AZERBAIJAN PRIMARY HEALTH CARE STRENGTHENING PROJECT

Year 2 Annual Report
September 1, 2008 – August 31, 2009

USAID FROM THE AMERICAN PEOPLE | PHCS PRIMARY HEALTH CARE STRENGTHENING

Submitted by
Abt Associates Inc.

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EXECUTIVE SUMMARY

In line with the Government of Azerbaijan's vision for health care reform, USAID/Azerbaijan is providing technical assistance to the Ministry of Health (MoH) to expand the comprehensiveness of primary health care (PHC) and to improve the way that PHC is organized, delivered, and financed.

The USAID Primary Heath Care Strengthening (PHCS) Project, implemented by Abt Associates, works closely with and provides technical assistance to the MoH to strengthen Azerbaijan's health policies and its PHC system. The three-year PHCS Project started in September 2007 with an overall funding envelope of $2,800,000. In February 2009, USAID allocated an additional $992,000 to PHCS to provide technical assistance to the Government of Azerbaijan to improve tuberculosis (TB) care and treatment through health reform and health system strengthening activities.

In Year 2, PHCS continued to provide technical assistance to the Government through five components:

- Component 1: Increase public expenditures for health and improve resource allocation for PHC
- Component 2: Create a policy and legal framework that defines PHC services and the delivery system
- Component 3: Improve quality of PHC services
- Component 4: Promote personal responsibility for health among individuals and families
- Component 5: Improve TB care and treatment through health reform and health system strengthening

Project components are implemented in an integrated and coordinated manner. Together, PHCS activities are assisting the Government of Azerbaijan to enact and make operational a legal framework and policies that are supportive of health care reforms; improve the mobilization, allocation and use of health care resources; improve the quality of health care services; and ensure that people are better informed about and can advocate for health care services, healthy lifestyles, and patient rights and responsibilities. Improving the quality, accessibility, and efficiency of health care will contribute to improving the health of the population and help Azerbaijan strive to meet the Millennium Development Goals. Project activities also contribute to USAID/Azerbaijan meeting its strategic objective of increasing use of quality health care services and practices in Azerbaijan in order to improve health and reduce the incidence of TB.

In Year 2 of the Project, PHCS continued to cultivate effective working relationships with the MoH and other national-level stakeholders, build capacity among counterparts in both designing and implementing health reform activities, and actively coordinated Project assistance and support with other development partners including other USAID projects, the World Bank, the World Health Organization (WHO), and the Global Fund (GF). More specifically, PHCS accomplished the following in Year 2 of the Project:

1. Provided in-depth technical assistance to the Government, along with other development partners, to **develop a new health care financing system** resulting in:
    - Initial steps being taken to begin to implement the Action Plan of the Concept for National Health Financing Reform 2008-2012 and prepare to pilot new provider payment systems;
    - Development of "The Program of Implementation of the New Health Care Finance System and Mandatory Health Insurance in the Republic of Azerbaijan" that includes calculation of a simplified diagnostic related group (DRG) system for hospital payment as well as guidance on a phased introduction of new provider payment systems for PHC and hospitals;
    - Development of a "Concept of PHC Financing Reform" that includes a detailed methodology for the calculation of per capita rate and risk adjustment coefficients based on age and sex of the population;
    - Refinement of a computerized database to capture patient discharge information to better inform design of case-based hospital payment systems; and
    - Development of a concept for a unified health information system (HIS).

2. Helped to **establish a supportive policy framework for health reform and PHC strengthening**, by:
    - Conducting a number of assessments or studies to improve the evidence base for policies and strategies, including:
        - Stakeholder analysis on attitudes toward PHC and Family Medicine (FM);
        - Rational drug use survey; and
        - Internal assessment of TB indicators and services.
    - Facilitating the establishment of working groups to improve policy dialogue and coordination among stakeholders and development partners:
        - Working Group on Preparation of New Health Financing System led by MoH;

    - Regular interagency coordination meetings on Health Communication led by National Center for Public Health and Reform (NCPHR);
    - TB Interagency Working Group led by National TB Program (NTP); and
    - Working groups for development of specific clinical practice guidelines (CPGs).
- Helping to draft or improve a number of policies, strategies, and documents, including:
    - The Program of Implementation of the New Health Care Finance System and Mandatory Health Insurance (includes Concept of PHC Financing Reform);
    - Concept for Unified HIS;
    - Essential Drug List;
    - National Drug Formulary;
    - National Health Communication Concept;
    - National TB Strategy;
    - MDR-TB Program Implementation Plan;
    - Health Care System in Transition (HiT) for Azerbaijan;
    - Health financing indicators for Health System Performance Assessment Framework; and
    - Health communication newsletters.

