

**Family Health Status Profile and Equity
to Access Health Services.
An Exploratory Study in:
Hadramout Governorate/Republic of
Yemen**

Thesis Submitted for Fulfillment of Master Degree in Public
Health

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DEDICATION

I DEDICATE THIS WORK PURELY TO THE SPIRIT OF
MY DEAR BROTHER, MY CHILDHOOD FRIEND,
COMPANION OF MY YOUTH AND MY COLLEAGUE
DR. AWNI MUBARAK KAITY GOD'S MERCY

I ASK ALLAH TO MAKE THE BENEFIT OF THIS WORK
MERITS DEDICATED TO HIS PURE SPIRIT...AMIN

LIST OF ABBREVIATION

- CSO:** Civil Social Organization
- DALYs:** Disability Adjusted Life Years.
- FDI:** Family Disease Burden Index.
- FHSI:** Family Health Status Index.
- FSRI:** Family Socioeconomic Risk Index.
- GDP:** Growth Development Product.
- HDI:** Human Development Index.
- HDR:** Human Development Report.
- HSRP:** Health Sector Reform Program.
- ID:** Infectious Disease
- IAH:** Intersectoral Action for Health
- LMICS:** Low and Middle Income Communities.
- MOHP:** Ministry of Health and Population.
- NGO's :** Non-Governmental Organizations.
- NCD:** Non-Infectious Disease.
- PAHO:** Pan American Health Organization
- PHC:** Primary Health Care
- SES:** Socio-Economic Status.
- UHC:** Universal Health Coverage
- UNICEF:** United Nations Children Fund.
- UNDP:** United Nation Development Program
- UNFPA:** United Nations Fund for Population Program.
- WHO:** World Health Organization

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ABSTRACT:

Introduction: Family health, equity and accessibility to health care services are important parameters in health system development. Each community has to provide research-based information to health services planners to consider equity to access to quality health care. The **objectives** of the study were to identify demands, accessibility to quality of health services according to socioeconomic, and disease burden at the family level. **Methods:** An exploratory study design had been conducted in the four PHC units in urban areas in Hadhramout governorate, **Republic of Yemen**. A convenient **sample** of 400 mothers attended PHC units for vaccination, were included in the study. A pretested **questionnaire** form was used during **structured interview** with mothers. **Results:** Families of the interviewed mothers had been categorized into at-risk families and non-at-risk families. According to socioeconomic parameters, at-risk-families formed 8% for education index, 52% for economic-dependency ratio, 70% for family size index, 32% for smoking father index and 42% for KAT addict father index. According to disease burden indices, at-risk families formed 52% for morbidity index and 30% for mortality index. Out of the total families, 96% reported occurrence of diseases during the last three months prior to the survey. Those who expressed demand for services formed 76% of the total families. Both at- risk, and non-at-risk families had access to health care (45% in governmental and 51% in private facilities). Families related to smoking father had high accessibility 83% to health services than their counterparts of the non-at-risk families (73%) ($p=0.04$). **Conclusion:** the studied community suffers from high incidence of diseases that need preventive services to reduce demand for health care. Despite the high caseload, equity in access to health care that was matched with families' demand is ensured by the health system.

Key words:

Equity, Family Health, Socio-economic indices, Disease burden Indices, at-risk families, access to health care, demand for health care, health system

INTRODUCTION:

The progress in economic development would lead to better health indicated by levels of morbidity, mortality and life expectancy at birth. The increase in the income, employment and access to health care will lead to overall health improvement. Health is thereby seen both as consequence and determinant of development. People's productivity depends on their level of nutrition and health **(UNDP, 1990)**.

Although increase in life expectancy and reduction in mortality have taken place during the last three centuries plus improvements in health care services, inequalities in health persist between and within countries, among different population groups, and between the rich and the poor.

Based on this information, there are needs to go beyond the bio-medical aspects of health so as to deal with factors that constrain the health of individuals and groups. Among these constraints are socio-cultural, economic, and political and gender factors. Yet though access to health care is crucial, even with equal access to health care, socially disadvantaged groups and people with low incomes and limited education would still have worse health and higher mortality than the privileged members of the society **(UNDP, 1990)**.

The Global Human Development Report issued each year shows inequalities between countries by ranking them numerically according to their respective Human Development Index (HDI) levels. This indicates that achievements in income growth alone do not reflect inequalities in health (increasing life expectancy, infant and maternal mortality) or education **(UNDP, 1996)**.

