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COLLEGE OF SOCIAL SCIENCE AND HUMANITIES

DEPARTMENT OF SOCIOLOGY

SOCIOE-CONOMIC CHALLENGES AND OPPORTUNITIES OF HEALTH SERVICE IN WOLKITE TOWN IDGET BER KEBELE

A SENIOR ESSAY PRESENTED FOR PARTIAL FUIFILLMENT FOR THE REQUIEREMENY OF BA DEGREE IN SOCIOLOGY

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ABBREVIATION AND ACRONOMY

FMOH; Federal Ministry of Health

HC; Health Centre

HDI; Human Development Index

HIV/AIDS; Human Immune Virus and Aids Immune Disease Virus

HO; Health Office

HS; Health Station

HSDG; Health Sector Development Goal

HSEP; Health Service Extension Program

HSDP ; Health Sector Development Program

HW; Health Work

GTP; Growth Transformation Plan

MM; Modern Medicine

MMD; Modern Medicine Development

MMR; Maternal Mortality Ratio

MOH; Ministry Of Health

NGO; Non-Government Organization

PHC; Primary Health Care

PH; Primary Health

WB; World Bank

WHO; World Health Organization

ABSTRACT

The study was all about soco economic challenges and opportunity of health service the case of wolkite town idget ber keble. The objective of this study is to assess the socioeconomic challenges and opportunities of health service delivery. The study was used descriptive survey research design and employed mixed research approach. The research was conducting by obtaining both primary and secondary data. In this study of the non probable method purposive or judgmental sampling and probable method systematic sampling technique was employed .In this study questionnaires and interviews were used to gather data. In order to conduct this study out of 531 of the target population, 44 respondents were selected. The study also purposively selected 3 health service workers in idget berprimary health care and purposively 3household members were selected to get further and detailed data. The majority of the respondents were 64% are male and 36% are female. The majority of the respondents on the study were the age between 29-38 years. As a resul in relation to the assessment of the social challenges and situations of health in the study area the data indicates that there are so many social challenges in the area related to the using of traditional medicine less or undeveloped health facilities, public health problems such as lack of sanitary water for drinking and other related social problems the people in the area also have economic challenges related to health fee, Extreme poverty and low economic status of the people when they answering why not they didn't used the modern health service their answere was because of the expensiveness of the health fee in both the government and the private. In contrast to the above the recent opportunities and current tendency of using of health service in the area show in improvement.

Keywords:-Socioeconomic, Opportunity, Challenge, Health Servic

CHAPTER ONE

1. INTRODUCTION

1.1 Background of the study

Globally, countries were faced with health system problems which vary from one to the next. While health service delivery challenges are more often seen in a very high Human Development Index (HDI), human resources challenges attract more attention with in those with a low Human Development Index (Roncarodo F, Boivin A, Denis JL, Hebert R, 2013). Health care systems in Africa have, over the years, suffered from man –made issues which out across institutional, human resources, financial, technical and political developments. With this in mind, the World Health Organization (WHO) in 2007 proposed a framework that describes health care system in terms of six care components or building block; Service delivery, health care workforce, health care information systems, medicine and technologies, financing, leadership or governance (WHO.2007). The majority of African countries are unable to meet the basic requirement for good health care systems. Poor governance and human resource challenges are linked to ineffective integration of services in resource limited nations (Marais DL, Patersen I. 2015 and Patersen I, Marais D, Abdulmalik J, et al. 2017).

Human resources shortages and "brain drainage" from Africa to Europe, the Middle East, and North America compound health care outcomes. As part of efforts to remedy the lack of financial risk protection mechanisms in Africa, some countries, such as Nigeria, Ghana, Tanzania, Kenya, Rwanda andEthiopia have started implemented social health insurance schemes. Globalization also has be far- reaching implications for health systems in Africa. By intensifying the economic and racial inter connectivity between countries, it was provided more employment opportunities for health care workers and greater integration of health care services, exchange of medical information, transfer of skills, information medical productions and standards of practices as well as resources and avenues for responding to challenges in the health sector, (Bessada 2013; 211-212). In terms of health and welfare, Ethiopia ranks among Africa's and the world's poorest nations. Health indicators are generally poor and the health care system is wholly inadequate. The Ministry of Health of Ethiopia expressed that the main causes of

Ethiopia's poor health conditions are high poverty rate, low income levels, low education levels, poor access to health services, insufficient access to clean water, and insufficient healthcare facilities. Ethiopia is among countries with lowest health status in the world. This is mainly due to backward socioeconomic development resulting in widespread poverty, low standard of living, poor environmental conditions and inadequate health services. As with other developing nations Ethiopia has experienced extreme resource constraints within the health care system for much of its recent history. It has depended heavily on government budget allocations for investments in need health facilities and in medical service and for the operating costs of delivering care. Weak infrastructure and limited distribution systems in low income countries complete 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 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.

Following the change of government in 1991, the new Government of Ethiopia put in place may political and socio–economic transformation measures. It developed a first national health policy. Which was followed by the formulation of four consecutive phases of comprehensive Health sector Development plans (HSDPs). Starting from 1996/97, the policy and the first HSDP were based on critical reviews of prevailing national health problems and abroad awareness of newly emerging health problems in the country (HSDP-IV 2010/11-2014/15). At the core of the health policy are democratization and decentralization of the health care system developing preventive, primitive and curative components of health care, assurance of accessibility of health case for all parts of the population, and encouraging private and NGO participation in the health sector. The major health problems of the country are largely preventable communicable diseases and nutritional disorders. More than 99%of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/ADS, and offer as a combination of these conditions.

For this reason, we were desired to make study on the socio-economic challenges and opportunities of health care services on residents in the case of Wolkite town Idget Ber Keble

1.2 Statement of the problem

Ethiopia is a poor country with weak health care systems and infrastructure. The shortage of health care professionals is also a major problem in Ethiopia, which causes doctors and nurses to be overworked and to become exhausted, ultimately creating more problems. Health care providers become unsympathetic, unethical, mismanaged, and disinterested when overwhelmed (Deere, 2003). One in 14 Ethiopian women face the risk of death during pregnancy and delivery; one in every 13 Ethiopian children dies before his or her first birthday, and one in 8 dies before age five (Surafel, 2012).