3. Supported continued introduction of evidence-based medicine (EBM), development of CPGs, and rational drug use (RDU) to **improve the content of clinical practice at the PHC level** resulting in:
    - Ongoing support to NCPHR to facilitate CPG development process (e.g., setting priorities for CPG development, identifying working group members, establishing working groups, etc.);
    - Significant contribution to the development/revision of 7 CPGs;
    - Establishment and training of District Monitoring Teams (DMTs) in 5 pilot districts;
    - More than 250 PHC providers in pilot districts trained in approved CPGs for acute respiratory infection (ARI), hypertension, peptic ulcer, and iron-deficient anemia;
    - Development and dissemination of patient education materials for anemia and ARI;
    - Introduction of quality improvement approaches and monitoring indicators in PHC facilities in pilot districts, and improvements in completeness of patient records; and
    - Documented improvements in quality of care in pilot PHC facilities in line with approved CPGs, as evidenced by increased routine screening for hypertension, reductions in unnecessary antibiotic prescribing for ARI, and improved drug prescribing for adults diagnosed with asthma.

4. Built capacity for health sector stakeholders through round tables, trainings, and workshops **to empower them to design and implement health reform interventions**, on topics including:
    - Health financing and health systems strengthening
    - PHC
    - EBM and CPG development
    - Health communication

This annual report covers the period from September 1, 2008 – August 31, 2009, and includes a summary of key achievements by component, results against monitoring indicators, success stories, and lessons learned during Year 2 of project implementation.

COMPONENT SUMMARIES

This section provides a detailed description of progress on PHCS interventions achieved in Year 2 under the Project's five components.

In Year 2, PHCS continued to work closely with the MoH, its institutional structures, and other national stakeholders to develop capacity to identify key policy options for strengthening health financing and the organization and delivery of PHC and to develop strategies and programs for the successful testing and implementation of selected options. Because fundamental reform of the hospital and specialist-oriented health system inherited from the Soviet Union is still in its early stages in Azerbaijan, the Project concentrated on assisting the government in the development of national-level health policy and financing changes, while simultaneously testing critical interventions at the level of individual facilities and communities in selected districts that serve as pilot demonstration sites. PHCS is supporting activities in pilot districts selected by the MoH – Absheron, Agdash, Qakh, Ismayilli, and Sheki districts.

In February 2009, USAID allocated an additional $992,000 to PHCS to provide technical assistance to the Government of Azerbaijan to improve TB care and treatment through health reform and system strengthening. These activities were integrated into the project as a fifth component with progress and achievements in implementing TB activities in Year 2 also reported below.

Component 1: Increase Public Expenditures for Health and Improve Resource Allocation for PHC

Significant progress was made on Component 1 activities in Year 2 of the project. PHCS progress in Year 2 is reported below in three sections focusing on: i) national health financing policy; ii) provider payment systems; and iii) capacity building in health economics, financing, and management. Project targets continue to be achieved in all areas of activity except for National Health Accounts (NHA). Implementation of NHA is being led by the World Bank-funded Health Sector Reform Project (HSRP). Implementation was delayed in 2008 for two years in agreement with the World Bank.

National Heath Financing Policy

PHCS continued to participate in national health financing policy dialogue through formal and informal discussions with MoH, Ministry of Finance (MoF), HSRP, NCPHR and WHO. The aim of this policy dialogue is to help the Government of Azerbaijan introduce changes in health financing that result in more equitable distribution of public sector resources and create incentives for more efficient use of funds in health facilities. In the process, the Project also helped the MoH and other stakeholders develop a number of strategic documents, concepts, and plans that continue to lay the foundation for implementing national health financing reform.

