

# Perceived barriers to health care for residents in vulnerable urban centers of Ethiopia

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## Abstract

**Background:** Slums in urban settings are fast expanding and unprecedented proportions of urbanites are now living in slums, with compromised provision of health services. Slum dwellers in urban settings often face multifaceted barriers to accessing available health services. There is a paucity of evidence on identifying barriers in vulnerable urban centers of Ethiopia. This study aims to explore the barriers to the use of health services in slum urban settings of Ethiopia.

**Methodology:** A qualitative study using in-depth and key informant interviews was conducted in 13 selected John Snow, Inc. (JSI) program operational urban areas of Ethiopia. Data were collected from community members, community opinion leaders, Urban Health Extension Professionals, and urban area health office representatives. The interviews were transcribed by data collectors and analyzed using a thematic content analysis approach. Accordingly, individual-, community- and health facility-level barriers were key themes under which findings were categorized.

**Results:** Findings revealed that barriers to health service use at the individual level include limited awareness about health problems, competing priorities and limited capacity to pay for services when referred. Institutional-level barriers include limited medical supplies, and a lack of passion, respect and positive attitudes on the part of health service providers. Barriers at community level include a lack of shared understanding of the problems, services and the community's established values in relation to the problems and services.

**Conclusions:** The provision of (maternal) health services in slums in Ethiopia's urban settings is affected by different barriers that work in tandem. The improvement of health service provision in slum settings requires multiple interventions, including strengthening the health system's responsiveness to health care demand. [*Ethiop. J. Health Dev.* 2020; 34(Special issue 2):04-11]

**Key words:** Barriers, slum sections of urban centers, community, service providers

## Introduction

Poor health outcomes have been documented in vulnerable populations worldwide (1). There are urban settings that are disadvantaged in several fronts and their residents have become increasingly destitute with compromised health(2). In most developing continents, including Africa, urban setting inequities are far more marked compared to some rural settings(2). Urban residents, especially those in slum settings, face a multitude of social and economic challenges and are subjected to sub-standard living conditions(3). Health vulnerability can be explained in various dimensions, of which health service availability, accessibility and affordability are some of the key indicators to measure the quality of health care in vulnerable settings(4).

Barriers to health services can be seen at different levels. In relation to vulnerable areas, studies have documented financial barriers related to the availability of health insurance, structural barriers related mostly to service availability and accessibility, and other barriers reflected in healthcare professionals' attitudes and discrimination(4-7). Moreover, vulnerable settings residents' education and literacy levels have been associated with the poor uptake of the available health services(4).

In Ethiopia, along with the pace at which the country is urbanizing, inequalities in accessing health services and structural issues – such as urban poverty, poor sanitary conditions, overstretched infrastructure, overcrowding and social exclusion – create marked disparities for residents, which result in a wide range of health problems(3).

Previous studies conducted in the same urban settings have shown that there are people and specific places that are more vulnerable to a wide range of health problems(8). However, there is still a paucity of data on perceived barriers to health care in urban areas in Ethiopia is limited.

The Ministry of Health in Ethiopia has taken proactive measures to ensure access to health services for all residents in urban settings through its Urban Health Extension Program (UHEP). Urban Health Extension Professionals (UHE-ps), who by training are nurses, are trained for a year and are expected to engage households in urban settings to contribute to their own health(9,10). Studies reveal that there are multiple barriers to accessing and using maternal care and other services(11). These were reported to include lower maternal education, unintended pregnancy, inability to pay for private health services, and being unmarried (11).

This study intends to generate evidence that will help to identify perceived barriers to accessing healthcare for vulnerable populations in selected urban settings. The rationale for this particular study rests on the fact that urban settings in Ethiopia are not uniform in terms of health service provision; residents in some quarters of urban centers are relatively destitute and lack awareness about problems and services; there is limited evidence about urban settings and their residents that make evidence-based urban health planning difficult.

## Methodology

**Study settings:** This study was conducted in 13 selected

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John Snow, Inc. (JSI) program operational urban areas of Ethiopia. The urban areas included in this study were: Adigrat, Mekelle, Bahir Dar, Woldiya, Arba Minch, Hawassa, Shashemene, Adama, Jimma, Harar, Dire Dawa (DD) and woreda 2, and 4 in Addis Ababa (AA). Two to three urban area representing different characteristics were purposively chosen for the study from Tigray, Amhara and SNNP regions, and Dire Dawa and Addis Ababa city administrations. Based on evidences from residents and city administrators, in each study area, at least three specific settings within the urban area were identified as vulnerable.

