Tenama Beteseb (Healthy Family) through decentralized NCD care in Ethiopia

Final Annual Impact Report

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Addis Ababa, Ethiopia

Acronyms

AA	Addis Ababa
B/Gumuz	Benishangul Gumuz
FMOH	Federal Ministry of Health
FHT	Family Health Team
GP	General Practitioner
HC	Health Centre
HCW	Health Care Workers
HDA	Health Development Army
HEW	Health Extension Workers
HF	Health Facility
HL	Health Limited
HPA	Health Poverty Action
NCD	Non-Communicable Disease
PACK	Practical Approach to Care Kit
SNNP	Southern Nations, Nationalities and Peoples
THET	Tropical Health and Education Trust
SWEP	Southwest Ethiopian People

1.0. Background:

Non- Communicable Diseases (NCDs) are responsible for 41 million deaths each year, an equivalent to 71% of all deaths globally. Of these, 37% are premature deaths affecting those between the ages of 30 and 69. NCDs comprise a large number of conditions, although the four major diseases are, cardiovascular diseases, cancer, diabetes and chronic obstructive lung diseases. These four diseases account for 82% of all NCD deaths and receive the most attention globally. NCDs disproportionately affect people in low- and middle-income countries, where more than three quarters of global NCD deaths, and 85% of premature deaths occur.

In Sub-Saharan Africa (SSA), for instance, NCDs are common causes of mortality accounting for over half of all reported adult mortality in certain SSA countries. Furthermore, the burden of NCDs in SSA is expected to increase by 27% in the next ten years.[1] This heightened mortality is exacerbated by the fact that most of the sub-Saharan African population lives in rural areas, far away from large health facilities that offer NCD services. They have no local access to diagnosis, treatment, and care for NCDs, and are further prevented from accessing these services at hospital level due to the high cost associated.

[1] Clinton Health Access Initiative, Addis Ababa, Ethiopia;

Ensuring that people have access to quality NCD care is paramount. Access to quality NCD care addresses not only Sustainable Development Goal (SDG) 3.4 specifically but would contribute to better health and wellbeing overall by reducing vulnerabilities to communicable diseases and the burden of NCDs on the health system. Furthermore, a lower prevalence of NCDs also contributes to other SDGs by for instance, eradicating the financial burden on the patient, and the burden of care on their families.

1.1. NCDs in Ethiopia:

In Ethiopia, Non-Communicable Diseases (NCDs) are responsible for 43.5% of deaths. In addition, the Disability Adjusted Life Years (DALYs) increased from below 20% in 1990 to 69% in 2015. With no action, Ethiopia will be the first among the most populous nations in Africa to experience a dramatic burden of premature deaths and disability from NCDs by 2040. However, the national response to NCDs remains fragmented with the total health spending per capita for NCDs still insignificant.

82% of Ethiopia's population lives in rural areas. They often live in poverty and have a substantial and increasing burden of NCDs, however, health care for NCDs in these rural areas is very limited.[2][3] Available primary care is directed towards the prevention and treatment of infectious diseases or maternal/child health, while services for NCD patients are still largely restricted to the secondary or tertiary hospitals found in the larger towns and cities. It is difficult for rural patients to attend these hospitals due to associated costs of travel and accommodation. There is, therefore, an urgent need to decentralize care and integrate the management of NCDs into the primary health system.

NCDs and their complications are responsible for over 40% of the deaths in Ethiopia, with patients in rural areas particularly affected. Since the Federal Ministry of Health's (FMoH's) NCD Strategy was launched in 2014, NCD services have been expanding, with THET supporting 60 sites in 6 regions under Novartis Social Business. Despite the success of the project, major gaps remain which continue to hinder access to quality NCD treatment and care. There is no single root cause or contributing factor affecting NCD care, therefore a holistic approach addressing the multiple causal factors is needed to ensure lasting impact.

2.0. Programme Overview:

The "Tenama Beteseb (Health Family) Through Decentralized NCD Care in Ethiopia" is a project implemented by Health Poverty Action/ Health Limited in Ethiopia in collaboration with THET with funding from Novartis Social Business Fund. The project is an extension of the previous project which started in 2018, with aiming at scaling up decentralization of NCD treatment and care to 60 sites in Ethiopia.

The project aimed to develop the capacity of general practitioners (GPs), nurses and other primary health care workers at hospital level including nurses, health officers, pharmacists, laboratory technicians and data officers at health centre level, and health extension workers

[2] Negin J, Cumming R, de Ramirez S S et al. Risk factors for non-communicable diseases among older adults in rural Africa. Trop Med Int Health. 2011;16(5):640–646.