PHCS supported the MoH and HSRP to begin to implement the Action Plan of the Concept for National Health Financing Reform 2008-2012 to which the Project provided substantial input in Year 1. In late 2008, PHCS helped the MoH and HSRP, jointly with other ministries, to evaluate the current system of health financing in Azerbaijan. The evaluation included a description of the financing of providers and payment of health personnel, as well as a summary of the problems affecting efficiency of resource allocation and use and the effectiveness of service delivery. PHCS provided advice and guidance in developing the evaluation reports and reviewed and provided comments on draft documents. Activities in the Action Plan that were planned for 2009 were largely contingent on the State Agency on Mandatory Health Insurance (SAMHI) being operational, which did not occur. PHCS remained ready to help the Government of Azerbaijan make SAMHI operational should the Government be ready to do so. PHCS also helped HSRP develop proposals for the MoH and MoF to test new health financing systems and provider payment mechanisms in HSRP pilot sites while SAMHI is not yet operational (see Provider Payment Systems section below for further details).

PHCS and WHO participated in a process led by HSRP consultants to develop a National Master Plan for Health Workforce and Health Infrastructure. The Master Plan was endorsed by the MoH in January 2009. The main objective of this plan is to develop a "roadmap" for optimizing the delivery of health services, beginning in five pilot districts and then expanding to the entire country. PHCS raised concerns that the proposed optimization, further defined in a subsequent MoH decree, was not accompanied by simultaneous changes in health financing. PHCS discussed with the MoH how implementing the planned optimization without health financing changes could have a number of negative results, including: i) closure of small rural hospitals and the introduction of new staffing norms resulting in a reduction of overall health

care funding levels at the district level; ii) increased fragmentation of existing funds as budgets for village ambulatories after closing village hospitals will move from the district level to the village level; and iii) administrative mergers of district polyclinics with central hospitals may weaken PHC.

PHCS then proposed several measures that may be put in place to avoid such risks, including: i) introduction of a new budget planning methodology for pilot districts that is based on the per capita cost of a basic benefit package; ii) permission to pool budgets for all PHC facilities at the district level; and iii) establishment of a District PHC Service based on district polyclinics merging with rural PHC facilities that would effectively transfer narrow specialists from district polyclinics to outpatient departments of central district hospitals. The MoH asked PHCS to help draft a letter to the MoF addressing the potential problems. The letter was drafted and reviewed jointly with MoH staff during several meetings with the Finance and Economic Department and the Department of Organization of Health Care. These concerns also were shared with the World Bank Mission. The Mission supports the Project's views and agreed to incorporate them in their report to the Government of Azerbaijan. As a result of these discussions, the MoF has agreed with MoH to pool budgets for all PHC facilities at the district level beginning in 2010.

PHCS staff members also were involved in updating the chapter on health financing for the Health Care Systems in Transition (HiT) profile for Azerbaijan. HiT profiles serve as key reference documents on health systems in Europe and the former Soviet Union and help countries to easily compare and contrast how health systems and services in other countries are organized, managed, and financed. Project staff provided technical input, collected health financing data, and participated in a number of meetings on developing the HiT, using the opportunity to cross-check the position of numerous players with regard to health financing and other health reforms in the country. PHCS submitted a draft health financing chapter to the primary author in March 2009. A full draft of the Azerbaijan HiT was completed in September 2009 in English and Russian and will be shared with the MoH for review before being published and distributed toward the end of 2009.

PHCS also provided technical assistance to HSRP and the MoH Health Policy and Planning Unit (HPPU) to develop a health system performance assessment (HSPA) framework for Azerbaijan. HSPA can help Azerbaijan measure its health system performance, compare performance over time, and modify their policies as necessary. WHO is working globally to set out a more comprehensive, explicit, and systematic basis for making comparisons over time within a country and across country settings in order to identify the types of policies that have been associated with high performing health systems. PHCS actively participated in the working group established to develop the framework and define a series of indicators to define performance of the Azerbaijan health system. PHCS provided significant input to the development of indicators on health financing and 27 health financing were ultimately included in the framework along with 200 additional health system performance indicators. PHCS provided training on the health financing indicators to staff of the newly formed HPPU who will be responsible for writing the first HSPA report for the country. PHCS will continue its close involvement in this process and provide technical assistance to the MoH in drafting the report.

