Evaluation of the Community Based Primary Health Care Programme in Azerbaijan

Executive Summary

Oxfam GB Programme Evaluation

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Executive summary

After the transition, Azerbaijan has suffered from decline in resources for health care and health outcomes. Despite the significant economic growth, the share of health expenditure from the total national budget dropped from 10% between 1995 and 2006. This resulted in a rapid decline in primary health care provision, in terms of access, coverage and quality. While staff numbers and facilities are comparable to the EU averages, rates of child and infant mortality are 16 times higher; and maternal mortality rates are 10 times higher than in the EU. The health care system in Azerbaijan remains highly centralised and characterized by inflexible management practices, ineffective financing mechanisms, poor health information and surveillance systems, and focused on curative services rather than primary care and prevention. There has been insufficient leadership and clear vision for the sector as well as corruption giving rise to informal practices. The current health sector reforms in Azerbaijan, implemented with the support of the World Bank, USAID, WHO and UNICEF, are aiming to decentralise the provision of health services to district level, but still do not reach poor rural remote communities. The government is designing a new health financing strategy involving the introduction of mandatory health insurance seeking to improve access to and the quality of health care.

Oxfam GB has been implementing the "Community based primary health care" programme in Central Azerbaijan since 2001 in partnership with Care for Children, currently covering 43 villages in Barda, Ter ter, Goranboy and Yevlakh districts, and funding is available until 2011. The programme seeks to improve the health of the population in rural communities through availability of first-line PHC at village level, and uses participatory approaches (management by Communities Health Committees). Members contribute US$1.20 per month, per family and receive out-patient consultations (including basic services as injections, blood pressure checks, simple blood and urine tests), PHC drugs and outreach activities. A total of 10% of community members, all pregnant women and children under one are exempted by the community on a rotational basis. Drug supplies come quarterly and are based on the health profile produced by each health post. The health posts are usually staffed by a doctor and a nurse who receive an incentive payment. Rehabilitation of the health post infra-structure and the supply of basic equipment are also part of the scheme activities. Funds are collected by the appointed treasurer, and oversight of the funds at community level is performed by the village health committees. All 43 communities are represented in the Health Community Forum established in 2007 as a strategic management body. Currently funds contributed by members ($80,000) are not used to fund recurrent and capital items, before decisions on their most strategic use are taken. The rate of participation of the villages and their population is variable, dependant on context and their perception of what the benefits for their community are. The CBHI schemes can contribute to achieving the PRSP and MDGs, by informing advocacy and feeding into the agreed aims at national level, but this potential has been insufficiently realised.

Oxfam is considering further scaling-up of these schemes and linking it to the health financing reform led by the Ministry of Health and Azerbaijan Parliament. This evaluation aims to support this process by seeking to a) assess the role of key stakeholders in the schemes: community, government, NGOs, donors and others, and their interrelationships; explore how the CBHI can be scaled up in view of the national health system setup and what contextual factors could influence this process. It would also suggest a strategy for transition from local level small-scale financing and provision, to nation-wide engagement and advocacy. This case study included a review of relevant documents on community based health insurance and scaling up options; focus group discussions with community members (with and without insurance scheme); key informant interviews with a range of providers and stakeholders at local, district and national levels.

The study's findings suggest that there are a range of problems with financing and delivery of primary health care in rural Azerbaijan where there is a high proportion of internally displaced people including a lack of adequate infrastructure, appropriately trained, supervised and motivated staff, modern diagnostic equipment, laboratories, and drug supplies at community level. The services fail to address adequately both most prevalent chronic disease but also maternal, reproductive and child health, and preventive care. The problems of primary care reflected in the poorer than average health indicators are more severe than the norm for the former Soviet Union region, due to overall financing shortages, deprioritisation of rural areas and system inefficiencies e.g. poor resource allocation, misallocation and inefficient use of staff, lack of supervision and targeting of essential drugs.

Patients faced multiple barriers when seeking health care, including financial (unable to join the insurance schemes), information (lacks knowledge of what services are available/appropriate), poor quality (lack of drugs/tests), lack of trust in effectiveness of local services. The community financing schemes sought to primarily cover households for acute illness, and provide limited protection against the cost of prolonged chronic diseases. This results in patients seeking care for chronic conditions at district level at higher cost (transportation, fees, informal payments, gifts, voluntary official payments).

The unavailability and affordability of drugs at PHC level is a major problem as most government expenditure is for health workers salaries. Purchasing of drugs at district level subsidised by the state is not cost-effective due to inefficiencies and corruption. To cope with costs of care, users resorted to borrowing money, formal credit, selling essential assets such as livestock. Unaffordability of PHC is problematic given the high levels of poverty, deterring care or cutting expenditure on food and other basic items. Besides the decline in health care resources, there are structural health system inefficiencies including bias towards specialist and hospital care, resource allocation not matching the need, spending mainly on staff rather than other inputs such as drugs and equipment, inefficient use of highly-qualified staff, a lack of rational drug use. Hence, there is agreement that major reforms in the organisation and financing of PHC are needed.

There seemed to be good accountability of the CBHI model in terms of community involvement, acceptability and awareness of the main principles of CBHI. The schemes were also seen as transparent, flexible and responsive to local needs, while trust in the government institutions was low due to perceived corruption and inefficiency. At the community level, there is a strong preference for the schemes to remain voluntary, while at district and national levels the view is for a move towards compulsory insurance to improve risk pooling. The attitudes of different actors to the schemes very widely, with scheme members and community representatives being positive, and district level specialists being most hostile.

Factors reported by respondents to have influenced people's decision in taking part of the CBHI schemes ranged from economic status, the scope of benefits package (not catering sufficiently for chronic disease), availability of infrastructure, equipment and drugs, and quality of PHC services, understanding of the benefits of insurance, not having to pay informal fees. Poor availability of drugs (e.g. for chronic conditions) is a major deterrent to participation in the scheme and cause high expenditure (for transport). Although there is a good level of satisfaction with the quality of the schemes, especially the care received, availability out of hours, limited availability of drugs and poor conditions in the facilities are problematic. Procedures for ensuring good quality care are often inadequate, and affected by poor system design, and poor collection and use of information about local needs, and clinical protocols are lacking. Increasing membership rates and PHC utilisation in rural areas would require investment in capacity, training, and change in population perceptions.

The CBHI schemes can be further developed in several areas according to the participants in the study: the benefit package should be expanded to cover chronic diseases (diabetes,

asthma, cardio-vascular diseases, and mental health) reproductive/maternal health and selected secondary care interventions of high priority. There was also support for CBHI schemes offering choice of different levels of contribution and benefit packages, allowing some co-payments. Quality improvements (training, better infrastructure and drug supply outreach, improved scheme management) were seen as key to the scheme development. A key issue that is insufficiently recognised is the lack of clear guidelines and clinical protocols for treatment and prescribing, which reduce the opportunity to optimise care and shift tasks to lower-level cadres (e.g. standard protocols may enable an appropriately trained nurse to monitor diabetes patients at community level, with a regular review by a doctor, thus freeing up resources). The study authors identified the need for stronger linkages between the village health posts and higher levels of care in terms of diagnosis, referral systems, continuity of care, a shared care approach, particularly regarding the treatment of chronic illnesses. It was suggested that there is complementarity between the CBHI schemes run by Oxfam and the government reform plans, and Oxfam's experience could contribute to the design stage and piloting of the insurance model in the Northwest region.

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