

Ethiopia's urban primary health care reform: Practices, lessons, and the way forward

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Abstract

Background: At present there is remarkable expansion of urbanization in Ethiopia. By 2050, 38% of the population in Ethiopia is expected to reside in urban settings. The majority of this future urban population is believed to live in slums. In response to this daunting health challenge, the Ministry of Health launched urban health extension program in 2009. The outcome of this initiative, however, is still uncertain - Urban Health Extension Professionals seem to have failed to meet the desired end. To improve the situation, experiences were drawn from middle-income countries and piloted in Addis Ababa in 2014. This is a report of the study conducted to assess the implementation of the pilot initiatives. In the assessment of the implementation, attempts were also made to identify lessons and challenges encountered.

Methods: Qualitative data were collected from purposively selected individuals involved in the design, implementation, and use of the pilot initiative. Checklists developed on the basis of the objective of the study were used for data collection.

Findings: The findings indicated that the initiative had a team of health professionals - people who had the skills needed to work as a team and implement the pilot activities. The health team improved linkages and collaboration between the health system and the community. Through the team, identification of the most neglected sections of the population was ensured and this section has accessed health services. For example, the disabled, the sick, the elderly, persons with chronic health problems, girls and women were identified as social sectors that had either no or very little access to health care. The health team created a strong sense of collaboration between itself and the community level structures. This has been recognized to have an important role in improving service delivery to community. However, the level of the team's recognition of local community set up and structures as facilitators of health services needs improvement. Furthermore, a shortage of transportation to distant places in the catchment areas and a lack of timely provision of supplies and drugs to address some basic health problems at household and community levels were identified as major problems.

Conclusions: Ensuring proper urban health care requires multifaceted and multi-sectoral responses. Defining strategies of enhancing the engagement of different sectors in achieving the objectives of the initiative is an important point to be noted. Ways to provide continuous supplies to the health teams need to be sought. An equally important point that needs to be noted to ensure further successes of the initiative is empowering and enabling community level structures to focus more on health-related activities. [*Ethiop. J. Health Dev.* 2018; 32(1):4-9]

Keywords:- Urban, health extension professionals, PHC, pilot

Background

The history of primary health care is an outcome of the challenges faced in health care provision during the 60s and 70s (1). Changing theories of development that linked health to other development sectors has also led to recognizing the power of inter-sectoral collaboration in health interventions. Such development frameworks, led to the Alma Ata Declaration of Primary Health Care (PHC) in 1978. Primary Health Care (PHC) was given a working definition as:

...an essential health care based on practical, scientifically sound and socially acceptable methods and technology, universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (2).

In Ethiopia, PHC has undergone numerous adaptations. In 1974, the former regime retooled the national health strategy and made disease prevention and control, decentralization and rural health services and self-reliance and community involvement the main focus of the strategy. This strategy paved the ground for the adoption of the PHC strategy and Ethiopia signed the Charter for PHC strategy in 1978 (3). Following the principles of PHC, as outlined in the Charter, the country launched a Ten Year National Perspective Health Sector Plan (1985 - 1994).

In 1993, the new government developed a new health policy with the country's renewed commitment to most of the primary health care principles. This introduced a new focus; encouraging the involvement of private sectors in health service provision (4, 5). At about the same time, Health Extension Program (HEP) that aimed to empower local community to look after its own health was introduced (6). This package was initially developed in consideration of the rural

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population that encompasses about 85% of the population. However, the package was later adapted to urban setting (7).

The size of urban population is rapidly increasing in Ethiopia. More than 17 million people (nearly 19 percent of the total population) now live in urban areas. The population expected to live in the urban setting by 2050 is projected to be 38% of the total population. The present urban population size (i.e., 19% of the total population) is among the lowest urban population size in the world. Thirty-seven percent is the average for the sub-Saharan Africa countries (8).