Most of the households (64%) use unclean water. There is a large variation among rural and urban households with only 25% of rural households having access to clean water against to more than 90% of urban households. About 77% of rural families still need to travel more than 20 km to get to a hospital (Tefferi and Endeshaw, 2006). Sanitation facilities in Ethiopia are very poor. Most of the people are deprived from modern sanitation facilities; as a result they suffer from various contagious diseases. The rural people have low facility of sanitation than that of urban. 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 socioeconomic development, improving the general physical infrastructure and strengthening health systems were dominant to improving health and require major investments and much time. 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 facilities 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 were by providing reproductive and other health services through primary health care facilities paying attention to quality of services, and strength being community participation working to improve equity of health service delivery within the context of available infrastructure and weak systems (Nada Chaya, 2007). Among these studies Haftom Gebralif (2016) carried out relevant research study on the topic economic challenges and opportunities of health service, but did not emphasized on social challenges and opportunities health service in Shashemene Oromia Regional state of Ethiopia. In addition the research was collected in relation to health financial policy of the country or some other specific areas such as habit of getting

health service and financial constraints. The previous study conducted in 2016 and this study the current conducted in 2021, so there was time gap. In addition the researches was didn't conducted the particular these areas. Therefore this study has fill the gap it is essential to assess the socioeconomic challenges and opportunities health service which can provide durable solution for the various factors which push the researchers team to conduct the study on relationship between the conducted on the living condition, such as house, food, income and access to commodities as primary factors influencing health and social infrastructures, such as social and public services for health, clear information about available social care and local support services, education or child care as important factors affecting health. Therefore, this study was conducted to investigate the socio-economic challenges and opportunities of the health service in the Wolkite Town Idget Ber Keble.

1.3 Objective of this study

1.3.1 General objective

The general objective of this study is to assess the socio-economic challenges and opportunities of health service delivery in Wolkite Town Idget Ber Keble.

1.3.2 Specific objective

1.To identify the determinant ofeconomic challenge for healthservice.

2.To examine the social challenge attitude toward the traditional medicine.

3.To describe the socio-economic opportunity and the provision of infrastructure in the study area.

1.4 Research question

1. What are the determinants of economic challenges for health service in Wolkite Town Idget Ber Keble?

2. To what extent societal challenges attitude towards the traditional medicine in the study area?

3. How to describe the socio-economic opportunities of provision of infrastructure in Wolkite Town Idget Ber Keble?

1.5 Significance of the study

This study of the significant for the primary health care provider or donors to understand the current gaps regarding opportunity of health service like, living condition, access to safe water, adequate water for washing and for drinking almost regularly, health opportunity safetyman health, and health facilities, economic challenges and problems especially with public health and wash (water sanitation and hygiene) and benefit socio economic opportunity and opportunity of health service. It also improves the current opportunity of health service. For practice: the studies are serve as to apply knowledge and theory learns in practical situation. For the future researchers: the study is serving as a ground work for further studies to be carried out. For academic purpose: the document is use as additional docent with the existing theoretical literature. For relating to opportunity of health facility: relatinghealth benefit from this research by using the study as a relating heath to their situation and studies.

The major significance of the study are the followings: it is provide the basic information about the factor of socio economic on opportunity of health service of Wolkite Town Idget Ber Keble, it is creates hope to initiate other researchers in order to undertake detail study on this issue, it is creates awareness on the health service as a whole and it can serve as a source for further researches.

This studies are significance for other researchers in order to investigate more researches and it has provide a data which has essential for those who want to develop further theories and practice. The study shall be enable other investigators to understand and know the relationship between socio economic challenges and opportunity of health facility and also it is provide access of basic data that will apply in other researches and studies.

1.6 Scope of the study

This study was delimited both geographically and thematically. Geographically the study was delimited to Wolkite Town Idget Ber Keble; it was not include other areas of health opportunity around the surrounding community. Lack income or social infrastructures include public water distribution networks, public health services, safety and security and related things are in consideration when we selected the study area. Thematically the study was delimited on socioeconomic challenges and opportunities of health service delivery. The

researcher were more comprehensive and reliable, if it was include all households in Wolkite town Idget Ber Keble. However, due to shortage of finance and time resources, the researchers were delimited to households in Wolkite town Idget Ber Keble.

1.7 Organization of the paper

The study has divided in to five chapters. The first chapter deals with about introduction part which comprises background, statement of problem, objective of the study, research questions scope of the study and organization of the paper. The second chapter deals with review related literature. The third chapter deals with the methodology of the study, research approach, research design, description of study area, source of data collection, sampling techniques and sample size, method of data collection, method of data analysis and ethical consideration. Finding from both descriptive and narrative analysis are presented discussed in the chapter four. Finally chapter five outlines main conclusions and recommendation.

1.8 Limitation of the study

1-Shortage of adequate finance and reference materials.

2-Lack of review related literature material or source, that is necessary to don more research.

3-Shortage of time, because when we done this study we have a formal class, test, and the like.

4-Shortage of finance. We are conduct this study at distant place as a result it require transportation coast, money to invite the respondent, and so on

CHAPTER TWO

2. LITERATURE REVIEW

2.1 The concept of health and health service

Health is a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living it was a positive concept emphasizing social and personal resources as well as physical capabilities (WHOTEWRM 2000).

Health service include, all services dealing with the diagnosis and treatment of disease, or the promotion, maintenance and restoration of health. They include personal and non –personal health services. Health services were the most visible function of any health system, both to user and the general public services provision refers to the way input such as staff equipment and drugs were combined to allows the delivery of health intentions improving access coverage and quality of services depend on these key resources being available; on the ways people centered and health services were critical for reaching universal health coverage (Encarta encyclopedia, 2009).

2.2 Theoretical Perspective on Health and Health care

A sociological understanding emphasizes the influence of people's social backgrounds on the quality of their health and health care. A society's culture and social structure also affect health and health care. The functionalist approach emphasizes that good health and effective health care are essential for a society's ability to function. The conflict approach emphasizes inequality in the quality of health and in the quality of health care.

2.2.1 Conflict theoretical perspective on health and health care

Social inequality characterizes the quality of health and the quality of health care. People from disadvantaged social backgrounds are more likely to become ill and to receive inadequate health care. Partly to increase their incomes, physicians have tried to control the practice of medicine and to define social problems as medical problems. The conflict approach emphasizes inequality in the quality of health and of health-care delivery (Weitz, 2013). Society's inequities along social class, race and ethnicity, and gender lines are reproduced in our health and health care.

People from disadvantaged social backgrounds are more likely to become ill, and once they do become ill, inadequate health care makes it more difficult for them to become well. As we will see, the evidence of disparities in health and health care is vast and dramatic.

The conflict approach also critiques efforts by physicians over the decades to control the practice of medicine and to define various social problems as medical ones. Physicians' motivation for doing so has been both good and bad. On the good side, they have believed they are the most qualified professionals to diagnose problems and to treat people who have these problems. On the negative side, they have also recognized that their financial status will improve if they succeed in characterizing social problems as medical problems and in monopolizing the treatment of these problems. Once these problems become "medicalized," their possible social roots and thus potential solutions are neglected.

