from it (severity). She has faith that a mammography exam can

detect cancerous growths at an early stage (benefit), her health care plan provides full coverage of the costs, and the mammography service is located in the same building as her primary provider (no barriers). In addition, her doctor provides what the health belief model calls a "cue to action"; that is, he reminds her to get a mammogram when she goes in for an annual checkup. Not surprisingly, this woman receives mammography screening on a regular basis.

2.1.9. Theory of Planned Behavior

The theory of planned behavior, which grew out of the theory of reasoned action, gives primary attention to cognitive factors that influence an individual's "intention" to perform a behavior (Ajzen, 1991).

Intention is singled out as the most proximate determinant of behavior because health-related actions are usually adopted in a conscious or "planned" manner. This model posits that intentional behavior is determined by three factors: (1) attitude toward the behavior, (2) subjective social norms, and (3) perceived behavioral control. The relationship among the model's components is depicted in **Figure 2.**

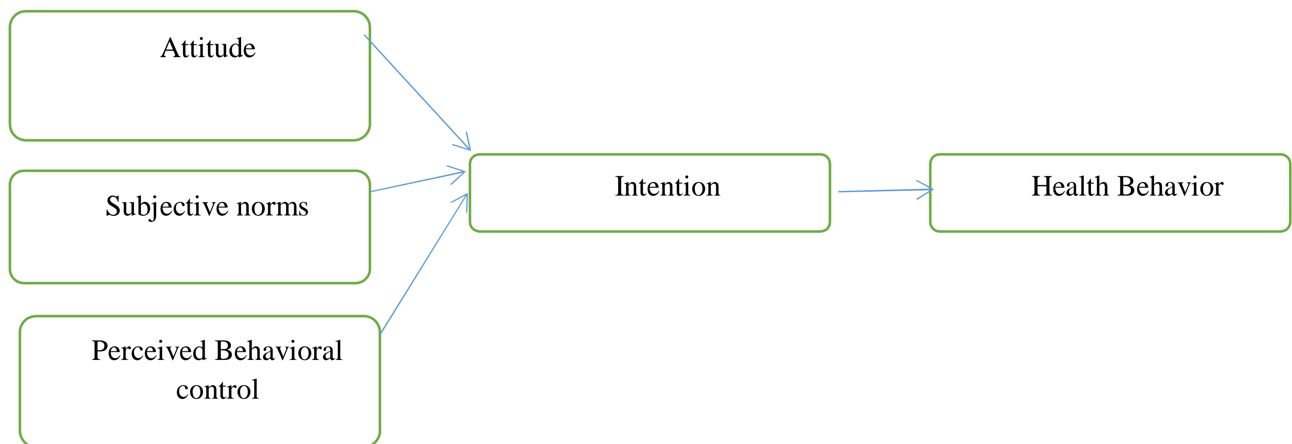


Figure 2. ***Theory of Planned Behavior***

Source: *Coreil, J. (2008). Social Science Contributions to Public Health: Overview.*

Here, an attitude differs from a belief in that it reflects some form of disposition toward the object of attention. Thus, an individual's attitude toward making a dietary change may range from negative to positive on a continuum. Subjective norms refer to people's perceptions of how their reference groups (people they think about when assessing what is normal or socially approved) feel about the behavior.

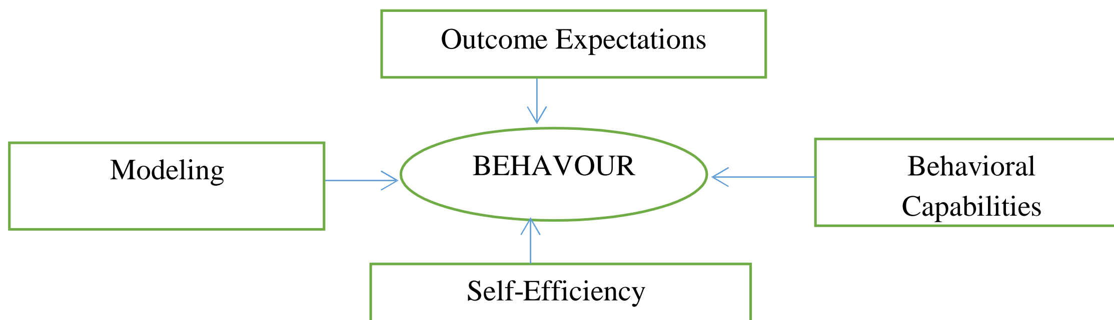
Someone living in a community where others rarely get an annual checkup but instead go to the doctor only when they are obviously sick might feel that getting a specific screening test is unnecessary, too much trouble, and a luxury he or she cannot afford. Perceived behavioral control refers to individuals' assessment of how easy or difficult it will be for them to successfully perform a behavior, a construct that is similar to what other models call "self-efficacy." Early trials at using a condom, for example, may have been problematic for an adolescent, leading to low perceived behavioral control when contemplating future use of condoms.

Putting the parts together, the model predicts that people will plan and carry out a health behavior when their attitude toward the behavior is positive, the people important to them endorse the behavior, and they expect to be able to perform the behavior successfully (ibid).

2.1.10. Organizational-Level Models

Much of the work of public health takes place through organizations, whether these are local or state health departments, community coalitions, civic associations, and schools, health care organizations, nonprofit corporations, professional associations, government agencies, or international organizations.

Figure 3: Organizational-Level Models



Source: *Coreil, J. (2008). Social Science Contributions to Public Health: Overview.*

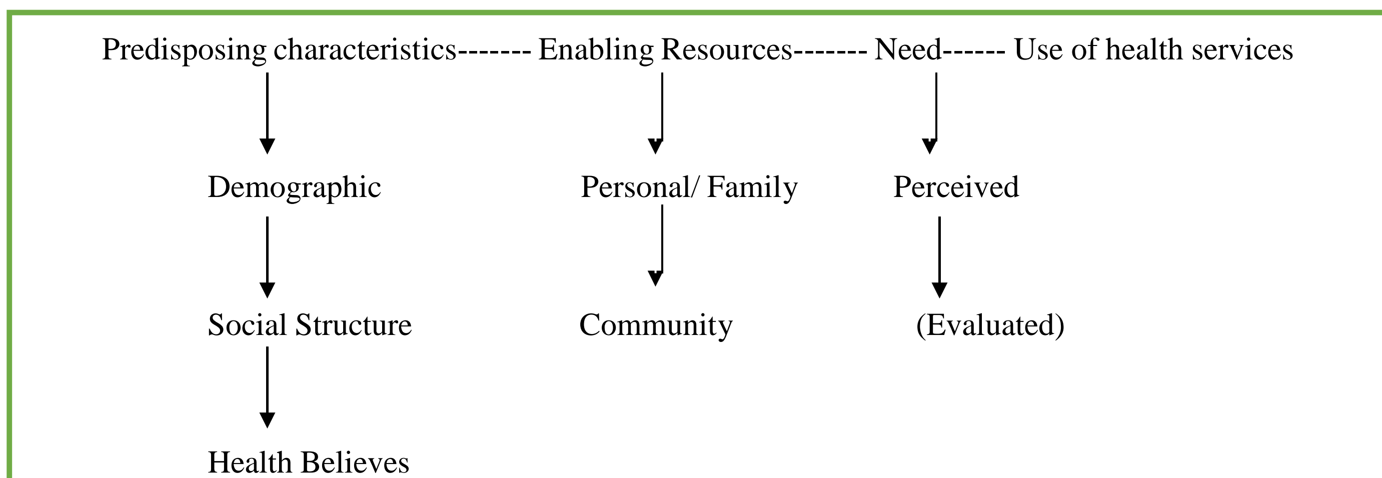
As was seen by the above model figure, thus, organizational theory can be useful in understanding the workings of these complex entities, and it can help plan programs that involve the collaboration of different organizations and sectors of society. For example, organizational culture theory is applied to the professions of medicine and public health, showing how basic values and principles differ in the practices of these institutions.

2.1.11. The Behavioral Model and Access to Health Care Services

The model was initially developed by Andersen in the late 1960s to assist the understanding of why families use health services; to define and measure equitable access to health care; to assist in developing policies to promote equitable access; and, not incidentally. It was not the first or only model at the time, but it did attempt to integrate a number of ideas about the "how's" and "why's" of health services' use.

The model of health services' use originally focused on the family as the unit of analysis because the medical care an individual receives is most certainly a function of the demographic social and economic characteristics of the family as a unit. It suggests that people's use of health services is a function of their predisposition to use services, factors which enable or impede use, and their need for care. The initial behavioral model-the model of the 1960s-is depicted in Figure 4.

Figure 4: The Initial Behavioral Model (1960s



Source: *Coreil, J. (2008). Social Science Contributions to Public Health: Overview.*

The model suggests an explanatory process or causal ordering where the predisposing factors might be exogenous (especially the demographic and social structure), some enabling resources are necessary but not sufficient conditions or use, and some need must be defined for use to actually take place. Among the predisposing characteristics, demographic factors such as age and gender represent biological imperatives suggesting the likelihood that people will need health services (Hulka 1985).

Social structure is measured by a broad array of factors that determine the status of a person in the community, his or her ability to cope with presenting problems and commanding resources to deal with these problems, and how healthy or unhealthy the physical environment is likely to be.

2.1.12. Behavioral and Social Science Theory

Both explanatory theories and change theories are rooted in an understanding of the social determinants of health and health behavior. Many social, cultural, and economic factors contribute to the development, maintenance, and change of health behavior patterns. It is now generally recognized that public health and health promotion interventions are most likely to be effective if they embrace an ecological perspective and include upstream approaches.

Interventions should not only be targeted at individuals but should also affect interpersonal, organizational, and environmental factors influencing health behavior. Today, no single theory or conceptual framework dominates research or practice in health promotion and education. Dozens of theories and models have been used, but only a few of them were used in multiple publications and by several authors. What follows is a description of the central elements of four of the most widely-used theoretical models of health behavior: The health belief model, the trans-theoretical model/stages of change/, social cognitive theory and the social ecological model. Karen Glanz:(2005).