**Study design and population:** A qualitative research approach was employed as the study aimed to explore the barriers for health care use and provision based on opinions from participants. Data were collected from community members, community opinion leaders, Urban Health Extension Professionals, and city health office representatives. Community opinion leaders included women's association members, elders, and chairs of the community police from the vulnerable sections of the selected urban area.

**Methods of data collection:** Trained data collectors first observed the vulnerable sections and selected study participants. In-depth interviews (IDIs) and key informant interviews (KIIs) were used to collect data. IDIs were collected from community members who were assumed to have rich information, while KII participants were Urban Health Extension Professional and health office administrators in each selected urban area. An unstructured interview guide was used to collect data from all interviewees. A total of 55 IDIs and KIIs were conducted in the selected 13 urban areas. All interviews were tape recorded to capture all the information.

**Methods of analysis:** Tape recorded data were transcribed by data collectors and transcripts were thoroughly read and compared for consistency. Preliminary data analysis was carried out simultaneously with data collection. Three members of the research team coded the transcripts independently using the word processor and developed a codebook

based on the objectives and emerging evidence from the data. Themes and sub-themes were developed in line with the objectives of the study. Thematic content analysis was used for final analysis. In presenting the findings, an attempt was made not to misrepresent the original meaning of the findings.

**Data quality assurance:** Qualitative checklist guiding questions, along with the objectives, were shared with colleagues who were not involved in the study to judge if the checklist and probes could help to answer the objectives. In addition to providing training for research assistants/data collectors, close supervision was provided during data collection to ensure proper recording. Data collectors were selected based on their familiarity with the local culture, fluency in the local languages and experience of qualitative research. Every day, at the end of data collection, debriefing was carried out to exchange notes between data collectors and discuss emerging themes to include in subsequent interviews.

#### **Ethical considerations**

Ethical clearance was obtained from the research ethics committee of the School of Public Health, Addis Ababa University. Official letters were obtained from the School and JSI head office and given to the respective urban areas to obtain permission for data collection. The respondents were advised of the objectives of the study and they gave informed consent. Interviews were made in places where confidentiality of the respondent could be ensured. In terms of reporting, to ensure the confidentiality of the respondents, individual identifiers were not used, although general details of the respondents are shown in their quotes.

#### **Results**

**Study participants' characteristics:** There were 55 IDIs and KIIs. Of these, 55% of the participants were female; 20% were 31-35 years old. Three quarters of the participants had a diploma or higher-level training; 60% were married; and 11% were unemployed (Table 1).

Table 1: Sociodemographic characteristics of the participants

Variables	Frequency	%
<b>Sex</b>		
Male	25	45.5
Female	30	54.5
<b>Age</b>		
20-25	6	11
26-30	8	14.5
31-35	11	20
36-40	4	7.3
41-45	1	2
46-50	2	3.6
>50	6	11
Not recorded	17	31
<b>Educational status</b>		
Illiterate	3	5.5
Primary	6	11
Secondary	4	7.3
Diploma or higher	42	76.4
<b>Marital status</b>		
Single	13	23.6
Married	33	60
Widowed	3	2
Divorced	1	5.5
Separated	1	2
Not recorded	4	7.3
<b>Occupation</b>		
Unemployed	6	11
Daily labourer	2	3.6
Urban Health Extension Professionals	16	29
Supervisors, urban Health Extension Professionals	6	11
Woreda health office representative	6	11
Others	7	12.7
Not recorded	12	22
<b>Total</b>	<b>55</b>	

**Perceived barriers to health service provision:** Health and health-related problems are pervasive in slum sections of urban settings. In such settings, communicable and non-communicable diseases, and injuries, work in tandem increasing the vulnerability of residents to various health problems. Yet, efforts to ameliorate such problems are not straightforward. Particularly, barriers to access and use common health services are categorized under individual, community and health facility-level barriers. Perceived barriers under each of the categories are further elaborated below.

