ORIGINAL RESEARCH

The Columbia University JOURNAL of GLOBAL HEALTH

ተስፋ መቁረጥ (loss of hope): The Precarity of Hope and Healing in Ethiopia's Medically Plural Health System

Meron A. Girma, BS[1] , Mary J. Hall, BA[1] , Sandra W. Gichuhi, BA[1] , Mia G. Schuman, BA[2] , Mekdes F. Abate, BA[3,4], Rachel R. Chapman, PhD[1]

[1]Department of Anthropology, University of Washington, Seattle, WA, USA
[2]Department of Gender, Women, and Sexuality, University of Washington, Seattle, WA, USA
[3]Department of Law, Societies, and Justice, University of Washington Seattle, WA, USA
[4]Department of Political Science, University of Washington, Seattle, WA, USA

ABSTRACT Despite recent efforts in Ethiopia to increase health coverage, underutilization of both public and private sectors—the two main sources of formal healthcare—continues. This study gathered ethnographic interviews from 50 patients and 25 healthcare providers and observations of 7 public and private sector hospitals in Addis Ababa, Ethiopia, to identify causes of public and private healthcare underutilization. Analysis of patient and provider narratives revealed patterned *itineraries of underutilization* and clear differences in service delivery and quality between the private and public sectors. Both sectors face accessibility issues that negatively affect patient and provider experiences. Public hospitals are congested, and underfunded, private hospitals are understaffed and expensive, and both sectors experience constant shortages of medical equipment and drug stocks. The complexity and gaps in the current healthcare system leave healthcare providers overburdened and patients feeling neglected, uncertain, and frustrated. Health-seeker trajectories in Ethiopia's medically plural system are characterized by prolonged searches and costly treatment dead ends without any healing or end to suffering; ultimately, this results in complete hopelessness. A conceptual framework is proposed to explain why the quest for healing generates hopelessness for both health seekers and providers. While providers combat hopelessness with referrals to other sites of care, health seekers navigate the precarity of the health system through an economy of affection - a wide range of community relationships of mutuality and collectivity. This labor has fostered the development of third spaces for community organizing and spiritual enlightenment, where suffering is addressed, healing occurs, and lost hope is regenerated.

KEY WORDS itineraries, trajectories, economy of affection, third spaces, health seekers

INTRODUCTION

In Addis Ababa, Ethiopia, both public and private sectors play a critical role in providing medical care for communities[1]. Historically the public health sector was the sole division of health provision. Today it still serves the majority of the population in addition to the health coverage delivered by the continuously expanding private sector[2]. Although both sectors strive to provide access to quality care, public hospitals face the challenges of congestion, funding, and resources, while private hospitals are understaffed and unaffordable for the vast population[2].

Current literature regarding healthcare access does not reflect the direct impact on a patient's overall health experience. Most literature overviewing the Ethiopian formal healthcare system, including the work of

© 2021 GIRMA, HALL, GICHUHI, SCHUMAN, ABATE, CHAPMAN. This is an open access article distributed under the terms of the Creative Commons Attribution License (CC-BY 4.0), which permits the user to copy, distribute, and transmit the work provided that the original author(s) and source are credited. Send correspondence to: mgirma99@uw.edu

Habtemariam, M.K and Semegn, S.T, discuss the current health options from a governance perspective with little to no emphasis on the accounts of direct users. The objective of this study was to understand how health seekers and providers navigated the current state of health options while facing barriers to access and other challenges. Exploration and analysis of the efficacy of current health options expose challenges that result from structural defects. The healthcare itinerary, defined as the health seeking journey for individual sufferers, reveals structural failures in the Ethiopian health care system that results in hopelessness and patient disengagement from the healthcare system. Community members in Addis Ababa have combated these issues through combined efforts by creating an economy of affection[3]. Within the economy of affection, health seekers have situated third spaces, literal sites for enacting physical solutions to health-related problems, where they feel like their healthcare needs can be met and their hope in health and healing can be restored.

BACKGROUND

Ethiopia's Healthcare

Ethiopia's government is organized as a federal structure with a central government, nine regional states, and two city administrations, Addis Ababa and Dire Dawa, both of which report to the federal government[4]. The Addis Ababa city administration oversees the Addis Ababa Health Bureau and third level sub city administrations[5]. As a result of this form of organization, the health sector is governed by shared power held between the federal government and the regional states, manifesting in a decentralized healthcare structure within Addis Ababa. Recent improvements in health services are due to the accelerated expansion of health facilities and the introduction of a three-tier healthcare delivery system by the public sector[5]. Table 1 displays the structure of the three-tier healthcare system, and the estimated number of people served per level of care. This system has increased physical access to health services with an emphasis on primary health care units[5].