The health challenge that arises from a rapid urban population growth is evident. Urban population is vulnerable to threats of infectious diseases such as HIV, TB, and diarrhea. There also dozens of non-communicable diseases like asthma, heart disease, cancer, and diabetes. Violence and injuries, including traffic fatal accidents are also among the threats to urban life. Addis Ababa, with a population of over 3 million, has the largest urban population in the country. It is ten times higher than the next largest city in the country. A large proportion of its population lives in slums (9). As is true elsewhere, slum characteristics such as poor housing, congestion, a lack of access to safe water and sanitation are reflected in the slums in Addis Ababa. Similarly, public health concerns such as an increase in the spread of non-communicable diseases, frequent outbreaks of infectious diseases and an increase in the risk of violence and injuries characterize the slums in our city (10).

Urban residents, as discussed earlier, are exposed to health care challenges. The recognition of this vulnerability of urban residents initiated the launching of Urban Health Extension Program in 2009. The main functions of the package of Urban Health Extension Program were: ensuring family and environmental health, addressing communicable and non-communicable diseases, and providing first aid and preventing accidents (11). After five years of Health Extension Program implementation, it was realized that health intervention in urban Ethiopia requires a new approach that addresses the multifaceted nature of the problem and the growing health care needs of the residents. Based on this, with the support obtained from development partners, the government piloted a reformed urban primary health care system in three health centers in Addis Ababa in 2014. This report is summary of the findings from the implementation of the pilot project initiative.

The piloted health care model is based on lessons obtained from middle-income countries; namely, Cuba and Brazil. Key components of the pilot initiative, based on the lessons drawn from the two countries, were identified and used as focal points during the process of the appraisal of the program. A number of issues such as assessing and grouping community risk factors; providing targeted health services through

forming family health team; screening social sectors that used to be denied access to health services and giving them priority of access were considered. There was also a need to survey households and categorize beneficiaries in terms of their socio-economic status. Designing regular home visits or outreach programs and providing health services beyond the usual limits was yet another aspect considered in the health program initiative. Establishing sustainable relations between households, community and urban health extension professionals was a further area of focus in the program. Equally important in the health reform program was the development of manuals that guided the implementation of the health initiative program.

A pilot implementation of the health initiative model was made in three selected health centers in Addis Ababa before scaling it up to 20 more health centers in Addis Ababa and regional towns in Amhara, SNNPR, Oromia, Tigray, Harari regions and Dire Dawa administration.

The primary purpose of this study was to assess the effectiveness of the implementation of Primary Health Care Reform in Addis Ababa and identify the challenges faced in the implementation. Health centers in three sub-cities; namely, Bole, Gulele, and Yeka were included in the study.

Methods

Study Area and Design: Three sub-cities (Bole, Gulele, and Yeka) were selected for the pilot study. The selection of the sub-cities was on the basis of their performance as ascertained by indicators drawn from Health Management Information System (HMIS) and the commitment of their leadership at Kifle Ketema levels. Health centers were also selected from the three sub-cities using similar criteria. The reform elements considered included: automation of HMIS and Community Health Information System; piloting community-based health insurance in the three sub-cities; ensuring inter-sectoral collaboration and engagement of private sectors. Reform implementation was introduced following background assessment of the health centers for their readiness to respond to the needs of the health reform.

One operational health center was selected from each of the three sub-cities in Addis Ababa. These were Entoto Health center (Yeka Sub-city), Gerji Health center (Bole Sub-city) and Selam Health Center (Gulele sub-city). Key informants were selected from each of the study sites and used as data sources. The study participants were nine responsible focal persons from different functional levels of the health sector i.e. the Federal Ministry of Health, Regional Health Bureau, Sub-city Health Offices, Wereda Health Offices, and health center heads. In addition, 14 health care providers at community level, eight women development army members and nine beneficiary households participated in the study. The participants were selected on the basis of their roles in the design and implementation of the pilot initiative.

Methods of Data Collection: Different methods were employed to generate data to address the objectives of the study. Desk review of relevant documents and reports was carried out to inform the reform process. Key informant interviews were carried out with those who are at different functional levels within the health sector to obtain data on the design and implementation of the pilot program. Beneficiaries of the pilot program who were randomly selected from the community were interviewed during the data collection period. In-depth interview was used to engage beneficiaries from the pilot initiative were requested to provide their opinion on what they considered as successes and the challenges of the pilot program at the service giving level. All the interviews were audiotaped and later transcribed. Additional data were obtained by visiting health facilities and neighborhoods of such facilities. During the field visit, pretested observation checklist was employed to record relevant information.

