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Urban Primary Health Care Reform

1. Introduction

1.1. Background

[1]Ethiopia is one of the least urbanized countries in the world. It has only 16% of its population living in urban centers (PCC, 2008). However, given the 2.73% total annual population growth rate, high rate of in-migration to towns, and increase in the number of urban centers, the rate of urbanization is increasing at a rate of 4.4% (MoFED, 2006). Furthermore, the country's urban population is expected to grow on average by 3.98%, and by 2050 about 42.1% of the total population is expected to be living in urban centers (UN-HABITAT, 2007). Even though there are more than 900 urban centers in Ethiopia, Addis Ababa, its capital city, consists of about 23% of the total urban population in the country (PCC, 2008). [2]According to MoFED, **70% of the urban population is considered slum dwellers** on the basis of quality of housing, overcrowded living spaces, access to and quality of infrastructure, and security of tenure. Overall, while rural poverty rates dropped from 47.5% to 39% from 1995 to 2005, urban poverty rates increased from 33% to 35% over the same period (HICES 04/05).

According to the Ethiopian Demographic and Health Survey (DHS) 2011, urban settings are better off in most of the indicators for health service coverage and outcomes compared to rural areas. However, some of the findings are similar to or not far from the rural settings despite relatively better access to health care in urban settings. The neonatal mortality rate was 41 & 43 deaths per 1000 live births for the 10-year period preceding the survey in urban and rural settings respectively. Half of mothers living in urban settings delivered at home. A considerable proportion of mothers living in Addis, Dire Dawa and Hareri gave birth at home (17.2%, 60% & 67.3% respectively). Less than 50% of mothers in Addis Ababa (47.7%), Hareri (28.4%) and Dire dawa (18.7%) received post natal care in the first 2 days. HIV/AIDS prevalence is higher in the urban setting, 51% of deaths in Addis Ababa are due to non-communicable diseases, and issues of sanitation and waste management is prominent among urban dwellers.

1.2. Primary health care services in urban centers

The health centers in urban settings are serving an average catchment population size of 40,000 people. The health centers provide predominantly outpatient services. The services provided at health centers include diagnostic and curative services for common illnesses, health promotion and disease prevention service packages and health centers are networked with hospitals for secondary and tertiary care. The community based activities by urban health extension workers are linked to the health centers. In some urban settings, Health Extension Professionals (HEPs) (Nurses with additional three months trainings) are directly accountable to the health centers; in others, they are under the district/woreda health offices. The program has essential packages of interventions including Hygiene and Environmental Sanitation, Family Health Care, Prevention and Control of Communicable, Non-Communicable Diseases and Injuries. The interventions are similar to that of the rural HEP with some differences from the rural setting in areas of non-communicable disease, mental health, and injuries, as these are expected to contribute more significantly to the disease burden in urban settings.

[1] http://www.environmentfordevelopment.org/centers/ethiopia/news-press/news-archive/2012/pdfs/Leulsegged%20Kasa%20paper%20presented%20for%2010th%20international%20conference%20on%20Ethiopian%20Economy.pdf

[2] Urbanization and Spatial Connectivity in Ethiopia, Summary of ESSP-II Discussion Paper No. 3: "Urbanization and Spatial Connectivity in Ethiopia: Urban Growth Analysis using GIS" (December, 2009)

1.3. Challenges of primary health care services

The primary health care delivery in cities is facing myriads of challenges; some of the challenges are simply attributed to the nature of the social, economic and demographic transitions, while others relate to the responsiveness of the health system. The following challenges were identified by a situational analysis conducted in three selected sub-cities: Bole, Yeka and Gulele, in Addis Ababa.

- Loose linkage between community and facilities
- Less than a third of households were visited by health extension professionals
- Interrupted supply of essential medicines, lab reagents and other consumables
- Inadequate utilities such as electricity, water and connectivity (availability as well as maintenance issues.)
- Medical equipment maintenance (lab machines, cold chain, etc.)
- Attrition of health workers mainly
- Sub optimal referral network
- Complex urban sanitation and waste disposal problems
- Increasing burden of non-communicable disease, including mental health
- Weak emergency medical service system
- Large number of street children and elderly in the city
- Inadequate organization of health centers & hospital services to effectively handle cases - lack of beds, and poor adherence to protocols (information to clients, use of referral slip, alert call, escorting and feedback)

1.4. Lessons from other countries

In the process of redefining of PHC- as part of envisioning the future of the health sector in Ethiopia, a series of consultations and reviews were made with various countries - middle income countries with better health profiles which had similar Gross Domestic Product (GDP) 30 years ago as Ethiopia currently has. Based on information gathered during the workshop and desk reviews, the Cuban and Brazilian primary health care systems were considered to demonstrate in the urban context.