2.2.3 Theoretical reviews

Faced with inadequate and declining funding for ministry of health services, many African ministries have recognized they cannot meet their traditional commitment to provide a basic level of health care, free of charge, to the whole population. The most sub- Saharan African countries have adopted is user fees for services, medicines, or both. The uses fee revenues had the only source of finance for non-salary recurrent costs (Mcpake, 1991). Most African believes in and relies upon the services of indigenous healers for relief for relief of physical illnesses as well as psychological and spiritual comfort. Indigenous healers include medicine doctors or herbalists, diviners, indigenous priests, oracles, birth attendants, surgeons, royalty, rain makers, and other specialists through informal and study these practitioners learn the healing value and use of aide variety of roots, leaves, barks, flowers, thrones minerals, animal and insect parts and leaving, and other materials in the treatment of patients. Healers also use taboos (bans or inhibitions), massage, incantations (ritual reaction of charms) ventriloquism, and purge actives (treatment to clean or purge the body). Their success was enhanced by their understanding of the personal, social, economic and political conditions of the individuals, families, and institutions of their community (Encarta encyclopedia, 2009).

2.4 Empirical reviews

The reform of health care systems was supposed to make access to health care better. But in the particular case of user fees the opposite effect was observed. During the 1980s and 1990s, health

sector reforms to improve the efficiency of health systems and the quality of care providing were implemented in low income countries mainly in Africa (nk's 1987) argument regarding equity requires redistribution of collected revenues to new facilities. But, this may conflict with the aim of using revenue to improve equality in existing facilities particularly where the volume of revenue raise was quite low (Mcpake, 1991).

2.5 Policy and program reforms

2.5.1 The health sector development program (HSDP)

The overall goal of the HSDP was to improve the health status of Ethiopian people through providing a comprehensive package of preventive, primitive, rehabilitee and basic curative health services via a decentralized health system in collaboration with all stakeholders. The initial sector development program (HSDP), which was draft in 1993/94, was designed for a period of 20 years, with rolling five years programs period; it have three main goals (World Bank, 2005).

1. Build basic infrastructure

2. Provide standard facilities and supplies and

3. Develop and deploy appropriate health personnel for realistic and equitable primary health delivery at the grassroots level**.**

The first phase, HSDP I, was implemented from 1997 to 2002. It sought to:

a. Increase access to health care from 40 percent to 50-55 percent

b. Improve the technical quality of PHC services, including their structuring of the pharmaceutical sectors and expanding the supply and productivity of health personnel

c. Develop an information, education, and communication plan to communicate PH messages to isolated areas.

One of the important policy measures recently taken by the MOH in 2002/03 were the development of the Health services Extension package (HSEP) initiative which seeks to provide health promotion and extension services to communities.

2.5.2 Accelerated Expansion of Primary Health Care Coverage

It proposes a faster rate of establishment of primary health care facilities, as an essential institutional framework to scale up PHC and for the successful implementation of HSEP. Therefore, new health posts were construction and equipped in order to support the provision of preventive and primitive health service to rural populations through the HSEP. Besides, construction and equipping of new health centers and upgrading of health stations to health centers were undertaken (MOFFE, 2005).

2.6 Organization of the Health Services Delivery

The role of Ministry of Health was declined in such a way that regional health bureau have autonomous power on planning, budgeting and supervision of the health facilities exist in their region. Health care services were providing through four sectors: public sector, private sector, NGO sector and traditional healers.

2.6.1The Public sector

In the Mid 1990s prior to the implementation of HSDP, the public health system was structures into a five system (World Bank, 2005).

-Central referral hospitals (Covering approximately 588,000 persons)

-Regional hospitals (N/A)

-Health centers (covering approximately 223,000 persons).

-Health stations (covering approximately 45,000 persons)

-Community health posts (covering approximately 21,000 persons)

2.6.2 The NGO Sector

As of December 2002, 508 NGOs were register with Center for Disaster preparedness and prevention (DPPC): 377 indigenous and 131 international NGOs (World Bank, 2005). Legal procedures and guidelines exist for NGO licensing operation and follow-up during implementation. However, actual processes were more extensive and vary across regions. As a result, project formulation, appraisal and final agreement take time because of the way NGO licensing and legal procedures are organized; lack of coordination between various stakeholders; procedural differences across regions human resources constraints; and bureaucratic red tape.

2.6.3 Traditional Healers

The traditional medicine ™ includes the use of herbs, the belief in the healing Prowers possesses by healers, Holy Water and other remedies for addressing both physical and mental illness.TM Plays an important role in health care for a large majority of the population. It appears that it was fairly common for people to seek Tm first and modern medicine (MM) only when TM fails. In cases where TM was sought first and the patient's health do not improve; patients were delayed in reaching a health facility sometimes to the point that it was too late.

2.6.4 Major Health problem

The health status of the people of Ethiopia was poor in relation to even low-income countries, including those in sub-Sahara Africa. The population suffers from potentially preventable diseases such as HIV/AIDS, malaria, Tuberculosis, interculosis, intestinal parasites, acute respiratory infections and diarrheal diseases, Health indicators were generally poor (WHO. 2005).

2.6.5 Determinants of Ill-Health

Living conditions: it was estimated that about 45% of the people in Ethiopia live on less than one US dollar par day in 2001.

Literacy rate: the adult literacy rate was 36% (46 % for males and 25% for females). The primary school enrolment rate was 57.4 % for both sexes ours of which girly constitute 45%.

Access to safe drinking water: Only 33% for the population have access to safe drinking water in 1999 the coverage in urban areas is 80% and in rural areas it was 14.3%.

Sanitation in terms of service delivery facilities: Sanitation coverage was estimate at 25%. According to MOH (HSDP II), 74% o of urban –dwellers have access to reasonable sanitation facilities Of three households in the country were using risky coping a strategies (WHO, 2006 that was the poor have reduce their consumption such as food and clothing and this deepens their poverty. Moreover they ration the use of health care and/or they fail to complete treatment. One of the reasons for the delays in care seeking was also cost. This has led to even higher costs of treatment and increase in preventable deaths.