**Barriers at individual level:** Perceived individual-level barriers are associated with ‘inherent’ factors, such as limited awareness of the services and personal motivation to seek services. In addition, competing priorities and lack of money to spend on services affect decisions to visit health services.

For example, the objective of the family planning service is to enable couples to freely determine the number and spacing of their children. Although participants know the different methods available, Depo-Provera (contraceptive injection) and ‘the pill’ are the most commonly mentioned methods. Yet, there

was widespread suspicion about the effectiveness of these methods. One of the participants shed light on common views regarding family planning services:

*“Initially, I used pills, but it was not comfortable because they irritated me. I left that and got pregnant. Now I am on Depo, but I heard a woman from another kebele who was on Depo got pregnant. So, I am now concerned.”* Woman, Bahir Dar

Another woman argued that there is gross deficiency in knowledge about family planning. Not every woman shares common information, and misconceptions prevail in different settings. Commonly held beliefs across the study settings include that the pill causes irritation, and that some contraceptives can remain in the body and affect health. One participant indicated that:

*“We are hearing that there is an intention to make us infertile by distributing different contraceptives. There is a strong fear about this. On the other hand, there are women who get pregnant despite the use of contraceptives, and this is God’s will. I personally think there*

*is confusion about family planning, for different people talk differently about it.”*  
Woman, Woldiya

From the findings, it was clear that religion, specifically Islam, has an impact on the use of the family planning services, and there were critical views in the use of family planning from Muslim participants. One common argument reflected by one of the participants indicated that:

*“Even though I do not want more children, I do not think I will use family planning services. I have had discussions with the health extension worker in our village but I do not feel comfortable. I cannot even think of this and I never heard my parents talk about this when I was a child. And now myself and my husband have never and would never talk about this.”* Woman, Dire Dawa

Urban Health Extension Professionals shared their experiences and challenges about awareness-creation programs for family planning. One of the workers argued that:

*“My Muslim clients find it difficult to discuss family planning let alone consider using it. This, I believe, is related to their religion. Husbands do not allow their wives to use family planning, although women tend to consider using the family planning service.”* Urban Health Extension Professional, Deha Sefer, Harar city

Regarding maternal health, particularly the use of ANC services, findings show that awareness-creation efforts through various mediums, specifically by Urban Health Extension Professionals, and access to services did not result in universal attendance. Women do not know much about the value of ANC visits. ANC visits were argued to have no major connection with routine visits to health facilities during pregnancy. Having an unhealthy feeling, especially during early days of pregnancy, is considered normal. Women may visit health facilities to check if they are pregnant, but once pregnancy is confirmed most women do not return to the facility. The view is that there are different types of discomfort related to pregnancy, all of which do not require visit to a health facility. One of the participants elaborated:

*“Repeated visit to a health facility for health check-up is not considered normal in our setting. Discomfort related to pregnancy is normal and unavoidable. This is what every woman has to live with. So, routine visits to a health facility should not be taken seriously”*  
(Woman, Woldiya).

Another participant shed light on common views regarding the lack of awareness about the value of HIV testing during routine ANC:

*“There was resistance to accept HIV screening at the first ANC visit. Some of the*

*women were convinced after repeated home visits. I realized that, despite so many media campaigns, still most women do not see the advantage of HIV testing as part of their routine ANC visit.”* Urban Health Extension Professionals, Adigrat

Attending postnatal care (PNC) services, where all women with new babies should visit health facilities for child and maternal health care services, remains far below expectations. Urban Health Extension Professionals' awareness-creation endeavors are reported to go well at community level. Nonetheless, the issue as to whether eligible women should attend PNC sessions remains controversial. For some, awareness is still a major barrier, where participants claim not to be completely convinced as to why they should visit the health facility after delivery. One of the participants summarized the lack of awareness of PNC:

*“No one has told us that a woman that has delivered would die, nor have we seen any such death by not attending a health facility after delivery. I, as well as those of us who got information about postnatal care from the Urban Health Extension Professionals, several times we have not been convinced on the need for such a visit. I still want to get convincing information, and so do my friends, to consider postnatal care service.”* Woman, Sodo

