ETHIOPIA'S PRIMARY HEALTH CARE REFORM: PRACTICE, LESSONS, AND RECOMMENDATIONS

BACKGROUND

The urban population in Ethiopia is increasing rapidly; currently more than 17 million people (nearly 19 percent of the total population) live in urban areas. The proportion of people living in urban areas is one of the lowest in the world, well below the sub-Saharan Africa average of 37 percent. But this will change soon, with projections that 30 percent of the country's people will reside in urban areas by 2028[i].

If managed properly, urban population growth presents a huge opportunity for multiple sectors, but may also pose a demographic challenge as cities struggle to provide health care, jobs, infrastructure, services, and housing to rapidly increasing population. If sound policies, institutions, and investments are not created immediately, it will be difficult to respond to the growing need of the urban population.

Urban populations face a triple threat: infectious diseases like HIV, TB, pneumonia, and diarrhea; non-communicable diseases like asthma, heart disease, cancer, and diabetes; and violence and injuries, including traffic collisions. Due to such multifaceted challenges a new approach to mitigate the complicated health problems of urban dwellers is needed. With this understanding the Ethiopian government in collaboration with partners[ii] piloted a reformed urban primary health care system in three health centers in Addis Ababa in 2014.

DESIGN OF THE NEW PHC MODEL

The new primary health care model is based on lessons from middle income countries, particularly Cuba and Brazil. Experience from these countries is believed to apply to Ethiopia's context as Ethiopia aims to become middle-income country by the year 2035.

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The key lesson from these countries are: have well-developed human resources with a mix of skills and adequate in numbers; family physicians/doctors and nurses providing team-based primary health care services; clinics and health workers located near or within the community; and services targeted to the specific need of the population through risk factor-based client segmentation or categorization.

The key components of the new PHC model are:

1) **Categorize communities based on risk assessment:** household-level census data consisting of basic demographic profile, health status, income, vulnerability, and related matter is collected from the catchment population of a health center. Based on data analysis community members are categorized as follows:

INCOME CATEGORY Client characteristic	(A) LOWEST	(B) MEDIUM	(C) HIGHEST
I: Pregnant women and children under the age of 5 years	Category IA	Category IB	Category IC
II: Adults with chronic problems and non-communicable disease	Category IIA	Category IIB	Category IIC
III: Others	Category IIIA	Category IIIB	Category IIIC

As indicated in the above table, pregnant women and children under the age of five who belong to the lowest income category will be targeted as first priority population group (Category I). Adult populations with chronic problems and non-communicable disease who belong to the lowest income category will be targeted as second priority (Category IIA).

2) **Introduce team-based approach to provide targeted services to identified priority population groups:** health workers deployed at heath centers are organized as a team, also called a "family health team" to provide targeted services to priority populations through home visit or outreach sites. These teams also make referrals for further care at health centers.

The plan is to organize the health center staff in five teams, each consisting of a family health doctor or health officer or nurse with a bachelor degree to serve as a lead; clinical nurses, and urban health extension professional and environmental health professionals. The family health team will rely on pooled serves for laboratory, pharmacy, delivery, and logistics and administrative matters.

3) **Modality of service provision:** urban health extension professionals, with support from their supervisors, will identify populations that need to be visited by the family health team and will make arrangements with the team leader. Based on the advance arrangement/preparation, the team will visit the identified families with all the necessary supplies to provide services at the household level. The team will also educate the family and make referrals if further care is needed at health center or higher level facility.

Current implementation status of the PHC reform: the model has been implemented in Gergi, Gulele, and Yeka Entoto Number 2 health centers in Addis Ababa. Based on what was learned at the three health centers, the reform is being expanded to 20 health centers in Addis Ababa and regional towns Hawassa, Jimma, Mekelle, Harar, Dere Dawa, and Bahir Dar in the current Ethiopian fiscal year (2009 EFY).

According a recent expert appraisal of the implementation of the reform at the three health center, the new model strengthened focus on family and community context bolstered by Ethiopia's Health Extension Program. The approach increased access to basic services for marginalized and vulnerable population groups. The team approach allowed provision of comprehensive care including previously neglected problems such as non-communicable disease, injuries, violence, and mental health. Programmatic efforts to ensure continuity of care starting at the community to the health center and tertiary levels of care through referrals are being strengthened, although there are challenges due to the lack of clear payment mechanism for patients to get paid services.

In addition, the reform introduced the practice of team work within the primary health care system and helped to draw health workers out of the health centers to work with community-based structures and members. For example, in one of the three pilot health centers (Gerji Health Center in Bole Sub-city) there are five family

health teams, each with two sub-teams (one that goes into the community and the other that stays at the health center to provide services to the community members referred by the other team).

In addition to home visits, the family health team goes to schools and work places. On Mondays and Tuesdays, the team provides services to children under-five and antenatal care for pregnant mothers. Services for chronic and non-communicable diseases cases are provided on Wednesdays. On Thursdays, the team goes to schools, youth centers, work places, and community centers. Fridays are reserved for weekly meetings.

Challenges: Inadequacy of human resources to staff the family health team; disruption of regular activities during emergencies, lack of office space to reorganize outpatient clinics according to the family health team's arrangement; lack of sustained follow-up support from health offices; financial constraints (or absence of fee waiver system) for providing medications for indigent people identified during visits by team; transportation problems; lack of links to private sector; and weak referral network between the health center and hospitals are the main challenges reported from the pilot health centers. In particular, the lack of a mechanism to cover the cost of medicines for poor families creates mistrust and cynicism when the team members who visit a family that has sick person are unable to provide any medical support.

Recommendations: The following recommendations require engagement of the respective city or town administrations and higher level health officials in all aspects of the reform work.

- Validate and simplify the client categorization approach and define the role of the family health team clearly in a written scope that specifies their engagement in emergency and ad hock activities.
- Ensure inter-sectoral collaboration by engaging the private sector.
- Implement an appropriate payment mechanism including financial protection mechanisms for the poor.
- Implement a technology-supported community health information system and integrate strong evaluation and research components.