In Year 2, PHCS also actively participated in policy dialogue regarding the future development of the national HIS which is closely linked to health financing reform. At the request of the Department of Health Information and Statistics (DHIS), NCPHR (E-health Card Program), HSRP, and the World Bank, PHCS agreed to take the lead in developing a conceptual framework for establishing a unified HIS. As part of this process, PHCS staff held a series of both bilateral and multi-lateral meetings with key stakeholders to discuss and agree on the fundamentals of HIS development in the country. Given a lack of clarity in the distribution of roles and responsibilities between the DHIS and E-health Care Program both at the current stage and especially in the future with the envisioned establishment of SAMHI, it is important to come to consensus concerning an overall vision for HIS reform and development. This is necessary in order to define clearly a division of labor between various MoH departments with regard to HIS to avoid unnecessary competition between departments, prevent a duplication of efforts, and reduce any potential confusion among health providers.

PHCS has drafted the major elements of a concept for a national unified HIS and has discussed the draft with key stakeholders. The concept includes an assessment of the current situation, definition of data needs and users, goals and objectives of a unified HIS, description of core modules to be included in the HIS, and suggestions on how to manage development and implementation of the HIS. It is envisioned that the HIS Concept will be finalized in Year 3 and submitted to the MoH for official review, revision, and approval. Key questions that remain to be resolved by the MoH are the institutional structure and staffing for managing an integrated HIS, improving the legal basis for data submission requirements and protecting data confidentiality, and creating incentives to improve data reporting and use at the facility level.

Provider Payment Systems

According to the Action Plan for implementation of the Concept for National Health Financing Reform 2008-2012, MoH, SAMHI and MoF are required to introduce new provider payment mechanisms in MoH pilot districts. Despite the delay with establishing SAMHI, the MoH is planning to implement this activity without waiting for SAMHI to become operational. Considering these plans, HSRP approached PHCS with the request to provide assistance to develop a strategy for implementation of provider payment reform in pilot districts based on various draft proposals that had been developed previously. HSRP intends to submit the strategy to the MoH and MoF in order to provide them with clear guidance on interventions required for piloting new provider payment mechanisms for both inpatient and outpatient care. In helping to develop a draft strategy, PHCS reviewed of all documents that had been developed in the field of health financing reform in Azerbaijan, consulted Abt Associates experts from Central Asia, and held a series of discussions with HSRP staff.

PHCS staff worked closely with HSRP to develop "The Program of Implementation of the New Health Care Finance System and Mandatory Health Insurance in the Republic of Azerbaijan." The Program describes specific implementation of the new provider payment methods and procedures including purchasing of medical services under the MHI system. The Program proposes phased introduction of the new health financing mechanisms to allow for piloting of the proposed model, allow health providers to adapt to new financing and management

mechanism, and foster a positive attitude among the medical community and population toward reforms.

The Program suggests that implementation be phased geographically and technically. In terms of geography, the Program recommends three phases: i) simulation: testing of the new provider payment methods "on paper" in pilot districts while actual funding continues to function under the existing scheme; ii) implementation: paying medical facilities using new payment mechanisms; and iii) dissemination: gradual roll out of the new payment model to the national level under the eventual direction of SAMHI. Technical phasing involves initial implementation of simplified payment models followed, as data is accumulated, by transition to improved, more effective models, accounting for a more significant number of clinical and economic parameters. Implementation of each phase is to be driven by analysis of the previous phase's results and followed by any necessary methodological corrections.

The document also describes the methodology for calculation of an initial 21 DRGs based on existing data to drive hospital payment methods, as well as capitated payment methods for PHC providers. In addition, the document provides a draft statute for SAMHI, the rules of payment to the medical facilities providing services under the state guaranteed package of services, and analysis of international experience surrounding providers' autonomy. Finally, the document discusses information system issues to support the case-based hospital payment system.

The draft document was submitted to the MoH and MoF for review in April 2009. During the review process, national counterparts asked PHCS for further assistance in developing detailed proposals for reforming PHC financing as an important integral part of overall health financing reform in the country. In response to this request, PHCS prepared a draft "Concept of PHC Financing Reform." This concept paper is based on the experience of similar reforms in other Commonwealth of Independent States (CIS) countries and provides a description of the components of a per-capita payment system as well as a detailed methodology for the calculation of per-capita rate and risk adjustment coefficients based on age and sex of the population. It also discusses the elements of performance-based payment of providers as a potential future direction for the PHC payment system. The document also provides a methodology for piloting the new PHC provider payment system including the necessary preconditions for successful implementation of the pilots, phased introduction of new financing mechanisms as well as the requirements for HIS both at provider and national levels. Finally, it describes experience with PHC financing reforms in other CIS countries that have implemented similar reforms. The draft was submitted to HSRP for review but due the changes in leadership in HSRP, PHCS expects to receive feedback in early Year 3.