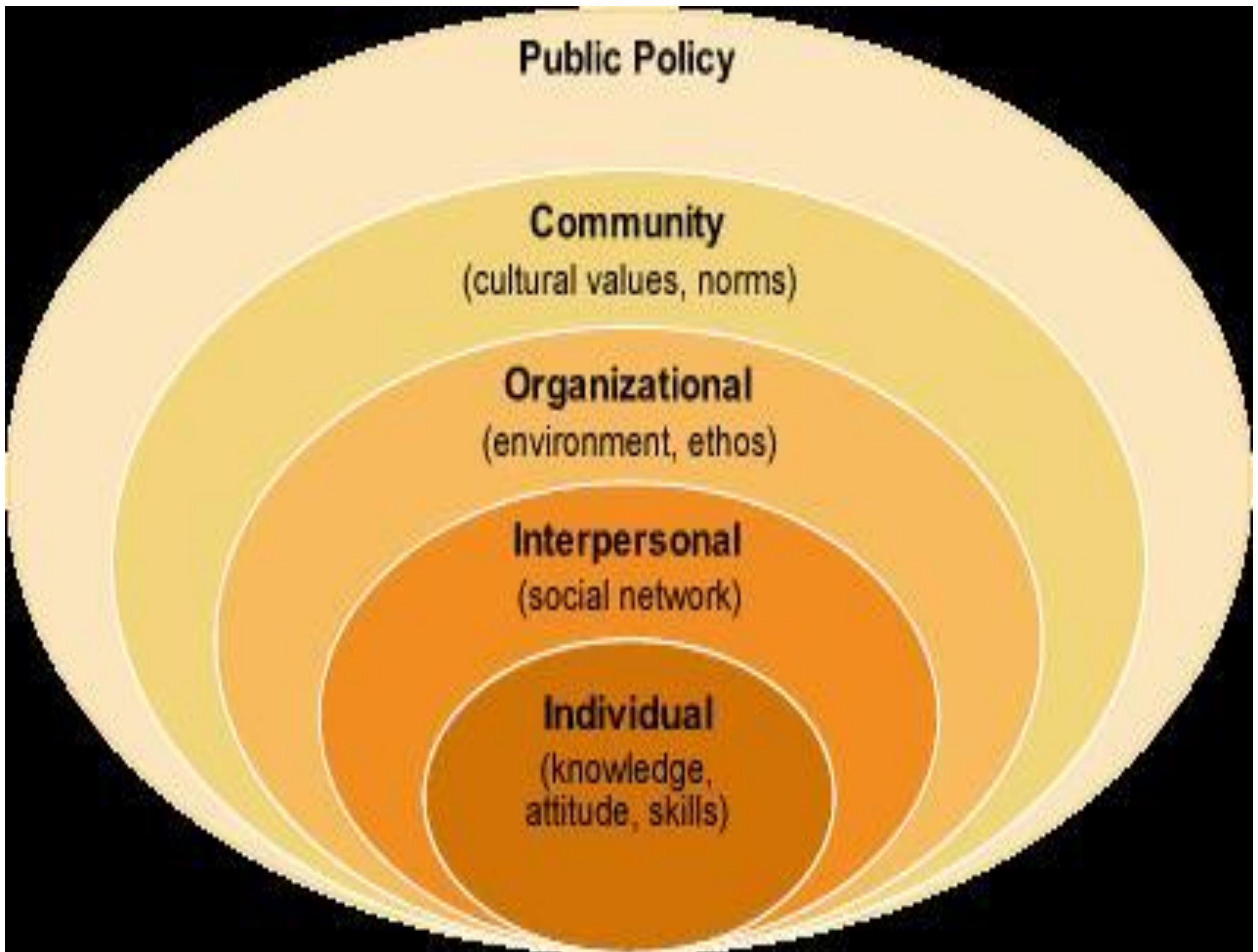
From these behavioral and social science theory mentioned above, let us focus on one of theory that is more explain the topic under study, which is social ecological model.

2.1.13. Social Ecological Model

The social ecological model helps to understand factors affecting behavior and also provides guidance for developing successful programs through social environments.
Social ecological models emphasize multiple levels of influence (such as individual, interpersonal, organizational, community and public policy) and the idea that behaviors both

shape and are shaped by the social environment. The principles of social ecological models are consistent with social cognitive theory concepts which suggest that creating an environment conducive to change is important to making it easier to adopt healthy behaviors.

Figure:5 Social Ecological Model



Source: Karen Glanz: A Guide to Health Behavior and Health Education: Theory, Promotion Practice (2005).

Health behaviors are shaped through a complex interplay of determinants at different levels. For example, physical activity is influenced by self-efficacy at the individual level, social support from family and friends at the interpersonal level, and perceptions of crime and safety at the

community level. Ecological models suggest that these multiple levels of influence interact across levels.

Traditionally, and especially in clinical settings, strategies to change health behaviors have focused on individual-level factors such as knowledge, beliefs, and skills. As ecological thinking has gained currency, intervention strategies have broadened to target factors at other levels of influence such as organizational policies and the built environment. This recognition of the complex range of factors that shape health behaviors can make the selection of intervention strategies daunting (ibid).

2.2. Overview of Ethiopian Health Policy and Programs

The National Health Policy emphasizes core principles of democratization and decentralization of the Health Care System of Ethiopia. Preventive, preventive and curative components of health services in the country have shown a remarkable improvement, meeting equitable and quality health components of health care for all parts of the population and encouraging private and nongovernmental organization participation in the health sector. (WHO, 2008-2011).

The health sector follows a 5-year rolling plan as part of the national development plan. Since 1997–1998, three consecutive phases have been completed and currently the country is implementing the fourth comprehensive Health Sector Development Programme (HSDP). (HSDP IV 2010/2011-2014/15). In line with the national policy of devolution of power, the Federal Ministry of Health and the regional health bureaus focus mainly on policy, strategy and technical support while woreda health offices manage and coordinate the operation of the woreda health system under their jurisdiction.

The health system has had a huge transformation over the past two decades, with a dramatically improved potential access to care through the accelerated expansion of health facilities. An innovative community-level health service, the Health Extension Programme was introduced by training and deploying female health extension workers and institutionalizing community health care at the health post level. Over the past decade, the Government of Ethiopia has given priority to the expansion of health facilities, especially those of primary health care. In order to expand comprehensive obstetric care services further to the community level, the Government is planning an accelerated expansion of primary hospitals in each district. (Ibid).

Recently, the Ministry of Health has introduced a three-tier health care delivery system. Level one is a district health system comprised of a primary hospital (for 60 000–100 000 people), health

centers (for 15 000–25 000 population) and their satellite health posts (for 3000–5000 population), connected to each other by a referral system. The primary hospital, health centers and health posts form a primary health care unit. Level two is a general hospital for 1–1.5 million people and level three is a specialized hospital for 3.5–5 million people. Over the past two decades, the private sector and private-for-profit sector has rapidly expanded. (Ibid).

The current 5-year health sector strategic plan, the HSDP IV is a component of the 5-year national development plan known as the Growth and Transformation Plan. Its priorities are improving maternal and newborn care, improving child health, reversing and maintaining the prevalence of HIV/AIDS, tuberculosis (TB) and malaria.(Ibid).

Despite the improvements made in expanding access to health services, the disease burden is still high and the service utilization rate remains low, partly due to the burden of high out-of-pocket spending that restricts an already poor society from health care utilization. The Government has initiated and is implementing community-based health insurance and social health insurance schemes to address financial barriers to accessing health services.

To improve the quality of health services, the focus is on the provision of quality health services at standard health facilities at all levels, including speedy delivery and effectiveness of services, patient safety, ethical considerations and professionalism, with adequate numbers of health workers and sufficient finance and pharmaceuticals. Quality improvement has become an integral part of service delivery in the health system, thus the Federal Ministry of Health has established a quality management committee and designed a reference manual to guide its implementation. The implementation of HSDP I, II and III has achieved notable results, especially in family planning. (ibid).

Health care facility expansion has improved physical access to health services with an emphasis on primary health care units, resulting in potential health service coverage estimated at 92.2%. In general, service coverage has increased over time, although the performance is not uniform across programmes. Owing to economic, sociocultural and geographical factors, health care utilization is still low, with a 0.36% utilization rate. (WHO, 2008-2011).

The shortage, uneven distribution, poor skill mix and high attrition of trained health professionals remain the major concerns. The medicine supply system is unreliable and has long procurement procedures, resulting in low availability of medicines. Availability of essential medicines is 52%

in the public sector and 88% in the private sector. To monitor the performance of its health services, the Government has designed and adapted a new health management information system and implemented it country wide. However, this health management information system is inadequate for data generation and dissemination and for decision-making at different levels of the health system. (ibid).

2.3. Factors Influencing the Utilization of Health Care Services

Predisposing factors: As the need for health care changes with age, gender, and marital status, utilization of health services also conforms accordingly. Studies in general found U-shaped relationship between age of patients and utilization of health care services. Other predisposing factors like education and family income have been seen to affect utilization of health services. For instance, a study in Ethiopia revealed that educational status of the mothers has a statistically significant association with the utilization of safe delivery services. (Nigussie M, Haile M, D.Mitike, 2004).

Lack of money may lead to self-medication using modern pharmaceuticals and traditional medicines as observed in North West Ethiopia. (Abula T.and Worku A, 2001).
Enabling Factors: Researches have shown that increased distance between residents and health care providers decreases the utilization of health care. (Magnus, 2004).

2.3.1. Socio-cultural factors

All cultures have disease theory systems which include attribution concepts to explain illness causality. Three commonly held paradigms of disease across cultures are naturalistic, personality and emotionality. (Kottak, 2008). These health attributions and beliefs, however, are significantly different from those of Western medicine. Some Asian cultures believe in the yin and yang principle in which there is a balance between opposite forces (e.g. positive and negative, light and dark, hot and cold) that reflect the difference between health and illness. Others believe that illnesses are caused by spirits or ghosts. (Bigby J, 2003).
Eating disorders span both physical and mental boundaries of cultural health. Eating disorders especially in highly industrialized societies continue to rise. Although in some cultures, being stout and plump is associated with good health and prosperity, and certain historical time periods. Have celebrated more voluptuous women (consider the Rubenesque woman) being thin and fit as a cultural ideal for women has increased in popularity. (Crawford, 2004).
In comparison to Western populations, African patients may be more likely to attribute illness to a

spiritual or social cause rather than a physiological or scientific cause. African patients are more likely to expect health practitioners to provide an experiential and a spiritual reason why they have been afflicted with illness. For example, one study found that Ethiopians were more likely to attribute mental illness to cosmic or supernatural causes, including curses or spirit possession. (Mulatu, 2000).

