CHAPTER TWO

2. STUDY SETTING

This chapter presents the general setting in which the study has been conducted. It highlights on the national socio-economic and cultural contexts and then provides a general background about the Addis Ababa (research site) from its foundation up to recent times. This is believed to provide a background understanding on the changes that the city underwent overtime in terms of physical size, socio-economic, cultural and demographic conditions. It is hoped that this background helps readers to have a bird’s eye view about the city in which medical pluralism is being practiced.
Map 2.1 The Location of Ethiopia in the African Continent.

2.1 National Context

2.1.1 Area and the people

Ethiopia is a country located in East Africa. It covers the area of 1.2 million square kilometers. It shares borders with Kenya in the South, Eritrea in the North and North East, Sudan in North West, and with Djibouti and Somalia in the East (Bahru, 2003:204). South Sudan borders the country in South West since its independence in 2011.

The country has great geographical diversity. The topography ranges from 4550 meters above sea level to 110 meters below sea level. Climatic zones could broadly be categorized into three as the Kolla or hot lowlands below approximately 1500 meters, the Weyna Dega or moderate at 1500-2400 meters, and the Dega or cool temperate highlands above 2400 meters. The low lands receive less rainfall than the high lands. Many rivers, including the Blue Nile; which contributes more than 86% of the waters of the Nile river; originate from the highland plateau in the country and flow towards lowland areas (WHO/AHWO, 2010:13; Paulos, 2011). These rivers are currently the focus of attention for mega hydroelectric power projects by the Federal Government of Ethiopia.

Ethiopia is the second populas country in Africa. The estimation for the year 2011, based on the results of the May 2007 National Population and Housing Census was 82,101,998 of which 41,431,989 were males and 40,670,009 were females. Most of this total population lives in rural areas. Only 16% of the total population is urban. Urban areas in
this context refer to all capitals of Region States, Zonal and weredas (districts) within Regional States. Urban areas also include localities with urban kebeles (lowest administrative units) whose inhabitants are primarily engaged in non-agricultural activities (CSA, 2011). The average annual national population growth between 1994 and 2007 was 2.6 percent. But it is important to note that the above population projection by Central Statistics Agency is slightly lower than the estimation by UNDP for the same year which is 84.7 million (UNDP,2011:164). It is common to come across inconsistencies between the figure released by government offices and international organizations not only on population size but also on the rate of economic growth, percentage of population living below poverty line etc.

The country is home to more than 80 linguistic groups. Christianity and Islam are the major religions in Ethiopia. The Christian population is greater in number at national level. Christianity represents roughly 63% where as followers of Islam constitute about 34% of the country’s population. The remaining 3% of the population is reported traditional believers (CSA, 2007:17; CSA, 2010:109). But the proportion could vary from one Regional State to the other. Among the interesting features of the interaction between followers of the two dominant religions in Ethiopia is the fact that there is no significant internally motivated religious conflict between followers of the two religions. People from both religions do interact, cooperate and help each other in different forms on different occasions. Yet, this harmonious interaction between followers of the two major religions is susceptible to externally instigated conflicts given the geopolitics of the
country and the rise of Islamic fundamentalism in the region. Ethiopia has also nine world heritage sites; eight of which are cultural while one is a natural site.

2.1.2 Economy

The country’s economy is based mainly on agriculture. Agriculture is the single most economic sector that employs about 80% of the population. It accounts for 90% of the country’s export goods (WHO/AHWO, 2010:15). Agriculture has won a substantial degree of attention in the national economic policy and strategic document. The current government has implemented the policy of Agricultural Development-Led Industrialization (ADLI) for more than a decade. The logic behind this degree of concern for agriculture is the assumption that it serves as the base for industrialization. In fact, its wider aim is to turn agriculture to “an engine of growth, surplus generation, market creation, provision of raw materials, and foreign exchange” though the economy is still heavily dependent on subsistence oriented and small holder’s agriculture (Vaughan, 2004:31).