2.7 CONCEPTUAL FRAMEWORK

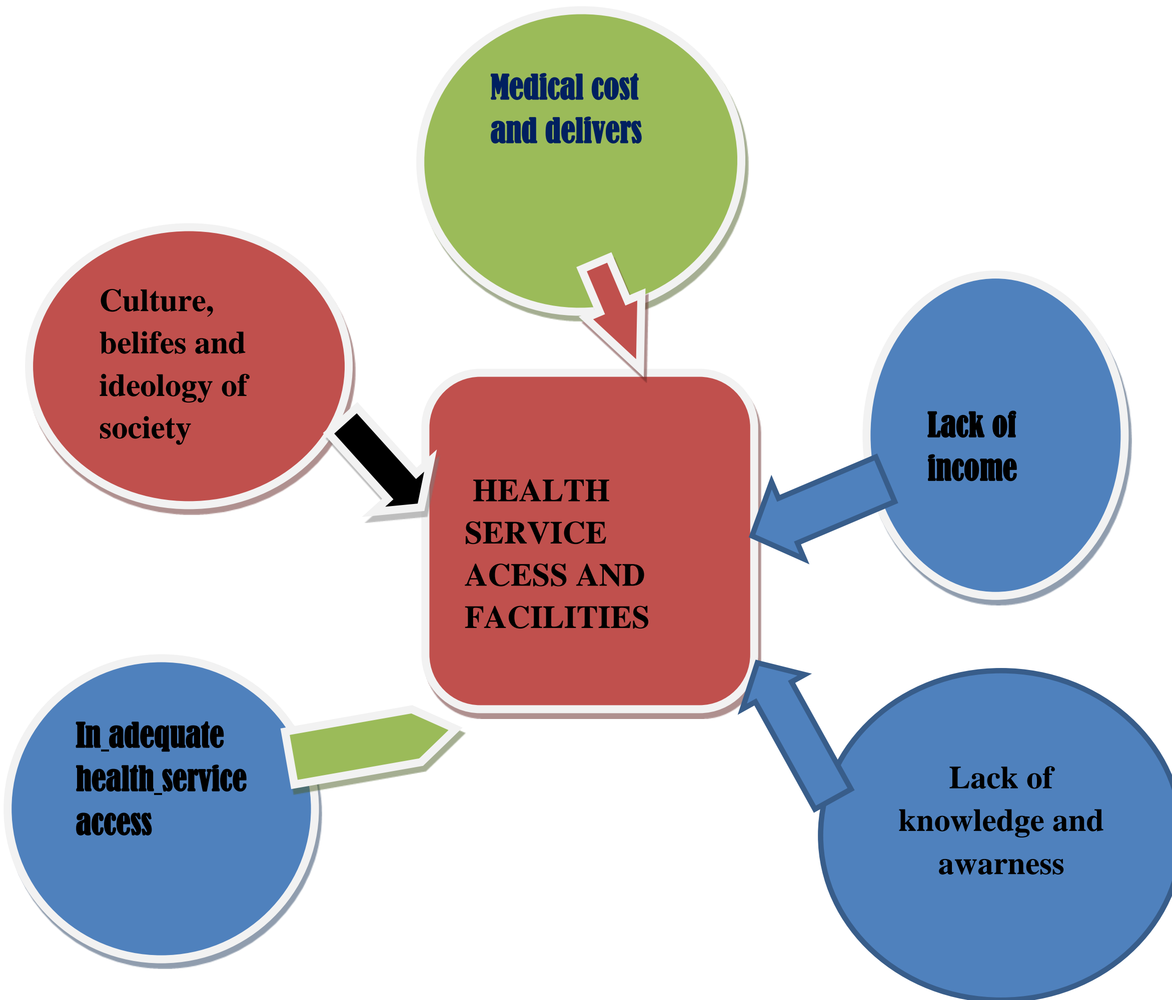

Fig1. The Conceptual Frame Work (source own 2021)

The above frame work shown that the relation ship between health services facilities and determinat socio economic factors. Many social and economical factors affecting the health service access and facilitates such as lack of income, inadequate health service,lack of transportation, tradtional medicine, culture, ideology,belives and attitudes to ward modern health service and other dependent varibles affect the health service access and facilities.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1 Description of the study area

The study was conducted in Wolkite town Gurage zone in Ethiopia. Its geographical location is from 7°44’ 46" to 8° 28’ 29"N latitude and 37° 27’ 30"to 38°42’ 42"E longitudes. Wolkite town was located in Gurage zone of Southern Nations, Nationalities and peoples Regional state of Ehiopia, (SNNPRSE) . It was the Capital town of the Zone and located at 158km South of Addis Ababa on the way to Jimma town and 427 km from the Regional City, Hawassa. Based on the 2007 census conducted by the central statistical agency, this town has a total population of 28,886, of whom 15,074 are men and 13, 792 are women. A plurality of the inhabitants practiced Ethiopian Orthodox Christianity, with 48.17 % of the population reporting they observed this belief, while 41.31% of the population said they were Muslim, 7.86% were Protestant, and 1.34% were Catholic. (Census 2007 Tables: Southern Peoples, Nations and Nationalities Region).

3.2 Research Approach

In this study we have used mixed research approach. We choose this approach because it has different importance. Mixed approach was important to compare quantitative and qualitative data (mixed methods were especially useful in understanding contradictions between quantitative results and qualitative findings). Reflects participants point of view (mixed approaches give a voice to study participants and ensure that study findings were grounded in participants experiences). The other advantage of mixed research approach was that it becomes efficient data collection and analysis with the data. The qualitative data provide appropriate information and facilitates understanding as well as interpretation of the qualitative data.

3.3 Research design

The researchers were used cross sectional study design because the researchers’ wants to address the data at one time to assess the socio-economic challenges and opportunity of health service. As we know cross sectional study design indicate a time which was very short and precise with limited time. For our purpose of study cross sectional study design was essential and related with the time that we have to collect the data that we went show and describe. We do not use

longitudinal research design because we must be graduated after four or five months. As the name indicate longitudinal research design takes long period of time and requires somehow wide range of time.

3.4 Source of Data

In the researchers both primary and secondary sources were used as sources of data in the researchers. Secondary data were obtained based on both theoretical and empirical literature on this area of study internet websites, books, journals and magazine was the main ways that were used for the collecting of secondary data.

Primary data sources questionnaire and interview were employed. It used to get more reliable and first-hand information from the respondents with regard to socio-economic challenges and opportunities of health service in Wolkite Town Idget Ber. Thus, the primary data were collected from the households.

3.5 Methods of data collection

Primary and secondary methods of data collection were employed to collect a data on the topic. As stated above secondary data were collected from the secondary sources which serve as the literature review in chapter two. During the primary data collection sample survey, and key informant interview were used. Questionnaire (open and close) and stricture interview were alsoused as instruments of data collection for the sample survey and key informant interview respectively. In the study the researchers we have employed mixed types of research method. The research team distributed the questionnaire through the quantitative whereas the interview through qualitative method.

3.6 Sampling technique and size

The researcher were used both probability and non-probable sampling method to collect these information which were for the qualitative and for the quantitative methodologies respectively. In the non-probable method purposive sampling technique was used to selected the key informants. Using these researchers were took two key in formats by using purposive sampling technique. On the other hand, in the probable method systematic sampling technique was used. By applying this technique 50 respondents were selected from 531 target population in the area. The researchers took the sample large because of the heterogeneity of the people in their

livelihood. These techniques were used to selected respondents from the sampling frame without any bias. The researcher also used these methods and technique of sampling because we considered them as convenient with the topic under study.