TABLE 1: Three-tier healthcare system

<table>
<tr><td>Tertiary Level</td><td colspan="2">Specialized Hospital
3.5-5 million people</td></tr>
<tr><td>Secondary Level</td><td colspan="2">General Hospital
1-1.5 million people</td></tr>
<tr><td rowspan="4">Primary Level</td><td>Rural</td><td>Urban</td></tr>
<tr><td>Primary Hospital
6000-1000 people</td><td rowspan="3">Health Centre
40,000 people</td></tr>
<tr><td>Health Centre
15000-25000 people</td></tr>
<tr><td>Health Post
3000-5000 people</td></tr>
</table>

Adapted from "Improving health system efficiency: Ethiopia: human resources for health reforms," Alebachew, Abebe & Waddington, Catriona. World Health Organization. 2015.

Although Addis Ababa is an urban city, the country is predominately rural. The population's health status remains poor: about 75% of the disease burden in the country relates to preventable and treatable diseases [5,6]. There is an inefficient distribution of medical supplies and a lack of funding of the health sector that has made it difficult to access health care services[5,8]. Progress in healthcare has suffered from historical displacement during the Derg era, the military junta that ruled for 17 years. Despite the fall of the regime in 1991, politically driven conflict from the era has had lasting effects[9]. The overwhelming demand for healthcare workers resulted in many of the country's doctors emigrating or never returning after going abroad[10]. The lack of retention of doctors is one of the leading causes of the current unavailability and scarcity of health providers (HPs)[9-10].

Comparing Private and Public Health Sectors

The majority of healthcare in Addis Ababa is delivered by the public sector and includes various ministries and government agencies that play the role of funding and technical support[11-12]. Health sector governance focuses on the public sector and its bureaucratic structures for the welfare of the Government of Ethiopia (GOE)[5]. The private health sector includes private for-profit entities and private non-profit organizations involved in different activities related to health services delivery[5,13]. The private provision of health services was legalized in order to extend resources and improve the efficiency of the healthcare system[13].

Over the past ten years, there has been an increased number of private facility care, creating a need for public and private sector cooperation[12]. Expanding the private sector reduces the burden on the government and helps the health sector increase its efficiency[13]. On the other hand, expansion of private facilities results in understaffing and cost increases for patients, making private care inaccessible for most people[2]. This then forces private care seeking patients to revert to public care, where they are faced with issues of overcrowding, lack of drugs, and poor health services[2]. The public and private health sectors are involved in treating diseases and health concerns, but the contribution of the private health sector is neither recognized nor integrated into the public health system planning and oversight[11,13]. With such a divide, existing issues become exacerbated.

MATERIALS AND METHODS

Qualitative methods including facility observations, ethnographic interviews and documentation of reported retrospective health-seeker trajectories were used in the collection and analysis of data. Ethnographic orientation was used to look at subjects within the framework of their cultural setting and produce information through the lens of their narratives.

Data Collection

A total of 50 patients and 25 healthcare providers across seven healthcare facilities from the private and public sectors were interviewed. Interviewees were chosen at random, and health facilities were selected from recommendations of the Federal Ministry of Health based on the most commonly utilized in Addis Ababa city. The goal was to approach an equal number of patients and providers between the public and private sectors. Table 2 shows the data set grouped by demographic and interview setting.

FIGURE 2: Sample selection of health facilities and participants.

		Patients					
Sampled Facilities	Healthcare Providers	Female	Male	15-24	25-55	55+	Total # of Patients Seen
Private Health Clinic 1	7	8	2	1	9	0	10
Private Health Clinic 2	3	5	1	4	2	0	6
Private Hospital 3	3	3	2	0	3	2	5
Private Hospital 4	5	3	2	3	0	2	8
Public Hospital 5	0	5	3	2	6	0	8
Public Hospital 6	0	6	2	4	4	0	8
Public Hospital 7	7	2	6	0	4	4	8
Total	25	32	18	14	28	8	50

Interviews were done on a one-to-one basis with both patients and health professionals, physicians and nurses. Interview questions were semi-structured. They were not cognitively tested; however, they were designed to be open-ended. Topics included barriers to accessing healthcare, general health seeking behaviors and the private versus public health sector. Questions were developed with the intention to identify deeply rooted barriers while seeking the experiences of participants familiar with the formal healthcare system.

Interviews took place in locations that were most comfortable and convenient for the interviewees. In most situations, patients were interviewed in general waiting rooms, and healthcare providers were interviewed in their offices. There was one interviewer for data collection and transcription. Before consenting, participants were introduced to the interviewers and explained the purpose of the research, including any possible implications of the project; there were no participant refusals. Observational data was unstructured and collected with permission from health facilities to track the overall functionality of the facility, how people moved throughout the hospital, and how people acted and interacted.

