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Faculty of Health Sciences

How are health professionals facing the NCDs challenges in the current Tunisian context of transition

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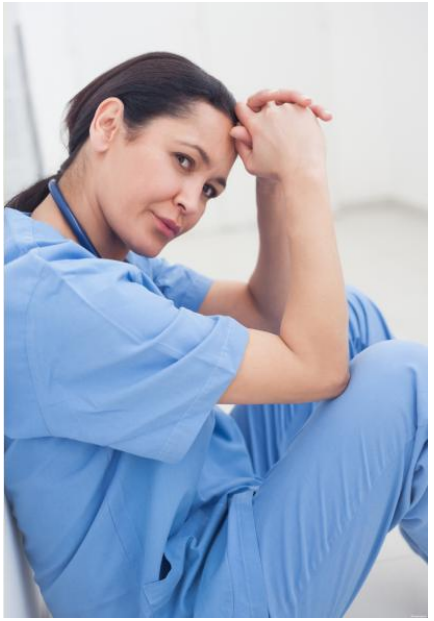

INTRODUCTION

- Tunisia a MICs considered as having one of the most **successful socio-economic transition** in the region
- this picture has been widely **disrupted after the popular uprising of 2011**
- The situation is characterized in this period of democratic transition by a **political instability** and **economic constraints**.
- In addition to some successes such as **the adoption of a new constitution** ensuring freedom of conscience, equality between citizens especially for women, and right to health.

Reference: UNDP (2009). Human Development UNDP Report 2009

Tunisian Context

- However, there is an accumulation :

-growing ***social vulnerability and regional disparities***

-growing ***budgetary constraints*** following the fading of the economic model

-the ***recent popular appraisal of January 2011*** that further complicated the situation.

These problems have <u>hampered the functioning of the Health system, weakened its performance</u> and <u>created a crisis of confidence among users</u>.

Reference: National situation analyses of current policy and health system contexts: Peter Phillimore & Shahaduz Zaman, Newcastle University, UK

Epidemiological Transition

- In parallel, There is a speed upset of ***New dietary habits and increasing sedentary lifestyles*** correlated to a
- ***growing burden and challenges in managing Non Communicable Diseases (NCD*)** in this critical historical juncture.
- **Diabetes** contributes substantially to this burden with most recent studies estimating the prevalence of diabetes in 2005 to 15.1% of Tunisian adults aged 35 to 70 years, corresponding to an increase of 52% in ten years.

References: Bouguerra et al 2007, Ben Romdhane 2014.

OBJECTIVE

- To gain insight into “**how Diabetes's care professionals are facing NCD’s challenges in this critical historical juncture**”

METHODS

- This study was planned to be conducted in 2014 in **three health care centers reflecting different levels of care**: (i)a primary health care center **(PHC)** , (ii)a **regional hospital** and (iii) the **only reference center for diabetes (INNTA)** located in the capital Tunis while the two first ones were located in the third most populated city of Tunisia Nabeul, located in the north east.

Unpredictably, the study included **only the PHC and the INNTA** because of one departure and one long term leave of the only two specialists integrated in the regional hospital.

METHODS

- Direct interviews were conducted with seven HCPs: a medical professor, nutrition specialist, training doctor and a nurse from the consultation department of the hospital and two general practitioners (GPs) and one nurse from the PHC.

- Semi-structured and self designed questionnaire :
- **quality of care provided in their clinics**,
- **main difficulties encountered** in their practice,
- **resources available** and finally **suggestions for improvement**.

Moreover 40 patients were asked about their satisfaction.

RESULTS

1) Process and outcomes

- Diabetes quality of care was judged by the majority of health care providers (4/7) as average, with some discordant point of view.
- The most optimistic were PHC's GPs saying that quality of care in their clinics was ***"generally good except that there are many things to correct and improve for example the waiting time is very long, the expectations rooms are very crowded"***.
- While the hospital intern was frustrated, saying that "***appointments are further apart than it should (six months instead of three), the blood pressure is not measured in all consultations given the large number of patient by doctor, finally the ECG are not done every year ,as well as patient's education is difficult"***.

1) Process and outcomes

- The specialist in the INNTA confirm that fact

  "The main difficulty is the overloading of the consultation; it is mainly the large number of consultants by physician that is dramatically reducing the time spent in each consultation in relation to the recommended half hour…we get no help from nurses as they are consumed in tasks they are not supposed to do (bring records, balance sheets, call patients ...".

- The professor of the INNTA said that the problem of the 3rd line hospitals in general is structural, indeed patients short circuit first and second levels of care to the reference centers.

1) Process and outcomes

- This had seriously affected process of care in the INNTA as voiced by patients of the INNTA who complained about lack of consideration by doctors **“the doctor doesn't even look at me, he is always busy with the medical records ” .**
- Patients also complained of miss clarification of the diabetes equilibrium and specially blood exams in both centers, but criticism were more pronounced in the hospital, making it harder for them to learn about the progress of their disease and the treatment expectations of the clinic.

