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Implementing Family Health Nursing in Tajikistan: From policy to practice in primary health care reform

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Abstract

The health systems of former Soviet Union countries are undergoing reform away from the highly centralised, resource-intensive, specialised and hierarchical Soviet system, towards a more generalist, efficient health service with greater focus on primary health care. Family Health Nursing is a new model designed by WHO Europe in which skilled generalist community nurses deliver primary health care to local communities. This paper presents a qualitative evaluation of the implementation of Family Health Nursing in Tajikistan. Using Stufflebeam's 'Context, Input, Process, and Product' model, the paper aims to evaluate the progress of this reform, and to understand the factors that help or hinder its implementation. A four-phase research design investigates the development of the Family Health Nurse role over time. In 5 rural areas, 6 focus groups and 18 interviews with Family Health Nurses, 4 observations of their practice, 7 interviews with families and 9 interviews with physicians were carried out. Data were analysed according to the components of Stufflebeam's model. Although the legacy of the Soviet health system did not set a precedent for a nurse who is capable of decision-making and who works in partnership with the physician, Family Health Nurses were successfully implementing new practices. Crucial to their ability to do so were the co-operation of physicians and families. Physicians were impressed by the nurses' development of knowledge, and families were impressed that the nurses could offer real solutions to their problems. However, failure to pay the nurses regular salaries had led to serious attrition of the workforce. We conclude that the success of the Family Health Nurse role in other countries will depend upon its position in relation to the historical health care system.

Keywords: Tajikistan; Family Health Nursing; Community nursing; Health care reform

Introduction

Health service reform is underway throughout the countries of the former Soviet Union. Apart from its quality of universal access, the organisation of the Soviet health system ran counter to the principles of Primary Health Care. The system was hierarchical and centralised, resources were concentrated on treatment at hospitals rather than prevention or outpatient treatment, and the workforce was highly specialised, rather than making effective use of generalist physicians and nurses (Gedik, Oztek, & Lewis, 2002; McKee, Figueras, & Chenet, 1998). Not only was this system ineffective, but it was highly resource-intensive and inefficient,

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to a level that has been completely unsustainable following the fall of the Soviet Union, and the subsequent economic crises of the countries in transition.

Consequently, at a policy level, it is widely agreed that these countries need to reform their health services to a system in which local-level comprehensive prevention and treatment are provided by generalist physicians and skilled generalist nurses (Healey, 2002). Despite this consensus, there has been little research on the implementation of reforms: on what happens at service delivery level when reforms are put into practice (Standing, 2002). This paper examines the implementation of one facet of Tajikistan's reforms: the introduction of Family Health Nursing.

Health service reform in Tajikistan

Tajikistan is emerging from a period of economic crisis and civil war. It is the poorest country in the WHO Europe region (WHO, 2005) with 72% of its 6.3 million inhabitants living below the national poverty line (World Bank, 2005a). Health is also poor in Tajikistan, with an under-five mortality rate of 96 per 1000 (World Bank, 2005b) and life expectancy of 59 for men and 63 for women (WHO, 2005). Independence from the Soviet Union in 1991, and a subsequent civil war and civil unrest, led to a period of drastic decline of GDP, rising unemployment, deterioration of infrastructure and a flight of skilled professionals to Russia (Falkingham, 2004; Healey, 2002). During the late 1990s, health expenditure fell to less than 2% of GDP, but it has been increasing gradually in recent years. Current health expenditure, at 54 international dollars per capita (compare to Turkey, 557; Uzbekistan, 160), is still the lowest in the WHO Europe area, both absolutely and as a proportion of GDP (4.4%) (WHO, 2007). Of this expenditure, only 21% is government expenditure, the remainder being paid for privately by individuals (WHO, 2007). Government expenditure was traditionally focused on hospitals, to the neglect of Primary Health Care, with hospitals allocated 78% of the budget in 1998 (European Observatory on Health Care Systems, 2000). In March 2002, the Government of Tajikistan approved a health reform programme, to reallocate resources from hospitals to Primary Health Care. Nonetheless, low levels of resourcing of health services continue to present major challenges to the health of Tajikistan's population.

Tajikistan's reform programme aims to deliver Family Medicine through teams of Family Physicians and Family Health Nurses (MOH, Tajikistan, 2002). Workforce changes are required, including greater numbers of generalist physicians, and a greater proportion of nurses taking on clinical responsibilities. Under the Soviet system, nursing was a low-status and low-skill profession, and many tasks that would have been done by nurses in Western countries were being carried out by physicians (McKee et al., 1998). In 1998 the number of physicians recorded was 11,771 while the number of nurses was 34,452, a ratio of 1:3.4. Tajikistan's Ministry of Health now aims to reduce the numbers of physicians, and increase the numbers of nurses, to arrive at a ratio of 1:6 (European Observatory on Health Care Systems, 2000). In order to enable nurses to take on greater clinical responsibilities, their level of education and skills are also being increased.

Family Health Nursing

Family Health Nursing has been introduced by WHO Europe in response to an identified Europe-wide need for a skilled generalist, community-based nursing role (WHO Europe, 2000). The role is being piloted in a variety of countries, from countries in transition such as Tajikistan, Kyrgyzstan and Moldova, to high-income countries such as Scotland and Germany (Hennessy & Gladin 2006). Family Health Nurses work with individuals, families and communities to improve health and to cope with illness. Visiting families at home, they carry out prevention activities, early detection of problems and prompt treatment. They may support people who are recovering from illness, or who need long-term care in their homes. They work in partnership with Family Physicians, ideally being a family's first point of contact with the health services, and serving as the link between the family and the physician (Macduff, 2006; WHO Europe, 2000).

In Tajikistan, Family Health Nursing has a core role in the government's nursing development strategy. A target of 8600 postgraduate Family Health Nurses have been identified as necessary to satisfy the requirements of the Primary Health Care sector (MOH, Tajikistan, 2006). This target is to be met through two routes. Firstly, in 2000, a