Data Display and Interpretation

Data was coded deductively and manually analyzed for similarities and recurring patterns that were translatable to statical summaries. Closed codes were developed from major common themes, in addition to rounds of repetitive analysis and revision with open coding. Observations were not coded for analysis. They served as an important context that corroborated and deepened subjects' reported experiences and actions. Triangulation strategies were used to confirm, and cross-validate conclusions made from data gathered through observations, interviews and literature review. Research objectives were continually revisited to best identify and code broad ideas, behaviors, and phrases. Themes and patterns within the results suggest a theoretical framework for understanding Ethiopian healthcare experiences and a potential avenue for further study.

FINDINGS

There is a clear divide between the private and public sector concerning affordability, facility maintenance, and lack of health education. Both patient and healthcare provider experiences highlighted serious issues within patient care in both sectors, but more so in the public sector. The results presented are the most frequently reported issues from both the patient and HP perspective.

Patient Reported Barriers

Patients expressed strong frustration with the experience of seeking care; overwhelmingly, issues of unsanitary facilities and long waits within the public sector resulted in patients delaying care. In contrast, the private sector is vastly unaffordable to patients but more sanitary and less crowded. Interestingly, both sectors have a lack of drugs. Figure 1 highlights the major issues for patients when trying to access care within private and public sector hospitals.

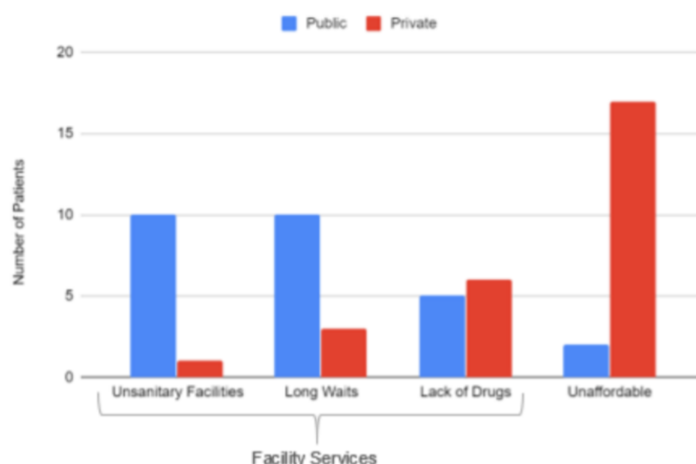
Facility Services

Numerous patients reported inadequate facilities in terms of cleanliness and a lack of access to appropriate equipment. A patient from Public Hospital 5 reported:

> People that are healthy come here and get sick by just walking inside. It is so dirty and smelly; I get sick every time I come here with my wife. Cleanliness is a huge problem everywhere in the public hospitals, private is the opposite - they have better services, and they are a lot cleaner.

Having experienced both the private and public sector, this patient was, like many others, concerned about getting sick solely from the toxic environment within public healthcare facilities. Overcrowding is a problem 100% of health seekers identified as an inevitable and normal part of the healthcare system in Addis. Wait times can extend months to years due to overrun capacity within the public sector. Patients also cited the scarcity of HPs in public hospitals as the main reason for long waits and an overburdened public system.

FIGURE 1. Comparison of barriers between the private and public health sector identified by patient participants.



Unaffordability

The issue of affordability is most directly linked to the private sector. A majority of patients interviewed from the private sector identified this as an issue, whereas a smaller percentage from the public sector mentioned it. Collectively, 76% of patients complained that services in both sectors were too expensive. High costs force patients to make difficult choices, including foregoing the care and medications they need. When asked, "What changes would improve hospital visits?" a patient from Private Health Clinic 1 responded:

> If all people were equal that would be nice, if it wasn't about affordability and instead everyone was able to get the same good type of care. Since I have money, I can come see private clinics, but for most Ethiopians they don't and so they don't receive good care if any.

This response, like many others, discussed alarming health disparity arising from socioeconomic differences and the ability to afford services. Most health seekers experience unaffordability as a huge barrier to accessing care. Many Ethiopians do not seek out care to begin with due to their inability to pay. Since the private sector is more expensive than the public sector, it largely serves higher income populations, leaving limited options for others.

Cultural Distance

Another barrier identified through qualitative analysis was the cultural distance between patients and HPs, which manifested in miscommunication. Health seekers consistently felt that poor communication undermined their ability to feel heard and cared for by doctors, resulting in mistrust between the health seeker and provider. A patient from Private Hospital 4 reported, "Doctors get mad at you when you tell them your problems, but they shouldn't—it is unwelcoming, and you can't address this problem because when you do, you are potentially risking any future care."