Furthermore, culturally, there are differences in healthcare-seeking behavior across religion. Orthodox Christian households are more likely to seek modern care, to seek higher level modern care and seek care earlier (for adult conditions) as compared with Muslim-headed households. While the reasons for this are not entirely clear, since the estimates control for socioeconomic status, education and ease of access to healthcare, it is possible that the religion variables reflect different levels of confidence and trust in the healthcare system. This finding is not unique to this study. For instance, a study on maternal health-seeking behavior based on the Ethiopian Demographic and Health Survey finds that Muslim women are less likely to seek delivery and postnatal care as compared with Orthodox women. (ESPS, 2008; 14–29).

2.3.2. Socio-economic factors

Health and health problems result from complex interplay of a number of forces including socio-cultural and institutional factors that affecting accessibility and the communities' health service utilization. An individual's health related behaviors/diet and exercise), the surrounding physical environments, and health care/both access and quality/, education level, employment, income, family, social support, religion and cultural believes and community safety are all components of socio-cultural, economic and institutional factors are the basic determinants of health. (Public Health of Los Angeles, 2013).

The social and economic factors are not only the largest single predictor or driver of health outcomes, but also strongly influence health behaviors and greatest contributor to health and longevity. The lower the social and economic position of a population or community, the more common is unhealthy behaviors and the more difficult is to practice healthy ones. (Booske, 2010).

The effects of socio-economic status on health care utilization in developing countries have been extensively documented.

For instance, in Ethiopia, richer households are likely to seek health care both more often and with a greater intensity than poor households. (Reniers G, Tesfai R. 2009). Home delivery is more common among poorer than wealthier women. In a study in Nepal, a higher percentage of women with a higher income level gave birth in a hospital compared with those with a lower

income (Pradhan 2005).

A study among expectant mothers in Ghana found that women from households in the highest income were more likely to demand institutional delivery, by 18 percentage points, compared with women in the lowest income. (Nketiah-Amponsah and Sagoe-Moses 2009).

Another variable that receives considerable attention in the literature is the financial cost of receiving care, which includes transportation costs, physician and facility fees (when they exist), the cost of medications and other supplies, and opportunity costs. Cost and distance often go hand in hand as considerations in the decision-making process. As longer distances entail higher transportation costs. (Young J. C, 1981).

2.3.3. Health-Institution factors

A study in rural India showed that institutional delivery is much more common for first births than for subsequent births (Kesterton et al. 2010). Regarding age at delivery, another study in rural India, Punjab, revealed that institutional deliveries were more common in comparatively younger age groups, at 43 percent for women age 18-25 compared with 23 percent for women age 36-45 (Garg et al. 2010).

Exposure to mass media is also another important factor associated with place of delivery. The same study in Ghana found that women who had access to media/health information via television were more likely to have institutional delivery (Nketiah-Amponsah and Sagoe-Moses 2009).

While distance and cost are major obstacles in the decision to seek care, the relationships are not simple. Institutionally, there is evidence that people often consider the quality of care more important than cost. These three factors-distance, cost and quality-alone do not give a full understanding of decision-making process. Their salience as obstacles is ultimately defined by illness-related factors, such as severity. Differential use of health services is also shaped by such variables as gender and socioeconomic status. Patients who make a timely decision to seek care can still experience delay, because the accessibility of health services is an acute problem in the developing world. For instance, in rural areas, a woman with an obstetric emergency may find the closest facility equipped only for basic treatments and education, and she may have no way to reach a regional center where resources exist. Finally, arriving at the facility may not lead to the

immediate commencement of treatment. Shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, become documentable contributors to maternal deaths. (Pergamon:1994).

Another study showed that, insufficient numbers of medical and nursing personnel at a facility necessarily lead to delays in patients' receiving the care they need. This shortage is often not only a matter of staff numbers; it is also a matter of competence. In other words, there is a shortage of trained, qualified personnel. (Walker G. J. A. et al. 1985.)

2.3.3.1. Culturally non-Competent Health Care Organization factors

Cultural competence in health care describes the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring health care delivery to meet patients' social, cultural and linguistic needs. Becoming a culturally competent health care organization is a critical component in reducing health care disparities. A recent survey by the Institute for Diversity in Health Management, an affiliate of the American Hospital Association, found that 81 percent of hospitals educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities, and 61 percent of hospitals require all employees to attend diversity training. (Health Research & Educational Trust. (2011).

Cultural competence in any health care system produces numerous benefits for the organization, patients and community. For this justification, (Wilson-Stronks, A. and Mutha,S.(2010, October), explain this issue as follows. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients, and increased participation from the local community. (ibid).

Therefore, having these evidence based ideas in mind, becoming a culturally competent organization requires a thorough understanding of the principles that characterize cultural competence. Therefore, to tackle these problems, first, staff needs to understand the factors that are pushing any health care systems to become culturally competent. Health care staff also needs to recognize and understand the cultural and clinical dynamics in interactions with patients.

Becoming culturally competent involves developing and acquiring the skills needed to identify and assist patients from diverse cultures. With the necessary skills and mindset, staff can quickly identify the services required by a patient, thereby increasing positive health outcomes.

To sum up, if any organization(including health care organization), not serving its client according to the societies' culture, culturally non-competent health care organization is one part and parcel of factors that directly or indirectly affecting communities' health seeking behavior in the utilization of health care system.

2.3.3.2 Distance/Accessibility/ factors

The distance separating potential patients from the nearest health facility has been shown to be an important barrier to seeking health care, particularly in rural areas. Distance exerts a dual influence: long distances can be an actual obstacle to reaching a health facility, and they can be a disincentive to even trying to seek care. In addition, the effect of distance becomes stronger when combined with lack of transportation and poor roads. Potential patients who have to walk or ride a mule over rugged terrain will take longer to reach a facility. Distance will therefore be a greater obstacle for them, and act as a greater disincentive to efforts to seek care, than for those who can travel by motorized vehicles on relatively good roads.(Lennox:1984).

2.3.3.3. Quality of care factors

Quality of care is an important consideration in the decision to seek care. Our review found that where potential patients have access to more than one facility, their perception of the quality of care offered at these facilities often takes precedence over concerns about distance. For instance, in the Guatemalan highlands, government health posts seemed to be conveniently located, yet that proximity did not guarantee utilization, probably because the facilities were understaffed and underequipped and thus unable to provide quality care. Detailed on-site inspection of 83% of the operating health posts showed that more than half were understaffed underequipped, or both. (Iyun F. 1983).

2.3.3.4. Illness factors

The literature reviewed indicated that people's recognition of illness and their perception of its severity are important influences on the decision to seek care. In addition to recognition of a health condition, the perceived severity of an illness is a very important factor in the decision to seek care. Utilization of services appears to be influenced by the recognition of symptoms and the assessment that the symptoms are serious enough to justify medical care.

The perception of a condition as normal or minor interacts with cost and distance in the decision to seek care. Just as certain conditions (such as pregnancy) are perceived as 'natural' and therefore not requiring medical care, conditions that are perceived as minor also do not justify the expenses of money, time and travel effort often involved in medical care.(Kloos H. et crl. 1987).

Chapter Three

3. Research Methodology

3.1. Description of the Study area and Population

Dedo is one of the 18 woredas of the Jimma Zone. Dedo is bordered on the south by the Gojeb River which separates it from the Southern Nations, Nationalities and Peoples Region, on the west by Gera, on the north by Kersa, and on the east by Omo Nada. The major town in Dedo is Sheki. The altitude of this woreda ranges from 880 to 2400 meters above sea level. Major peaks include Haro Gebis, Walla, and Derar Korma. Perennial rivers include the Unat, Kawa, Waro and Offele. A survey of the land in this woreda shows that 63.1% is arable or cultivable (38.4% was under annual crops), 13.6% pasture, 9.3% forest, and the remaining 14% is considered swampy, degraded or otherwise unusable. Teff, corn and vegetables are important cash crops. Coffee is also an important cash crop for this woreda; over 50 square kilometers are planted with this crop. Dedo district is one of 18 districts of Jimma zone geographically located south west 21 km far from Jimma town. In the recent political administration division, the district further divided into 54 local administrative Kebeles. (Source: From the 2007 EC local administrative census of the district.)

According to the 2007 EC local administrative census of the district, the majority, approximately (98%) of the population lives in rural areas. The district has 182,300 men and 183,256 women totally constitute about 365,556 populations in in general. Among these total population of the district, 5448 men and 5849 women totally 11,297 and 2735 men and 2595 women totally 5330 population found in Sheki and Hoffole selected Kebles as the study area respectively. At the study district, there are different nationalities and peoples in which the Oromo population has the greater number within political administrative area.

The five largest ethnic groups reported in Dedo were the Oromo (78.87%), the Yem (8.75%), the Kullo (8.54%), the Amhara (1.47%), and the Kafficho (0.94%); all other ethnic groups made up 1.43% of the population. Oromiffa was spoken as a first language by 87.03%, 7.3% Dawro and 2.55% spoke Yemsa, and 1.6% spoke Amharic; the remaining 1.52% spoke all other primary languages reported.

The majority of the inhabitants were Muslim, with 89.57% of the population having reported

they practiced that belief, while 10.11% of the population said they professed Ethiopian Orthodox Christianity. In its health profile, all Keble's of the district has its own health care post center with one medium public health care center commonly functioned in the district common town which has been used as referral health center up to its serving capacity for all 54 kebeles. Finally, one Hospital was built in the city but still no begun health care service function. (Ibid)

3.2 Study Design

According to Creswell, qualitative research is done in naturalistic setting and interpret phenomenon in terms of meaning people brings to them. This method focuses on process, qualities and meaning that cannot be experimentally measured or frequency (Creswell, 2007).

There are different strategies of qualitative research among which case study is one way of study method. Specific case narration is a strategy of inquiry in which the event, activity, process one or more individual is studied. Again through qualitative method, few people /cases intensively and qualitatively arrive at generalization as that of those who studied many people cases are bounded by time of activity and researcher collect detailed information using variety of data collection procedures over a sustained period of time (Creswell 2009).

Qualitative research was used to study the problem at hand. Because, qualitative research is a means for exploring and understanding the meaning individuals or groups ascribe to a social human problem. Qualitative research can be employed when the concern is with people because researcher to study in depth and detail. Furthermore, qualitative method focuses on the in-depth of information rather than generalization of the whole population. Qualitative methods produce a wealth of detailed information about a much smaller of people and case. As described by Patton, qualitative methods produce a wealth of detailed information about a much smaller of people and cases. (Patton: 1990).