Most key informants argued that the lack of time they have for visiting of health services, due to competing responsibilities to generate a livelihood, is another key factor for limited consideration of ANC services and PNC. One woman argued that:

*“I am struggling to generate daily bread for my children and do not have time for a routine discussion with the health extension worker and follow her advice to visit a health facility to get [check] my pregnancy. For me, I wish this pregnancy hadn't happened, but I am fine and should take it to term. There is no need to visit a health facility, since I am fine with it.”*  
Woman, Arba Minch

In line with this, one Urban Health Extension Professionals emphasized that:

*“Those who live in a slum neighborhood struggle for survival and they do not care much about visiting a health facility in connection to pregnancy or after delivery. If they visit a health facility, it happens only after it gets worse. They also complain to have no money for laboratory tests, drugs and even for transport.”* Urban Health Extension Professional, Harari city

**Barriers at community level:** Using family planning is generally found to be important in all the study settings. Yet, there are major concerns over how the family planning service works and what the consequences are. In different study settings, different understandings prevail, depending on the extent of

awareness and religious beliefs. Lack of awareness on which of the methods works best, and the potential side effects, were common factors identified as having an impact on the use of family planning services. A participant captured common arguments on this:

*“The problem with family planning has to do with a lack of convincing information on how the different methods work and potential side effects. There are different views in the community on family planning, including its permanent effect of making women infertile.”*  
Woman, Debre Birhan

Yet, once pregnancy occurs, consensus is evident that it is natural and taking it to term is a source of great pride. A woman who gets pregnant still considers it worthy, even if not desired. One of the participants appreciated and adored pregnancy, even under circumstances when it was not part of her plan:

*“Pregnancy is not a health problem. As a woman, getting pregnant and taking it to term is normal. I do not know if this is still the case, but at the time of my mother, women’s pride depended on how she carried her pregnancy to term without any problem. To me, visiting a health facility when a problem occurs is normal. But, I wouldn’t just do that [for a normal pregnancy], especially when you have the experience.”* (Woman, Shashemene)

There is no uniformity in terms of how the different participants viewed pregnancy. Irrespective of the study settings, those who repeatedly got pregnant and have the experience are not concerned about the consequences of pregnancy compared to those pregnant for the first time. As such, one of the participants pointed out that:

*“Women who get pregnant for the first time listen to my advice to visit a health facility for check-up in connection with their pregnancy. Although not as much as expected, they tend to return to the facility on an appointment. Those who have been pregnant more than once are, however, hesitant to visit a health facility in connection with their pregnancy. This has not changed, despite my repeated endeavours.”* Urban Health Extension Professionals, Mekelle

The commonly held view is that a health problem is a reason to visit a health facility, while a visit for a mere check-up is not appreciated by husbands, family members and the public at large. Family members and the public at large do not encourage women to visit health facilities for check-ups. Findings show that endeavors to ensure women visit health facilities to get ANC services during pregnancy, and receiving support from relatives and the public at large to do so, is at a rudimentary level. Women in slum settings are relatively worse off, because they claim to have competing priorities. Participants in all settings reported that a visit to health facility for a pregnancy

check-up is a luxury. One of the participants argued that:

*“I have to make life possible from petty trading, and at times I work as a daily laborer to make up for difficulties in life. So, I do not have time for a check-up. If I am sick then there is no way out – I have to go to a health facility. There are my colleagues who cannot even afford that, for payment is a concern.”*  
Woman, Dire Dawa

Regarding PNC, in all study settings, women are expected to stay at home after delivery. Although there are variations on the number of days/weeks a woman and her newborn stay indoors, the belief is that women and newborns should not be exposed to wind, sun and cold for days after delivery. In all study settings this was a consistent belief. As a result, failing to attend PNC sessions is rather common in all study settings. One of the participants explained that:

*“...culturally, women are not encouraged to get out of home right after delivery. There is an established belief that women and the newborn should stay away from sunlight, wind and cold for at least 12 days following delivery. This affected our postnatal care indicator, not only in vulnerable sections of urban area but also in the better-off parts of the town.”* District health official Adigrat

There are challenges posed by how the local communities feel about services, be they for women or children. Local perceptions were generally found to affect how services are provided to specific targets. For example, the provision of vitamin A supplementation for children is one of the challenges in some settings. One of the respondents highlighted that:

*“... there are households that refuse the provision of vitamin A and the de-worming service for children. They assume that such services hinder the physical growth and brain development of children.”* Urban Health Extension Professional, Deha Sefer, Harar city

**Barriers at health facility level:** All participants across all the study settings unanimously reported a shortage and lack of diagnosis facilities in government health facilities. Besides, prescribed drugs are often not available in the health facilities. Under such circumstances, clients report that they are advised to visit private facilities, which is rather expensive. One of the participants stated:

*“The main problem is that government health facilities fail to provide services that clients are supposed to get within the compound. Usually, we learnt that clients are sent to private facilities for laboratory services and some drugs following diagnosis. I think government facilities are not equipped with all necessary supplies. A woman who is encouraged by health extension workers to*

*come to a health facility is embarrassed to fail to get required services. Even those who get letter for free service from the kebele do not get the service since government facilities do not have such services.*" Local self help group [Idir] leader, Woldiya

This was further emphasized by one of the Urban Health Extension Professionals:

*"Health facilities were found to lack necessary supplies. If health facilities lack required diagnosis and treatment supplies for pregnant women, it not only affects subsequent interest to visit the health facility. We [health extension workers] lose confidence in our service provision and trust from the public."* Urban Health Extension Professional, Deha Sefer, Harar city

Urban Health Extension Professionals in all study settings unanimously complained about the lack of basic medical consumables, including gloves, emergency kits and blood pressure apparatus, which could be taken during home visits. One of the participants summarized the common arguments:

*"My kit is empty. During my home visit, women ask me for support I can't provide. I do not even have single gauze and can't help someone bleeding when I visit. We should, at least, have a first aid kit, which is basic but appears to be a luxury."* Urban Health Extension Professional, Arba Minch

Besides, UHE-ps in some settings complained of a lack of space within the health facility to engage and support their clients. This was mentioned in a few study settings in Harar, Arba Minch, Mekelle, Debre Birhan and Dire Dawa. One of the participants explained that:

*"Not only me, but all of us working here, do not have room for HIV counseling, despite much demand for such a service from our women clients. I carry my blood pressure apparatus with me all day."* Urban Health Extension Professionals, Mekelle

In addition to limited supplies at health facilities, provider attitude is another concern. At health facility level, a lack of respect for pregnant women was not uncommon. This problem at facility level was repeatedly mentioned as a major barrier to seeking health care in connection with pregnancy, delivery and post-partum. The mistreatments of women, humiliating them at facility level and overlooking the pain women suffer have an impact on the desire to visit a health facility. Participants in all settings unanimously argued that the extent of abusive treatment is a serious concern. One of the local opinion leaders underscored that:

*"After having been encouraged to visit a health facility for maternal health care, women return back unsatisfied for not being*

*respected and not receiving the expected care, for being sent to another facility. Sometimes providers give such lame reasons as 'time for service is over', the right provider is not available, laboratory is not functioning and medicine is not available"* Opinion leader, Hawassa.

Findings show that the poor quality of service delivery is attributed to the non-supportive attitudes of health professionals, who give women tough time. One of the participants summarized the common challenge in this regard:

*"As it stands now, health centers are much better compared to the hospital in how caring providers are. Previously, Arba Minch Hospital was recognized for its service. However, recently, mothers are dying while giving birth. I think this is due to the carelessness of providers."* Opinion leader, Arba Minch

Lack of passionate care and support is only one component, while limited numbers of providers play yet a role, making service provision non smooth and not up to the expectation of women. This is a critical problem in all study settings. One of the participants explained that:

*"There are critical shortages of the health professionals in this health center, since [the number of] active workers are much below what the structure requires. Currently, we are dealing with a number of clients with diverse problems, including routine maternal health care, with a limited number of professionals."* District health official, Adigrat

Residents in slum sections of the urban centers studied do not trust government health facilities. Institutionalized mechanisms to provide free health service to patients did not work for women who visit health facilities in connection with their pregnancy. Pregnant women from slum settings may not be able pay for services that providers order to get from private facilities. This is one of the barriers to service use.