Other than its agrarian nature, the Ethiopian economy has additional features since the current government came to power in early 1990s. The current government inherited a damaged economy from a centralized and authoritarian rule whose economic policy was in line with the principles of command economy. Therefore, among the issues for reform on the list was the liberalization of the economy. The other two non-economic fundamental reform agendas were decentralization and democratization of the politics.
through multiparty electoral system (Vaughan, 2004). However, decentralization and democratization are among the reforms whose outcomes are not yet visible to the opposition political parties in the country and international human right groups. Neither is the reform in the economy free from critics of government’s involvement in economic activities through party owned companies which in contrary to the principle of liberalization and the development of free enterprise.

Some sources indicate the country’s economy has shown strong economic growth since 2003/2004. The annual GDP growth has been an average of 11.2% between 2003/04 and 2008/09. This figure places Ethiopia among the top performing economies in Sub-Saharan Africa. The increasing role of the service sector is noted in this economic growth. However, the economic growth is susceptible to exogenous shock due to its dependence on rainfed agriculture and primary commodities (ADB, 2010:2-3).
Despite the sustained economic growth for five consecutive years, per capita income is only $USD 392 (NBE, 2011:9). Some observers even argue that the sustainability of the current economic growth could be endangered by factors such as the involvement of the State and the ruling political party in many business activities, and macroeconomic imbalances. Moreover, about 39% of the households in Ethiopia are below the national poverty line (IFAD, 2009: xiv) in spite of the economic growth. The figure has been reportedly declining recently on government owned mass media and becomes 29% of the households. Many people whom I came across however, expressed their reservations on
the reliability of such tremendous decline in poverty in a country where many are still staggering to survive.

**2.1.3 Administration**

Scholars state the political structure in Ethiopia since 1991 as radical and pioneering transformations. These scholars call the political transformation radical because the system introduced the principle of self-determination for federated regional units up to secession. The federated regional units have formerly been under centralized unitary state. The political transformation is labeled “pioneering” in a sense “Ethiopia has gone further than any other African State, and further than almost any state worldwide in using ethnicity as its fundamental organizing principle.” (Clapham, 2002:27 in Turton, 2006:1)

The political structure in the country is ethnic federalism that decentralizes power to nine Regional States and two City Councils (CSA, 2007:9; Paulose, 2011:86). The federal system is meant to accommodate the rights of different linguistic groups in the country. The political structure has received criticisms from some groups and appreciations from others. The critics argue that ethnic based federalism which they argue is adapted from the former Union of the Soviet Socialist Republic (USSR) weakens national unity and eventually could not ensure lasting peace and development in the country. Those who argue for the current form of federalism in the country appreciate the system as the best option available to a country like Ethiopia which hosts more than eighty linguistic
groups. Still some others criticize the federal system for failure to implement federalism as stated in the Constitution which grants much authority to Regional States (see Assefa F., 2006; Chone G., 2006; Clapham C., 2006). In any case, ethnic federalism has been in place for the last two decades in Ethiopia facing both criticisms and appreciations from different scholars. One may safely conclude however, the sustainability of the radical and pioneering political transformation would be potentially at risk unless the government works hard on common national interests instead of capitalizing on the differences among linguistic groups.

2.1.4 National Health Care Profile

2.1.4.1 Health Status

Medical historians documented Ethiopia had faced ranges of epidemics and diseases in the past. Early unidentified epidemic is mentioned in Ethiopian Synaxarium which is believed to strike the country around 831 AD. After similar successive unidentified epidemics, the country suffered from a small pox epidemic and influenza in early 18th century. The prevention and treatment to these epidemics and other disease were administered through traditional medicine and surgery until the introduction of foreign medical practitioners (Pankhurst, 1990).
The national health status is still poor after more than a century practice of biomedicine in the country. The Health Sector Development Plan document (MoH, 2011:22) summarizes this challenge as:

The major health problems of the country are largely preventable, communicable diseases and nutritional disorders. More than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often as a combination of these conditions. Despite major strides to improve the health of the population in the last one and half decades, Ethiopia’s population still face a high rate of morbidity and mortality and the health status remains relatively poor. Vital health indicators from the DHS 2005 show a life expectancy of 54 years (53.4 years for male and 55.4 for female), and an IMR [Infant Mortality Rate] of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010. Although the rates have declined in the past 15 years, these are still very high levels.

But some improvements in the health status have been noted by UNDP Human Development Index such as an increase in life expectancy at birth from 54 to 59.3 years (UNDP, 2011:129).

