

**THE ILLNESS BURDEN AND USE OF HEALTH SERVICES
IN A RURAL COMMUNITY, SOUTH-WESTERN ETHIOPIA**

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ABSTRACT

An interview-survey of perceived morbidity in a rural community in South-western Ethiopia was conducted in partial-fulfilment of the phased teaching objectives of the under graduate community-based medical education in Jimma Institute of Health Sciences. Two hundred and seventy household heads were randomly selected to participate in the study, to examine the recall of recent health problems during a two-week period and actions sought for. Of the respondents, 65% reported illness which varied with age and sex. From those reporting illness, 55.4% did not take any action while 30.3% applied to health institutions. Self care and use of traditional healers were reported to be 9.2% and 5.2% respectively.

The survey demonstrated a huge burden of perceived morbidity in a rural community for which the sick did nothing much indicating a large amount of unmet needs for the health delivery system, and further study on patterns of illness behaviour.

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BACKGROUND

The challenges of conventional health systems the world over are whether the health services offered are really relevant to the health needs of the society; the education / training given to health workers is relevant to the needs; and the health workers serve the needs in the best possible way (11). In this accord, the World Health Organization (WHO) has stipulated that "in many countries health personnel are not appropriately trained for the tasks they are expected to perform, or are not provided with the equipment and supplies they require" (12).

Many developing countries including Ethiopia have adopted the global resolution of Health For All (HFA) by the year 2000 through Primary Health Care (PHC). But these countries are far from achieving the goal of HFA by the year 2000 because of several constraints, the major ones being limited budgets, shortages of supplies and unmet training needs (6).

Experiences in Ethiopia and elsewhere have witnessed that the traditional methods of training health workers have shown deficiencies in management, community approach and research undertaking (10).

From the empirical observation of the major health problems of Ethiopia, it is observed that infectious and nutritional disorders dominate the picture (7). In addition, the available socio-economic indices witness that a lot of effort needs to be put in health and other development endeavours to improve the standard of living of the population. A critical analysis of the health problems in Ethiopia suggests that health cannot be achieved in isolation, and that greater inter-sectoral collaboration is needed. In addition, the analysis reflects the existing gap between the health departments and the limited primary health care facilities.

The gap depicts the weakness in the administrative chain manifesting itself in a weak leadership and a failure to utilize the considerable community interest in health and lack of adequate supervision of health personnel.

The Ethiopian ministry of health demonstrated the District as the most appropriate point at which to strengthen the health system and mobilize people by training different health workers in the same setting to become managers, team members and practitioners.

To this effect, Jimma Institute of Health Sciences (JIHS) was established in 1984, at Jimma, South-western Ethiopia. It was conceived and developed by the Ministry of Health in recognition of the need for change in training relevant health workers in Ethiopia. The concept of relevant health manpower signifies the training of health professionals that are responsive to the needs of the communities they serve.

The cornerstones of JIHS's educational Philosophy are community based training, team approach and integrated teaching (1). There are 5 categories of professionals trained in JIHS : General Medical Practitioners, Nurses, Medical Laboratory Technicians, Sanitarians and Pharmacy Technicians.

The learning experience of each category of students is phased and geared at a planned educational objectives. The theoretical classroom education is supplemented by community based experience at every stage of the training. While in the community, the students undergo through defined phases of performance consisting of development of survey instruments, data collection, community diagnosis, planning, implementation and evaluation. During their final year of training, students (from all categories) are posted to study and work in Training Health Centres as team members in partial fulfilment of their course requirements for graduation.

The purpose of this paper is to report on a perceived morbidity survey carried out in collaboration with phase II (year III) medical students undergoing Community Based Training attachment during the period July to August 1988.

Such area of inquiry is considered to have implications towards exercising community diagnosis and so as to prioritise problems and draw feasible action plans for intervention.

