1. Introduction

1.1. Background

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 inhabited in urban centers. 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 inhabited in urban centers (UN-HABITAT, 2007). Even though there are more than 900 urban centers in Ethiopia, the number of people living in urban centers is growing rapidly.

1.1.1. Urbanization

According to EDHS 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 in Addis Ababa are accounted for non-communicable diseases, and issues in sanitation and waste management are prominent among urban dwellers.

1.1.2. 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 services, and are networked with hospitals for secondary and tertiary care. The community-based activities of urban health extension workers are linked to the health centers. In some urban settings, Health Extension professionals (Nurses with additional three months training) are directly accountable to the health centers; in some, 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 impose significant burden in urban settings.

1.2. Challenges of primary health care services

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

- Loose linkage between community and facility interventions
- Limited number of administrative staff in health centers
- 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…)
- Attrition of Health workers mainly HEPs
- 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 bed, poor adherence to protocols (information to clients, use of referral slip, alert call, escorting and feedback)

1.4. Lessons from other countries

In due course of recommending the redefining of PHC in envisioning the future of the health sector in Ethiopia, series of consultations and reviews were made with various countries - middle income countries with better health profile and had similar Gross Domestic Product (GDP) with Ethiopia before 30 years. Based on information gathered during the workshop and desk reviews, the Cuba’s and Brazil’s primary health care system were found to be interesting to demonstrate in urban context.

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

- Have 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 PHCs 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
- Less than a third of households were visited by health extension professionals
- 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 quality and equitable services to the community at the primary health care unit level.
The main purpose of the team based approach is to ensure every household has easy access to all spectrums of health care services using the Family Health Team (FHT) as an entry point. The team will be formed by two physicians/health officers/BSC nurses, 2 diploma nurses, 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 family health team as deemed necessary. The team will thus split into two sub-teams – Facility based and Community based team. On average one health center might have five family health team and each Family health team will be assigned to specific section of the catchment woreda.

2.2. Team based approach

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

2.3. Service delivery modality

The service delivery will have three parts: facility, household, and community level interventions. The facility level intervention follows the existing service delivery modality, however, the 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 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 could be categorized and prioritized based on their risk factors, diseases, and income levels.

Table 1: client categorization mechanism

<table>
<thead>
<tr>
<th>Over all Category</th>
<th>A (Lowest Quintile (1st and 2nd quintiles))</th>
<th>B (Medium Quintile)</th>
<th>C (Highest Quintile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Pregnant women and children U-5 year</td>
<td>CAT IAI (1st priority)</td>
<td>CAT IB</td>
<td>CAT IC</td>
</tr>
<tr>
<td>II: Chronic and NCDs (DM, CVDs, Cancer, Asthma)</td>
<td>CAT IIA (2nd priority)</td>
<td>CAT IIB</td>
<td>CAT IIC</td>
</tr>
<tr>
<td>III: Others</td>
<td>CAT IIIA</td>
<td>CAT IIIB</td>
<td>CAT IIC</td>
</tr>
</tbody>
</table>

The team at 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, 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 level, the team will cover schools, youth centers, and streets for homeless people, and workplaces.

2.4. Service packages

The family health team is putting together services which can be provided at household and community levels. The following table lists the type of services to be provided at the household and community level.

Table 2: List of health service packages

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Nutrition</td>
<td>1.2. Management of childhood illness</td>
<td></td>
</tr>
<tr>
<td>2.1. Antenatal Care</td>
<td>5.1. Hypertension and other cardiovascular problems</td>
<td></td>
</tr>
<tr>
<td>2.2. Delivery Care</td>
<td>5.2. Cancers</td>
<td></td>
</tr>
<tr>
<td>2.3. Post-natal Care</td>
<td>5.3. Diabetes</td>
<td></td>
</tr>
<tr>
<td>5.4. Mental Health</td>
<td>5.5. Asthma and other respiratory tract problems</td>
<td></td>
</tr>
<tr>
<td>6.1. HIV,</td>
<td>6.2. STI,</td>
<td></td>
</tr>
<tr>
<td>6.3. Malaria,</td>
<td>6.4. TB,</td>
<td></td>
</tr>
<tr>
<td>6.5. Hepatitis</td>
<td>8. Hygiene and sanitation</td>
<td></td>
</tr>
<tr>
<td>4. EPI</td>
<td>10. Palliative care services</td>
<td></td>
</tr>
<tr>
<td>13. Services for Homeless</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.5 Other components of the reform

The family health team by its own will not bring the intended changes in the primary health care in urban settings. Other initiatives, such as, emergency service, referral and consultation network, role of private sector, occupational Health and safety are equally important. These changes will also not be successfully unless the health system establish or play 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 is 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 and private sector. However, for reaching every household with the intended services, community based health insurance will be a key component of the reform in urban centers. Availing these resources, thus, require very motivated and committed leadership at all levels of the health system.

2.7 Performance management

The reform does have 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. A lessons from those sites will be used to finalize and scale up the system.