In this study, the researcher has chosen specific case narration in order to generate detailed information about the individual's health seeking behavior while in need of health service. Because it would enable the researcher to have an in depth insight of the problem at hand, and thus, the study was bounded to a small geographical lactation, Sheki and Hoffolle, the two sub-kebeles of Dedo district, purposely selected for the study. The data was collected from May 2015 to August 2015.

3.3. Sources of data, sampling technique and sample size

3.3.1. Sources of data

As the health care service seeking behavior of individual is differently characterized among and different members of the society, for the data source, health professionals (nurses, health extension workers), and different members of house hold informants (notable cultural, religious and other community leaders) were included as information sources from these selected kebeles.

3.3.2. Sampling technique and sample size

Although health care service situation is the very problem at the district, after having surveyed the area and consulted the local notable district administrators, the researcher purposely selected two localities for the study. These localities were Sheki and Hoffolle kebele of the Dedo disrict which are located at about 21 and 9 kilometers south west of Jimma zone respectively.

The selection of these sites is attributed to the following personal reasons: Sheki Kebele is located and situated just in the center of the district from where the researcher intended to gather general information about the district. The second selected study area Hoffole was selected for its location on the main road between Jimma and Dedo district which is somewhat better in transportation facility for the researcher at a time. Finally, the number of sample was not pre-determined but depends on data saturation and informant's idea reputation.

The criteria for selection of all cases and key informants were according to their willingness and responsibility in the society. In addition to their responsibility, their social role and their knowledge about the way of life of the local community is taken into consideration. They were selected based on the recommendation of the local community leaders due to their assertiveness and willingness in order to represent all accordingly.

Health care institution managers (nurses) and health extension workers were selected because of their direct daily health care attachment in addition to their willingness and their responsibility. In similar way, community leaders, and religious leader's criteria of selection depended on willingness and their responsibility in the local society. Because, these groups are socially notable persons in the community. Finally, secondary source (health care document review) of data was also taken from health centers clinical dairy as document reviewed.

3.4. Methods of data collection

Data gathering in qualitative research is multi-stage. There is no one and final technique in order to gather the data rather varieties of techniques are used. Relevant information for this study has been collected during data collection period from both primary and secondary sources with the following set of methods such as formal interview, case study, observation and document review. Each technique and procedure was discussed below.

3.4.1. Informant interview

In qualitative research, interview is a major instrument of data gathering (Creswell, 2009). It is used to collect live from the data the interview was conducted in face-to-face encounter (between the researcher and the informant) and in a place where convenient for the interviewees. The interview was conducted in Afan Oromo because of its suitability to the study population; questions were constructed not as an end by themselves rather they were developed in a manner under investigation. Participants were in the age range of 27-52. Interview was lasted for about 45-50 minutes.

Formal in-depth-interview was done with voluntarily selected nurses, health extension workers health professionals, religious and other well-known community leaders as cases and key informants. Semi-structured questionnaires were also used to conduct in-depth personal interviews with voluntarily selected nurses, health extension workers health professionals, religious and other well-known community leaders as cases and key informants. These questionnaires were set with the intention of guiding the informants, rather than restricting them to answering what were just asked to collect additional valuable information beyond the scope of the questionnaires.

The responses of some informants were recorded using audio tape note was taken depending on their willingness to be recorded while of others only note was taken based on their comment. The interview was conducted in the form of local culture mannerly dialogue. This mannerly conversation enabled the cases felt free, relaxed and confident. The researcher and the informants used flexible program. They were not rigid to complete the dialogue based on predetermined time and place. The researcher felt necessary to elicit the required data. Finally, the audio taped data were transcribed by the researcher.

3.4.2. Specific case narration

This method was selected more as a research design because, the specific case narration claims to offer a richness and depth of information not usually offered by other methods. Moreover, this method was selected to identify how a complex set of circumstances come together to produce a particular manifestation although generalizability is not normally as issue for the researcher who is involved in studying a specific situation. Because, generalizability an issue for the readers who want to know whether the findings can be applied elsewhere, whether or not the case being described is sufficiently representative or similar to their own local situation.

3.4.3. Observation

In this study observation was used because, observation is one of the most appropriate methods to gather valuable information in anthropological studies. For instance, in order to take health care related assessment in a locality, survey observations to provide broad descriptions of the key features of the area. For example, whether the area is in inner city, urban or rural; the geographical location; the size of the population, the availability of services, type and location of health care facilities such as hospitals and health centers.

Techniques used for collecting data through observation was written descriptions (record observations of people, a situation or an environment by making notes. Furthermore, photographs were taken through a single shot or series of shots.

3.4.4. Document Review

From the health care center, the clinical daily service provision process was viewed in order to compare and contrast the service user's personal reflection to the health care center service provision in relation to different health care center facility.

3.5. Data Analysis Procedure

According to Creswell 2009 qualitative data analysis is conducted concurrently with gathering data, making interpretation and writing reports. The author further added that case study involves a detailed description of the setting of an individuals followed by analysis of the data for themes or issues. The data gathered by interviews were first transcribed. The researcher attempted to read all the data bit by bit .Continuously till the researcher could get the meaning of those varieties of data collected by different sellected techniques. After a thorough reading of data the researcher attempted to develop categories or codes and reducing the voluminous data into manageable sets

of themes. Using direct quotations and narrative descriptions each theme was analyzed.

3.6. Ethical Consideration

In order to conduct this study, administrative ethical procedures was very important. Therefore, at first the researcher proposed his personal request letter to Jimma University. Next to this step, letter of request was written by Jimma University of College of Social Science and Humanities Department of Sociology and Social Work to Jimma University Research Ethical Review Committee of College of Medicine and Health Sciences (JURERCCMHS).

After the proposal was approved by Jimma University Research Ethical Review Committee of College of Medicine and Health Sciences, another letter was written by JURERCCMHS to Jimma zone health office in which Jimma zone health office proceeded letter of permission to Dedo district where the study had took place.

Finally, the last and go-ahead letter of permission was obtained from Dedo district administrative and health offices. Following the above all maintained sequence, verbal consent was obtained from the study subjects after they were informed about objectives and procedures of the study and their right to refuse participation any time they want was assured. Assurance was given on anonymity of their identity and confidentiality of the information they give.

Chapter Four

4. Data Presentation and Discussion of Results

Strategic policy formation in all health care systems should be based on information relating to health promoting, seeking and utilization behavior and the factors determining these behaviors. All such behaviors occur within some institutional structure such as family, community or the health care services. The factors determining the health behaviors may be seen in various contexts: physical, socio-economic and cultural.

Therefore, the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions, and the disease pattern and health care system itself.

Thus, detailed information and individual accounts, views and self- reflections regarding factors under the study topic were presented as per the category it falls.

4.1. Factors affecting health care seeking behavior

4.1.1 Socio-cultural factors

The specific narration cases and key-informants given their suggestion how different factors affecting health seeking behavior and utilization of health care services. Socio-cultural factors were among the factors that were raised by the study participants. Hence, the responses will be presented successively followed by the views of the key-informants.

Case 1

> *My name is "X", I am 37 years old living in Hoffolle Kebele. I have a husband and seven children. Our life depends on farming. Frankly speaking, I and my children have never been in a position to decide on our family affairs and resources. We depend on my husband's will to visit a health center in times of illness and to fulfill our other needs. Though my children and I have interest to utilize health centers for different types of illness my husband is not usually interested to give us money needed for health cost. For instance, I was suffering from heart burn in 2007 E.C.and I wanted to visit one local- clinic in order to-*

get relief from my illness. However, I was afraid to ask him fearing that he might reject my request as he often does. As the day pass, my health condition got worse and forced me to request him money to go to clinic. But he was willing to give me the money I requested. Rather, he informed me to seek God's help through prayer. Eventually, he arranged a praying occasion with our neighbors and local grandees that resulted in expenditure of money perhaps more than what is needed if I get treatment in the clinic. Though I am feeling better I am still struggling with my health problem as the condition has not been improved completely.

Another woman, a 32 years old key-informant community leader from Hoffolle area stated about the impact of socio-cultural beliefs on the underlying causes of illness and the measures needed to get rid of the health problems in the following way.

Once up on a time, I developed constant pain after giving birth to a normal baby in the nearby clinic. The pain was severe to the extent of making me nagging. After a long wait when things got worse, my husband along with our relatives and neighbor, sit together to discuss solution for my problem. Here, the discussant group was divided in to two. The members of one group agreed about my health problem as there might be an infection. Therefore, they prefer health practitioners advising. However, the second group members agreed without any opposition up on about the problem. Therefore, they agreed up on the evil-eyesight that only can be only cured from local herbal leaf. Finally, the latter group was practicing on me what they agreed up on. But I didn't cure from the then problem all in all except minor progress as the group said, rather still I struggle with the remain problem.

Supporting an idea given earlier, a 36 years old male community leader key informant from Sheik has narrated his views as follows:

In most cases, most of our local community has believed and a tendency to use local traditional medicines as safer than what is prescribed in health care center. For instance, most of the community have concerned about the time, money and the effort they exert in seeking health care service are often wastage. Because most health care service center lacks proper health related facility such as medicine,

available human power and well visitor reception in their medical care center at a time of the community's visit. But in local and cultural medicine, the community have no difficulty of access, cost and well manner of reception. Care provisions are also better in the private health care service center than public health care service center although the cost of medication is higher than the community's capacity particularly for the poor.

Regarding the socio-cultural influence of the area, Mr. "F", a 36 years old key informant from the area explained similar ideas as that of the above informant.

Most of local individuals had seek health care service both traditionally and in a modern way but in most cases, still they more prefer the tradition based way of health care service seeking behavior. The reason was traditional care provision more attracting most of the community as its service care preferred as compared to that of modern way of modern health care service provision due to its access and cost and time. Because, when this situation is applied to any health care service center, community's delay is one the reason in the area.

A 46 years old religious leader from Sheiki Keble narrated health institution factor that affected his health seeking behavior by giving as an example what he encountered during his visit.

