Federal Democratic Republic of Ethiopia
Ministry of Health

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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[1].

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[2] piloted a reformed urban primary health care system in three health centers in Addis Ababa in 2014.

DESIGN OF THE NEW PRIMARY HEALTH CARE (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.

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. Based on the lesson, the following approaches were tested in Addis Ababa;

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:

[1]Ethiopia's Central Statistics Authority. Statistical Report on the 2016 Urban Employment Unemployment Survey, Addis Abba, Ethiopia, 2016.

[2]The partners that supported piloting of the Primary Health Care Reform are USAID funded Strengthening Ethiopia's Urban Health Program project implemented by John Snow, Inc and Fenot project implemented by Harvard School of Public Heath in collaboration with John Snow, Inc.

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 IA). 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 3-5 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 services 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 more health centers in Addis Ababa and regional towns ; Ha- wassa, Jimma, Mekelle, Harar, Dere Dawa, and Bahir Dar in the current Ethiopian fiscal year (2009 EFY).

According to an expert appraisal of the implementation of the reform at the three health centers, 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 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 including homeless. Fridays are reserved for weekly meetings for review and planning.

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 medical support.

Future Recommendation: The model is found to be the right and cost effective approach to make primary health care accessible to the needy urban population. A standalone health extension program that relies on young female health extension professionals is facing critical challenges to respond to the complex urban health needs. The new model has created team based engagement that is fit to the multiple needs of urban residents. FMOH did a cost effectiveness study that confirmed the cost effectiveness of the new primary health care service delivery model. Hence; the next step is to address the challenges and expand the approach to all urban health centers which needs the support of stakeholders and the commitment of government bodies at different levels.

REACHING THE UNREACHABLE: FHT'S EFFORT TO PULL A MOTHER OUT OF A SEVERE LIFE

"I feel like I am born again after I met Tirhas and then the Family Health Team. They are the ones who helped me to survive. Besides, Tirhas coordinates the Women Development Army to support me."

Yalfal Garedew was only 17 when she left Menz, her birth town and came to Addis Ababa looking for a job. However, life was not an easy as she expected it to be. "I know no one in Addis and I had no one to consult. Getting a job was not as easy as I thought it would be," said Yalfal.

Yalfal stayed on the streets, begging as her means of income. After a while, she started working as a daily laborer. However she got sick and nobody was willing to give her a job. "I was covered with itching rash from head to toe. Then people started stigmatizing and discriminating me. No one was willing to give me work." added Yalfal.

It was during this difficult time that Tirhas Gebreselassie, an Urban Health Extension Professional from Woreda 6 Health Center, met Yalfal. Tirhas is among the UHE-ps in Addis Ababa who took different trainings facilitated by Strengthening Ethiopian Urban Health Program (SEUHP), a project implemented by JSI through a fund from USAID. With SEUHP's support, FMOH revised UHEP implementation manual that required UHE-ps to provide services for hard to reach population under their catchment. The ministry also reformed Primary Health Care and trainings on the reform was given to health professionals starting from March, 2017. The objective of the reform is mainly focusing on providing community based health care services by Family Health Team (FHT) to the neediest segment of the population.

Hence, Tirhas consulted Yalfal's case to her Family Health Team at the health center for a better follow-up and support. The first thing the team did was to get Yalfal to a health center so that she gets her skin condition cured. Yalfal then learned she was HIV positive and started taking her medicine and following her check-up properly. Tirhas also continued following Yalfal's health status at her residential area.

Living on the streets was very challenging for Yalfal. To the worst, one day, a guy whom she doesn't know forced himself on her and she got pregnant. "I didn't expect that and I was not ready to have a baby. I was shocked when I found out that I was pregnant. I knew I have nothing with which to survive let alone raise a child. So I look to my good friend and advisor Tirhas for a solution" said Yalfal.

Since, the FHT visited Yalfal frequently they helped her deliver a healthy baby boy at a Health Center. However, it was very difficult for the team and also the UHE-p to leave Yealfal just there. As she didn't have a place to live and any means of income to support her newborn, they needed to create a mechanism. Hence, they linked Yalfal to Women Development Army (WDA) of the ketena. Fortunately, there were very cooperative and willing to support Yalfal financially though most of them sell vegetables on the streets for their living. "The women collected around 2000 ETB for her. Besides, they rented a house for 800 ETB per month. What they did is so amazing. They still bring her some vegetables from what they are selling," added Tirhas.

Just after the delivery, Yalfal's baby started taking prophylaxis - Nevirapine (against HIV infection) on daily

bases for 45 days and discharged from the health center. On the 45th day, blood sample, DBS-Dried Blood Spot, was taken from the child and test result shows that the child is negative for that time being. His regimen had changed to cotrimoxazole accordingly. This regimen will continue until 18 months along with close follow-up on the child's and Yalfal's health. The FHT advised Yalfal to take her child when he becomes 18 months old for confirmatory antibody test.

For a woman like Yalfal, who doesn't have a permanent place to reside in and a person to rely on, it is very important to use family planning method. The FHT took this into consideration and advised her about the different methods to make her safe at least from unwanted pregnancy. Finally, she decided to use long term family planning method, Jadelle - a five years contraceptive implant, based on her own choice.

Currently Yalfal, 27, lives in Nifas Silk Lafto Sub City wereda 6 Ketena 1 but doesn't have a permanent address or a house. The owners of the house increased the rental fee and hence, she moved out as she couldn't afford to pay that. "It is becoming very difficult for us to follow on her health as she doesn't have her own house. The WDA is still supporting her and she lives with one of them," said Tirhas.

Yalfal, is a single case from the works of Woreda 6 Health Center FHT. There are so many similar cases that the team has addressed and need to address. However, they face challenges while performing community based health service. It's well known that other aspect of life circumstances such as food and shelter need to be addressed in order to provide appropriate solution for health problems. For such matters, a professional social worker is needed. Unfortunately, though the guideline allows a social worker to be part of the team, the FHT doesn't have a one yet. For the cases like Yalfal, having a social worker in the team would have helped the team to focus on their job which is providing health care service while people like Yalfal also get the social service they need for professional social workers.

Located in Nifas Silk Lafto Subcity of Addis Ababa, Woreda 6 health center serves around 9,964 house households and 40,850 of total population in its catchment area. This catchment area is divided in to five geographic sub-catchment called 'ketenas'. The health center has 89 health professionals of which 18 of them are UHE-ps and 3 supervisors. The FHT of the health center compromises of a BS.C nurse, clinical nurses, HO, UHE-p and other health professionals including psychiatric nurse and midwife who joins the team when needed.

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