

AZERBAIJAN

Transforming primary health care during the pandemic

APPLYING PARTICIPATORY APPROACHES IN DESIGNING A STRONGER SERVICE DELIVERY MODEL IN REMOTE RURAL AREAS

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MOTIVATION

In a change process focusing on improving the quality and accessibility of primary health-care services, it is valuable to evaluate health priorities and the learning needs of primary health-care workers through participatory methods. It is equally valuable to assess the community's attitudes, expectations and perceptions towards primary health-care services as important determinants of utilization and access (1).

A participatory approach through community and health workforce engagement for health needs assessment and service design was followed in the Shamaki District (106 000 population) of Azerbaijan in the context of a comprehensive primary health-care strengthening project (PROACT-Care). The project aimed to strengthen primary health care to respond to the disruption of essential health-care services in the context of COVID-19. It will also serve as a pilot testing site for a new primary health care model for the whole country. The participatory, bottom-up approach was applied to obtain knowledge for action, which considers local priorities (2), processes and perspectives.

DELIVERING PRIMARY HEALTH-CARE SERVICES IN RURAL AREAS

The health system in Azerbaijan is based on the Semashko model (3), in which ambulatory facilities (polyclinics) provide both primary care and outpatient specialist services. Other primary health-care facilities are village medical points and village or town doctor points. In village medical points, non-physician health-care workers provide primary care to a population of about 500–1500 people in rural areas. Village or town doctor points are staffed by one therapist (internal medicine doctor for adults), one paediatrician, midwife, nurse and/or feldsher and manage most common health conditions, antenatal care and major preventive services, including immunization. A village or town doctor point typically has a catchment population of 2500–4000 people. Village hospitals provide services through rural physician clinics plus delivery care, laboratory services and dental care. With the rollout of compulsory medical insurance since the beginning of 2020, all village hospitals were transformed into primary health-care facilities, and inpatient care services were referred to central district hospitals.

Currently, poor infrastructure, absence of medical equipment, shortage of health-care workers and lack of training are limiting the scope and quality of primary health-care services. Most primary health-care facilities do not have access to a central water supply. The shortage of physicians in rural areas has worsened through a combination of low salaries and existing physicians retiring and not being replaced. As a result, currently, primary health-care facilities and services in rural areas are either not operating or rarely used by the community.

A PARTICIPATORY HEALTH SYSTEM ASSESSMENT

To strengthen the delivery of primary health-care services in rural areas, participatory assessments were carried out with two different resource groups: primary health-care workers and community representatives.

A coordination group was formed, creating a network that includes all health-care authorities, financial and educational institutions related to primary health care in Azerbaijan and the local government of the district, which helped to foster community participation during the assessments.

1. Organizing focus group interviews with primary health-care workers

The goal of the focus group discussions with primary health-care workers was to identify the priority health problems in the area and to describe the necessary knowledge and skills to provide relevant high-quality health-care interventions.

A total of 42 health-care workers (doctors, nurses, midwives and feldshers) participated in 7 focus group interviews, representing 47% of all health-care workers from 27 primary health-care points in Shamakhi. The sampling aimed to involve all types of health-care professionals in the focus groups, and sufficient participation was achieved.

A dual moderator model was carried out using a semistructured focus group guide (4) comprising nine questions with 2–7 probes for each. Focus groups were stratified according to two main categories: urban versus rural settings and type of health-care profession. Interviews were carried out by two researchers. The local project manager was present as an observer, whose presence was useful in preventing misunderstandings and detecting verbal and non-verbal communication.

Besides qualitative data, quantitative data were collected. A form consisting of a list of primary health-care services related to noncommunicable diseases and maternal, newborn and child health was given to participants, who were asked to set priorities for these services, assess the competencies of primary health-care workers for these services and state whether they would be able to provide this service if they were trained.

Focus group participants initially perceived this exercise as a test and inspection. The moderators ensured the participants that the purpose was to improve the service delivery in the area. The initial hesitation was overcome quickly.

2. Setting up focus group interviews and phone surveys with the Shamakhi community to analyse their needs and participation in the change process

Community engagement was deemed an integral part of the overall project in Shamakhi, a typical rural area of the country.

Focus groups were organized for generating hypothesis on local features of community engagement (5) and for identifying authentic ideas, themes and concepts to be used in developing the items of the survey instrument.

The local government hosted the meetings, and trained consultants chaired the sessions. A semistructured topic guide including 14 questions and probes was used. A total of six focus groups were conducted, with support from UNICEF, and groups were stratified according to gender, urban versus rural settlements and availability of health-care facilities nearby.

Based on the results from the focus groups, a survey questionnaire was designed and a telephone survey was conducted in February 2020.