2.1.4.2 National Health Care System

The country did not have an official national health policy that clearly guides the organizations of national health care system until mid-twenty century. It was in 1950s that the World Health Organization (WHO) influenced the formulation of a substantive
health policy which aims at primarily preventive care side by side curative treatments. The political system that replaced the Imperial rule pursued the preventive policy with emphasis to rural areas (Massow, 2001:23). Regime changes in 1991 again led to put in place by the then Transitional Government of Ethiopia a new health policy that is aligned with its aim of federalism and decentralizes the national health system. But the emphasis is on meeting the health needs of the rural population like the regime it replaced. “At the core of the health policy are democratization (sic) and decentralization of the health care system; developing preventive, promotive (sic) and curative components of health care; assurance of accessibility of health care for all parts of the population; and encouraging private and NGO participation in the health sector.” (MoH, 2011:4).

A National Health Sector Development Plan was formulated in 1998 with consecutive four phases for twenty years. The Federal Ministry of Health has devised and been implementing a framework to improve the health of all. The Ministry designed and implemented strategies such as Reproductive Health Strategy, Safer Pregnancy, Adolescent and Youth Reproductive Health strategy and the revision of Laws on abortion. Moreover, There has been a strategy on Health Care Financing that allow free service or access to key maternal and child health services, the training and deployment of female health extension workers and health officers. The health officers are trained at postgraduate level with integrated skills of Emergency Obstetric and Surgery (MoH, 2011:4).
However, it seems that the understanding of the Ministry about National Health System is largely confined to the prevention and treatment of disease using biomedicine. Such tendencies could be noticed from the organization of the national health care delivery, which will be discussed below. Nonetheless, it is essential to raise a few points about the anthropological understanding of medical system which consist the theory of disease causation and the health care system (Kleinman, 1980; Bhasin 2007). The health care system that logically follows the disease causation theory deals with the sickness and maintenance of health. The health care system therefore may employ biomedicine, non-conventional medicine or both to deal with sickness and the maintenance of health. The context in Ethiopia is that the health care system is in line with the principles of biomedicine at least at official level. I will discuss how this official subscription to biomedicine is an incomplete health care system in the next chapter.

2.1.4.3 Organization of the Health Care Service

The health care service is organized based on the principle of the decentralization of services to Regional States and local communities. It has an interlocked tier of facilities. The link among each tier follows referral systems. The referral system begins from community level up to specialized hospitals in the national capital. The National Health Sector Development Plan clearly stipulates the referral health system organization has three levels. It states:
Recently, the health sector has introduced a three-tier health care delivery system: level one is a Woreda/District health system comprised of a primary hospital (to cover 60,000-100,000 people), health centers (1/15,000-25,000 population) and their satellite Health Posts (1/3,000-5,000 population) connected to each other by a referral system. The primary hospital, health centre and health posts form a Primary Health Care Unit (PHCU). Level two is a General Hospital covering a population of 1-1.5 million people; and level three is a Specialized Hospital covering a population of 3.5-5 million people (MoH, 2011:4).
Figure 2.2 Ethiopian Health Tier System

Source: HSDP Phase IV, 2011: 74
Biomedical health care service is delivered mainly by the government although the participation of private sector and voluntary organizations is gradually growing. There have been efforts by the government to expand health service facilities. There were 149 public and private hospitals, 1343 health centers, 3305 health stations/clinics and 12,488 health posts providing health services at various levels of the country as of 2009 (AHWO/WHO, 2010:19) However, the distribution of these health facilities especially hospitals and specialized clinics is skewed towards urban areas despite the fact that the majority of the population is living in rural areas.

2.1.4.4 Health Workforce

There were 66,314 health workforce including health extension workers as of 2009 in Ethiopia. Despite the tremendous increase in the number of health workforce especially in recent years, the health workforce to population ratio is still low. The health workforce densities of about 0.027, 0.018 and 0.26 per 1000 population were documented respectively for physicians, midwives and nurses in 2009.
### Table 2.1. Health worker/population ratios at national level