[3] Mamo Y, Seid E, Adams S et al. A primary healthcare approach to the management of chronic disease in Ethiopia: an example for other countries. Clin Med. 2007;7(3):228–231

(HEWs) at the community level. All these health workers are tasked with tackling NCDs in their communities. They were trained, supervised, and mentored in their roles throughout the project period. This entailed health centre staff being trained to diagnose, treat, and care for NCD patients as effectively as staff at hospital level. HEWs posted at the grassroots level were trained to raise awareness about NCDs and facilitate referrals of community members for diagnosis and treatment. In terms of geographic coverage, the project focused on 14 hospitals and 45 health centers in Addis Ababa, Amhara, Oromia, SNNPR, SWE, Benshangul-Gumuz, and Afar as agreed with the FMoH, a key partner in the intervention.

To date, in the areas indicated above, the project led to the screening of almost 369,434 people, enrolment of 19,239 patients in NCD treatment, training of 17 GPs, 208 health care workers and 602 HEWs, and education of 582,101 community members. All of this has been underpinned by the link we've created between the 45 health centers, who are supported by a network of FMoH and regional health bureau supervisors and mentors (Master Trainers) running the NCD care decentralization program.

The project aimed at increasing access to and improving the quality of NCD care in rural areas of Ethiopia by addressing the needs that exist at a community, health facility and national health systems level. This has happened through educating the community using IEC/BCC materials & HEW outreach, training healthcare workers to diagnose and treat NCDs, improving medical record keeping as well as ensuring better patient follow up and care.

The project also aimed at addressing four specific aims as denoted below.

Specific 1: To improve the knowledge and skill of primary health care providers in NCDs prevention, screening, diagnosis, and management.
Specific 2: To maintain quality service through ongoing mentoring and supportive supervision of health care providers in the respective health facilities.
Specific 3: To raise awareness and promote health seeking behaviour of the community in NCDs.
Specific 4: To generate information and disseminate to MOH and stakeholders on NCDs drug supply to ensure/inform appropriate drugs supply mechanism.

2.1. Key project activities (components) and achievements

2.1.1. Improved access and availability of quality NCD services in 15 hospitals, plus 45 health centers in six regions and one city administration.

The project has played a significant role in improving access and quality NCD services in the target health facilities by strengthening the health system and leadership in the health facilities as well as offices (including regional and local health offices). A much higher attention to NCD care has been witnessed in the health facilities which has resulted in establishing an OPD NCD clinic in the health facilities, which was not the case before the implementation of the project. The focus towards NCDs at leadership and health worker level has created increased access to NCD services in the facilities.

Planned: The project aimed at expanding access to NCD services by screening 200,000 people and enrolling 15,000 patients to treatment of NCD services at all health facilities.

Achieved: A total of 369,434 people were screened and 19,239 (5.2%) were enrolled for NCDs. Among enrolled cases, hypertension was the most common diagnosis (74.4%) followed by diabetes (12.2%), chronic respiratory disease (9.3%) and epilepsy (4%).

2.1.2. Improved capacity of health workers to screen, treat and manage NCD cases:
The project has improved the capacity of primary health care workers through capacity building training on NCDs. This has enabled them to be confident and manage NCDs at health center level which was not the case before. NCDs (Chronic care) were used to be treated at hospitals and specialized health facilities where the resource and personnel are limited and competing over other complicated care. However, through our decentralization and task shifting approach, we have trained GPs by qualified specialists so that they can cascade the training to primary health care workers (such as nurses and health officers) which will contribute towards higher reach and access to patients at lower/primary health facility level. ***Planned:*** The project planned to train 15 GPs who will conduct cascade training and mentoring in the health centers and 180 primary and mid-level health professionals to lead screening, enrollment, and treatment of NCDs.

Achieved: Trained 17 GPs and 208 nurses and health officers from project supported health facilities to deliver quality diagnosis, treatment, and care to NCD patients.

- Trained 602 health extension workers on the risk factors, symptoms, and diagnosis of NCDs, and the referral systems.

2.1.3. Improved community engagement at the catchment areas of the target health facilities:
The project has implemented awareness raising activities using HEWs, by furthering engagement with churches, mosques, and community leaders with a view to designing further awareness raising events collaboratively. The main topics addressed were education on what NCDs are, major risk factors, available services at health centers, referrals, and on improving health seeking behavior.

Planned: The aim was to improve awareness raising initiatives at community level in the project sites reaching 500,000 people.

Achieved: Almost 600,000 individuals were reached with health education on NCDs to improve health seeking behavior.

- Distributed a total of 25,000 copies of brochures and 1,000 posters across the target locations on NCDs, risk factors, and available services in nearby health facilities.