Analysis

Data collected from the different sources were first transcribed and expanded into field note. Subsequently, two independent readers with pertinent experience studied the transcription and expanded notes to define themes in reference to the objectives of the assessment. Later, the themes developed by the two independent readers were followed to categorize raw data and interpreted (12-14). The data gathered was thus organized into three categories to respond to the objectives. These include: 1) Process in the implementation of the reform activities; 2) Effectiveness of the implemented reform activities and 3) Success stories and challenges faced in the process of implementing the reform activities.

Findings

The population of Addis Ababa is estimated to be well over 3 million. Remarkable proportion of the population lives in slum areas (9). Clearly, slum life is characterized by deplorable living conditions, including lack of access to health services and associated components. In an attempt to respond to the health challenges in the city, the city's health office initiated a pilot PHC reform. Such reform initiative encompasses shifts such as shifting health related accountability from the woreda to health centers and re-targeting home visits by urban health professionals to those most in need of the services.

Design and Approach of the Urban Primary Health Care Reform:

Finding from this assessment suggests that the piloted model was implemented following an incremental reform approach contrary to what is often known as comprehensive, integrated and centrally coordinated approach. According to the key informant interviews, Urban Primary Health Care (UPHC) Reform was initially introduced to address the health needs of the under-served and vulnerable sector of the population in urban setting. The reform, however, failed to achieve its initial objective. Data from the key informant revealed that this failure of the reform program initiated the pilot reform program.

Implementation process of the UPHC Reform

The Family Health Team (FHT): Family Health Team is composed of leading Health Officer or BSc nurse and 2-3 diploma nurses and 3-4 other members representing environmental health officer, mid-wife nurse and pharmacist.. The team in all the centers visited miss professionals of mental health and social workers in their teams. FHT is responsible for a number of households and community networks and facilities (youth centers, schools, community centers) in their catchment area. The number of households, community networks, and facilities each team was responsible for depends on local context. This is to mean the size of population served and the types of community networks that existed in the locality determines the scope of each teams' responsibility.

The FHT is divided into two sub-teams. Each team is responsible for providing services at HH/community and HC levels by taking turns to work in the community and at the health center. While one team works in the community for four weekdays, the other team works at the health center. Fridays are dedicated to discussions, evaluations and reporting of the work done by each team during the week.

All the health centers involved in the study had established activities and schedules for the FHT. Priorities are given to pregnant women and children. The workload for team members was found to vary markedly depending on the number of health facilities in the catchment area and community networks to be supervised. An increasing demand for the team's service was the case while such barriers as inadequate supply, drugs at community level and problems related to transportation service for community activities leave the demands for health service unfulfilled.

Effectiveness and Benefits of the Implemented Reform:

In all the assessment sites, Family Health Teams have identified chronic patients who were in bed for many years and street community and industrial workers who were neglected by the health system. Besides, the theme referred pregnant women and sick under five children to health centers. They were also able to provide treatment for emergencies encountered during their community level activity. Similarly, they were able to provide health education and counseling to women at household levels and to children in schools.

All the study participants recognized benefits of the pilot program particularly in addressing the health needs of members of the community that were neglected by the health system. Furthermore, the program has created an opportunity for health professionals to recognize the magnitude of health problem at community level. One of the participants had this to say in this connection:

Family health team has initiated equal distribution and access to health care services. The program has facilitated smooth referral linkage between communities, health centers and hospitals. Besides, it

has brought together urban health extension workers and professionals working at facility level to work as a team (FGD respondent, Selam Health Center FHT).

The implementation of the pilot initiative enhanced team spirit between professionals in the health team and those working at the health center. The health center professionals developed better insight into the health problems at community level. As such, they improved means of caring for patients. The program has made useful contribution to defaulter tracing in TB, ART, vaccination, and family planning services. Besides, team members provided home-care services to those who were discharged from hospitals but who had no one to look after them at home. In connection with this, one participant was quoted saying:

“One of the benefits of this family health program was that it addressed those who were bed ridden and did not have any support. As a team, there were times when we had to give bed baths, even mobilizing resources from residents in the neighborhood to buy clothes for such people.”