<table>
<thead>
<tr>
<th>Health occupational category</th>
<th>2003-2004</th>
<th></th>
<th>2009</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Health workers per 1000 population</td>
<td>Number</td>
<td>Health workers per 1000 population</td>
</tr>
<tr>
<td>Physician (general practitioner, specialist)</td>
<td>1,996</td>
<td>0.0281</td>
<td>2,152</td>
<td>0.0272</td>
</tr>
<tr>
<td>Specialist</td>
<td>775</td>
<td>0.0109</td>
<td>1,001</td>
<td>0.0126</td>
</tr>
<tr>
<td>Health officer</td>
<td>683</td>
<td>0.0096</td>
<td>1,606</td>
<td>0.0205</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>172</td>
<td>0.0024</td>
<td>632</td>
<td>0.0081</td>
</tr>
<tr>
<td>Pharmacy technician</td>
<td>1,171</td>
<td>0.0165</td>
<td>2,029</td>
<td>0.0258</td>
</tr>
<tr>
<td>Nurse (all types)</td>
<td>14,269</td>
<td>0.2009</td>
<td>20,109</td>
<td>0.2576</td>
</tr>
<tr>
<td>Midwife</td>
<td>1,274</td>
<td>0.017</td>
<td>1,379</td>
<td>0.0176</td>
</tr>
<tr>
<td>Laboratory technician</td>
<td>2,403</td>
<td>0.0338</td>
<td>1,957</td>
<td>0.0249</td>
</tr>
<tr>
<td>Laboratory technologist</td>
<td>NA</td>
<td>NA</td>
<td>866</td>
<td>0.0110</td>
</tr>
<tr>
<td>Environmental health professional</td>
<td>1,169</td>
<td>0.0164</td>
<td>1,246</td>
<td>0.0159</td>
</tr>
<tr>
<td>Radiographer</td>
<td>300</td>
<td>0.0042</td>
<td>169</td>
<td>0.0021</td>
</tr>
<tr>
<td>Health assistant</td>
<td>6,628</td>
<td>0.0933</td>
<td>1,486</td>
<td>0.0189</td>
</tr>
<tr>
<td>Frontline health worker</td>
<td>15,752</td>
<td>0.2217</td>
<td>-</td>
<td>0.0000</td>
</tr>
<tr>
<td>Health extension worker</td>
<td>-</td>
<td>0.0000</td>
<td>30,950</td>
<td>0.3943</td>
</tr>
<tr>
<td>Other (health educator, physiotherapist, X-ray technician, dental technician, biologist)</td>
<td>-</td>
<td>-</td>
<td>1733</td>
<td>0.0221</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>45,817</td>
<td><strong>0.6447</strong></td>
<td>66,314</td>
<td><strong>0.8444</strong></td>
</tr>
</tbody>
</table>

Source: AHWO/WHO: 2010:22
2.1.4.5 Health Care Financing

Health care is financed from four major sources in Ethiopia. The government finances health services through the allocation of annual budget. Multilateral and bilateral donors finance health care in Ethiopia through grants and loans. The other two sources are NGOs through health care projects; and private contributions (e.g. out-of-pocket spending). Although the national health care expenditure is growing, it constitutes only 5% of GDP in 2004 and 2005. The national per capita health care expenditure was lower by 50 % than the USD $ 34 per capita need of the WHO target (AHWO/WHO: 2010:19).

Table 2.2: Health Care Expenditure, 2009

<table>
<thead>
<tr>
<th>Financing sources</th>
<th>US$</th>
<th>Per capita (US$)</th>
<th>% of total health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>145,501,590.74</td>
<td>1.99</td>
<td>28%</td>
</tr>
<tr>
<td>Households</td>
<td>160,042,854.70</td>
<td>2.19</td>
<td>31%</td>
</tr>
<tr>
<td>Other sources</td>
<td>192,293,175.25</td>
<td>2.63</td>
<td>37%</td>
</tr>
<tr>
<td>Public enterprises</td>
<td>13,796,059.21</td>
<td>0.19</td>
<td>3%</td>
</tr>
<tr>
<td>Private employers</td>
<td>6,129,755.76</td>
<td>0.08</td>
<td>1%</td>
</tr>
<tr>
<td>Other private funds</td>
<td>3,966,145.77</td>
<td>0.05</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>521,729,581.43</strong></td>
<td><strong>7.14</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

2.2 The Research Site

Map 2.2 Location of the research site in Ethiopia

2.2.1 The Genesis and Current Conditions of Addis Ababa

Urban centers are recent phenomenon in modern Ethiopia. Pre 20th century Ethiopia lacks permanent urban settlements mainly due to frequent warfare among regional lords and the frequent change of military headquarters. It was in the mid-way during expansion of Menilk II that the state capital Addis Ababa was established. Addis Ababa may be labeled the first human settlement to assume a metropolitan level from scattered settlement in recent Ethiopian history (see Pankhurst, 1968; Bahiru, 2002).