Case 2

Once up on a time, I went to the nearby hospital for an immediate treatment. As I had reached the hospital, the doctors tried to check my health problem with all medical facility and soon informed me that your health problem was so serious. Therefore, my health situation of the then forced me for better health facility and regular medical follow up although this would cost a lot of money. Thus, I opted to return back home to seek other options from traditional healers in the area. As I went there, the traditional healer asked the symptoms that soon advised me to bring a white sheep for cultural occasion that I did so. At the slaughtering occasion, the traditional healer threw half of the sheep's meat to the secrete area while the other half was eaten by a group at the ceremony. The next day, soon I recovered from my illness at one night that I was still very surprised. Therefore, still from that day on wards, I begun of advising my fellow members to follow my footsteps if their symptom of illness looks like mine.

A 29 years old health care center health professional key- informant from Hoffolle health center also emphasized on the impact of culture about the community's health care seeking behavior. He stated:

I came across a lot of local community's cultural problems in relation to health seeking behavior including the degree of health care awareness. For instance, once up on at time, a group of men and women came to our health care station carrying pregnant woman whose residence was not so far from the health care center. They brought her having lost lots of blood and their expectation of home delivery fades. For the negligence of her family of seeking an immediate help in local health center. As result of such long time home delay due to the disagreement over the situation, the case of that woman became serous. Finally, when a continuous flows of blood and difficulty in breathing, they forced to bring her to the care center.

A female nurse working in a health center also attributed the low health seeking behavior of the community to the preference of traditional health care over the modern one. In this regard she said that:

From my professional experience, I regularly provide community service regarding public health care awareness as that of other fellow work-mates to enhance communities' concern toward their health. I encourage the society to come forward and visit health centers and posts in their localities early when they felt health problems before the situation gets complex. But most of the societies of the area did not give priority for this modern health related orientations instead, they give high emphasis to local cultural treatment to all care seekers center in most cases for women about their health on preventive aspects. For instance, pregnant women are oriented how to follow up their pregnancy at all steps clinically with the health professionals. But more than half of them do not follow as advised rather they stop checkup service after one or two terms. What is rather chilling is the decline or disregard in seeking health care service during final stage of pregnancy. In other words pregnant women prefer to give birth at home.

4.2. Socio-Economic factors

Similar to other social factors, socio-economic factors may affect community's health care seeking behavior in the utilization of health care services. For instance, a 42 years old mother and religious leader case from Hoffolle area narrated about her socio-economic problem as follows:

Case 3

> *I am the mother of seven families whose father passed away some years ago. Climatic condition around this area is not favorable for farming so we often harvest less than our family needs. When any of our family member came across health problems, we turn to the meager harvest to cover the health cost. This puts extra pressure on the family resources. As we have economic problem, we often visited health care service center only when things are worse.*

Mr. "K", a 30 years old religious leader key informant from Sheki described the socio-economic influence of the area with the following ideas. He stated that:

> *Economic problems are dire in our area. Just to give you one instance, once I met a guy who had come to the health care center with his relative. The man borrowed the money to cover the medical cost for his relatives. After some regular treatment at the health center the problem exacerbated and finally the case referred. So the patient gave up the hope immediately because we are already in debt having borrowed a lot of money. Therefore, he refused to seek health treatment further in order not to cause his family further economic problem. Finally, this individual returned home with frustration and lived for a while and finally died without any additional treatment.*

Mr. "L", a 44 years old community leader, who was another community leader key informant from Sheki area on the other hand, explained the following views. He said:

> *We have different economic back-ground. For instance, some of us are economically better off while others are not. For instance, one economically poor person who has been living in our Keble. One day while we came back from far town to our Keble, unfortunately accident happened to the bus we- were in and as a result my head skull badly injured while my friend sustain leg injury. Following*

this un-expected matter; I follow a consecutive medical follow up even up to Black-Lion Hospital of the country and totally recovered. But my fellow member still remains with one leg totally paralyzed. He also tried his best to his economic level at the local health center although he had an interest for more medication that he was unable to get more medication due to economic shortage.

From Sheki area, Mr. "D", a 38 years old community leader stated his case regarding his economic problem as follows:

<u>Case 4</u>

Recently, I visited the nearby health care center and began treatment at the center for quite some time. But as my health condition became worse, unfortunately, I was forced to visit the zone hospital that the hospital refused me requesting the referral paper. At the time, my option of the then was returning back to the earlier clinic in order to ask the referral paper. But in all doing this, my illness became harsh that I was forced to visit one of private clinic. Here, the payment of the given private clinic I was asked for diagnosis and drug was together three times more than the money I had. Finally, I was immediately back home and forced to visit the nearby traditional healers for local-made medicine with less price without my interest. For that, I didn't blame else except my low level of economic back ground.

4.3. Health Care Service facility Factors Influencing Health Seeking Behavior and Utilization of Health Services

From Sheki area, a 27 years old religious leader key-informant explained about the health care service facility factors of the area. He said that:

I often use this health care center service. From its care service, health care related education service has been unsatisfactory to the information the care seekers expected. Because, the community's health care concept and health care safety mechanism is far from each other. Furthermore, although the concerned body at the health service care center oriented us the way we protected our health although their orientation was lasted only for not less than five or six minutes. Again, this short time-

orientation was not with constant time but according to the concerned body will and self-interest which is always only at morning. Because, an orientation for such short period of time was not cover what is important in health care issues as the care service seekers expected. Therefore, most of the care service seekers didn't so much attracted to come to this care institution. Therefore, instead, we have prefer other area like urban health care center where care facilities are better.

A 52 years old community leader and key informant from Sheki explained to the extent care service facility factors of the area has been affecting the care service seeker at the area. He said that:

Some of care service seekers of the area in most cases preferred to go to the private health care service centers than the public without a credible information about the center facility service paying higher and unfair prices for the services. As to me, paying a lot of money to any health care center doesn't mean getting what was expected. Because, when these care service seekers didn't get the service they have expected, finally, they have frustrated both for their health condition and for money they paid which the issue needs health care service center facility differentiation.

A 30 year's old health-extension worker key informant from Sheki indicated about the local health care facility problem. She said that:

Unfortunately, our health care service users in general and women in particular have no formal education in the area in relation to health care service seeking. For instance, we always advice the health care service users how and when, before and after the health problem about the care service. Furthermore, we observed that, not only these individuals with no formal education, but these group of individuals with formal education particularly women didn't put our effort into practice to the extent what they have been learned and to the degree of our expectation. Compared to the rural health care seekers, visitors who came from town have better focus for their health protection than these who come from far rural areas. For instance, these individuals who have visited the care center from far rural areas come to the center after their health situation became worse and after their money wasted to different unnecessary areas that verily opposes to the recent government health protection effort and policy.

4.3.1. Culturally non-Competent Health Care Organization as factors

Let us see a 31 years old religious leader and the key informant's narration about the issue he came across at their health care center at Sheki health care center as follows:

> *Whenever the care service seekers have visited the Keble public health care station, some workers of the health staff treated them with the language they don't understand, For instance, if not all, some care providers tried to communicate the service seekers in Amharic language which is not commonly spoken in the rural area that the care seekers didn't expect from the local health institution and also we couldn't freely inform them our problem although this manner has not been common behavior of all staff workers. Not only communication and behavior problem at the center, Furthermore, in most cases, women has been hosted by male medical workers and inform their health problem almost by half fearing male medical professionals that makes them hiding what they want to inform to the service provider of the time.*

Among others, the following information was heard from a 44 years old community leader case from Sheki as follows:

Case 5

> *The government constructing health station, clinics and even hospital at every zone's district. But, what has been practically seen at our district is the construction of health care center houses with no available facility such as human power, medicines, and reception beds including the present health care center. Furthermore, one hospital was built at district town three or four years ago by the government effort but still remain without service provision due to an unknown reasons and for its un-functionality no one responsible. Had the hospital began functions, it would have solved many problem including unnecessary transportation cost, time wastage and other health related problems.*

From Sheik's public health care center, a 36 years old nurse key informant's idea supported the above idea.

> *This health care center has been functioning as a district main health care center as a medium referral care center for all kebeles' of the district at their referral stage that sometimes make us with an over load work as we deal with many numbers of care seekers that is beyond our serving capacity in the presence of our many problems such as un-available human power both in terms of numbers and specialty skill. Furthermore, the service care center lacks enough medicines as well as a continuous supervisions. These all issues altogether decreases the quality of health care provided and more affecting the service intended by the service users.*

Regarding the behavior of some health care staffs, a 30 years old health extension worker and key informant from Sheki explained the matter as follows:

> *Repeatedly, I saw when some of our health workers behaved inappropriately in care service provision period towards the health care service seekers. This badly manner in turn deeply frustrated the care service users and negatively affects their health seeking behavior and psychology. For instance, I was told by one of old mother service seeker who has lost her card and so informed to the service provider for help instead of unnecessary re-payment at the station but she was refused and insulted by the service provider of the day that deeply frustrated her. Finally, she was forced to go up to the zone health care center that exposed her for 170 Birr total unplanned payment at the new care service center for the 7 Birr card she had lost.*

The data obtained from a 37 years old a nurse from Hoffole health care center health professional key informant narrated what came across opposite to the idea given above.

> *Although sometimes our clients complain about the service we provided, they themselves dissatisfied by their personal idea. Because, in most cases, they thought as if the health care center provider provide all the service they expected. For instance, most of them do not happy when their case referred to the higher health-care institution. Often they ignored what they had told and finally back to their home with dissatisfactions.*

A 34 years old health care professional of Sheki resident key informant narrated how the dis-agreement between the health service user and provider in one way or another can be influenced the care service provision. He said that:

> *Most of our health care professionals in our health care center serve their clients in well manner although at the same time, some of them did make many mistakes at the time for care advice and service provision. Because, good communication has been important for health care service provider and service user. Once up on a time, for instance, I saw while the visitors waiting the provided service sitting up on a long line seats in front of the health care station, one of our health worker had come from the inside room and had scattered the care service seekers without any tangible reason that made the care seekers in frustration that forced some of them to decide back home and others search other option for the service intended but with additional payment.*

4.4. Geographic accessibility factors

Lack of transportation coupled with poor roads can affect health care service seeking behaviors regardless of the distance. For instance, a 46 years old community leader key informant of Sheki resident explained about geographic accessibility problem of the area. He said that:

> *Our district is found on rugged terrain location which is difficult for transportation to be reach some health care service provision centers particularly for care service from far rural areas to come to the facility. Therefore, by large, the community have been used mule, horse and by far, most of the individuals come to the facility on foot. But at an emergency time, this is very difficult to come to the facility as soon as possible. Furthermore, they have come to the facility carrying their sick and injured person by traditional stretcher as an alternative.*

A 45 years old community leader key informant from Hoffolle explained the local transportation problem similar to the above idea. He said that:

> *In terms of geographical location, our Keble is located between Dedo district and Jimma zone. It has only 9 Km distance from Jimma town. But compared to its distance, transportation is our serious problem. For instance, we have no a regular transportation system in the Keble except some private cars and minibuses*

that transporting us from the district to the zone. Furthermore, the number of these private minibuses are still less in their number when is compared to the population-number in the area. Therefore, we have been used transport cars which have come from Jimma town to Dedo district and vice versa. Most of the time, these private cars forced us an over payment which is above the tariff but this is not fair both for riches and poor. Therefore, this needs an immediate solution from now on onwards.