Nigatu (2008) explain that the precision of facts are always in obtained from census. With this reason sampling is one of the methods, which allows the researcher to study a relatively small number of units representing the whole population. To select the sampling units of the study which represent the whole population is by using statistical calculation which is approved by Yamane 1967.

$$n=N/1+N\ (e)^{2}$$

Where n=sampling size

N=total population

e=marginal error

Given N=531 solution n=N/1+N(e) Required n? n=36

e= 14%=0.14 531/1+531(0.0196) =531/10.4076 =50.02

By using this mathematical formula our sample size in the study were 50 from the 531 total number of population.

3.6.1 Questionnaire

The researchers were use primary data that as an important method for collect through questionnaires for sample population. In this questionnairs 50 respondents was participated from this 36 were household , 7 health service workers and community members who live with their surroundings the study area. Primarily, the questionnaire translates in to Amharic that is familiar language for respondents. The questionnaire was containing both open ended and close ended types of questionnaires was administer by the data collectors, 25 questionnaires proposed for respondents. Open ended questionnaire was used, because it helps the respondents to express their feeling on the idea freely with regard to the questions presented to them and

simultaneously, the research team was used close ended questionnaire, because it easy to analyze and helps respondents to easily answer the questions.

3.6.2 Key informant Interview

The researchers were also used Semi-structured interviews that encounter face to face contact with idget ber keble family or household would interview 14(8 for men and 6 for women informants), 9 family leaders and 5 the primary health care providers or donors who are proximity to issue experience and willingness to participants; because it enable the researchers to get more information through in the reliability of data. Accordingly the key informant interview was administered by the researchers in asking different perspective of socio-economic challenge and opportunity of health service on wolkite town idget ber kebele. The researchers were used key informant interview in order to gain essentially requires data from the target population those who have main role in providing the whole activities of the socio-economic challenge and opportunity health service available.

3.7 Method of data analysis

The collected data was analysis through the uses of quantitative (numerical) method of data analysis through using frequencies and percentages and present by using tables. And also, the qualitative (non-numerical) data present through description.

3.8. Data Quality Control Mechanisms

To enhance the reliability and validity of the data the researchers is take data quality assurance. In order to apply a reliable data, the researchers were taken across check the data which was collected not be stored type. And the validity of the method was improved by knowing the actual behavior of the respondents, while the data was collected. This means respondents were asked and interviews while they are in a good condition. The carefully sampling methods were ensures the Representativeness on survey research

3.9 Ethical Consideration

The researchers respected the etical morality of the target population in general and respecting morality, honors, dignity and was the respondent in particular. Confidentiality of th respondent was the back bones of the response the gave. So it was respeced to get reliable information.When we were conducting our research at moment of data collect by any means were confidential,

secretive, and systematic and take only information for purpose of study issue. Because as we have learned in research course confidentiality, secretive and systematic gathering of information are are the main principle for any doing research and get for appropriate information and the respondents are assured that their participation voluntary and are they free to pull -out of the study at any stage.

CHAPTER FOUR

4. DATA PRESENTATIONS, ANALYSIS AND INTERPRETATION

This chapter deals with the presentations, analysis and interpretation of the data which gathered from respondents through the employment of a mixed research approach. Therefore,

this section of the paper has analyzed and intrepreted the data based on responses which obtained through sample survey,key informant, the data which gatherd through the survey method is analyzed in the form of descriptive statics such as percentages, and frequency table; and after the raw data is analyzed in this form the researchers have provided an interpretation in detail. This chapter is subdivided in to four main section. The first part deals with respondents' background information that includes family participation, age group participation, religion participation, marital status educational level, occupation status, income level and family size. The second section the assessing the social challenges and situations of health in the study area, the recent opportunities and current tendency of using of health service in the study area. Third is about the economic challenges for getting health services are among the major points of analysis. Finally, the finding of the socio economic challenges and opportunities of health service.

4.1. Background information

Table 4.1:Respondent distribution based on sex

Sex	Frequence	Pecentage (%)
Male	32	64%
Female	18	36%
Total	50	100%

Source: survey data, 2021

As indicated in the table 4.1 in terms of the respondents sex, 32(64%) of respondents were male and 18(36%) of the respondents werefemales. The study shows that there was equal participation of females and males in study relatively. Therefore, equal consideration of gender respondents is important of identifies the socioeconomic challenge and opportunities of health services. Percentage of the respondents and can give more information about the health service status of the family.

Table 4.2: respondents by Age

Age	Frequency	Percetage(%)

18-28	16	32%
29-38	18	36%
39-49	12	24%
5o and Above	4	8%
Total	50	100%

Source: survey data, 2021

As the above table (table 4.2) indicates that concerning to the age of respondents were found between 18-28 years 16(32%), 18 (36%) of respondents were found between 29-38 years, 12(24%) of respondents were found betweenthe age of 39-49 years old, 4(8%) of the respondents were found between 50 years old. So in this study many adult and young were participated and minimum numbers of elders peoples also participated. In general the study age demographic of respondents shown almost all age group populations were involved but adult takes the majority numbers.

Table 4.3: Respondent's distribution based on religion

Religious affiliation	Frequency	percentage (%)
Orthodox	15	30%
Muslim	20	40%
Catholic	5	10%
Protestant	10	20%
Othes	-	-
Total	50	100 %

Source: survey data, 2021

The above table 1 in terms of religions background of the respondents shown that, 15(30%) of the respondents have orthodox religious back ground, 20(40%) of respondents have Muslim religious back ground, 10(20%) of respondents were follow protestant religion and 5(10%) of respondents were follow catholic religion. So, the majority of the respondents have Muslim

religion back ground and followed by orthodox religious back ground. Societal believes and ideologies have great challenges in opportunities of health service. So religious back ground has its own challenges for opportunities of health services.

Table 4.4: Marital status of the respondents

Marital status	Frequency	Percentage (%)
Unmarried	11	20%
Married	30	60%
Divorced	5	10%
Windowed	4	8%
Total	50	100%

Source: survey data, 2021

The above table 1 in terms of the marital status of the respondents shown as the following 11(20%) of the respondents were unmarried, 30(60%) of the respondents were married, 5(10%) of respondents were divorced and 4(8%) of respondents were widowed. Thought, the majority of the respondents were married followed unmarried. So, the married adults and community members have great contribution increasing the awareness change the negative attitude of the society towards the young age people. Marital status has also its own contribution on opportunities of health services facilities. Divorced and widowed households faced more economic and other challenges than married, because the married young can support emotionally and economically each other's.unmarried respondents were health service workers who give further information.