Cultural distance also results in confusion around how to care for medical issues and/or administer prescriptions. HPs are then unable to be informative or effectively explain a diagnosis or instruct further care. Patients also recognize that there is a lack of educational training opportunities for HPs and worry that public HPs are less competent than their private counterparts, resulting in mistrust. One experience particularly stood out on the issue of mistrust and a lack of adequate healthcare providers from Private Hospital 3.

> There was a huge problem when I went to the hospital to get an operation and residents were the one that did the operation and treated me even though I didn't want and begged to have a doctor, but they declined to listen and continued. Anyways, after a few weeks I got an infection from the operation, and then I did not know where to go or who to trust.

Lack of education, training and medical research have been identified by patients as reasoning to why they are being treated poorly. If they can't trust their providers, they do not return to seek care. Health seekers regularly expressed anger for not being heard and fear of trusting any future HPs.

Patients Combating Barriers

Community members fill in the gaps created by the lack of government involvement and the dysfunction of the health system. To fix issues of accessibility and inspire hope, patients shared their experiences with community-based and faith-based efforts.

Many people turn to spaces of religion and spirituality when they feel that the secular world has failed them. A patient from Public Hospital 6 described her health seeking experience as an "additional opportunity to find healing," but ultimately, her faith in her physical and emotional wellbeing laid in her Christianity. In spaces such as church or tsebal (holy water) rituals, she finds healing, but more importantly, she consistently finds hope.

Most patients described community efforts to alleviate barriers and stressors when trying to access care. One example came from an interview from the Private Hospital 3. The interviewee was a bajaj (two-wheeler car) driver at the hospital assisting a community member with a health emergency. The driver reported that along with a few friends, he created a system to help transport people to hospitals that need immediate attention.

These examples are avenues health seekers have created and utilized to progress their health journeys. When issues of accessibility arise, community members are seen combining their efforts to alleviate these barriers.

Healthcare Provider Reported Barriers

Generally, HPs feel an overwhelming burden without proper support to do their work. HPs expressed frustration stemming from a desire to provide adequate care without sufficient resources. The lack of involvement from the GOE and other sectors has left healthcare providers to take on responsibilities beyond their profession.

Lack of Support

There are high tensions for healthcare providers working on the ground associated with a lack of pay. There are not enough HPs to support the number of patients in Addis Ababa, increasing the burdens placed on HPs.

With the lack of government involvement, HPs are not compensated fairly for their additional workload. A Medical Physician (MP) from Private Health Clinic 1 said, "The health professionals are overworked because there are only few of them and they are underpaid, the level of work they put in doesn't equate to how much they get paid." Another MP also attested to this from Private Hospital 4: "There needs to be more government involvement, we need healthcare insurance, so that the doctors can really work on their jobs instead of taking on their patients' financial responsibilities."

Both HPs speak on structural issues such as lack of government involvement and inadequate wages that have increased the difficulty of their jobs. Insufficient pay and lack of support have affected the retention of HPs. There is a lack of opportunities to find paid work after school, so trained professions resort to solutions such as emigration. Emigration or brain draining thus reduces the number of HPs available in Ethiopia.

Lack of Resources

Lack of education, training, and advancement opportunities was a key issue for HPs seeking professional mobility and the ability to provide better care. HPs repeatedly highlighted the importance of medical research as a key component to providing continuous quality care while expressing the desire for additional resources to support these investigations. An MP from Public Hospital 7 spoke on the lack of medical education saying, "The root problem is the lack of education, there are about 1-3 schools with education, but even then, they are just called medical doctors and then sent here but they are not well trained."

This complaint was also identified by patients as having a direct impact on their health care experiences. With HPs not being fully trained and equipped to enter the workforce combined with a lack of research on how to combat evolving health disparities, low quality of care becomes an ongoing problem. HPs feel that the education and training they received do not prepare them for a difficult work environment.

Lack of cleanliness, necessary equipment, and poor availability of medications was continually expressed as stressors and strong hindrances to providing adequate care to patients. When asked the greatest challenge faced in his profession, an MP from Private Hospital 4 said, "Lack of equipment and resources." This lack of access to necessary resources ultimately resulted in an overreliance on referrals. HPs reported facing ethical dilemmas around providing out-of-country referrals, recommending under-researched medicines, and prescribing medications that were necessary but of limited availability. Internal hospital politics and poor communication were mentioned as additional challenges to sustained employment, staff retention, strong customer service, and ultimately, high quality of care. An HP from Public Hospital 7 said, "There are not enough monitors in the emergency rooms, there is not adequate machinery in the ICU room, and most of the medication that patients need they cannot get." Similarly, a Gynecologist from Private Health Clinic 2 said:

> I have worked in both public and private healthcare, there are inadequate facilities, there is no medical investigation, and not only is it hard for patients to get their medicine, it's hard to prescribe medicine that does not exist in the country.