THE STUDY SITE AND PROCEDURES

The site of the study was Tinishu Borie, a rural community located 10 kilo meters away from JIHS. This community has been the site of attachment for phase I and II training programs for these same students where they did census and socio-demographic surveys. There are 2020 inhabitants of which 50.3% are males and 49.7% are females. The inhabitants are all peasants, traditional method of agriculture and animal husbandry being their major economical activities. Of the population, 97.7% live in single rooms of thatch roofed huts where they share with domestic animals if they have any. The greater proportion of inhabitants are moslems and enjoy a rather homogeneous ethnicity and dialect. The source of domestic water is from river during the dry season, wells and springs during the rainy period. Some 20% of the households have hand dug pit latrines which are not properly utilized nor maintained. The preference to "an open air human waste management" in such settings is greater for it is assumed less discomforting. There is no conventional health institution in the community and the nearest is a health centre located 9 kilometres away.

In line with the objectives of the phase of training, a questionnaire was designed to seek information on illness behaviour, frequency of health service contact and actions taken by heads of households who were randomly selected. A recall period of 14 days was used and only heads of households interviewed. A total of 270 households were randomly sampled from an earlier census. The interview schedule was given to household heads by a house to house visit by students.

RESULTS

From a total sample of 270 Household Heads, 176 (65%) reported illness in the past 2 weeks where as 94(35%) did not. The frequency of illness reports for the total population (722) i.e. in the sampled households is shown in Table 1. The population distribution in the sampled households was in the order of < 15, 15-45 and >45 (decreasing). The frequency of illness reports for age groups over 45 was highest 60% and for those less than 15 was least (16.2%) There was higher preponderance of illness reports for females as a whole.

TABLE 1

Frequency of Perceived Morbidity by Age and Sex,
Tinishu Borie, Illubabor Region, Ethiopia, 1988.

Age range (in years)	S E X						Total		
	Male			Female					
	n	N	%	n	N	%	n	N	%
Less than 15	31	180	17.2	26	171	15.2	57	351	16.2
15 - 45	28	145	19.3	40	141	28.4	68	286	23.8
Over 45	21	42	50.0	30	44	68.2	51	85	60.
Total	80	367	21.3	96	356	26.4	176	722	100

n = Heads of households interviewed

N = Total population in age category of the sampled households
i.e in 176 households

Table 2 depicts the frequency of types of perceived symptoms (Primary) as reported by Heads of households for household members during the last 2 weeks. As noted, fever was the most frequently occurring symptom (35%). There was higher preponderance of symptom incidence reported for females (54.5%) in general. The illness report for age group 15-45 (in both sexes) was highest (38%).

TABLE 2

Primary symptoms as Reported by Household Heads for Age and Sex categories in the Household, Tinishu Borie, Illubabor Region, Ethiopia, 1988.

Age Range (Years)	Perceived Symptoms				Total
	Fever	Cough	Diarrhoe	Other	
Less than 15					
Male	13	7	6	5	31
Female	9	7	4	6	26
15 - 45					
Male	12	3	6	7	28
Female	14	8	9	9	40
Over 45					
Male	5	4	4	8	21
Female	10	6	3	17	30
Total	63	35	32	46	176

Actions sought for treatment of illnesses is shown in Table 55.4% didn't resort to any external health care while 30.3% applied to health institutions. Self-care and resorting to traditional healers were reported to be 9.2% and 5.1% respectively.

TABLE 3

Places where actions or treatments were sought for perceived illnesses, Tinishu Borie, Illubabor Region, Ethiopia, 1988.

Places Sought	Number	%
Did not resort to any external Health care (No action)	97	55.4
Self care	16	9.2
Resorted to Traditional healer	9	5.1
Resorted to Health institute	53	30.3
Total	175*	100

* One Household Head did not reply

DISCUSSION

This study demonstrates the burden of self perceived morbidity on a population characterized by poverty, illiteracy and poor environmental situations. Other similar studies (2,3) have documented perceived Morbidity Rates unadjusted of rather differing results (48.3%, 57.4% respectively) as against our finding of 65.2%.

The fact that the medical students who were known by the community used as interviewers could have produced an over reporting of illness by the respondents in the hope of getting immediate medical attention in our case. Comparisons of such studies may; however, be difficult due to differences in ecological conditions, population characteristics and study methodologies.

