



Assistance to Health Systems Expansion in Ethiopia

Structural Assessment of Primary Health Care Facilities in Five Regions of Ethiopia

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Introduction

In an effort to improve the country's health status, the Ethiopian government is implementing a 20-year health sector development program, which began in fiscal year 1996–1997 and is divided into four five-year periods, which are congruent with the timeline of the Millennium Development Goals. Since the 2010-2011 fiscal year, the government has been implementing the fourth health sector development program.

Although the government has made significant improvements in construction of health facilities and service coverage, it has much left to do in the area of quality of health care. Other developing countries share this situation. The main reasons for the poor quality of health care in developing countries are an overemphasis on increasing the number of health facilities and access (evidence suggests that the perceived low quality of health care could hinder people from attending health care services even if services are available) and a focus on inputs (including drugs, staff, electricity, and running water), rather than equal emphasis on the health care process. This suggests that the Ethiopian government's recent achievements in increasing the number of health facilities may not lead to a better health status, unless the health system embraces the idea of continual quality assurance and quality improvement.

Although little recent data exist on the issue, available evidence suggests that the health care system in Ethiopia suffers from structural deficiencies and poor outcomes, such as a chronic shortage of professionals, a lack of access to appropriate laboratory tests, high customer dissatisfaction with some aspects of services at government facilities, and a lack of appropriate medicines and equipment. The privacy of service provision is deficient, and service-providing facilities are unclean. Cognizant of such shortfalls, the Ethiopian government has emphasized improving the quality of health services in its fourth health sector development program. However, such efforts will be effective only if complemented by appropriate baseline data on the status of health care services at different referral levels.

Objectives

The overall aim of this assessment of health facilities was to measure the capacity of the primary health care infrastructure in selected regions of Ethiopia and assess the potential of the facilities to implement national intervention strategies in terms of current practices and available resources.

Methods

In 2011, the project conducted a facility-based descriptive cross-sectional survey using a quantitative

method of data collection. Conducted from April to July, the survey assessed the overall situation of hospitals and health centers in four heavily populated regions and one city administration. The survey used structured checklists based on national standards of the Food, Medicines and Healthcare Administration and Control Authority. It focused on 131 health centers and 25 hospitals. It included hospitals because they serve as the immediate higher referral level. The survey was conducted in the Addis Ababa City Administration and the Amhara, Oromia, Tigray, and Southern Nations Nationalities and Peoples Regional States.

Results

Most (121 or 92.4 percent) of health centers reported having client satisfaction measurement tools. Only 29 (22.3 percent) have functional backup generators with fuel and an attendant, and 87 (66.4 percent) are not friendly to patients with disabilities. Of the 126 health centers that reported having a safe and functional toilet, more than 92 percent have open-pit latrines. The majority (94 or 71.8 percent) reported that they do not have adequate numbers of health personnel. Laundry and sluice room services are available in few of the 114 health centers that claimed to provide inpatient services.

Slightly more than half of health centers (70 or 53.4 percent) provide minor surgical services. All surveyed health centers provide maternal and child health, voluntary counseling and testing, emergency, and immunization services. Most (91.6 percent) reported having adequately ventilated and illuminated emergency rooms and waiting areas. However, only 68 (51.9 percent) reported having an emergency room accessible to people with disabilities. Hospitals reported deficiencies in adequacy of personnel, equipment/instruments for professional practice, and fire extinguishers in pharmacies. Toilet and shower facilities were present in 17 service units (13.0 percent). Only 33 health centers (25.2 percent) have changing areas for staff, and 55 (42.0 percent) have cafeteria services.

All hospitals have extra reservoirs for water and reported the presence of safe and functional toilet rooms, 54.2 percent being pit latrines. The survey revealed a weak performance in documentation in hospitals. Slightly more than half (54.2 percent) have documented site plans. A quarter of the hospitals have inadequate numbers of standard treatment guidelines. A total of 22 (91.7 percent) hospitals provide antenatal care and 24-hour delivery service. Only 17 (70.8 percent) have separate rooms for labor, delivery, and postnatal services, and only 16 (66.7 percent) reported having reliable suppliers for drugs, medical supplies, and vaccines. Moreover, only 13 (54.2 percent) of the hospitals reported adequate finances to purchase supplies and drugs.

The survey showed that 21 (87.5 percent) of the hospitals have systems for managing nursing staff and have developed job descriptions for nursing positions. However, only nine (37.5 percent) have nursing workforce plans that define nurse-to-patient ratios for service areas. Eighty-seven percent of the hospitals have cafeteria services, and 95.7 percent have general stores. However, only three (13.3 percent) have toilet facilities at each service unit.

Conclusion

The survey documented health facilities' positive performance, especially in the types of services provided, but showed shortfalls in many structural aspects, such as human resources for health, backup generators, adequacy of finances, access to patients with disabilities, and the presence of important guidelines. This was true in both health centers and hospitals, although the magnitudes differ. Health offices at the regional and national levels, along with partners, should make an orchestrated effort to physically upgrade health facilities, as well as improve documentation and quality of service provision. Work on structural deficiencies should start in areas where swift changes are possible.

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