Among others, a 33 years old nurse key informant from Hoffole health care center supported the above idea to the extent geographic accessibility has been to the care facility has been a serious factors of the study district. He said that:

In our district, we have only one ambulance for health emergency service despite our wide geo-location of the district. Although the district is only 20 km far from the zone, most of the time, our community extremely have been affected by the lack of transportation facility and poor roads which has still an obstacle for the community in-general and the health care service seekers in particular in order to reach particularly from rural to the district and to the zone health care facility center. Of course, there are some private automobiles and cars which have been given unsatisfactory services in relation to the district diverse number of population. Furthermore, as these private automobiles and cars' priority concern has for their self-interest more than the community's interest, transportation service has our serious daily problem especially at an emergency time. If an individual have missed for instance, the morning car turn, he/she must have wait the next turn that has also with uncertainty.

4.5. Discussion of Results

Based on the data gathered from cases, key informants, observation and health care center dairy review socio-cultural, economic, different health care service facility factors were therefore interpreted and discussed for each factors as follows:

Socio-cultural factors has played the great role in the study community's health care service seeking behavior especially on women. For instance, regarding the socio-cultural factors, as earlier discussed with cases, some of the local society particularly women were verily affected whenever they want to have get care service they want. This is because, culturally there is male dominancy at the area. Here, two things are seen clearly.

The first one is patriarchy, meaning the husband is the head of the family and solely maintains the right to own and decide on the family's property despite every member of the family equally worked hard for it. Second, we understood as the husband in the story is not mean because the husband spent substantial amount of money for cultural praying occasion of the woman's health care problem instead of money for modern care service. Regarding the socio cultural influence of women, the following reviewed research justified the study findings.

According to the research, for instance, health care seeking behaviors, therefore, was influenced by male dominancy as well as religious culture in this particular community even though the picture is not the same for every family. Various literatures provided justification for this type of socio-cultural (religious) reflection. (Mulatu, (2000).

Furthermore, the data gathered from key informant revealed that, husband's advice refusal by some wives indicates how far cultural factors entrenched into the community and affect changes in behavior. Normally, this indicate gender difference behavior change. Women are less likely accepts the awareness and orientation as they are more culturally closed. At the same time men also do not force their wife to seek maternal services during the pregnancy even though they have awareness.

In health care service seeking, the society know to what extent health care center has an advantageous to the society especially when things are beyond their local cultural curing capacity. But compared to their respective culture, the community didn't give the priority for modern health

care service with societal modernity in respective of their local culture.

According to the key informant's narration, there is a time when the individual completely divided in opinion in health care service seeking at the modern medical care service as compared to their cultural and traditional mind set-up. Due to such big differences of community's division, there is a time lag in the community for care service utilization. For instance, In comparison to Western populations for instance, stated that African patients may be more likely to attribute illness to a spiritual or social cause rather than a physiological or scientific cause. Moreover, he noted African patients expect health practitioners to provide an experiential and a spiritual reason for their illness. Furthermore, one study made on Ethiopians corroborate this by attributing mental illness to cosmic or supernatural causes, including curses or spirit possession. (Mulatu (2000).

In most cases, most of the local community have a tendency to use and believe local traditional medicines as safer than what is prescribed in health care center. Because, they more concerned about the time, money and the effort they exert in seeking health care service in most areas of health care. For instance, in their health service seeking behavior, the societies have more accessed to traditional healers culturally. Because, culturally this didn't solve only their health problems instead according to them save their time, because of less medicine price as well as due to less distance that geographically they have from health care service center.

Culturally, in addition to what was mentioned earlier, case's data revealed that, from health seeking point of view, despite the individual's visit to the modern health care, but sometimes there has been a time when they lost what they earlier expected, therefore, they have changed their idea of service seeking to cultural health care seeking practices. This is on one hand, by fearing the time they spent at the health care service center, and on the other hand, due to local religious-culture which forced them to traditional healer for cultural treatment at their locality whether they recover or not with uncertainty.

On their part, the key informants were also described about the issue. The data collected from the key informant indicated that, for instance, an individual's geographically nearest to the health care service institution, lag for care service due to their local culture some times over shadowed and polarized opinions among the groups regarding what and when to do. From this the indication

was sometimes even determined when an individual's health problem forced itself and left the aids with little option than seeking hospitalization. This long delay in turn made the degree of treatment more complex both for health workers and care service clients.

Regardless of continuous health care related orientations, key informant's data justified to what extent the local society fails to turn the awareness into practice as required. Therefore, more time and persistent efforts are needed to break the status quo of cultural and social hindrance.

From the ideas of cases and key informants, Generally speaking, geographical nearness to the given local health care center does not mean determined community's care seeking behavior as it depends because of their local culture. Because, the local society fails to turn the awareness into practice as required due to the local cultural emphasis.

On the other hand, case's data reveled that, at the area, economic problems hinders health care service provision of the poor groups when compared to rich groups although seeking care service was their ambition behavior. This also has some reviewed research justification. For instance, the social and economic factors are not only the largest single predictor or driver of health outcomes, but also strongly influence health behaviors and greatest contributor to health and longevity. The lower the social and economic position of a population or community, the more common is unhealthy behaviors and the more difficult is to practice healthy ones. (Booske, 2010).

On the other hand, the key informant narration indicated that, since all the community not self-sufficient and at equal level economically, economic problem of one family could cause an economic hardship even for relatives and neighbors as economically unable groups borrowed money from their relatives for care service.

On the other hand, the difference between individuals in economic back-ground also made individuals health care service seeking different. For instance, as discussed with the key informant, these individuals economically better have better degree of care seeking up to their ability and economic capacity while others are not.

As indicated from the case's personal ideas reflection, economically, in order to gate the better health care service, sometimes, individuals tried their best even up to hospital. But, when they

were unable to pay what was asked, they were forced to return to the local traditional medicine. Here, they were forced for different problems. On one hand, due to their less economic back ground, on the other hand, due to the local and traditional culture influence of the study area. Generally speaking, the data from cases and key informant tried to explain how economic back ground of the individuals can determine the way economically well families seeking health care treatment economically without time and the place influence than the poor families in one way or another.

In relation to the health care service facility factors, although there were government's continuous health care information explanation from the media, all the society cannot equally access information delivered through media due to their economic and social back-ground of the area. According to the informant's data, one of the reason for the local care service institution unsatisfactory to the care service users was the time and the methods of health care orientation as it lacks continuity (only at morning) while the institution continuously on its regular care service. Furthermore, the local care service users expected more health related advice from the center than from the government media but miss it to the extent they expected.

Regarding the influence of media to this particular issue, For instance, the following reviewed research is one of the justification. Exposure to mass media is an important factor associated with place of delivery. The study in Ghana found that, women who had access to media/health information via television were more likely to have institutional delivery (Nketiah-Amponsah and Sagoe-Moses 2009).

Regarding health care facility problem of the area, as clearly indicated from the key informant's discussion, one can easily understand how individuals who are economically in better position seek information to discriminate between alternative private health care centers in terms of provision better facility, capable human resource and health care services than public health care service centers while economically the disadvantaged groups of our society forced to seek health service at their locality.

In order to compare with the data collected from the area about the health care facility influence, the following research findings support with the key informant's narration. Patients who make a timely decision to seek care can still experience delay, because the accessibility of health services

is an acute problem in the developing world. For instance, in rural areas, a woman with an obstetric emergency may find the closest facility equipped only for basic treatments and education, and she may have no way to reach a regional center where resources exist. Finally, arriving at the facility may not lead to the immediate commencement of treatment. Shortages of qualified staff, essential drugs and supplies, coupled with administrative delays and clinical mismanagement, become contributors to maternal deaths (Pergamon: 1994).

Furthermore, health care internal facility another problem in health seeking behavior of care seekers. For instance, insufficient numbers of medical and nursing personnel at a facility necessarily lead to delays in patients' receiving the care they need. This shortage is often not only a matter of staff numbers; it is also a matter of competence. In other words, there is a shortage of trained, qualified personnel. Walker G. J., et al. (1985).

Key informant's data indicated that individual's access to formal education and health care related information differs individual's behavior in care service seeking due to the individual's degree concern to the information received. From this narration, what has been understand easily was that, although there was health care orientation at the care center by health extension workers and other health care co-workers to the care service users both from rural and town, health center visitors came from urban has at the better position than these from the rural care visitors. This is because, the former was gave less attention , less access to the information source when compared to the latter who came from urban.

Culturally competent health care organization is a critical component in reducing health care disparities between health care service seeker and service provider. Because, if health care's system becomes culturally competent, it produces numerous benefits for the organization, patients and for the community. The key informant's narration revealed that the community's problem was not only characterized with the absence of health care institution also the problem has been within the health care institution itself due to the presence of less human power, the issue of non-cultural competency of some staff workers when the service provision has been compared to the local culture of the society both in communication, reception and treatment way. Because, the communities' expectation was to the opposite.

According to the following research's finding, if any institution culturally competent, it has numerous benefits for the society as well as for the organization itself. For instance, cultural competence in any health care system produces numerous benefits for the organization, patients and community. For this justification, explain this issue as follows. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients, and increased participation from the local community. (Wilson-Stronks,A. and Mutha, S.(2010, October).

In justifying the key informant's response, cases complain about health care facility problem of their area, For instance, although, there has been improvement in different health center construction and availability, including the newly constructed hospital which has been without function at the district. From the discussion, another justification was there was the lack of responsible body which addresses the social problem immediately exacerbates the provision of health services that needs a continuous supervision to tackle the problem.