Table 4.5: Educational level

Educational level	Frequency	Percetage(%)
Illiterate	22	44%
1st and 4th grade	11	22%

Diploma	13	26%
Degree	4	8%
Total	50	100%

Source: survey data, 2021

The above table 1 also in terms of educational level of the respondents indicates 22(44%) of the respondents were cannot read and write, 11(22%) of the respondents were only can 1st and 4th grade, 13(26%) of respondents have diploma status and 4(8%) of respondents have Ba degree level. Therefore the educational level of respondents shown that the majority of respondents only can not read and write or illiterate. Education was an important factor for affecting opportunities of health service. So the educational status of people highly determines their attitudes and perceptions toward health service opportunities. Health service worker respondents were has diploma and degree status, but the majority of people in study area have no awareness in the opportunities of health service.

Table 4.6: Occupation

Occupation	Frequency	Percetage(%)
Farmer	7	14%
Dairy labour	33	66%
Civil servant	10	20%
Other	-	
Total	50	100%

Source: survey data, 2021

The above tables (table 4.5) also explain that of the daily labour respondents are (66%) beside to that (20%) of the respondents are civil servant and the farmer (14%) give the respondents own ideas. This means that all the respondents respond that their livelihood is depend on daily labour and the different activities. This indicates that the respondents are heterogeneity in their livelihood.

Table 4.7: Income level

Income level	Frequency	Percetage (%)

Below 1500	13	26%
1501-2000	21	42%
2001-2500	16	32%
Above 2000	-	-
Total	50	100%

Source: survey data, 2021

The above table 1 in terms of respondents does gets income and its sources shown that 13(26%) of respondents were gets below 1500monthly income of respondents were engaging of in minimum and small scale trade activity in local markets, 21(42%) of respondents were gets income monthly income level 1501-2000 and also 16(32%) of respondents were gets income level 200l-2500 monthly were may be monthly salaries and who support by government workers and in this background data involves the health service workers who gets their incomes in one month. Therefor the majority of respondents were face economic hardship it made the health status of opportunities were poorer. So the majority of respondents were has not saved assets or wealth as well as money which invested for health services opportunities.

Table 4.8:Respondent distribution based on family size

Family size	Frequency	Percetage(%)
2	15	30%
2-4	27	54%
5-7	6	12%
Above 7	2	4%
Total	50	100%

Source: survey data, 2021

As the above table(4.8) indicates that when we see the family size of respondents (54%) of them have family size 2-4 children. The families 2 family size also follows by holding (30%) get the respondents and family size of respondents 5-7 also follow by (12%) and the above 7 (4%) give the respondents respond your ideas.

4.2.Toassess of the social challenges and situations of health in the study area

Table 4.9:socialchallenge in getting heath service in local area

8, Do you have social challenge to get health service in your local?		Frequency	Per cent (%)
	Yes	32	90%
	No	4	10%
Total		36	100%

Source: survey data, 2021

According to the above table (table 4.8)45(90%)of the respondents answer "yes"; and (90%) they have challenges to get health service in there locale. As they stated in the followed open ended question they faced social problems or challenges in health facilities and peoples faced isolation, discrimination and ignorance in health service opportunities.As they indicate even the available facilities are not equipped and haven't enough personnel. In addition the respondents stated that they have problems related to public health especially in water sanitation and hygiene which is the cause for deferent health challenges. On the other hand 10% of the respondents answered no faced social challenges in health service delivery.

Table 4.10: habits to use traditional medicine

10, Do you have the habited to use traditional medicine (healer to cure when you are sick?		Frequency	per cent (%)
	Yes	24	68%
	No	12	32%
Total		36	100%

Source: survey data, 2021

As the above table (table 4.9) indicates the habited of using traditional medicine (healer) is common in (68%) of the respondents. The respondents stated that they have the habited of

Using traditional medicine (healer) or as they called that "nail abash medhanit".

In addition they stated in the followed open ended questions that they use these things because of their belief and habits they practice in their daily today life. Among the traditional medicines practices are matelot (holy water), Nail hanta (a leaf which is believed to cure a child) and others which are similar to the stated ones. Contrary to the above (32%) of the respondents are not using traditional medicines or healer but the modern medicine

Table 4.11: Traditional medicine is the challenge to use modern health facilities

11,Do you have challenge traditional medicine to use modern health facilities?		Frequency	Per cent (%)
	yes	34	94%
	no	2	6%
Total		36	100%

Source: survey data, 2021

Here the table (Table 4.10) indicates that 94% of the respondents are respond the use of the traditional medicine higher problem on modern health facilities. This indicates majority (almost all) of the respondents have a negative attitude to ward modern health facilities on society. In contrast to this 6% of the respondents have no to use traditional medicine to respond because of diferent reasons.

Table 4.12: Societal reaction towards the modern medicine extension programmers and health packages in local area

12, Do you have positive reaction in modern medicen extension program?		Frequency	Per cent (%)
	yes	7	28%
	no	29	72%
Total		36	100%

Source: survey data, 2021

The above table (table 4.12) 28 %of respondents who have positive attitude towards modern medicine extension prograam (72%) of respondents have negative reaction to the extension of modern medicen,

4.3 The assessment of economic challenges for getting health service in the study area

The economic challenges of the getting health service, such as low living condition or low economic ststus of the people and economic challenges related to health fee, extreme poverty, under developed health facilities, and lack of clean water, inadequate health service.

Table 4.14: economic challenges in health service

15, Do you have economic challenges in health service in your local?		Frequency	Per cent (%)
	Yes	34	100%
	No	2	-
Total		50	100%

Source: survey data, 2021

In the table above (table 4.13) (100%) of the respondents that they have economic challenge to get health service. This is to mean that they have economic challenges to implement get and apply of the health packages which were provided by the government in contrast to this (%) of the respondents respond that they do not have economic challenges to get the health service or apply the packages of health and reforms in the followed open ended question the respondents who respond ‘’yes ‘’in the preceding question explained the something and 84% of the who said answered or explained that they are in low economic status.

Table4.15: Main providers or donors of the health service

16, who are the main providers or donors of health service deliver in your local?		Frequency	per cent (%)
	NGO'S	2	5.6%
	Government	31	86.1%
	Private	3	8.3%
Total	Other	-	-
		36	100%

Source; survey data, 2021

According the table above (table 4.14) the main provider of health service is the government (86.1%) of the respondents respond that only the government is the main provider of health service in their local according and 5.6% of respondents response NGOS organizations were the main health service deliver and providers and 8.3% private health service.

Table4.16: Regular vaccination after birth

17, After birth do they got a mother of regular vaccination?		Frequency	Per cent (%)
	Yes	16	44.4%
	No	20	55.6%
Total		36	100%

Source; survey data .2021

In the table above (table15) 44.4%of the respondents respond that they vaccinate regularly to their children or there brothers in the health posit available there contrary to this 55.6%oftherespondents answer "”NO' who did not vaccinate three children after birth from this we understand that even most of the respondent that they vaccinate their children after birth a number of respondents in contrast to the above didn't vaccinate children some of them also respond that the children born who are elder in the family aren't vaccinated but the children born in the recent past are vaccinated regularly .