In this data set, females were seen to have the over all higher (54.5%) reports of illnesses. This issue will not be of surprise due to the fact that higher prevalence of risks to health such as reproduction, labour, low social status, etc. are associated to women in such a society.

The frequency of illness reports for age group 15-45 (both sexes) was the highest (38%). This is probably due to more people in this group to have been interviewed (nearly 40%) and/or are more likely to remember their health problems. That only the primary recalled symptoms were considered in the analysis and the symptoms having not been adjusted to the total population in the sampled households limits further discussion and extrapolation if any.

It has been reported that perceived illness to be a major determinant of health facility use and demand (3,5). Of those who reported illness, only 30.3% resorted to health facility, the great majority, 55.4 % did not resort to any external health care. This

seems to be indicative of a problem of access to the health care system.

The under-utilization of the scarce health facilities has been reported in Ethiopia (8). The data in this report also supplement the earlier report. There are however, problems in health service utilization world-wide (4) despite differences in urbanization, modernization, wealth, etc. Such phenomena underscore the need for health workers (professionals), trainers and planners of health services to gain more insight into people's perspectives on health care. Of the many contributing factors for health facility under-utilization in our settings are cultural, lack of health information, accessibility, financial, other competing demands, etc.

In this data set, the fact that a large proportion of the sick did nothing about their problems may be surmised as indicating a large amount of unmet needs for the health delivery system. However, due to the fact that the given symptoms or illnesses may be differently perceived, evaluated, acted or not acted upon by persons, demand further illness behaviour studies .

Self-care, e.g. staying home from farming, limiting activity, limiting some kinds of food and drinks, etc. is frequently (9.2%) used in this community. If "No actions" and "self care" are combined, the finding from this survey, i.e. 74.6% (Table 3) corresponds to a higher estimate than the other studies (2,3).

This study is only exploratory and therefore may raise more questions than it attempts to answer. Above all it helped our new generation of students to analyse available information more than to accumulate it. It is thought to give impetus of intuition for young medical students and us, the trainers that there is a lot more to health care than the conventional approach particularly the " Socio-ecological Paradigm " of health (9) which needs to be

further explored. The whole issue of how people perceive disease and health related action must be thoroughly investigated to maximize the use of the meagre health resources.

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REFERENCES

1. Academic Commission. Community Based Training Program and Team Training Program Manuals 1988. Unpublished Document. Jimma Institute of Health Sciences, Jimma, Ethiopia.
2. Buschkens, W.F.L., and Slikkerveer, L.J. 1982. Illness behaviour of the Eastern Oromo in Hararghie (Ethiopia). Health Care in East Africa. Van Gorcum, Assen, The Netherlands . pp.6, 97-116.
3. Dagneu, M. 1984. Pattern of Health Care Utilization in a Small Rural Ethiopian Town (North-west). Ethiopia. Med. J. 22, 173-177.
4. Joseph, A. 1985. Training doctors for primary health care: the Vellore (India) model. World Health Forum. pp. 6(2): 118-121.
5. King, M. 1966. Medical Care in developing countries: A primer on the medicine of poverty, Para. 2:5. Oxford University Press, Nairobi.
6. Malison, M.D. et al. 1987. Estimating Health Service Utilization, Immunization coverage, and childhood mortality a new approach in Uganda. Bull WHO. 65(3): 325-330.
7. Ministry of Health, Ethiopia, 1988. Comprehensive Health Services Directory Planning and Programming Bureau, Addis Ababa.
8. Ministry of Health, Ethiopia. 1985. Primary Health Care Review. Addis Ababa, pp.55.
9. Noack, H. 1987. The Socio-ecological Paradigm of Health. In: Measurement in Health Promotion and Protection. European Series No. 22, WHO, Geneva. pp. 5-28.
10. WHO, 1987. Strengthening the District health system to meet the challenge of primary health care in Ethiopia (Monograph. pp.30.
11. WHO, 1976. Report on consultation on Health Services and manpower development, Geneva, 6-8 September 1976. WHO, HMD/77.1. pp. 34.
12. WHO, 1981. Global strategy for Health For All by the year 2000, series No. 3. pp. 23.