The key informant's response was supporting what was responded by other cases about internal facility problems which indicated us as an institution still needs an immediate solution about the facility with all concerned body. Another key informant's idea suggested that, proper reception of service seekers at any health care centers has paramount advantages. For instance, if the clients are happy with service provided, they get come again whenever they wish to. To the contrary neglecting the interest of the client may expose them for further cost, wastage of time and withdrawal. Therefore, health care service professionals should responsible ethically to their clients especially for women. The data gathered during an observation strengthens key informant's idea. Because, when the service provided to the service seekers at the study area, if not all, most of the visitors complain was circulating around the un-ethicality of some workers.

According to another key informant's narration, if not all, sometimes, service seekers themselves affect their psychology during service seeking behavior due to their predetermined expectation. Implicit to the idea, some care provision users did not want the service provider challenging their expectations. This implied that there was a gap between the service user and provider at the given health care institution. Another informant's idea from the area strengthens how the gap between the service user and provider dis-agreement affect each other. For instance, un-ethicality service

provision affect the care service user's decision to wait or not to wait at the station for the service provided.

Another factors that has been as serous issue of the area was accessibility factors. The data obtained from both key informant, cases and through observation revealed that, the main problem of the community in the utilization of health care service seeking has been the lack of transportation and poor roads which has an obstacle for the society especially at an obstetric and during referral stage. In its geographical location the district has no far distance from the zone town. But, the problem has been not geographical proximity.

At the study area, lack of transportation facility together with poor roads aggravated the transportation problem and became an obstacle especially at an obstetric and during referral stage. As the data obtained from key informant, cases and through observation revealed, of course, there were some private automobiles and cars has been used by the society with unsatisfactory services in relation to the district diverse number of population. Because, these private automobiles and cars' mainly work mainly for their interest than the community.

For instance, as seen from these data collection methods, If an individual have missed for instance, the morning car turn, he/she must have wait the next turn that has also with uncertainty**.** Therefore, most of care service seekers have been used traditional transportation system such as mule, horse, by large come to the facility on foot which is more difficult at an emergency time. For instance, at an obstetric and emergency time, in order to tackle their transportation problem to come to the facility, their sick and injured individuals transported with a stretcher as an alternative.

This also has some reviewed research justification. For instance, the effect of distance becomes stronger when combined with lack of transportation and poor roads. Potential patients who have to walk or ride a mule over rugged terrain will take longer to reach a facility. Distance will therefore be a greater obstacle for them, and act as a greater disincentive to efforts to seek care, than for those who can travel by motorized vehicles on relatively good roads.(Lennox:1984).

To summarize results in the discussion briefly, the following ideas are some of the main points of the finding results. Health seeking behavior is important in understanding, planning and providing health services. Decisions to seek care are complex and depend on a range of factors: Nature of

the illness or injury and its perceived severity and consequences, understanding of disease and communicability, understanding causation of disease (spiritual or infectious), availability, affordability and acceptability of services.

Generally speaking, these factors interact in a dynamic way within and across social groupings to determine how actively people seek any health care in response to a health threat. Hence, health seeking behaviors will therefore be different, being dependent on individuals, their knowledge and prior experience with services, the social perspective in which they live and exist, and perceived and/or real obstacles they face in accessing services (time, distance, cost, quality, and acceptability).

Chapter Five

5. Conclusion and Recommendations

5.1. Conclusion

From the review, different factors affect healthcare services at various levels. In conclusion, the study identified factors such as, individual, household, health care service facility centers, community and government. Intervention measures should target the underlying individual, household, community and at the government level factors.

At the study area, the findings from the review showed that a variety of factors have been identified as the leading causes of poor utilization of health care services: including poor socio-economic status, lack of physical accessibility (distance to health care facilities and place of residence), cultural beliefs and perceptions, low literacy level of the mothers and large family size were seen as a major factors that determine the utilization of healthcare services in the study area.

Review of the global literature also suggests that these factors can be classified as cultural beliefs, socio-demographic status, women's autonomy, economic conditions, physical and financial accessibility, and disease pattern and health service issues. For instance, as the data showed, cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers where this study was taken cannot be ignored. These factors result in delay in treatment seeking and are more common amongst women, on one hand, due to their less health care awareness on the other hand, due to women's less autonomy in decision making in the family. Because, men play a paramount role in determining the health needs of a woman. For instance, men are decision makers and controllers of all the resources they have the lion share right in order to decide when and where their wives should seek health care.

Furthermore, the findings showed that care service seekers from urban are more likely to utilize the delivery services than rural care service seekers due to less attention and less access to the health facilities and lack of awareness and information.

In terms of economic factors, economic polarization within the society make the poor more vulnerable in terms of affordability and choice of health provider. This because, poverty not only excludes people from the benefits of health care system but also restricts them from participating in decisions that affect their health, resulting in greater health inequalities.

Physical accessibility to and from health care service facility in rural communities were other local community's problem. Because, the effect of distance on service use becomes stronger when combined with the dearth of transportation and with poor roads, which contributes towards increase costs of visits. Furthermore, availability of the transport, physical distance of the facility and time taken to reach the facility undoubtedly influence the health seeking behavior and health services utilization.

On the other hand, the pattern of health facilities in the area is another problem within the health care service utilization. For instance, the quality of services, the responsiveness and discipline of the provider has been questionable. As the data indicated, if not all, sometimes there was the communication barrier due to differences of language or cultural gaps and that can also affect the choice of a specific health provider or otherwise. This is because, client-perceived quality of services and confidence in the health provider affect the health care service utilization.

According to the data gathered from cases and key informants, for the researcher, an overall finding revealed that, in some family, there has been positive intention in health care service seeking behavior starting from their local health care center and zonal public health care service care provision centers. Generally speaking, health care seeking factors starts from home delay (delay in deciding to seek care on the part of' the individual, the family, factors between home and health care center delay such as illness characteristics; distance from the health facility (physical accessibility factors such as travel time from home to facility, availability and cost of transportation and condition of roads), and finally the delay in reaching an adequate health care facility factors include shortages of supplies, equipment, and trained personnel; and competence of available personnel were some of the reasons of the study area.

From the clinical document review, although some very few service users' comment was encouraging the provision service given by the health service care institution, if not all, the

majority comments and information was circulating as they were not satisfied at the time of care provision with their respective care center. Therefore, from their hints, their local health service care institution had still need more improvement in human resource availability and with other health care related facilities. Furthermore, from the review, cultural competency of some health professionals in relation to their client at the time of care service provision needs an immediate solution for future in relation to their local culture.

To sum up, in study after study, it is clear that the major obstacles to seeking care includes distance (accessibility from the facility, cost (affordability), care service utilization disparity between poor and rich groups, local culture influence (preferring traditional religious healers for its easy access, flexibility of payment and availability of drugs, trust in the services being open, or skilled staff being present, un-necessary and an ethical communication of some health care service providers towards their clients (cultural barrier gaps) and other similar issues are some of the major obstacles among others in the study area in seeking the care service in general and of the study area in particular.

5.2. Recommendations

Considering the massive factors and challenges facing the study area in particular, several major reforms will be needed continent-wide to ensure and tackle social and health-care institution related factors which influence societies' health service seeking behavior at study area, the following are possible intervention areas to help minimize delay in seeking health care service in the in the health care service utilization.

- In order to keep gender balance in health care service provision for individual's psychological safety, if females hosted by females is preferable. For instance, facilities should staffed with professionals with both genders.
- Supplying relevant and qualified health workers of different categories governed by professional ethics.
- Improving the quality of health care by ensuring the availability of adequate human resources, and other essential and supportive inputs.

- Monitoring and evaluating activities of the health care center with continuous supervision to ensure the provision of health service by health facilities which is adequate in quality, human resources, and professional ethics in order to make acceptable by beneficiaries.
  For instance, enhancing more health education and behavioral change communication between health care providers to improve rates of client satisfaction.
- Encouraging and supporting traditional medicine practitioners. For instance, collaborating the modern health care service centers with traditional healers who are significantly contributing the care service traditionally at the study area. For instance, integrating traditional medicine into the general network of health services, particularly in view of the skills possessed by certain healers: bone-setters (wogeshas), herbalist's (kitel betash), traditional birth attendants, and equally importantly "spiritual healers". Because, traditional medicine is often used when the economic, social and cultural cost of using public health services are perceived as too high.
- Scaling up the scope of information about health care systems, the way in which those health care accessed by the service users to the information that will help them to manage their own health. For instance, teaching people about their health in giving health education at family and community level (public places such as schools, churches and other social organizations) to improve awareness about health care ahead to avoid further health problem.
- Ensuring the involvement of the kebele people in health actions at all times.
- Reducing accessibility problems to and from health care facility centers. For instance, opening additional health care service centers in selected locational areas to avoid the significant service user's delay to seek treatment.
- Working with local road and transportation authorities to find workable solutions to transport for health care provision seekers especially to those individuals who need long road transport at an emergency and referral stage by encouraging vehicle owners to play their role.
  E.g. improving health infrastructure particularly the rural road connection to the district town considering the geographical un-favorability for an immediate transportation function including for health care service. Finally,

- Under taking more and wide health care concerned research to understand the impact of health policies, programs, processes, actions or events originating in any sector including the health sector itself and encompassing economic, environmental, social and other determinants of health. Because, this was a mini research that was taking place for the fulfillments of master's degree by the individual. In particular, the focus will be operational research tailored to service delivery and geared towards addressing key challenges.

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Appendix: 1.

Guide questions for health care professional key-informrents (managers, nurses and health extension workers)

At this point, the researcher and his fellow member introduced themselves to the rest of the group. About their (Name, age, education status) and then asked each of cases, how long they have lived in the area and their work experience. The question asked by researcher during every question was an interview followed by different probes with different questioning style in relation to the topic under the study.

Theme 1 questions:

1. What are the opinions on health care service seeking behavior of the community in your locality?
2. What are the major health care problems of the community?
3. How and from where the community get information about health care service provision in your area?
4. Where is the community more seeking health service provision? Why?
5. What are the factors influencing individuals behavior in selection of place of service provision in your locality? Why?
6. What are the differences of health facility at your health center when compared to other facility? How and why?
7. What are your opinions on the quality of health care in your working area? Why?
8. What are the social, religions, traditional and cultural practices of the community in health service seeking behavior? How, when these mentioned factors can be solved?
9. How do health provision centers affect the communities' health seeking behavior? Why? and by whom these problems solved?

Thank you for your participation!