2) Resources: equipment and investment

- Lack of resources was pointed out differently according to the context. The educative nurse in the INNTA said about her experience in diabetes education ***"The biggest problem is the lack of resources (no data show, no computer, no educational materials ...), in fact I work with my own, I am the one who supports and organizes meetings with my modest tools".***
- The Professor highlighted the difficulty cited above ***"The diabetes education should be audiovisual with scrolling messages carefully selected and adapted to a homogeneous target audience (children, youth, elderly, pregnant women), unfortunately we do not have such resources to do therapeutic education correctly"*.**

2) Resources: equipment and investment

- While, treatments availability and Glycated hemoglobin testing was specifically cited by the PHC's GP ***"…….and do not forget that the determination of glycated hemoglobin is not always available despite the fact that it is of a primary consideration,…… we must make new molecules available at clinics".***
- The other GP confirm that proposal "***the main difficulty is to obtain new molecules used in the treatment of chronic illnesses in clinics".***
- Unexpectedly, Referral to specialists was not voiced as problems to them, since they consider themselves not facing much difficulty in managing their patients.

3) Staffing: experience and outlook

- Specific aspects to each context of care were raised:
- In the hospital, doctors inspired to computerize boxes of consultation and medical records, as the specialist said ***"to equip medical consultants with a computer and a printer to computerize patient records and archive".***
- Concerning education, the intern proposed ***"I think the presence of an educator nurse will settle many problems in outpatients. Also educational video will be more effective than posters especially that patient spends hours in the waiting room; we could invest that time spent in education".***

3) Staffing: experience and outlook

- For the PHC, proposal of improvement were more basic such providing treatments, Glycated hemoglobin testing and recruiting nutritionists. The main obstacle to implementing these measures is simply lack of resources since budgetary allocations process is central and not flexible.
- While for the hospital Professor ***"The budget is available, since INNTA has its own recipes, but the manner of using the budget is not effective in the absence of priorities identification, the INNTA is managed by administrators who are not very sensitive and difficult to convince about the effectiveness of technical measures".***

Key Messages…

- So when the study took place, **there was no specialized outpatient care in public sector for Nabeul's diabetics**. When needed patients were directly referred to the third line. Interviews highlighted three main themes:

✓ **Overloading of teaching hospital and a consequent tense labor relations climate: clinic staff feeling pressured by their lack of technicality, and patients feeling misconsidered and their own needs ignored.**

✓ **chronic treatments shortage and lack of basic biological testing in the PHC .**

✓ **Problems of governance and priority setting in both HCC.**

- **Nevertheless,** this results must be extendable to other PHC cautiously…

DISSCUSSION

Structural Governance Failures in : Macro Level
Meso Level
Micro Level

Macro level

- Nowadays, **shortage of specialists** in public sector ranks among highly controversial failures of the health system.
- Meanwhile, the know-how acquired by **staff of primary health care** and the framework established **would be better invested** in tackling health issues related to the transition such diabetes. Such reorientation of the first line was engaged decades ago but wasn't effective, due to lack of funding (H Ben Romdhane et a. ***Health system challenges of NCDs in Tunisia***l, IJPH 2014)**.**
- Funding problems, are responsible for the lack of **basic treatments** and very **useful biological tests in the PHC** equipments, so patients are referred up to regional and teaching hospitals to perform such exams, but fail to come down to GPs.

Macro-Meso Level

- For Hospitals, **budget allocation is highly centralized**, disconnected from the reality of health care facilities. **Administrative procedures are heavy** and complicated and provides no incentives for performance and improvement initiatives. Budgetary constraints following the appraisal of 2011 had compounded the situation.
- Greater **decentralization** and accountability could contribute to:

➢ adapt health system to local conditions

➢ greater openness to new forms of financing

➢ Improve governance and accountability process in health facilities (meso level) so continuous quality improvement and evaluation systems can be implemented.

Référence: Contandriopoulos A.P. (2008). Santé publique.

Micro Level

- Evident in our interviews but also in previous study, was the lack of humanism and communication perceived by the user from the professional, this has severely affected the trust in their relationship (***Faten Tlili et al, IJPH 2014***)
- From a patient focused care perspective, patients must have "***sufficient support and knowledge to actively participate in their health care***": **we do not yet have this vision of care !!!**
- However as the TAHINA (2005) study reported, ***Tunisian health professionals*** are not trained enough to improve their attitudes and relational quality in order to for a more 'patient centered' approach.

CONCLUSION

- Achieving equitable, safe, effective and high-quality care for patients across the spectrum of type 2 diabetes is no small task. It requires a coordinated interaction between patients, healthcare providers and the healthcare system.
- Currently in Tunisia, it is well recognized that any health reform process is obscured by the growing popular anger and finance difficulties accentuated by the recent popular appraisal of 2011.

- Fortunately, in addition to political instability, revolution brought a new culture in Tunisia, that of dialogue and health democracy.
- the “Health National dialogue“ is an original approach for two reasons: it involves for the first time citizens and the entire health care system, not on a particular health topic. For the first time the citizen is recognized to be central to the health system as well as professionals.
- First results are promising, that’s why such an approach have to be widespread in local scale, to ensure that users and professionals voices are mutually and vertically heard.

Health care providers and patients

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