

Poor Access to Health Services: Ways Ethiopia is Overcoming it

By Nada Chaya

Weak infrastructure and limited distribution systems in low-income countries complicate access to health services, especially in rural areas. Government health outlets may be relatively few and widely dispersed, and private-sector sources often favor wealthier urban areas, resulting in uneven service availability within a country. In the absence of a solid health infrastructure, strengthening primary health care and innovative community-based health service delivery systems help provide more equitable access to health services. Some programs are underway in Ethiopia whose successes do not depend on the availability of a strong infrastructure.

Ethiopia is a poor country with weak health care systems and infrastructure. Reproductive health, like most aspects of health in Ethiopia, is generally poor, with significant regional disparities in access to services and in health outcomes. Almost 80 percent of morbidity in Ethiopia is due to preventable communicable and nutritional diseases, both associated with low socio-economic development.¹ Improving the general physical infrastructure and strengthening health systems are key to improving health and require major investments and much time.

In the absence of a well-functioning health care infrastructure, initiatives that complement traditional health care provision help reach specific population groups, communities or geographical areas. Here we will highlight two such initiatives. The first is an ambitious government-led community health service delivery program that is national in scale. The second is driven by a non-governmental organization and is locally-developed and owned and is taking root in one region in Ethiopia.

Uneven Access To Services And Health Outcomes

The diversity of socio-economic environments, climates, and terrains among regions in Ethiopia greatly impacts health conditions and outcomes. Poor health coverage is of particular concern in rural Ethiopia, where access to any type of modern health institution is limited at best. Health systems and roads are underdeveloped, and transportation problems are severe, especially during the rainy season.

Almost all births take place at home in Ethiopia (94 percent) with only six percent of women delivering in a clinic or hospital. Many of these women live in remote areas that are too far from a road, let alone a health facility where they can receive emergency obstetric care. The majority of these births (61 percent) are assisted by a relative or some other untrained person and five percent are delivered without any assistance.²

Less than 28 percent of all Ethiopian mothers receive prenatal care from a trained doctor, nurse or midwife. The quality and frequency of this care is variable; many women receive the care either too late in their pregnancy or too few times.³

Women in Ethiopia are at a very high risk of death during pregnancy and delivery. One in 14 Ethiopian women faces the risk of death during pregnancy and childbirth.⁴

The risk is higher among rural, poor and uneducated women. Infant and child mortality are equally high; one in every 13 Ethiopian children dies before its first birthday and one in 8 dies before age five. Across the board, mortality is lower in urban than in rural areas in Ethiopia.⁵ High maternal and infant mortality are reflective of the low socio-economic status, including public health services and health-care infrastructure.

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Urban women marry two years later than rural women on average. Marriage at the age of 7 or 8 is not unheard of in rural parts of Ethiopia.⁶ Such early marriage and consequent pregnancy is one cause of higher rates of maternal and infant mortality and morbidity, including from obstetric fistula, and increased vulnerability to sexually transmitted infections (STIs), including HIV.

Contraceptive use, although it has increased consistently over the past decade, remains low with only 15 percent of currently married women using a method of contraception. Women in urban areas are four times more likely than their rural counterparts to use contraception (42 versus 11 percent).⁷

There are significant regional differentials in fertility. On average, Ethiopian women have 5.4 children during their lifetime, but women in rural areas tend to have significantly larger families (6 children) than women in urban areas (2.4 children).⁸ These differentials in fertility are, however, consistent with regional differentials in fertility preferences; people in rural areas favor bigger families.

Infection with HIV is one area where rural areas fare better than urban areas. National HIV prevalence Ethiopia was estimated by the Demographic and Health Survey at 1.4 percent among adults aged 15-49 in 2005. Prevalence is much higher in urban areas (6 percent) than in rural areas (1 percent). It is twice as high among women (2 percent) than men (1 percent).⁹

Discrepancies in access to health services are not limited to reproductive health. Vaccination rates vary significantly between rural and urban areas; vaccination coverage in urban areas is three times that of rural areas. Malaria is a major health problem and cause of mortality and is the leading cause of outpatient visits in Ethiopia.¹¹

Improving Access And Equity: The Health Extension Workers Program

The government is the main health provider in Ethiopia but the coverage and distribution of its health facilities among regions remains uneven. It is, however, seeking to address inequities in health service delivery through its Health Extension Program (HEP). This program aims to improve access to basic essential health services in severely under-served rural and remote communities, with the goal of achieving universal primary health care by 2009. Infrastructure challenges faced by the program are great: deteriorating transportation infrastructure and road conditions, inadequacy of primary health care facilities, shortages of trained health workers, unreliable supply of health supplies, and weak health information, vital statistics and administrative systems.

Expanding physical health infrastructure and developing a cadre of Health Extension Workers (HEWs) who will provide basic curative and preventive health services in every rural community are strategies that the HEP is applying to meet these challenges. By 2009, a total of 30,000 extension health workers will receive one year training and will be deployed in villages to provide basic curative and preventive health services. Prevention and control of communicable diseases such as providing malaria bed nets, health education, and contraceptives, with active community participation, are priorities of the HEP. This program, including procurement of medical supplies, drugs and commodities, is supported by several external donors.

