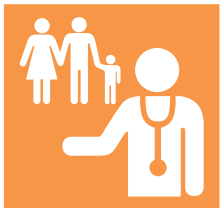
ETHIOPIA'S PRIMARY HEALTH CARE SYSTEM IN URBAN AREAS



INTRODUCTION

In urban areas of Ethiopia, basic primary health care (PHC) services are provided by urban health extension professionals (UHE-ps), at public health centers, private clinics, and other health facilities run by nongovernmental organizations. One health center (HC) is expected to provide primary health care services to approximately 40,000 people. HCs provide preventive, health promotion, and curative services for basic care such as comprehensive maternal and child health services, including delivery. UHE-ps, each of whom serves 500 people, make home visits, educate community members, visit schools and youth centers, mobilize community members, and establish referral linkages to enhance health promotion, preventive, and curative care.

GOVERNANCE AND HUMAN RESOURCE

The way PHC is set up in urban areas varies from place to place. For example, in Addis Ababa the HCs are well-organized and adequately staffed, with an average of 60 technical staff (health officers, nurses, laboratory technicians, pharmacy technicians, environmental health experts) per center. Each HC has an average of 15–20 UHE-ps, depending on the population covered. But HCs in urban areas outside Addis Ababa have an average of 30 technical staff, which is significantly low.

The HCs are led by a medical director and have disease prevention and health promotion departments that are responsible for preventive and promotive care, including coordinating UHE-ps under their catchment. Each HC also has a curative department and an administration and finance department. Health centers report directly to sub-city health offices, although they work closely with the Addis Ababa City Health Bureau. Recently, the government created woreda health office structures, but they are not fully functional and their role is not well-defined.

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In Harari and Dire Dawa, city administration HCs are directly managed by the regional health bureaus, with UHE-ps reporting to HC. In these city administrations, health extension worker activities get relatively better attention from the health system. On the other hand, in cities and towns in the four agrarian regions (Amhara, Tigray, Oromia, and Southern Nations, Nationalities and Peoples), the health centers report to either zonal health departments or woreda health offices. In these regions, urban health centers are inadequately staffed relative to the population they serve. On average, these health centers have 20–30 technical staff but cover similar numbers as HCs in Addis Ababa. While UHE-ps are assigned based on the standard 1: 500 household ratio, they are not uniformly provided with technical supervision and support, as mandated by the revised Urban Health Extension Program Implementation Guide. Reasons include a lack of human resources, administrative feasibility, budget, and lack of health center management and staff commitment.

In addition to the technical and administrative relationship that exist between HCs and zonal or regional health departments, almost all HCs have governing boards comprising kebele leaders, representatives from woreda or town administration, HC directors, HC staff and health extension workers or professionals. The establishment of governing boards enhances efficient decision-making by cutting bureaucratic chains and increases the responsiveness of health institutions to their local communities. The governing board approves the health facility plan and budget, decides on revenue retention and use, reviews implementation of the new fee waiver system, and evaluates performance of health facilities, among other duties. Additionally, governing boards enable HCs to advocate for more resources and implement innovative income-generating activities that could improve service quality.

Unlike rural areas, community structures in urban areas are not well-organized. The health development army is functional in some but not all cities and towns. The lack of a community-based structure that fits the lifestyle and context of the urban set up hinders community engagement with the PHC system.

The other challenge is that HCs lack coordination with key relevant government sector offices like the municipality, water and waste disposal offices, women and child office, youth and sport offices, and law enforcement. This makes it difficult for UHE-ps to execute their tasks well, particularly those related to water, sanitation, and hygiene. Another gap is the lack of any formal relationship between the private sector and health centers.

Health management information system: The Ethiopian Health Management Information System (HMIS) was implemented in 2008 to capture and provide core indicators to improve the provision of health services, and ultimately, to improve health status of the population. HMIS reports are used for varied decision-making processes in almost all urban HCs.

Health care financing reform: Generally, the financial sources for HCs are budget allocated by the local government; revenue collected from user fees, sales of drugs, and other medical supplies; fees collected from wavering services and insurances; sales of non-health goods and services (renting of rooms/hall, selling of grass, etc.); and in-kind or cash gifts or donations. Improving retention and use of health care financing reforms (HCFR) is a key financial mobilization strategy. HSDP IV has set a target of increasing the proportion of public health facilities retaining and using their revenue from 20 to 100 percent. Since implementation of the HCFR began, regions have formulated proclamation, regulations, directives, and implementation manuals to align with the national strategy. The HCFR is being implemented in almost all urban HCs except new ones.

The amount of retained revenue generated by health facilities varies by facility and region. On average, HCs generated 30 percent of their total budget, while hospitals generated 23 percent from retained revenue. Hospitals on average retained ETB 1.56 million per year, while HCs retained ETB 0.37 million. The retained revenue has improved the availability of essential medicines, diagnostic equipment, and medical supplies. It is also used for renovation and expansion of rooms and staff housing.

INTRODUCTION OF URBAN PRIMARY HEALTH CARE REFORM

The urban primary health care reform being piloted in Addis Ababa and regional towns require each HC to have adequate technical staff to form five family health teams. Each team is led by a senior clinical staff (medical doctor or health officer or BSc nurse) and has clinical nurses, health extension professionals, environmental health professionals, and other staff type as needed and available. Although the staffing structure is strong in Addis Ababa, the staffing and administration structures of HCs in other urban areas need extensive restructuring. These HCs must double the number of technical staff from the current average of 30 to 60 by hiring more medical doctors, health officers, and nurses.

References:

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