Data were collected from 300 respondents: 100 from the city and 200 from 31 rural villages.

Box 1. Example questions for focus groups

1 What do you think about the current situation of health care where you live?

Has it improved or worsened over the past five years? If so, in what ways?

What do you think causes the most health problems in your community?

Who uses local family health centre or village medical facilities? When and why do people use them?

2 How do you get information about health services? (Prompt: this may include word of mouth, newspapers, and online sources, among others)

3 How would you describe the relationship between health-care providers and the community in the area you live? What, if anything, could be done to improve this relationship?

4 Besides health-care providers, who most enables people to stay healthy where you live? (Prompt: this may include family members, teachers, social services providers, NGOs, community workers, employers, and any other community members.)

FOCUS GROUP FINDINGS FOR PRIMARY HEALTH-CARE WORKERS

Raising awareness on the concept and potential of primary health care emerged as a priority. The participants were not fully aware of the concept of primary health care and mostly perceived primary health care as “first aid”. The potential of it becoming a responsive and effective first contact care and increasing the comprehensiveness of primary health-care services was very welcomed. Nevertheless, the participants defined and emphasized accessibility and coordination aspects of primary health care as priority features.

Expanding the scope of work and competencies of all primary health-care workers is vital for increasing responsiveness and effectiveness. Primary health care currently functions like traffic police, by just referring people with noncommunicable diseases to specialist care after very basic triage. Internists are not engaged in health promotion and disease prevention activities and assume limited roles in chronic disease management. For example, internists do not consider ECG assessment as their business; they think only that cardiologists should order and assess ECG. Nurses’ and feldshers’ work is mainly limited to vaccination, drug administration and basic emergency care. Non-physician health-care workers do not generally examine children or pregnant women; they do not even take anthropometric measurements or assess risks by taking personal history. Nurses reported vaccine hesitancy as an increasing problem in the past five years and highlighted their need to learn ways to deal with this.

The primary health-care workers identified noncommunicable diseases, immunization and maternal, newborn and child health services as top priorities. The priority primary health-care services list used in the focus groups on learning needs revealed that both physicians and mid-level health-care workers gave top priority to anthropometric measurements, risk assessment tools and strengthening the self-care capabilities of patients with noncommunicable diseases. Immunization, well child follow-up and family planning were the top priority topics for services related to maternal, newborn and child health.

Improving primary health-care infrastructure and equipment is critical.

Unanticipated needs were mentioned during the discussions beyond the original focus. Although the focus was on the learning needs of primary health-care workers, the need for substantial infrastructure improvements of the buildings, the lack of running water, heating, uninterrupted electric power and public transport were emphasized in all groups. In some places, health-care workers made repairs using their own money; in others they started to work from home. There was a shortage of health-care workers, and the generally advanced age of health-care workers constituted an actual threat for the workforce. Primary health-care centres generally had very basic furniture and had sphygmomanometers and stethoscopes owned by health-care workers themselves as medical equipment.

“A PARTICIPATORY APPROACH CONNECTED THE VOICES OF HEALTH-CARE WORKERS AND THE LOCAL COMMUNITY IN RETHINKING AND SHAPING A NEW PRIMARY HEALTH-CARE MODEL.”

FINDINGS FROM THE COMMUNITY FOCUS GROUPS AND TELEPHONE SURVEY ON HEALTH NEEDS

Community members identified inappropriate water supply, poor nutrition, suboptimal infrastructure and lack of public transport to the closest health facility as the most important problems.

Respondents mentioned poor trust, lack of competencies and low utilization of primary care services, suggesting that the relationship between primary health care and the communities has ample room for improvement.

The early results of a phone survey on community engagement revealed low levels of regular engagement in community activities and potentially low levels of trust between community members. Television was the main source of information about community events and health. Over half of all men surveyed indicated an interest in participating in healthy lifestyle and sports groups, and there was frequent engagement with the health system, since half the respondents, both from villages and Shamakhi City, reported having visited a health facility in the past one to six months.

The needs and priorities identified by community members varied substantially according to gender, urban versus rural living arrangements and age. Both men and women mentioned the impact of low-quality food products and poor nutrition. However, the focus groups with men did not acknowledge any problems with water supply. Women, who do the majority of the work to ensure household water supply, spoke about problems related to water supply and negative health effects. Focus group participants living in rural areas cited poor infrastructure, including poor roads, absence of bridges and lack of public transport and/or lack of an ability to pay for transport as important barriers to accessing health care. Younger focus group participants less frequently voiced dissatisfaction or expressed negative views.