The indicators and indices have been used for quantitative measurements of health status as well as to monitor and evaluate health programs. **Abdel-Razik (2007)** had categorized indicators used for evaluation of maternal care programs into input, process, output, outcome and impact indicators. **Knowles et al, (1997)** developed the indicators for health system performance to include access, equity, quality, efficiency and sustainability indicators. **El-Zanaty & Associates (2009)** had used the wealth index to reflect economic status of the families in the national demographic and health survey. The Maternal and Neonatal Program Effort Index (MVPI) is a tool that reproductive health care advocates, providers and program planners can use to assess the current health care services, identify the program strengths and weaknesses, encourage political and popular support and track progress overtime (**Futures Group International, 2002**)

The importance of using indices to describe family health status is linked with equity-oriented research. Those equity oriented research studies identify disparities as major obstacles to access to health care and to have quality healthy life. Disparities refer to differences in one or more health-related variables associated with membership in some population group or subgroup. Disparities in health exist between groups of people not individuals. Differentials in environment, health status or access to health care are persuaded to be underlying causes of health disparity. Health disparities do not refer to all differences in health but to those that are potentially avoidable or that occur as the result of injustice. Group membership based on such factors as gender, class inequalities may confer limits on one's access to adequate nutrition, safe living and working conditions, educational opportunities and personal medical services, which in turn result in differential health outcome.

Health disparity studies are important to policy makers because resource allocation and health care access would also be based on and distributed according to the

greatest need. However, the current health care system often functions according to the inverse care law in which regions with the highest disease burden receive the fewest health resources **(Peterson et al, 2008)**.

The studies conducted in Egypt showed that the utilization pattern and expenditure on health vary according to the wealth index of the families **(El-Zanaty and Associates, 2002)**.

Despite of well-known association between socio-economic risks and disease occurrence, there is no enough information about accessibility pattern to different health services at the family level. Additionally there is no enough information that shows the association between disease burden profile of families and accessibility pattern to different medical services provided by the governmental sector and private sectors, and across the different socioeconomic strata of families through equity-oriented research.

Therefore, there are needs to conduct equity-oriented health research to guide policy making towards achieving equal opportunity for health care that buffers the health-damaging effects of poverty and marginalization. Additionally, such type of research guides to reducing disparities between families in the underlying conditions such as: education, living standards, behaviors and practices necessary to be healthy.

Background:

The study was conducted in four primary health care units in coastal region of Hadhramout Governorate / Republic of Yemen.

Hadhramout Governorate is about 61,749 Km² which forms about 36% of Republic of Yemen area. It is located in the south region Yemen on the Arab sea. For administrative purposes it was divided to costal and valley regions. The coastal

region subdivided into, 16 directorates in the coastal region and 14 in the valley directorate.

The population size in the coastal region was 672,068 populations, according to the Ministry of Health and Population/ Hadhramout (<http://sahel.health-hadhramaut.info/view/246.aspx>).

The involved four PHC units are located (the most distal one) within 250Km from the capital Mukalla. The four PHC facilities are locates in urban cities.

AIM OF THE STUDY

Goal:

The goal of the current study is improvement of family health by ensuring equity in access to medical care services.

Objectives

Attendants of the governmental PHC facilities for immunization services represent different socioeconomic strata of the community. The proposed exploratory study has the following objectives:

- 1) Explore the profile of families according to demographic risk characteristics.
- 2) Identify disease burden among families and Socioeconomic Risks
- 3) Examine the association between disease burden and access to health services.
- 4) Highlight demand versus access to health services by source of medical care
- 5) Recognize institutional accessibility to health services according to quality of health care items.

REVIEW OF LITERATURE

The literature review is organized in five sections:

1. Health system.
2. Family health.
3. Health equity.
4. Access to health care facilities.
5. Disparities and health status.

1) Health System:

Health is a critical contributor to the success of social policies that enable the attainment of national goals of social and economic development.

A health system is understood to comprise the set of institutions responsible for interventions in society that are mainly responsible for health (**World Health Report 2000**)

No health system in the world can provide everything for everyone: each country faces tradeoffs with regard to what services will be provided, to whom, and with what level of affordability. The prioritization across the three dimensions of coverage – population, service, and cost – is perhaps the most difficult political challenge on the path towards UHC, and it is ongoing as new health services and technologies are developed. What is especially problematic, however, is when a system does not keep its promises, i.e. when services that are meant to be guaranteed for the population are not provided in practice.