As these quotes illuminate, both sectors are hindered by the lack of resources for healthcare providers to deliver quality services. The lack of resources increases the burden that healthcare providers feel in addition to the lack of support from the government.

Healthcare Providers Combating Barriers

Most HPs felt that their job just came with the extra barriers, responsibilities and burdens; this was what they had signed up for. Yet, in most instances, HPs were limited in the extent to which they could alleviate the barriers they faced as most issues were only addressable by the efforts of the government and other health bureaus. For cases where HPs felt that they could not complete their job due to the lack of resources, they reported that they would often resort to referrals. Since most hospitals accepted referrals, it is very common for an HP to refer patients to another facility. When asked, "What is the process for the patient if he/she needs treatment or special care that your facility cannot provide them?" 92% of healthcare providers responded by saying they would refer the patient to another facility. As the Head Nurse from Private Hospital 3 responded, "We use the referral system very frequently, by calling a bunch of hospitals and assessing the best facility that the patient can potentially receive further care. Sometimes it takes days to weeks to figure out."

The referral system is popularly used in both the private and public sectors. For HPs that cannot provide

further care to a patient, this is the best way they can help. This is one of the widely used tools by HPs to combat the barriers that they are faced with as well as to help patients continue their health seeking journey.

Patient-HP Relationship

Treatment dead end, mistrust of HPs, and endless itinerary are the underlying barriers prevalent throughout the narratives of health seekers in both the private and public sectors. Mistrust of HPs stems from the cultural distance that patients experience, resulting in fears of returning to seek care. HPs working within the hospital deal with the lack of resources and medical equipment while being overextended in their workload. They are faced with pressures from the Ministry of Health and other government organizations while also feeling pressure and blame from their patients, hindering their ability to provide quality care.

Whether patients explore private or public care options, both sectors were reported having inadequate resources and services. As a result, HPs rely upon a referral system, causing patients to face endless itineraries. Treatment dead end is a common theme for most patients due to their experiences with HPs and the healthcare system. In almost all interviews from both sectors, patients questioned the actual benefits of going through such a corrupt and strenuous healthcare system. There are few common ways that the itinerary of health seekers come to an end:

Avoiding Further Care: The utilization rate of health services in Ethiopia remains extremely low[14]. While Ethiopians are covered by health services, people aren't participating in the health system. Receiving healthcare has become so inaccessible that once individuals attempt it, they realize that it is not worth sacrificing their emotional and mental well-being.

Lack of Medicine: In interviews with both the patients and providers, the lack of medicine was mentioned as a barrier to the Ethiopian healthcare system. Lack of medicine not only means a shortage of medicine, but no existing medicine in the country. Patients expressed feeling that the healthcare system was a "joke and pointless" because there is never medicine available. Likewise, HPs could not successfully do their jobs when there was a lack of drugs to prescribe for patients.

Chronic Illness or Death: Many patients lose all hope even as they experience worsening symptoms; they ignore their bodies' cry for help. They become reluctant to seek treatment within a healthcare system that has already failed them multiple times over.