(FGD Respondent, Entoto II Health Center).

Family Health Team identified priority groups through vulnerability assessment focusing on epidemiological and economic factors. Besides, during the home visit they made, FHT members screened residents' risk factors against non-communicable diseases such as diabetes and hypertension. Overall, FHT members involved themselves in community level activities almost every day. Based on such assessment, pregnant women, children, the homeless, the elderly and people diagnosed with chronic diseases were found to be priority groups of concern.

Whenever community members visited the HC, they met familiar persons from their FHT who facilitated the services they sought at the facility level. FHT members were also able to create a strong link between themselves and the community. They also strengthened the link between urban health extension workers and health professionals at facility level.

Health Development Army (HDA) Members: The activities of the FHT were found to be supported by members of the HDA who were widely recognized to play key roles in facilitating and supporting the routine activities of FHT. They were found to coordinate and mobilize the community for improved environmental hygiene. Women HDA members, in particular, advised, or even encouraged pregnant women and other people with ill health to visit health centers whenever they were given referral by FHT.

Success Stories and Challenges: This appraisal of the health reform program has identified a number of challenges encountered during the pilot phase. The challenges identified were at the level of the team, individual urban health extension program and health development army levels. Designing strategies to meet the challenges may serve as important input in the

maturing process of the pilot as well as in the scaling up phase of the health initiative program.

Family Health Team (FHT): The finding of this pilot project appraisal has revealed that health center leadership faced inadequacy of inputs and support from the regional health bureau for community level intervention. There were also complaints about shortage of supplies and emergency drugs needed for household level interventions. Lack of transport and allowance for FHT members at community level was also another challenge that tested the quality of the services. Furthermore, the need to update program implementation manual and integration of routine reports into HMIS was among the major factors that constrained the function of FHT.

Urban Primary Health Care Professionals (UPHP): Urban Primary Health Care Professionals were found to be very busy with other competing responsibilities. This immensely disrupted the continuity of their services. Members of Health Development Army were reported to have played remarkable roles in facilitating routine functions of the Urban Primary Health Care Professionals, but coordinating them was found to be a challenging task. In addition, carrying medical supplies (kit) for household level intervention was mentioned as inconvenient. This inconvenience was reported as follows:

“Some of the households within the catchment are very far and reaching out to them is tiresome especially on sunny and rainy days. The problem is more pronounced when we have to carry kits along to distant places. Lack of means of transportation makes endeavors to reach far sites of the catchment difficult.” (FGD respondent, Selam Health Center FHT).

Urban Primary Health Care Professionals often followed certain steps to identify priority households. While the implementation of some of the prioritized activities got delayed, other activities to be prioritized were excluded by Health Development Army member. Although UHEPs who participated in this appraisal expressed their satisfaction with their work, they were often frustrated with the challenges they encountered. For example, they reported lack of software and gadgets to feed data at the catchment area made completing the formats difficult. Besides, all UPHPs members mentioned, among others, lack of opportunities to update themselves and cope with developments in the field and absence of clear career structure as factors that often frustrated them.

Health Development Army (HDA) Members: It was found that the efforts of the HDA to improve environmental sanitation and practices of waste disposal didn't yield much result. Members of the HDAs attributed the cause to a lack of space for proper waste disposal. In addition, community members' attitude towards the activities of Health Development Army was mentioned as a hindrance to the success of their activities. The excerpt cited below illustrates this.

“Waste is everywhere as you may have seen. The reason for this is that people tend to dispose waste everywhere. this happens due to lack of space for waste disposal in the vicinity. Besides, community members also do not care much about this although we keep on telling people about the consequences. We are trying to do as much as is possible, but the problem remains still to be serious.”

(HDA respondent, Gerji Health Center area).

In addition, community members felt that HDA and one-to-five grouping of people were affiliates of government’s political agenda, and this, they said, is assumed to have affected their endeavors to improve the practice of waste disposal. One of the participants had this to say in connection with this:

“Since members of the community have different practices of disposing waste, the problem persists. Our efforts to ensure community members understood concerns on waste and how to dispose it is often met by the question where to dump it? The community’s assumption of HAD’s members’ political affiliation had also a role to play in constraining our success.”