Located in central Ethiopia at an average altitude of 2,400 meters, Addis Ababa has been playing a historic role in hosting organizations such as the organization of African Unity/African Union that has contributed to the territorial and administrative decolonization of African countries. This is perhaps attributed to the fact that it is the capital of a non-colonized country in Africa. This historical circumstance eventually made the city to become the seat of many international agencies.

Except for its initial military strategic layouts, Addis Ababa had no modern plan at the beginning. The first attempt to sketch a modern master plan for Addis Ababa was made during the Italian occupation in 1936 (Ayalew, 2003:71). The plan was designed to lay practical evidences on the ground showing Italian domination during its brief occupation of the country. This plan proposes the creation of new neighborhood, new market (Markato) and business and retail district. The plan segregates local population in terms of residence areas, streets and location of religious centers (Ayalew, 2003:71; ORAAMP,
2000:30). Although the implementation of this master plan was terminated following the withdrawal of the Italian force, it had left important marks on the city. It was Patrick Abercrombie who took the assignment to prepare the master plan for the city after the one under the Italian occupation was rejected by the then Ethiopian government.

The next master plan for Addis Ababa was prepared in 1980s by Addis Ababa Master Plan project through technical cooperation with the Italian government. The plan was meant to serve for 20 years. It was based on the previous ones in its content and scope. It also gives much consideration to K. Poloy’s approach that tried to create the megapoles of Addis Ababa and proposed to connect Addis Ababa with Adama ( Nazareth). The towns found between Adama and Addis Ababa were regarded as development poles. The plan also intended to make Addis Ababa self-sufficient with agricultural products (AACG, 2000:6, ORAAMP, 2000:31). This master plan has been under revision for “its inability to function as effective development guide in the currently (sic) socio-economic order” (Ibid). It is this revised master plan which is guiding different activities in the city at the moment and which itself is going to be revised currently. The city covers an area of 530km² and divided into ten sub cities. The Addis Ababa City Administration has been granted some level of administrative autonomy and reports directly to the federal government rather than to the Regional State in which it is located.
2.2.1.1 Population

There is no documented evidence on the number of people living in the settlements before or during the establishment of Addis Ababa. Some sources estimate a large number of local population were displaced and Addis Ababa was occupied by Menelike’s army and their servants (Foucher 1987 in Feleke, 1999:21). So, excluding the seasonal population increase following the arrival of provincial governors and their retinues, the emperor’s retinue and personnel alone was estimated to be 15,000 at the outset of the establishment (Pankhurst, 1968:708).

Merab (1921-29) in Pankhurst (1968:709) attempted to show the estimated population of the city in 1910 along murky ethnic lines. Accordingly, while the total estimated population was 65,000 by then, the ethnic distribution was 20,000 [Oromos], 15,000 [Gumuz], 15,000 Shoans (sic), 5,000 Wolaitas, 3,000 Amharas, 2,000 Gurages, 1,000 Tigres and others (Somalis, Afars….) estimated to be 3,000. However, the population in the city gradually grew to larger sizes. The annual population growth was 7% up to 1970. The steady population growth resulted from natural population increase (Birth minus death) and the yearly in-migration from rural areas (CSO, 1972:71).

The estimated population living in the city in the year 2011 was about 3 million. The projection for the year 2015 is 3,792,000 (CSA, 2010; MOH, 2004:5; Golini A., et al, 2001:115). The proportion of children under the age 15 was 32 % where as the
population between 15 and 64 age category constitute 2/3 of the total population. The
annual population growth rate in Addis Ababa has been 2.1 %. Similarly, the ethnic
composition in the city was estimated to be 48.3% Amhara, 19.2 Oromo and 17.5%
Gurage (CSA, 1995:5; CSA, 2010:25). However, these figures should be cautiously
utilized because different international organizations suggest different estimates; for
example, UN-HABITAT estimates the city’s population was four million in 2008 and the
number is estimated to rise to 12 million by 2024 (UN-HABITAT, 2008:7). About 83%
of the population in the city is Christians from which 90% are the followers of the
Ethiopian Orthodox Church. The remaining population is Muslim and followers of
traditional beliefs. Moreover, the average literacy rate in the city is 85.3% from which the
figure is 91.3% for males and 79.9 % for females (CSA, 2010:56; 90).