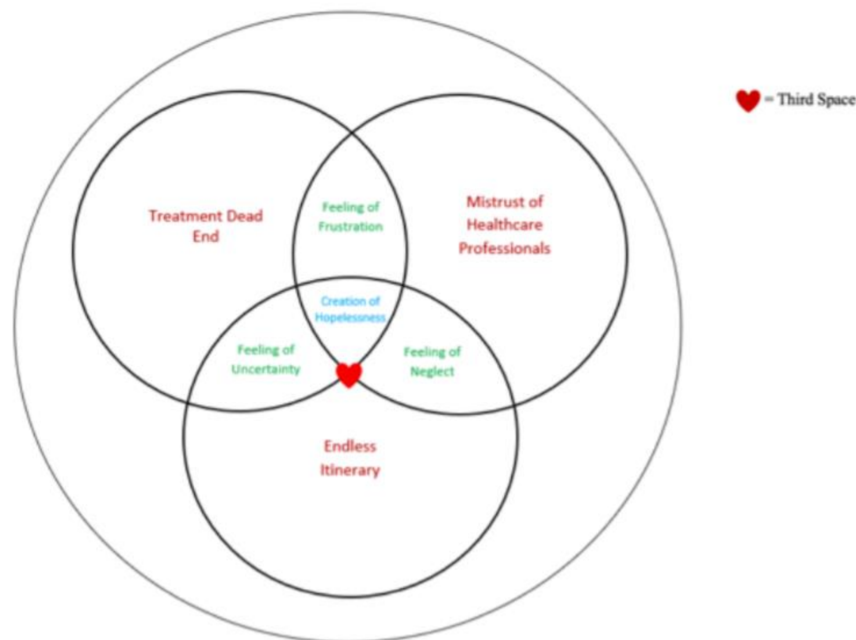
DISCUSSION

Findings show a divide in quality of care where private health is much more preferred by both patients and HPs. Patients feel that the private sector provides more resources with fewer barriers if patients can afford it. HPs also feel that the private sector treats their workers better in terms of wages and equitable practices. On the other hand, the public sector displayed several clear issues, with the only benefit being that patients paid less for services. When comparing the two sectors, the biggest difference is affordability, exacerbating socio-economic imbalance within a country that already faces poverty and class discrimination. However, affordability and resource inadequacy are far from the only challenges within Ethiopia's health care system. The public and private sectors differ in certain issues but largely are involved in the same underlying barriers: the current climate of the Ethiopian healthcare system perpetuates a sense of hopelessness for patients and HPs alike. HPs are abandoned and unsupported, while health seekers must initiate their own solutions to receive care.

The definition of feeling better is complex within the context of health in Addis Ababa. To feel better does not only mean to have been healed but to feel that there is hope that healing is possible. Without hope, patients are less likely to try to navigate the health system; their journey to healing becomes tainted by lingering feelings of resentment and disappointments that override any potential physical healing. *Tesfa*, which means hope in Amharic, is the ultimate solution patients seek in Ethiopia.

When seeking *tesfa* through the current healthcare system, patients are left feeling even more hopeless. Figure 2 conceptualizes how the three main barriers discussed in the findings create hopelessness, but also how it is combatted through community efforts. These barriers result in overwhelming feelings for patients that hinder their progress in the quest for healing. The feelings within this framework overlap where they are most prominent. These three barriers combined with the resulting feelings ultimately destroys any hope patients have in the formal healthcare system.

FIGURE 2. Conceptual framework for understanding the experience of health seekers within the formal healthcare system.



Mistrust of Healthcare Professionals

Health workers at entry are dismissive and do not show empathy for health seekers. This first encounter is vital to a patient's health seeking experience because it dictates the rest of their emotional state of being. The best opportunity to assess patient needs is during the consultation. Those moments of vulnerability are where patients explain their problems and reveal personal information. This is the time for providers to not only respect the patients but listen and make sure the patient feels understood and comfortable. Instead, patients in Addis Ababa face dismissal miscommunication that leaves them feeling uncared for, neglected, and unheard. HPs also identified the lack of trust between them and patients as a result of the structural and political pressures that HPs face. The shortage of HPs and resulting stress becomes a burden for providers that negatively affects their delivery of services. This lack of quality service delivery also stems from the inadequate education system that is currently in place. There are undeniable external factors that play into the dynamics of service delivery in Addis Ababa and add up to a common experience for health seekers of distrust in providers and the healthcare system as a whole.

Endless Itinerary

The definition of itinerary is a plan for a journey, a list of places to be visited. Health seekers in Addis Ababa have very complex medical itineraries in their search for treatment, or “pattern of resort.” In Addis Ababa, patients seeking treatment often do not receive full services in their first visit to an HP. Due to a lack of medical equipment or medicine or unaffordability, patients continuously have to expand their itinerary in the hopes of finding healing. A majority of patients talked about being referred to their current facility or having been referred another time. The illusion of the referral system is that it is useful for reallocating resources and facilitating partnerships and cooperation between different facilities. The reality of referrals is that they prolong care for patients and stand as empty promises. Referrals are often the only recourse for HPs with their limited resources and no external support. However, referrals essentially dismiss the patient, making them feel uncertain, unwanted, and suspicious that the HP is not committed to ending their suffering while prolonging the deterioration of their health.

Treatment Dead End

“*Tesfa mecrot*” is Amharic for “losing all hope” and describes when a person has truly given up and the depth of their anguish. Patients felt that they were on the brink of losing all hope, having lost trust in their providers and the system, as well as feeling tired and frustrated from visiting several different facilities without receiving any

conclusive treatment. The journey for health seekers is successful when they find healing, and part of that is also finding medication. When the goal to get medicine is unattainable, patients reach a dead end. Patients might also decide to prolong their care or avoid further care, which can be very detrimental to their health. This avoidance of care and lack of medicine has led health seekers to experience worsening illness or even death.