One of the participants argued that:

*"I got support letter from the kebele to get free health services. At the health facility, I am advised to get a test for something I do not remember. I went to the suggested health facility, who asked to me to pay for a [registration] card and then for the test. I did not have the money. I returned to the government health facility and told them my problem. The provider did not care and said: 'I cannot help you. That is it.' I did not go back to them. I delivered my child safe."* Woman, Hawassa

Findings suggest that, in vulnerable settings, residents may need to travel on uncomfortable roads and paths to access health services. This is evident in view of the

poor road access and lack of public transportation in vulnerable quarters of the study settings, which affect timely access to health facilities, especially in emergency situations. This was further substantiated by one of the participants:

*“No vehicle can enter into our village, let alone quickly take a patient to a health facility, or carry a dead body. It is difficult to carry a dead body for burial. One finds it difficult to pass through this village and I do not know how this could be solved.”*Opinion leader, Woldiya

Many Urban Health Extension Professionals in all study settings expressed frustration and concerns over the limited community recognition of their role in health service provision. The main challenges identified during the process were: perceived low acceptability of UHEP, overburdened UHE-ps by other commitments, the shortage of health workers, limited infrastructure, the lack of community integration, and community fatigue. One of the participants pointed out that:

*“We are overburdened by many more expectations by other sectors, including distribution of letters to offices. Every sector has something for us and these additional tasks have nothing to contribute to the community’s health needs...”* Urban Health Extension Professionals, Shashemene

## Discussion

Barriers to health service use were categorized into individual-, community- and health facility-level factors. Access to health services is not uniformly characterized within countries: the poor have less access to health services compared to those who are better-off (12). Different definitions and perspectives have been used to look at the association between poverty and health service utilization. In this study, we used demand- and supply-side parameters to define barriers to access health care services. Individual barriers were related to limited awareness about health problems and services. Residents in slum sections have competing priorities and lack time to seek information on different health services. A previous study from Ethiopia has reported that the health awareness of slum residents remains grossly weak (8). It is important to appreciate the fact that residents are characterized by a poor state of life, with limited income and precarious livelihoods. In addition to awareness, previous negative experiences affect the decision to use available services(13).

Similarly, findings suggested that being poor or residing in the identified vulnerable quarters of urban centers is one of the barriers to seeking health services. Findings from this study suggested that, though the identified barriers to using health services are not specific to those who reside in vulnerable quarters, the extent of the problem is relatively pressing for them.

Community-level barriers were evident from this study. Findings show that pregnancy is not perceived by the community as a health problem, and that staying

indoors after delivery is considered healthy behaviour. Available evidence from other African countries reveals that, of women who deliver in facilities, a little over 10% receive PNC (14). Studies unanimously argue that individual- and facility-level factors play pivotal roles in the access and use of maternal health and other services. In addition, community-level values have a negative impact on women visiting health facilities after delivery, irrespective of where they deliver. The community upholds and appreciates if women and newborns stay indoor for days after delivery, which is otherwise believed to be risky, risking the life of both mother and child(15,16).

In this study, health care facility-level (supply) barriers contribute to the low uptake of available health care services. Findings from this study indicate that the shortage of medication and medical equipment, and the level of friendliness of health health care providers, affected the use of services.

The shortage of medical supplies has contributed to the low uptake of available health care services at nearby health facilities (17), indicating that the shortage of medication and medical equipment have been frequently mentioned as forcing clients to go to private medical care at a much higher expense.

The other most prominent barrier related to accessing facilities in all the study settings was disrespect by health professionals at all levels. Mistreatment of patients by health workers ranges from abusive humiliation to withholding service or care when most needed. The implication of this on health care-seeking behaviour is evident, affecting patients’ satisfaction and reducing patients’ confidence in health facilities (17,18).

Access to health facilities was mainly gauged by the availability of roads in slum areas. This was found to be a critical barrier, particularly in some selected urban area such as Adama and Woldiya. Participants from these settings characterized their section as locked in and not having a route for bigger cars and ambulances. Participants also argued that such problems were most prominent during emergencies, when they were most needed. This finding is consistent with a study conducted in Nepal (19).

Inasmuch as beneficiaries complain of barriers to services, providers were found to have complaints about challenges they encounter in the provision of health services. This was particularly emphasized by UHE-ps, who are overburdened with additional responsibilities and are blamed for failing to meet expectations.