Table 2.3 Population size, growth rate and density of Addis Ababa from 1961 to 2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
<th>Growth rate (%), Area (km2)</th>
<th>Density (Inh/Km2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>455,470</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1967</td>
<td>683,530</td>
<td>7.1</td>
<td>3,079</td>
</tr>
<tr>
<td>1978</td>
<td>1,167,315</td>
<td>6.4</td>
<td>5,258</td>
</tr>
<tr>
<td>1984</td>
<td>1,423,111</td>
<td>3.6</td>
<td>6,410</td>
</tr>
<tr>
<td>1994</td>
<td>2,112,737</td>
<td>3.7</td>
<td>4,191</td>
</tr>
<tr>
<td>2011</td>
<td>2,980,001</td>
<td>2.1</td>
<td>5,654.8</td>
</tr>
</tbody>
</table>

Sources: - AADIVO, 2002:3-8; CSA, 2010; Finance & Economic Development Bureau, 2010:4
2.2.2.1 Rural-Urban Migration

Population influx to Addis Ababa commenced from the outset. The influx during the early period was due to the fact that Addis Ababa became the emperor’s residence, his army’s headquarter, the seat of the emperor’s council which made people travel to the city (Pankhurst, 1968:705). In fact, since the foundation was affected largely by the people outside Addis Ababa’s geographic area, the city’s demographic pattern differs from the traditional Ethiopian towns. The quarters (safars) that Menelik’s commanders established within the city became centers to pull friend from their respective home areas (Benti: 1994:521).

But the trend of migration to Addis Ababa gradually changed after the Italian occupation. The infrastructure development, established Ministries with their headquarters in Addis Ababa and transportation networks facilitated increased migration to the city. Benti (1994:22-25) puts broadly the post Italian occupation migration to Addis Ababa under four categories. The categories are the economic and employment opportunities in the city; expansion of educational opportunities that created human power seeking employment in modern sector (usually found in the capital); improvement in road transportation facilities; and family ties and socio-cultural factors. Other studies as well consider rural-urban migration as a common phenomenon to Ethiopian urban centers (Mohammed, 2001:1). Studies show that 46% of the residents in Addis Ababa are migrants. When we look at the migrants’ area of origin, 58 % came from rural area where
as the remaining 42 % of the migrants came from other urban areas in the country (Eshetu, 2000 in Mohammed, 2002:11).

Nevertheless, migration to Addis Ababa had multi-face impacts on the social services. The impact is being reflected on the physical coverage of Addis Ababa as well. For instance, the area of the city in 1984 was 222.7 km². After ten years, the city’s area is increased by 108.7 km². The increment in the area of the city was through encroachment on and expansion to surrounding villages, towns and barren lands “to accommodate the fast growing population of Addis Ababa mainly due to rural to urban migration” (Mohammed, 2001: 5). The city covers an area of 526.99 km² at the moment.

2.2.1.3 Salient Socio-economic and cultural Conditions

Addis Ababa entertains diverse socio-economic and cultural conditions. The official statistics shows that in 2007, about 119,197 people in the city were engaged in trade and commerce; 113,977 in manufacturing and industry; 80,391 homemakers of different variety; 71,186 in civil administration; 50,538 in transportation and communication; 42,514 in education, health and social services; 32,685 in hotel and catering services; and 16,602 in agriculture.

Among the striking paradox in Addis Ababa nowadays is the gap between economically well to do who could afford the basic desired necessities of life and the poor that fail to earn their daily bread and hence, for whom meeting their basic needs is a luxury. About
three decades back, Herbert (1979) had clearly stated about the common features of third world urban areas as "most people living in these mushrooming urban areas are desperately poor. Often 80% of all urban households have daily income of US $0.50 or less. The members of many of these households are . . . undernourished and weakened by debilitating diseases" (Herbert, 1979:4).
2.1 A partial View of the study area from one of the main streets in the city.