The primary health care system in Ethiopia is comprised of a health center with five health posts attached to it. The HEP will assign two HEWs to each health post. In addition, thousands of other health care service staff, mostly at the health center level, will receive training as part of the HEP.

This community level service provision is much needed especially in a context of increasing demand for services. Demand for family planning, for example, though still weak, is increasing. In rural areas in Ethiopia, there is much room for expansion of family planning services—in access and quality. Poor quality of services such as interrupted availability of contraceptive supplies, limited method mix,¹⁰ and family planning knowledge through counseling about method choice and side effects, can be as much of a barrier as lack of physical access to services.¹¹

Just like the government, the non-governmental community in Ethiopia is also employing community-based strategies to help improve health outcomes where access to health services and information is weak. Community participation and work at the local level facilitates change in attitudes towards gender norms that adversely affect health.

Implementing Programs In Context: Kembatta Women's Self-help Center

Since its founding in 1998, Kembatti Mentti Gezzimma (KMG), or Kembatta Women's Self-Help Center, has been working to empower women at the individual and community levels and ensure that their constitutionally granted rights are well-known and well-protected. To empower communities and especially women, KMG links social, economic and political aspects of change. For example, it educates women on the electoral process and provides leadership training to young women as well as working with police and attorneys to uphold and enforce laws protecting women from violence.

Through a process of community involvement in both the development and execution of interventions, KMG works directly with women and other local community members, ensuring a focus on local needs and promoting self-reliance. The organization works to achieve community consensus, structuring programs on the strengths and traditions of each community.

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One of KMG's successes has been its work on reducing female genital cutting (FGC), which was, until recently, a nearly universal practice in the Kembatta area in Southern Ethiopia, where KMG originated. Through its community-based programs, KMG helped parents, husbands and wives, and young women understand the many harmful effects, both physical and emotional, of FGC. For example, KMG has been successful at educating the community about the epidemiological connections between FGC and increased risk of contracting HIV and with complications during childbirth, as well as highlighting the lack of religious justification for the practice.

KMG tackled a practice believed to be at the heart of the religion and culture of many Ethiopian communities. Not only is the practice of FGC declining in many communities, but the communities and their elders are publicly celebrating the end of the practice; communities now organize celebratory rallies that have attracted nearly 20,000 people at a time, including entire villages and their elders.

KMG has introduced reproductive health curricula into local schools, constructed clinics for maternal and child health and for HIV/AIDS testing, prepared adults and young people to be community-based health workers and classroom peer educators. KMG is working to improve the health and overall status of women by providing needed services and affecting local socioeconomic change which would change attitudes and gender norms that adversely affect health.

Conclusion

The reproductive health needs in Ethiopia are great, and so are the challenges to providing more equitable access to health information and services.¹² With a poor transportation infrastructure and the limited reach of the formal public sector health infrastructure, men and women residing in rural and remote areas can neither be assured that a health outlet is reachable nor that when one is reached, it will contain the needed health supplies and services. This is especially important for pregnant women whose timely referral and arrival to adequate facilities in case of emergency are essential to her survival and that of the baby. These challenges include having a much-needed system-wide approach to improving roads and other transportation and communication systems as well as strengthening the health system altogether.

In this context, reaching the poor and those in remote areas can be delayed due to weak infrastructure. Strengthening the primary health care system and decentralizing health service provision facilitates reaching those living in remote and hard to reach rural areas. At the same time, mobilizing, educating and training communities and individuals is empowering to communities and individuals in those communities. Programs described are—by providing reproductive and other health services through primary health care facilities, paying attention to quality of services, and strengthening community participation—working to improve equity of health service delivery within the context of available infrastructure and weak systems.

Notes

- 1 The Earth Institute at Columbia University, Center for National Health Development in Ethiopia. Accessed on March 1, 2007, from <http://cnhde.ei.columbia.edu/healthsystem/index.html>.
- 2 Central Statistical Agency (Ethiopia) and ORC Macro. 2006. *Ethiopia demographic and health surveys 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.
- 3 Ibid.
- 4 WHO, UNICEF and UNFPA. 2003. *Maternal mortality in 2000: Estimates developed by WHO, UNICEF and UNFPA*. Geneva: WHO.
- 5 Central Statistical Agency (Ethiopia) and ORC Macro. 2006. *Ethiopia demographic and health surveys 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.
- 6 Ibid.

- 7 Ibid.
- 8 Ibid.
- 9 Ibid.
- 10 The contraceptive method mix in Ethiopia is dominated by injectables and, to a lesser extent, the pill. Long-term methods may be more appropriate to meet the contraceptive needs of women in rural areas where women have to walk miles to reach a clinic.
- 11 Cleland, John, S Bernstein, A Ezeh, A Faundes, A Glasier, and J Innis. "Family planning: the unfinished agenda." *The Lancet*, Vol 368, November 18, 2006.
- 12 Gillespie, Duff, S Ahmed, A Tsui, and S Radloff. "Unwanted fertility among the poor: an inequity?" *Bulletin of the World Health Organization*, February 2007, 85 (2).

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