Third Space

Where do health seekers regain hope or find healing if they are constantly met by experiences that undermine their trust in HPs and the health care system as a whole? Hope from patients seems necessary for health seekers to constantly face barriers yet continue their quest for healing. The heart in the center of Figure 2 represents third spaces from which hope is regenerated. Third spaces are the anchors of a community that fosters the economy of affection[15]. They are used to create spaces and solutions within communities to facilitate the nurturing of individuals.

The community network based on an economy of affection has allowed Ethiopia to remain at peace and constantly hopeful. People are united by religion, ideology, and similar values. Often, patients' quest for healing is found through their religion; it is where they find hope again. The bond between one another based upon a basic concept of humanity allows Ethiopians to treat each other, strangers and family alike, with love and empathy. This is what fuels community-based organizations and combined efforts.

The efforts of communities and health seekers have bridged the gaps in services created by government failings. The quest for healing is also a quest for hope that healing is possible. However, the feelings of frustration, uncertainty, and neglect in patients navigating Ethiopia's healthcare system ultimately destroy any hope they had. Without hope, patients are less likely to continue their health journey. In a healthcare system that perpetuates the creation of hopelessness, health seekers improvised and created third spaces to regenerate hope for healing.

CONCLUSION

The public and private sectors face contrasting limitations, and the private sector is often depicted as offering better care[13]. This is true when comparing structural measures, such as sanitation of facilities, wait times, and availability of medical equipment. However, these factors are not a full measurement of "better" care and instead signify the inaccessibility to proper healthcare in relation to socioeconomic statuses. Although, the private and public areas appear to be separated, HPs and health seekers from both sectors talk about similar fundamental barriers.

Third spaces fill the gaps where the healthcare system and the GOE have neglected their patients. Through community organizing and spaces of spiritual enlightenment, health seekers have established solutions to inspire their own hope and healing.

This research discloses the narratives of directly affected patients and HPs through a paradigm that illustrates health seekers' experiences. The analysis shows that the economy of affection in Ethiopia has been the most vital part of a patient's healing despite the failing healthcare system. Health seekers have generated solutions in order to complete their quest for healing. The limitations of this analysis were the further exploration of the sustainability and viability of community organizing. Undeniably, third spaces exist and alleviate barriers for health seekers, but further research needs to be done to evaluate the efficacy and future of community-based programs. With the integration of third spaces in the formal healthcare system, there is a strong potential for an increase in positive and successful health experiences and higher utilization of health facilities.

ABBREVIATIONS

GOE: Government of Ethiopia; HP(s): Healthcare Provider(s); MP(s): Medical Practitioner(s)

AUTHOR CONTRIBUTIONS

Meron A. Girma
Conceptualization http://credit.niso.org/contributor-roles/conceptualization/, Data curation
http://credit.niso.org/contributor-roles/data-curation/, Formal Analysis
http://credit.niso.org/contributorroles/formal-analysis/, Funding Acquisition
http://credit.niso.org/contributor-roles/funding-acquisition/, Investigation
http://credit.niso.org/contributor-roles/investigation/, Methodology

http://credit.niso.org/contributorroles/methodology/, Project Administration http://credit.niso.org/contributor-roles/project-administration/, Resources http://credit.niso.org/contributor-roles/resources/, Software http://credit.niso.org/contributorroles/software/, Validation http://credit.niso.org/contributor-roles/validation/, Visualization http://credit.niso.org/contributor-roles/visualization/, Writing - Original Draft, http://credit.niso.org/contributorroles/writing-original-draft/, Writing-Review & Editing http://credit.niso.org/contributor-roles/writing-reviewediting/
Mary J. Hall Formal Analysis http://credit.niso.org/contributor-roles/formal-analysis/, Resources http://credit.niso.org/contributor-roles/resources/, Software http://credit.niso.org/contributor-roles/software/, Validation http://credit.niso.org/contributor-roles/validation/, Visualization http://credit.niso.org/contributorroles/visualization/, Writing- Original Draft http://credit.niso.org/contributor-roles/writing-original-draft/
Sandra W. Gichuhi
Formal Analysis http://credit.niso.org/contributor-roles/formal-analysis/, Resources http://credit.niso.org/contributor-roles/resources/, Software http://credit.niso.org/contributor-roles/software/, Validation http://credit.niso.org/contributor-roles/validation/, Writing- Original Draft http://credit.niso.org/contributor-roles/writing-original-draft/
Mia G. Schuman
Formal Analysis http://credit.niso.org/contributor-roles/formal-analysis/, Resources http://credit.niso.org/contributor-roles/resources/, Software http://credit.niso.org/contributor-roles/software/, Validation http://credit.niso.org/contributor-roles/validation/, Writing- Original Draft http://credit.niso.org/contributor-roles/writing-original-draft/
Mekdes F. Abate
Formal Analysis http://credit.niso.org/contributor-roles/formal-analysis/, Resources http://credit.niso.org/contributor-roles/resources/, Software http://credit.niso.org/contributor-roles/software/, Validation http://credit.niso.org/contributor-roles/validation/, Writing- Original Draft http://credit.niso.org/contributor-roles/writing-original-draft/
Dr. Rachel Chapman
Conceptualization http://credit.niso.org/contributor-roles/conceptualization/, Supervision http://credit.niso.org/contributor-roles/supervision/, Validation http://credit.niso.org/contributor-roles/validation/, Writing- Review & Editing http://credit.niso.org/contributor-roles/writing-review-editing/

The authors have no conflicts of interest.