2.1.4. Improve quality of services delivered at health facilities through conducting mentorship and supportive supervision:
The project has implemented mentorship as a key approach to transfer and cascade skills from GPs to other primary health care workers who work in the target health facilities. GPs were identified to received Training of Trainer so that they can train, mentor, and closely support nurses and health officers in their catchment areas on a regular basis. The aim of this approach is to empower the primary health care workers in delivering quality and improved NCD care at health center setting which will ultimately contribute towards increased access and quality of NCD

service in the community. On the other hand, supportive supervision has been planned to closely monitor, support, and identify administrative gaps in delivering NCDs at facility level and this has been mainly done by officials from regional, zonal and district health offices who are also the responsible authorities of the interventions.

Planned: The project aimed to conduct 180 mentorship and supportive supervisions

Achieved: A total of 237 mentorship and supportive supervisions were actually held to identify problems and challenges faced by health workers in their workplaces.

Table 1: Summary of achievement against targets set.

Indicator	Targets set	Number reached	Achievement
Number of screened	200,000	369,434	184.7%
Number of enrolled to treatment	15,000	19,239	128.3%
Number of Mentors trained	15	17	113.3%
Number of Primary health care workers trained	180	208	115.6%
Number of Health extension workers trained	600	602	100.3%
Number of Mentoring & supportive supervision conducted	180	237	131.7%
Number of episodes of health education conducted	540	695	128.7%
Number of beneficiaries reached with health education	500,000	582,101	116.4%

3.0. Lessons learnt:

- Decentralization of health services for NCDs closer to the community is an approach that addresses access, quality, and coverage. It does not only bring services near to the people's homes but also aids in achieving high coverage and removal of barriers to access.
- The project has also decreased the unnecessary burden to hospitals and burnout of the very few specialists when most of the problems could be addressed at the lower health care tiers. Hospitals will then be able to give their undivided focus on those that need their attention more, their highly specialized personnel equipment for evaluation and interventions where it matters most and to those filtering up to them. Taking services from the top of the pyramid of care such as highly specialized referral and teaching hospitals to regional, and primary tiers then to the health posts requires strengthening the services at these various levels so that tasks are shared appropriately.
- Primary care interventions produce more health seeking behavior, resulting in more screening and earlier detection. So, this intervention should be scaled up and we have witnessed that this will work.
- Engagement of leadership at all levels (starting from FMoH to facility and community) is key in creating ownership, smooth implementation and improving quality of services on NCDs. We have witnessed the importance of intensive and close collaboration with all including

facility leadership in improving the service, addressing gaps at local level without expecting support from outside and filling gaps.

4.0. Contribution towards sustainability:

- The existing health system is strengthened; a separate chronic follow up clinic (for diabetes and hypertension) is opened. This will enable the supported facilities to continue their work.
- Local ownership is created: Due to the support provided and high level of engagement of leadership from MOH to facilities, there is a strong and improved level of ownership on NCDs. In addition, the project has created a culture of assigning NCD focal person at facility level and this has been seen as a best practice by MoH. In addition, the management of health facilities have included NCD as a priority area and they regularly monitor NCD activities on monthly basis.
- The capacity of health workers and health facility leaders have been built through training and strengthening the system. This will enable them to run the NCD clinics and embed supervision and mentoring into their day-to-day job roles.
- Tools and easy to use job aids have been developed and provided to facilities which will enable them to continuously create demand creation at facility as well as community level.
- Mentoring has been a key aspect to sustain the interventions where the facilities will exchange skills and support from the nearby networked hospitals. This will enable them to get an on-job training to transfer skills and build the capacity of new primary health care workers.

5.0. Challenges

- Shortage of medical supplies, and bureaucracy around procurement and distribution of medicines, are among the main bottlenecks for delivering NCD services in different settings.
- Although this has improved, there is a gap in terms of referral and linkages for transfer of patients into and out of the facility which might need policy advocacy.
- Delayed drug supply from EPSA which has led to increasing number of lost to follow-up.
- Limitation of resources to support and expand best practices, innovative community engagement approaches, digitalization, and policy advocacy issues.
- Staff turnover required continued training to fill the gap and this had placed it challenges on the use of limited resources.
- Has been difficult to maintain data quality due to limited number of staff who had to closely monitor and support all the 60 sites under our sphere.

6.0. Way forward

The project has been instrumental in improving access to and quality NCD services in the supported health facilities. The support has enabled health facilities and health workers to build their capacity to deliver services, improved service provision, and increased access. However, given the focus towards NCD is at infant stage at all level, the support needs to be intensified and should address areas where there are critical gaps and needs in improving quality of NCD care in the supported sites and expand what has been done in new sites.