(HDA informant, Gerji Health Center area).

Overall, the pilot initiative noted useful lessons in terms of improving access to services, improving community and health system linkages and reaching the most neglected sections of the community. The assessment of the implementation of the health reform program also generated equally useful evidence on the challenges that compromised the level of the achieved success. Firstly, FHT was expected to cover catchment areas that were often difficult to access due to a lack of transportation infrastructure. The attempts made to meet this challenge proved to be frustrating to the team. Secondly, given the number and mix of FHT, the workload of the team was thought to be low. This is believed not to have burned the health team members out. However, the share of the workload that went to FHT was likely to vary due to the differences in the catchment size and the size of the beneficiaries found in each catchment. Thirdly, FHT faced shortage of supplies such as emergency drugs to meet the demands at community level. This lack frustrated FHT members. The excerpt cited below clearly reveals this.

“There was a need to provide basic emergency drugs when necessary although the service was not based just on drug provision. If drugs were to be given free, who would be asked for reimbursement? Hence health care financing body at woreda level should be worked on, those who could not afford to pay for service should be selected and community health insurance be implemented. If these were improved, it could resolve issues of free service. Otherwise, people who could not cover the cost of the needed services would remain without treatment.”

(FGD respondent, Selam Health Center Management).

Finally, the pilot initiative covered not all health programs at community levels such as community health care financing. Also, it did not have well defined

operational guide. For example, how the program could or should fit into HMIS has not been defined.

Discussion

Following the principles of primary health care, the pilot urban primary health care reform in Ethiopia has focused on family and community over the last few years. The pilot program provided comprehensive care and ensured community access to services. It also established a good linkage between the various sections of the health sector.

The family health team had a good mix and number of health professionals. Members included a health officer or a bachelor’s degree holding nurse and 2-3 diploma holders in nursing. The health team also had 3-4 UPHP as members. The family health team contributed to improving access and quality of services at household and community levels. More particularly, the team helped in drawing attention to social sectors that were neglected in health service provision. Homeless people, the elderly, persons with chronic diseases and school children were among the social sectors that were previously denied access to health services. The team’s endeavor to screen residents for risk factors, particularly NCDs, has the potential to contribute to improved understanding of the state of NCDs in urban settings.

The team did not have mental health professionals and social workers as members. This may compromise the completeness of health service provision at household and community levels. This lack is particularly serious in countries like Ethiopia where mental health patients are among the most neglected sectors of the society.

In addition to providing improved access to services, the pilot health team managed to build sound relationships with community members. One previous study also shared similar findings in which the team’s deployment among the community improved relationships between community members and the health system (16). Other than family health team, engagement of the UHE-PS at household and community levels and health team’s provision of free health service at community level has improved the relationship between health care providers at community and health facility level. Evidence in the finding witnessed the essential role that the involvement of health care team played in achieving successful and sustainable health service provision at household and community levels (17).

Conclusions and Recommendations

It is important to base urban health intervention on evidence. Among others, the pilot initiative has generated evidence of reaching the most neglected social sector and improving community-health system linkage. Nonetheless, maintaining sound urban health care system requires multifaceted and multi-sectoral responses. In the pilot program, the extent of the engagement of sectors was not found to be encouraging. Further work needs to be done to ensure the engagement of public and private sectors in the

years to come. Finding of the present assessment revealed FHT members frustration due to lack of transportation services and heavy workload. It may be possible to address this by contextualizing the number and mix of health teams on the basis of the geographic and population size of the catchment. Besides, getting sustainable supplies and drugs was among the serious challenges that faced the teams, and this, affected the community's overall trust in the teams' activities. In this connection, it is important to mention the need for improving supplies at health centers.

Finally, structures as model families, HDA, one-to-five networks were seen to be useful to ensure the community's role in health reform initiative program. Evidence also shows that voluntary community-based structures play major roles in building relationships between services and communities. In particular, their involvement enhances integrated care and reduces health inequalities (18). However, the perceived association of these structures with politics in the present assessment, if allowed to continue, may immensely limit the success of the program. Empowering community level structures further and enabling them to commit more time to improving community health may help the pilot initiative to achieve its objectives more successfully.

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