Possible lessons captured from the Cuban and Brazilian Health system include the following:

- Relatively well developed human resource in both numbers and skill mix (e.g. high Physician to population ratio),
- Family physicians/doctors with nurses are engaged in PHCUs which gives comprehensive care (public health & clinical care),
- Clinics are near by the neighborhoods (with residency for clinic staffs within the clinic in Cuba; Family Health Team lives in the community they serve in Brazil) and available on call during emergency hours,
- Pre-service training produces cadres tailored to the health system (e.g. family physician…),
- Segmentation/categorization of the clients based on the risk factors in the Cuban health system
- Strengthened local pharmaceutical institutes, and
- The positive contribution of high Literacy rate

2. Descriptions of the urban primary health care reform in Ethiopia

2.1. Goal

The general goal of the reform is developing and introducing a well-functioning system which provides high quality and equitable services to the community at the primary health care unit level.

2.2. Team based approach

The main purpose of the team based approach is to ensure that every household has an easy access to all spectrums of health care services using the Family Health Team (FHT) as an entry point. The FHT will be formed by two physicians/health officers/BSC nurses, 2 diploma nurses, and 4-5 health extension professionals. In addition, additional professionals, such as environmental health technicians and social workers, will be placed at the health center level to provide support to the FHT as deemed necessary. The team will thus split into two sub-teams – Facility based and Community based teams. On average, one health center will have five FHTs and each FHT will be assigned to a specific section of the catchment woreda.

2.3. Service delivery modality

The service delivery will have three parts: facility, household, and community/outreach level interventions. The facility level intervention follows the existing service delivery modality, however, the outpatient department (OPD) services will be divided based on the number of ketenas in the woreda. At the registration and triage areas the ketene/village of the person is captured and assigned to the OPD or any other rooms providing the pooled services to the person.

The household level interventions will follow the clients' categorization. The category will be based on epidemiologic and socioeconomic conditions. As presented in the table below, beneficiaries will be categorized and prioritized based on their risk factors, diseases, and income levels.

Table 1: client categorization mechanism

Over all Category	A Lowest Quintile (1st and 2nd quintiles)	B Medium Quintile	C Highest Quintile
I: Pregnant women and children under 5 years	CAT IA(1st priority)	CAT IB	CAT IC
II: Chronic and NCDs (DM, CVDs, Cancer, Asthma)	CAT IIA (2nd priority)	CAT IIB	CAT IIC
III: Others	CAT IIIA	CAT IIIB	CAT IIIC

The team working in the community supports the physician/clinical nurses on clinical and palliative care, and following up patients at home after receiving curative services. The follow up may include adherence to medication, detecting side effects, monitoring improvement or worsening of conditions and targeted health promotion and diseases prevention activities. In addition, they may assess patients in their house to house or community function and link them to their respective facility based team. The environmental health professionals will assist the team in environmental hygiene component of the package.

At the community/outreach level, the team will cover schools, youth centers, homeless people, and workplaces.

2.4. Service packages

The family health team provides services listed in table 2 at household and community/ outreach levels.

Table 2: List of health service packages

1. Family Planning Services
2. Maternal Health
   - 2.1. Antenatal Care
   - 2.2. Delivery Care
   - 2.3. Post-natal Care
3. Newborn health
4. EPI
5. Child Health
   - 5.1. Nutrition
   - 5.2. Management of childhood illness
6. Non-communicable disease
   - 6.1.Hypertension and other cardiovascular problems
   - 6.2. Cancers
   - 6.3. Diabetes
   - 6.4. Mental Health
   - 6.5. Asthma and other respiratory tract problems
7. Prevention and control of communicable disease
   - 7.1. HIV,
   - 7.2. STI,
   - 7.3. Malaria,
   - 7.4. TB,
   - 7.5. Hepatitis
8. Hygiene and sanitation
9. Medical Emergency prevention and response
10. Palliative care services
11. School health
12. Occupational Health and safety
13. Services for Homeless

2.5 Other components of the reform

The family health team by itself will not bring the intended changes in primary health care delivery and outcomes in urban settings. Other initiatives, such as, emergency service, referral and consultation networks, engagement of the private sector, and occupational health and safety are equally important. These changes will also not be successful unless the health system establishes or plays an active role in pushing an agenda of multi-sectoral collaboration. Since the start of the reform activities, the role of the leadership at various levels of the health administration and facilities has been of paramount importance. Re-structuring and capacity building of the governance and leadership structure of the health system is quite important to further the cause of the reform.

2.6 Financing

Budget for running the reform activities are needed from the government, development partners, community and private sector. However, for reaching every household with the intended services, community based health insurance (CBHI) will be a key component of the reform in urban centers. Availing these resources, thus, requires motivated and committed leadership at all levels.

2.7 Performance management

The reform has its own indicators to be measured regularly and at the end of the pilot phases in Addis Ababa and selected urban centers. However, the new introduction of automated/digitalized Health Management Information System for urban centers will be started in the pilot sites. Lessons from those sites will be used to finalize and scale up the system.