A simple observation of the daily routine of the residents in Addis Ababa reflects the aforementioned features regarding the striking paradox of the gap between the poor and the rich. There are helpless children crying for their daily meal on one hand and business men/women in their latest 4 wheel Drive on the other. Addis Ababa is the home for many destitute people. There were for example over 2,000 destitute old persons counted in one day on the streets of Addis Ababa in 1998 (HAI 2001:6). Studies estimated more than 45% of the households in the city live below poverty line (Yasin, 1997: 27). The latest reports from government offices indicate a significant decline of this figure to 29%.

A total of 374,742 housing units were found in Addis Ababa a few years back, out of which 97.2% were non-storied buildings whereas 2.7% were in multiple storied buildings. About 40% of the housing units in non-storied were detached while 60% of the housing units in non-storied were attached buildings (CSA, 1999: 219). But the situation has significantly been changed especially in the past five years due to increasing number of real estate developers engaged in the construction of modern apartments and villas.

None the less, there exists wide gap between the demand for housing and the supply to meet this demand. Scholars estimated the deficit in Addis Ababa at 30,000 housing units in 1997. They projected that over 19,000 households per year require housing in Addis Ababa for the consecutive 10 years (Eyasu, 1999:26). On the other hand, the Ethiopian Government had sought to fill this wide gap through free market oriented approach to
residential land and housing development. The land lease proclamation stipulates the right to land for residential buildings will be leased for a maximum period of 99 years. The proclamation however, gives discretion to Regional States on setting the maximum and minimum plot size together with fixing the equivalent cost for the plot (Negarit Gazette, proclamation No 80/1993).

Earlier studies revealed housing and land costs are much higher relative to household incomes. The housing price to income is extremely high. Hence, housing costs stand still well above the level ordinary urban poor would offer (Eyasu, 1999:55). The city government has been engaged in massive condominium housing construction to reduce the problem of housing. It was planned to construct 175,000 condominium housing units from 2006-2010. (UN-HABITAT, 2011:11).

There were 27 health centers, 136 health stations, 387 private clinics, 25 hospitals and 2346 hospital beds in Addis Ababa as of December 2004 to cater for the health service needs of the population. About 65 primary and 174 junior secondary schools were reported to exist as of 1999. The number of secondary high schools in the same year was 48 (AACG, 2000:10-12).

The number of health and educational institutions are increasing since then through public and private funding. The figures for health facilities for instance increased to 50 hospitals, 30 health centers, 464 private clinics of different size and capacity, 262
A great number of populations in Addis Ababa are pedestrians. This population category is mainly the poor who fail to afford motorized transportation expenses. Each trip takes these pedestrians more than half an hour in most cases. Non motorized animal drawn carts are used to transport goods and passengers especially in the peripheries. Other than an estimated large number of donkeys owned by inhabitants, about 3,172 heads of pack animals enter Addis Ababa each day on market days (AADIFO, 2002:35).

The most expensive private cars do also glide on the street of Addis Ababa. The traffic density has increased together with traffic accidents from time to time (Dejene, 2011). Moreover, more than 77% of the total vehicle population concentration in the country is found in Addis Ababa. The city’s roads entertain 9443 taxis, 377 buses, 36,047 salon cars and 19,770 commercial cars at peak hours. Furthermore, 15,408 fright trucks and 638 motor bikes compete for the same limited road infrastructure. Concentrated economic activities in the city core is another factor that exert great pressure on the roads which lead to the city center (ORAAMP, 2000:3). There is an international and domestic airport too in the city.
In general, Addis Ababa is a city of contrasts. On the one hand, it is a city in which many poverty stricken households toll for their daily bread, many people from rural areas make transactions and go back to their villages; many in the city are seen in elaborate religious festivities and other cultural celebrations.

On the other hand, the city is a hub for many national and international activities. It is regarded as the diplomatic capital of Africa for it is the seat of the headquarters of the United Nations Economic Commission for Africa (UNECA), the African Union (AU) and other regional and international organizations. The fact that there are more than one hundred embassies and consular missions has enabled it to serve as the venue for international conferences and other gatherings, and this makes the city one of the most important seats of international organizations and embassies in the world.