Table 4.17: Societal perception or understanding of traditional medicine

15, Do you have good perceptions about traditional medicine?		Frequency	Per cent (%)
	Yes	1	2.8%
	No	35	97.2%
Total		36	100%

Source: survey data, 2021

The above table shows that of the respondents does not heve good perception about traditional medicine 97.2%(35) and 2.8%(1) of the respondents had good perception about traditional medicine. So it can conclude that minority of society in the keble does not have good perceptions and understand about traditional medicine. The above table show that tradional medicine perception has few respondents of the people perceive good tradional health services.

4.4. The Asses of the Socioeconomic challenges' and Opportunities of Health Service

4.4.1 Interviews question for health workers

The key informants to get occupational information from the key informants selected by the purposive sampling technique. The key informants include here are two health post workers in the area. The workers gave the researcher are responses as followed.

1**. These assess and identification of socio–economic challenges of health service available**? As the informants disclose to the researchers in the area there are more socio economic challenges in the area. Even the problems are involving; so many fundamental problems are available in the area which has a significant effect in the people's health. These problems were based on the government bodies and people themselves this means the government have its own negative side and the people have their own negative side. To identify the major challenges here, social challenge related to attitude of the people towards modern medicine or packages health personnel and facilities, economic challenges and problems especially with public health and WASH (water sanitation and hygiene) works. These are among the most problems in the area.

2. **What seems the government (and other stakeholders) response to these challenges face the people?**.

Concerning to the above stated problems the informants by considering themselves as the governments agents in the government to rehabilitee reforms and provide the major problems are more relevant and made the people to change their habit of using traditional medicine and experience. Among the government provisions, the responses were making mother to give birth in health centres, providing health packages and other health reforms. In addition the government provision of health facilities, ambulance service and in deploying their required personal is more reinforced than before. In general the informants respond that the government is providing more tasks to solve the above stated socioeconomic challenges in health service.

3. **What opportunities are developing or forecasted to develop in a near future in your Keble and are these responsive to the stated challenges?**

As the informants are inform the researchers that the people who live in the area getting more opportunities especially after health service development programs (HSDP), 1, 2, 3, and 4. In this programmed more health service improvement are ensured and the people become beneficiary from the opportunities developed in the programmers and reforms.

The plan which would be ended this year brings more opportunity especially in health service improving the attitude of the people in material care and giving birth at health canter, decreasing the child mortality ambulance service provision ,and other provisions. The next and force-feed opportunists are also expected to be successful in their draft and implementation this is to mean the next growth and transformation plan no 2(GTP2) will better improve the health services especially the stated challenges would be solved.

3.What seems the assumption and attitude of the people in modern medicine or service verse versa of traditional medicine /healer?.

Before few years ago there was a habit of using traditional medicine but now except some it already abolished. The attitude of the people towards modern medicine and its service delivery is almost postive and accepted by the people but contrary to this there are few who react to the birth control and giving birth at health canters. This is because of lack of awareness and shortage of incomemade the use and practice were poor.

5. **How do you see the relationship between economic status of the people and their habit of getting health service delivery?**

The informants told the researchers that there is a positive relationship between poverty and the habit or amount of getting health services. If the economic status of the people is low it was real that they couldn't get the health service delivery since they are unable to cover the health fee. This means they live with their disease or health problems because of lack of income.

We can consider that said the informants ''the people who live in urban with high economic status undertake regular health service ''but this was not always true since there are rich households who haven't any habit of using the modern health service

CHAPTER FIVE

5. CONCLUSION AND RECOMMENDATION

Conclusions

The study on the socio economic challenges and opportunities health service is administrated by the predetermined objectives. In relation to the social, economic challenges and recent opportunities of health service the research is made to conclude as follows.The study show challenges there is health services problems. Majoritty of the respondents stated that there is un balanced between health service and society of the living condition, unequal distribution of health services and lack of sanitation service of deliver facilities. In additionally, there are some challenges in existing situation of health service that means lack of access to safe drinking water, low living condition.

In relation to the assessment of the social challenges and situation of health in the area the data indicates that there are many social challenges in the area related to the using of traditional medicine less or underdeveloped health facilities, public health problems such as lack of sanitary water for drinking and other related social problems. The people in the area also have economic challenges related to health fee, extreme poverty and low economic status of the people when they answering why not use the modern health service their answers are because of the expensiveness of health fee in both the government and pharmaceuticals. This is also because of the low economic status or the extreme poverty that make them to left from medical treatment. In contracts to the above the recent opportunities and current tendency of using of health service in the area is in improvement.

Despite of the above challenges the area is with some provisions health facilities in which some of them under construction, health personnel deployment and implementation of health packages. The area is now with the ambulance service that serves the mothers to give birth in health centres. Inadequate health services provision is necessary aspects for resident and to fulfil their socio economic challenges. Without health services like electricity, clean water, health center, human lif is nothing and there is alternative to service. Howeve, most of the society of the study areas are also affected inadequate health services provision, such as lack of access to safe

drinking water, poor a road and transportation services and lack of adequate another related health services.

Generally in the area there are so many socio –economic challenges that affect the health service of the peoples in the Keble. These challenges are related to the attitude of the people low adds the modern medicine expensive health fee, and that available poverty. In contrast to this the area is also with socio –economic opportunities related to the provision of infrastructure and packages.

RECOMMENDATIONS

The enjoyment of efficient and effective health service can only be ensured with the joint effort of the people; NGO'S and governments, as stated above there are so many socio economic challenges that affect the people from using modern health service delivery.

. Majority of the opportunity of health services need comprehensive package of the care and support which may including several of the services (educational awereness, economic strengthening, food and nutrion, health care, legal protection and improve living condition, access to safe drinking water).

. Providing training of the primary health care and reducing socio economic chaalenges, other problem and it is crucial to build their dignity, and improve health services at the this area.

Measures to be taken by the people

The people should be active in practicing the health package and reforms of the government which can ensure the good health conditions of the people, the main things which are expected to be done by the people to be aware of the government and other stakeholders who active in health packages .

Measures to be taken by the government

The government also should be play a key role in solving the socio-economic challenges of the people and provided opportunities in the health service delivery the most expected thing from the

government especially in the provision of health facilities, development of health personnel and providing the key things which are necessary to the health of the people such as providing and supplying sanitary water.The government should increase the number of health services in the keble and should facilitate and fulfill the material equipment of health center. The keble admistration should preserve and protect the existing health organization and other infrastructures. To solve the problem of health services , the keble leaders should work hand in hand with higher government administration in adequate distribution of health services. The keble official should play great role creating health opportunities and the project to get donors for establishing financial and credit institutions.The governments and the keble household or primary health providers work co-operatively to solve the health service problem.Then households should take responsibility on existing health service and should use them properly.