“ENGAGING COMMUNITIES IN NEEDS ASSESSMENT PROCESSES CAN HELP MOVE AWAY FROM PURELY BIOMEDICALLY FOCUSED SOLUTIONS TO PUBLIC HEALTH ONES THAT ADDRESS THE WIDER DETERMINANTS OF HEALTH.”

EARLY ACHIEVEMENTS

Training programmes were organized based on the focus group study on learning needs. The priority primary health-care services list revealed that both physicians and mid-level health-care workers put anthropometric measurements, risk assessment tools and strengthening the self-care capabilities of patients with noncommunicable diseases as a top priority. Immunization, well-child follow-up and family planning were the top priority topics for services related to maternal, newborn and child health. Based on these results, two training programmes were organized in February and March 2021 on cardiometabolic risks and hypertension management in primary health care and on parental counselling on vaccines. A total of 61 primary health-care workers of 89 attended both courses. Six national protocols on noncommunicable disease management and maternal, newborn and child health care were drafted during the process.

The needs for upgraded infrastructure and equipment were highlighted and initial solutions implemented. Training alone is not sufficient for improving the competencies of health-care workers. Appropriate equipment must be available to transfer learning into practice. To facilitate this, each health-care worker (a total of 61) who participated in the course was provided a medical bag containing basic medical equipment. A set of diagnostic and medical care equipment (such as an infant scale, ECG, glucometers, etc.) was delivered to each primary health-care facility. In addition to these, three mobile clinics, furnished and equipped as primary health-care facilities, were procured and started providing health-care services in areas with limited infrastructure and poor accessibility. Two additional four-wheel-drive cars were bought to access remote villages with limited accessibility due to poor road conditions.

A plan for community action for health was developed. Building on the key findings from the focus groups and the telephone survey on community engagement, a community engagement plan for health activities for 2021 was drafted and discussed with relevant stakeholders. Proposed activities included community action for hypertension, establishing community groups for health and establishing a health promotion unit in the Shamakhi District.

Context-specific needs and factors were used to inform training and service design. Participants' concerns, expectations and priorities reflected the uniqueness of the local situation. Especially for learning needs, priority services were sorted quite differently than standard priority lists, which reflected the authenticity of local circumstances, and got the researchers to think out of the range of the standard interventions. The results steered the project team towards organizing a tailor-made learning process for local health-care workers with the contribution of local and national experts.



SUSTAINABILITY PROSPECTS AND NEXT STEPS

The health system assessment in the Shamakhi District informed the learning needs of the health-care workers and community engagement for health.

For actions related to meeting the learning needs of health-care workers, the following steps include:

- nurturing motivated and knowledgeable primary health-care workers from Shamakhi as local trainers and monitoring officials;
- establishing continuous improvement through monitoring;
- mentoring of primary health-care workers in translating learning into practice; and
- developing clinical guidelines for primary health-care workers, starting with priority needs.

Empowering local primary health-care workers for in-service training of their colleagues and monitoring the influence of interventions are crucial for the sustainability and rollout of the primary health-care service delivery model.

For the community engagement aspect, sustainability depends on the improvements in the quality and accessibility of primary health care services. Early results imply that women and men and young and older groups have separate needs. The COVID-19 pandemic is still a constraint for organizing community health activities to increase community participation.

LESSONS LEARNED

1. The health priorities of the community and the learning needs of primary health-care workers need to be assessed through participatory methods by involving local people and the local health workforce to ensure that the most appropriate actions are taken.

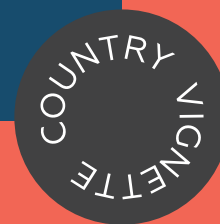
2. Both community engagement activities and health workforce learning assessment need to be inclusive. The former, needs to include all community groups as their perceptions may vary, and the latter all health workforce cadres.

3. The results of the participatory assessments and analyses suggest that standard activities developed in advance by outside experts are generally inefficient. Instead, it is necessary to develop actions designed by and undertaken with the local community and workforce.

4. The needs identified as priorities by the community were more related to the social determinants of health than to purely biomedical aspects. Thus, engaging communities in needs assessment processes can help move away from purely biomedically focused solutions to public health ones that address the wider determinants of health.

5. A participatory approach connected the voices of health-care workers and the local community in rethinking and shaping the new primary health-care service by analysing shared challenges and joint learning to help to overcome gaps in trust. The opportunity to obtain knowledge for action is the major strength of participatory approaches (2) to ensure sustainability by engaging local resources and communities.

6. Participatory assessment and planning approaches require enormous effort and time. Developing context-specific tools and methods, although challenging but fruitful, is more helpful for improving understanding of local circumstances. The local government is a key actor to reach communities and health-care workers.



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