## Conclusions

This study clearly show that average/aggregated health indicators in urban settings give an inaccurate impression, since there are specific sections in urban settings that are much more affected and presumably exhibit poorer health indicators. Unfortunately, the aggregation of urban evidence has masked such realities for a long time. While this has been proven, further studies may help to elaborate this. While health

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facilities are relatively easy for urban clients to access compared to clients in rural settings, the use of such services is not at the expected level. This study shows that multiple barriers that operate at different levels affect community visits/use of health facilities. Individual-, community-, institutional-(health facility) and infrastructural-related factors were found to work together simultaneously to affect communities' decision to use available health services. The health sector and health development partners are expected to give special attention to slum areas in urban settings through multifaceted interventions considering individual, community and institutional levels.

## References

1. Chesnay M de, Anderson BA (eds.). *Caring for the vulnerable: Perspectives in nursing theory, practice, and research*. Fourth edition. Burlington MA: Jones & Bartlett Learning; 2016.
2. Obaid TA. Health cities for the elderly. *UN-HABITAT, Habitat Debate*. 2007;13(4):14.
3. WHO. *Implementing Rio: Monitoring action on the social determinants of health: Background paper: 20–22 June 2016*, Canada. [www.who.int/social\\_determinants/Background-paper-final.pdf](http://www.who.int/social_determinants/Background-paper-final.pdf).
4. George S, Daniels K, Fioratou E. A qualitative study into the perceived barriers of accessing healthcare among a vulnerable population involved with a community centre in Romania. *Int J Equity Health*. 2018;17(1):41.
5. Barik D, Thorat A. Issues of unequal access to public health in India. *Front Public Health*. 2015;3:245.
6. Loignon C, Hudon C, Goulet É, Boyer S, Laa M de, Fournier N, *et al.* Perceived barriers to healthcare for persons living in poverty in Quebec, Canada: the EQUIhealThY project. *Int J Equity Health*. 2015;14:4.
7. Scheppers E, van Dongen E, Dekker J, Geertzen J, Dekker J. Potential barriers to the use of health services among ethnic minorities: A review. *Fam Pract*. 2006;23(3):325-48.
8. Kaba M, Taye G, Gizaw M, Mitiku I, Adugna Z, Tesfaye A. A qualitative study of vulnerability to HIV infection: Places and persons in urban settings of Ethiopia. *Ethiop. J. Health Dev*. 2016;30(3):105-11.
9. Federal Ministry of Health. *Health Sector Transformation Plan-I. Annual Performance Report (2015/16)*. Addis Ababa: FMOH; 2016.
10. Federal Ministry of Health. *Urban Health Extension Program implementation guideline*. Addis Ababa: FMOH; 2009.
11. Bayou YT, Mashalla YS, Thupayagale-Tshweneagae G. The adequacy of antenatal care services among slum residents in Addis Ababa, Ethiopia. *BMC Pregnancy Childbirth*. 2016; 16(1):142.
12. Peters DH, Garg A, Bloom G, Walker DG, Brieger WR, Rahman MH. Poverty and access to health care in developing countries. *Ann N Y Acad Sci*. 2008;1136:161-71.
13. Simkhada B, van Teijlingen ER, Porter M, Simkhada P. Factors affecting the utilization of antenatal care in developing countries: Systematic review of the literature. *J Adv Nurs*. 2008; 61(3):244-60.
14. Sines E, Syed U, Wall S, Worley H. Postnatal care: a critical opportunity to save mothers and newborns. *Policy Perspectives on Newborn Health – Saving Newborns Lives*. Save the Children and Population Reference Bureau; 2007:1-8. [www.healthynewbornnetwork.org/hnn-content/uploads/Postnatal-Care-a-critical-opportunity-works\\_0.pdf](http://www.healthynewbornnetwork.org/hnn-content/uploads/Postnatal-Care-a-critical-opportunity-works_0.pdf)
15. Limenih MA, Endale ZM, DacUrban Health Extension Professional BA. Postnatal care service utilization and associated factors among women who gave birth in the last 12 months prior to the study in Debre Markos town, northwestern Ethiopia: A community-based cross-sectional study. *Int J Reprod Med*. 2016; 2016:Article ID 7095352.