Appendix: 2.

Guide questions for specific cases (community and religious leaders)

As was done for theme 1, the researcher and his fellow member introduce themselves to the rest of the group. About their (Name, age, education status) and asked each of the cases how long they have lived in the area and their job.

Theme 2. Warm up questions

1. What are your opinions about health care? Why?

Probes 1. Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

2. What are the major health care problems of the community? Can you give some examples of the problems?

Probes 1. Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

3. What are your opinions on health care service seeking behavior of the community in your locality? Can you give some examples?

Probes 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

4. How are the social, religions, traditional and cultural practices affecting the community in health service seeking behavior?

Probes: 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else? 5. "I don't understand."

5. What are the factors influencing individuals behavior in selection of place of service provision in your locality? Why?

What are the advantages?

Probes: 1.Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

6. What has been done here to improve social, economic, religions, traditional and cultural practices of the community in health service seeking behavior? How?

Can you give some examples?

Probes: 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand".

7. From where is the community more seeking health service provision? Why?

Can you give some examples?

Probes: 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

8. How do health provision centers affect the communities' health seeking behavior? Why? and by whom these problems solved? Can you give some examples?

Probes: 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

9. What are the differences of health facility at your health center when compared to other facility? How and why?

Can you give some examples?

Probes: 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

10. How does the community get information about health care service provision in your area? Can you give some examples?

Probes: 1. Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

11. Who is more responsible more responsible for making decisions on the common resource of family in health care seeking at your area? Why?

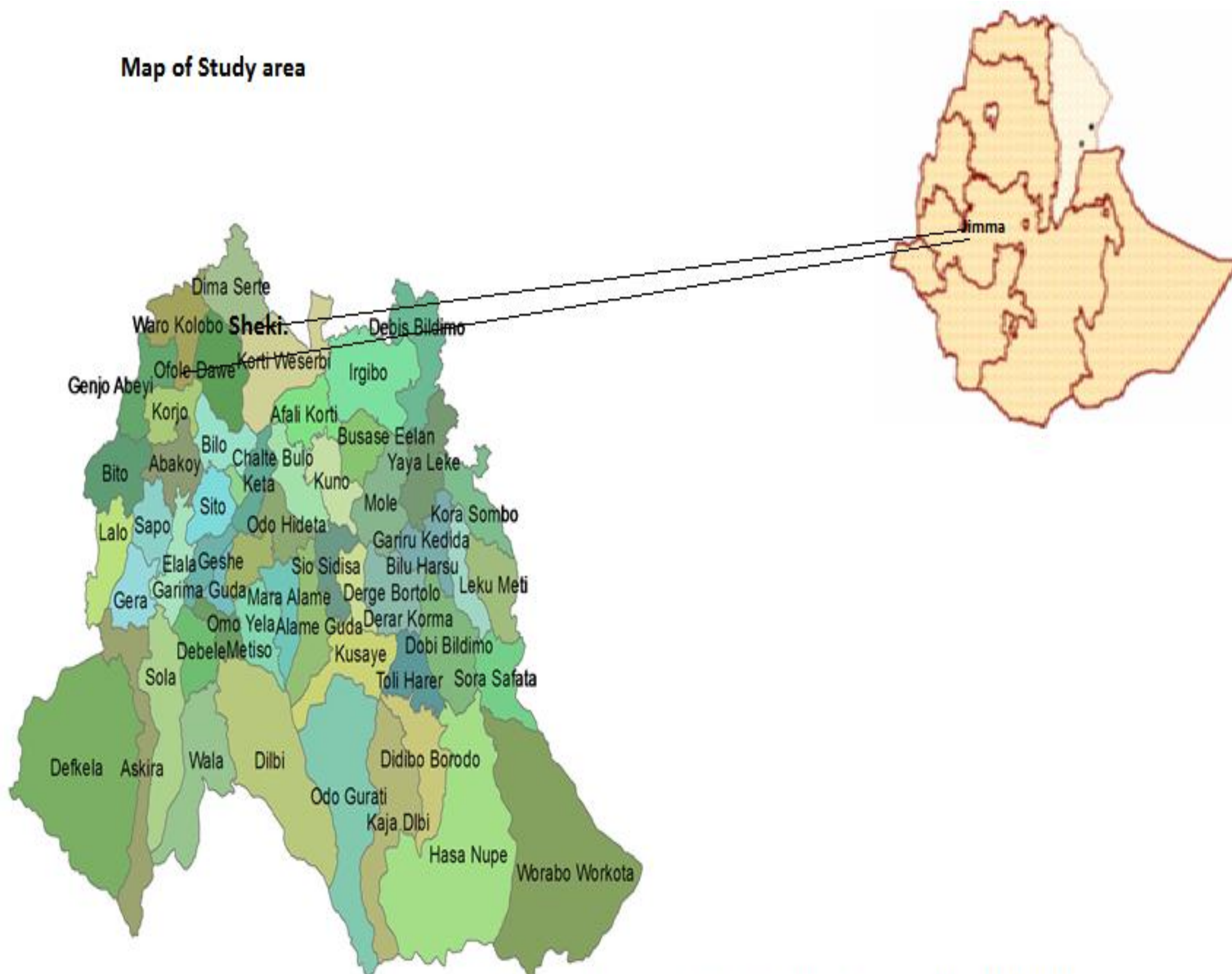
Can you give some examples?

Probes: 1 Would you explain further?

2. Would you give me an example?
3. Has anyone else had similar experience?
4. Is there anything else?
5. "I don't understand."

Thank you for your participation!

Appendix: 3. **Map of the study area**



Appendix: 4. Different Ethical Consideration Letters

JIMMA UNIVERSITY
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Ref.No. SoSW)107/03/07

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Date 18/06/07

TO: Dedo District Health Office

Jimma

Subject: **Request for cooperation**

Mr. Adam Kunti is an MA program student in Social Anthropology in our department. He is currently undertaking a study on the **Social and Health Related Factors Affecting the Utilization of Health Care Services** for his thesis.

For this, purpose he is collecting information. Therefore, this is to request your cooperation to provide him the information he needs for the study.

Thank you in advance

Nega Jibat
Head, Department of
Sociology and Social Work

Telephone: 0471122435

Tel. +251-47 11 114 57
PBX: +251471111458-60
Fax: +2514711114 50
+251471112040
P.O.Box. 378
JIMMA, ETHIOPIA
E-mail: ero@ju.edu.et
website: http://www.ju.edu.et

Ref No. SoSW 135/08/07
Date 16-04-2015

To college of Public Health and Medical Sciences research coordinating office

Jimma

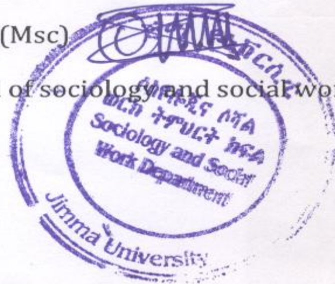
Issue: **Request for ethical clearance**

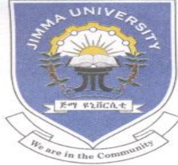
Mr. Adem Kunti Chikako is an MA student in social Anthropology at college of social sciences at department of sociology and social work, and he is currently undertaking a study on "Social and Health Institution Related Factors Affecting the Utilization of Health Care Services" for his MA thesis. His research site is Jimma zone, specifically Dedo district. Therefore, we kindly request your good office to give him ethical clearance; he defended his proposal at our college and it was approved.

With Kind Regards,

Diribe Makonene(Msc)

Department head of sociology and social work





JIMMA UNIVERSITY
ጅማ ዩኒቨርሲቲ

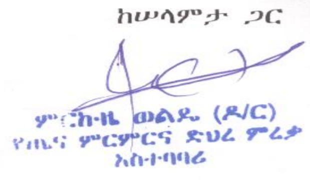
ቁጥር Ref.No. ጤ/ሣ/ሣ/55/07
ቀን Date 16/08/2007

ለ---

ጉዳዩ:- *ትብብር ስለመጠየቅ::*

በዩኒቨርስቲያችን ውስጥ ከሚካሄዱ ጥናቶች መካከል *"Social and Health Institution Related Factors Affecting the Utilization of Health Care Service: The Case of Dedo District of Jimma Zone, Oromia"* በሚል ርዕስ ምርምር እየሰራ መሆኑን እየገለጽን ለተመራማሪው ለ አደም ኩንቲ እና ለመረጃ ሰብሳቢዎቻቸው አስፈላጊው ትብብር እንዲደረግላቸው በትህትና እንጠይቃለን::

ከሠላምታ ጋር



JIMMA UNIVERSITY
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ቁጥር Ref.No. HRPGC/54/15
ቀን Date 24/04/2015

Institutional Review Board (IRB),
College of Health Sciences,
JU, Jimma
Tel: +251471120945
E-mail: mirkuzie.woldie@ju.edu.et

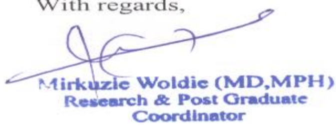
To **Adem Kunti**

Subject: Ethical approval of your research protocol

The IRB of College of Health Sciences has reviewed your mega research project entitled: "***Social and Health Institution Related Factors Affecting the Utilization of Health Care Service: The Case of Dedo District of Jimma Zone, Oromia***" This is to notify that this research protocol as presented to the IRB meets the ethical and scientific standards outlined in national and international guidelines. Hence, we are pleased to inform you that your protocol is *ethically cleared*.

We strongly recommend that any significant deviation from the methodological details indicated in the approved protocol must be communicated to the IRB before they are implemented.

With regards,



Mirkuzie Woldie (MD,MPH)
Research & Post Graduate Coordinator

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Lakk 6F4 / 71/07
Guyyaa 19/9/07

B/ Fayyaa Offeele [illegible]
B/ Jirfanuu [illegible]

Dhimmi isaa: Deggarsa Hojii, qorannoo isaa beeksisuu ta'a.

Akkuma armaan olitti ibsuuf Yuunivarsitii Jimmaa irraa barataa University Jimma Social Antropology ta'an obbo. Adam [illegible] [illegible] [illegible] qorannoo barnoota barataa [illegible] Gs/ godina Jimmaa Xalayaa [illegible] [illegible] guyyaa 19/05/2007 [illegible] [illegible] [illegible] Gama keessaniin [illegible] [illegible] gahaa akka [illegible] isaa beeksifna.

Nagaa wajjiin