FUNDING

Ronald E. McNair Post-Baccalaureate Achievement Program Presented: Society for Advancement of Chicanos/Hispanics and Native Americans in Science Conference, and Annual Biomedical Research Conference for Minority Students Conference

ETHICAL APPROVAL

No IRB / Ethical Approval was necessary.

ACKNOWLEDGMENTS

I would like to extend my sincere gratitude to many individuals and institutions that provided me with support, resources and an opportunity to work with them: Ethiopian Federal Ministry of Health, Addis Ababa Private Health Facility Employers Association, Ronald E. McNair Post-Baccalaureate Achievement Program. I send my deepest gratitude to Rachel Naomi Lee who have assisted in the development of this project.

REFERENCES

1. Abuzaineh, N., Brashers, E., Foong, S., Feachem, R., Da Rita, P. (2018). PPPs in healthcare: Models, lessons and trends for the future. Healthcare public private partnership series, No. 4. San Francisco: *The Global Health Group, Institute for Global Health Sciences, University of California, San Francisco and PwC*. Produced in the United States of America. First Edition, January 2018.
2. Ethiopia Health Private Sector Assessment. (2019, October). *Global Financing Facility*. https://www.globalfinancingfacility.org/sites/gff_new/files/documents/Ethiopia-healthprivate-sector-assessment.pdf.
3. Hyden, G., & Hyden, G. (1904). "The Economy of Affection." African Politics in Comparative Perspective, *Cambridge University Press*, 2010, pp.
4. World Bank Group. 2015. Ethiopia Poverty Assessment 2014. Washington, DC. © *World Bank*. https://openknowledge.worldbank.org/handle/10986/21323 License: CC BY 3.0
5. Alebachew, Abebe & Waddington, Catriona. (2015). Improving health system efficiency: Ethiopia: human resources for health reforms. *World Health Organization*.
6. World Health Organization. (2012, April 13). Resource Mobilization for Health Action in Crises: Ethiopia.*World Health Organization*.
   www.who.int/hac/donorinfo/callsformobilisation/eth/en/.
7. Habtemariam, M. K., & Semegn, S. T. (1908). "Setting Health Sector Priorities: A Brief Overview of Ethiopia's Experience." Cost Effectiveness and Resource Allocation, vol 16, no. Suppl 1, *BioMed Central Ltd*., 9 Nov. 2018, pp. 5–6, doi:10.1186/s12962-018-0117-
8. U.S. Embassies. Ethiopia - HealthcareEthiopia.
   Healthcare.https://www.privacyshield.gov/article?id=Ethiopia-Healthcare
9. Marcus, H. G., & Mehretu, A. (2020, December 3). Ethiopia. https://www.britannica.com/place/Ethiopia/Health-and-welfare
10. Tamrat, Wondwosen, T. (2019, July 15). Medical Education and the Ethiopian Exodus of Talent: Inside Higher Ed.
11. Ministry of Health. (2015, March). Strengthening Public Private Partnerships for More and Better Health Outcomes in Ethiopia: Expert Reviews and Case Studies. *MOH & Harvard TH Chan School of Public Health*. https://cdn1.sph.harvard.edu/wpcontent/uploads/sites/1325/2013/01/HEPCAPS-PPP-Report-FINAL.pdf
12. Wakiaga, J., Kibret, H., & Mamuye, R. (2015). Prospects of Public- private Partnership (PPP) in Ethiopia. *United Nations Development Programme*, no.1.
13. Nair, V. D., Morankar, S., Jira, C., & Tushune, K. (2011). Private hospital sector development: an exploratory study on providers perspective in addis ababa, ethiopia. *Ethiopian journal of health sciences*, *21*(Suppl 1), 59–64.
14. World Health Organization. (2014). Atlas of African Health Statistics. *WHO African Health Observatory and Knowledge Management*, no. 1. doi:10.1007/s13398-014-0173-
15. Butler, S. M., & Diaz, C. (2017, August 22). "Third places" as community builders. https://www.brookings.edu/blog/up-front/2016/09/14/third-places-as-community-builder/