Measures to be taken by the NGO'S

Like the government the NGOS should be active gin improving the general health status of the people who are affected by so many socio economic challenges as the people indicate there is no NGO in the area. Looking the challenges, gaps and recent developing opportunities the people aid associations and other concerned NGOS should involve.

REFERENCE

Abaya .et al (2004). How big is the crowding out effect of user fees in the rural area of Ethiopia implications for equity and resources mobilization world development vol 32, no 12 pp 2065 2004.

Alma –ata {1978), Alma-Ata Declaration international conference on primary health care Alma –Ata, ussr.61september 1978.

Amarech (2007), Challenges of health care financing economic and welfare fees in urban Ethiopia.

Adua E, Frimpon K, wangW, Epma S, {2017}. Emerging issues in public health a perspective On Ghana health care expenditure, policies and outcome .

Buckser, A. (2009). Institutions, agency, and illness in the making of Tourette syndrome. Human Organization, 68(3), 293–306.

Dejene T (2003). Health situation in Ethiopia. German Ethiopian Association, retrieved.

Encarta encyclopedia, (2009)

Essien MJ, Assian Bus Rev, {2018}. The socio-economic effect of medical union's strikes on the health sector of Akawa Iborb state of Nigeria.

Farbank A, (2001): improving the quality of services and adjusting user fees at Ethiopia government health facilities; estimating the potential impact of implementing various Options abt associates in an Addis Ababa.

Health sector development program IV 2010/11-2014/15

Mepake B (1991) restructuring the health sector in developing countries economic perspective London school of hygiene and tropical medicine keppet street London WCLE 4HT.

MOH (1998) programs actions plan for the health sector development programs, the federal Ministry of health.

Marais DL, Petersen I, Int J Mental health Syst, [2015}. Health system governance to support integrated mental health care in South Africa; challenges and opportunities.

Nada Chaya (2007). Poor access to health service ways Ethiopia is overcoming it.

Oleribe OO, Udofia D, oladipo O, I shola TA, Taylor-Robinson SD, Hum Resour Healt {2018}. Health care workers industrial action in Nigeria across- sectional survey of Nigerian physicians.

Patersan I, Marais D, Abdulmalik j, et al {2017}. Strengthening mental health system governance in six low- and Middle- income countries in Africa and South Asia; challenges and potential strategies.

Roncardod F, Boivin A, Denis JL, Hebert R, Lehoux P, {2013}. What do we know about the needs and challenges of health system? A scoping review of the international literature

Russell S and Abdalla K (2002). Too poor to be sick coping with the cost of illness in east harghe Ethiopia London save the children UK.

Surafel F (2012). Assessing and improving Ethiopia's health care services, Thesis: Barrett Honors College, Arizona state University.

Tefferi H and Endeshaw Y (2006). Country analysis: Ethiopia.

Talcott Parsons, T. (1951). The social system. New York, NY: Free Press.

Weitz, R. (2013)The socioology of health, illness, and health care: A critical approach (6th ed.). Thousand Oaks, CA: Wadsworth.

WHO (1946). Constitution of world health organization?

Whoterm (2000). World health organization terminology information systems.

World Bank, (1987) financing health services in developing countries an agenda for reform Washington D.C.

Appendix I

WOLKITE UNIVERSITY

COLLEGE OF SOCIAL SCIENCE AND HUMANITY

DEPARTMENT OF SOCIOLOGY

QUESTIONNAIRE FOR RESPONDENTS

These questionnaires were prepared to collected information for our senior essay thesis that concerning about the assessment of socio-economic challenges and opportunities of health service delivery in your Keble the researcher is conducting this study for academic purpose only.

Dear respondents

First of all, we would like to say thanks to very much for your willingness to give valuable information to the following questions. At this time our conducting the objective of this questionnaire is to gather information about the socio economic challenge and opportunity of health service the case of wolkite town idget ber kebele, please give you answer the following question.

Part 1; back ground information

1. Gender; A. Male B. Female

2. Age ; A. below30 B.31-40 C.41-50 D. above 50

3. Religion affiliation.

A. Orthodox Christianity B. catholic

C. protestant D. Muslim E. other, specify

4. Marital status . A. un married B. Married

C. Divorced D. Windowed

5. Educational status ;

A. 1st -4th grade B. 5th -8th grade C. diploma D. degree E. other

6. Occupation /livelihood:

A. farmer B. daily labor C. civil servant D. other, specify

7. Income;

A. below 5000   B.5001-10000   C. 1001-15000 D. Above 15000

8. Family size:

A. 2   B. 2-4   C.5-7   D. above 7

Part2: To assess the social challenges and situations of health in the study area.

1. Do you have social challenge related to using traditional medicine to get health service in your locale?

A. yes   B.no

2. If the answer for question number 1 is ‘’yes or no’’ what are the majority social challenges your household (family) face or related from getting health service?

____

____

____

3. Do you have the habited use traditional medicine (healer) to cure when you are sick?

A. yes   B. No

4. If the answer for Q no 3 is’ ‘yes or no’’ what cultural impediment are there in your local which enable you to use traditional medicine or healer?

Explain ____

____

____

5. What is your attitude towards modern medicine?

A.   positive   B. negative

6. If the answer for question number 5 is ‘’positive ‘’is there a full acceptance for the health service works conducting in your local;

A. yes B. no

7. If the answer for question number 5 is ‘’negative ‘’is here any society reaction toward the modern medicine extension programs and health packages in your locale? A. yes B. no

Part3; Do you have the economic challenges for getting efficient health service in the study area.

8. Do you have Economic challenges in health service?

A. yes B. no

9. If the answer for Q no 8 is ‘’yes ‘’ or ‘’no ‘’ how do you explain the economic challenges of healthy service?

____

____

____

10. Who are the main providers or donors of your health service cost?

A. NGO’S B. Government C. private

D. other, specify________

11. After birth do they go to a mother of regular vaccination?

A. yes B .no

12. Do you have good perception or understanding of modern medicine?

A. yes B. no

Appendix II

WOLKITE UNIVERSITY

COLLEGE OF SOCIAL SCIENCE AND HUMANITY

DEPARTMENT OF SOCIOLOGY

Interview Question on Gide line

1. Is there any socio –economic challenges available in your locale? If yes what are the major socioeconomic challenges in your locale?

2. What seems the government (and other stakeholders) response to these challenges face the people?

3. What opportunities are developing or forecasted to develop in a near future in your Keble and are these responsive to the stated challenges?

4. What seems the assumption and attitude of the people in modern medicine or service visa Vis of traditional medicine /healer?

5. How do you see the relationship between economic status of the people and their habit of getting health service delivery?