Also in Year 2, PHCS supported pilot districts to implement a computerized database for discharged patients, which is an important part of the process of developing a new hospital payment system. Monitoring of hospital HIS by a PHCS consultant and DHIS in the pilot districts revealed the need to improve the database software. PHCS recommended that DHIS address a number of issues with the software currently in use, including: i) improve data entry to reduce errors in inputting data and avoid incomplete entry of data; ii) improve analysis and reporting modules so data could be used at hospital level. A series of meetings were held with DHIS and HSRP to discuss these findings and develop the plans to correct the situation. DHIS

staff made improvements to the software based on the Project's recommendations. In addition, DHIS made changes to Form #66 – the discharged hospital patient form – and developed new instructions for hospital statisticians in completing the form.

Considering the relatively low patient flow in hospitals in MoH pilot districts and the relatively limited range of health conditions managed at the district level, PHCS held a meeting with HSRP, HPPU, and World Bank to discuss the introduction of the computerized data entry of Form #66 in several pilot facilities throughout Azerbaijan. Thirty-one hospitals were selected including in Baku city, four other large cities (Ganja, Sumgayit, Mingechivir, and Shirvan), and four major districts (Sheki, Lankoran, Tovuz, and Shamkir). Implementation of the database for Form #66 in these facilities was approved by MoH order in August 2009.

Build Capacity in Health Economics, Financing, and Management

In Year 2, PHCS continued to build the capacity of national counterparts in health economics, health financing, and health management. PHCS organized national roundtable discussions on PHC in Azerbaijan jointly with WHO and NCPHR. The Project invited Dr. Ainura Ibraimova, former head of the Health Insurance Fund in Kyrgyzstan, to facilitate the discussion jointly with an expert from WHO. These consultants also conducted a separate two-day workshop on health systems and financing for more than 20 representatives from MoH, HSRP, and NCPHR and participated in a meeting with senior officials from MoH. Dr. Ibraimova shared valuable experience and lessons learned from PHC reforms in Central Asia and provided her recommendations on the health reform process in Azerbaijan.

PHCS is also building the capacity of the MoH HPPU. The HPPU's role is to strengthen the MoH's stewardship function over health sector reforms. Based on an agreement with WHO and HSRP, the project provided a series of trainings and consultations to the HPPU on several issues related to health financing including provider payment systems and MHI. With regard to health financing, the HPPU will contribute to the monitoring of provider payment systems in selected pilot sites in Baku city. Also, the unit is tasked with writing the first HSPA report based on the HSPA framework. Considering that the indicators on health financing and financial protection of the population were developed by PHCS, Project staff conducted a separate training for the HPPU explaining the definitions, methodology, data sources, and presentation specifics for these indicators. Finally, PHCS shared with the HPPU staff all technical documents and reports that were developed both by the Project as well as other parties and may be useful for the unit's future work.

Component 2: Define an Effective Legal Framework for an Improved PHC System and Begin Restructuring PHC Sector

In Year 2, PHCS continued to help the Government of Azerbaijan create a vision for and develop a reformed PHC delivery model, introduce EBM and FM principles into the health system, and develop a national drug policy (NDP). The Project continued to work with the MoH and other stakeholders to define and execute legal and regulatory changes to improve PHC. PHCS progress in Year 2 is reported below in four sections focusing on: i) health policy development; ii) NDP development; iii) institutionalization of EBM; and iv) FM development.

Health Policy Development

PHCS continued to provide technical assistance to develop sound health policies and to create more transparent, consensus-based processes to develop and revise health policies and regulations. This work crossed all five components of the Project and together helped the Government establish a more supportive policy framework for health reform and PHC strengthening. In Year 2, PHCS:

- Conducted a number of assessments or studies to improve the evidence base for policies and strategies, including:
    - Stakeholder analysis on attitudes toward PHC and FM (Phase 2);
    - Rational drug use survey (Baku city and rayons);
    - Internal assessment of TB indicators and services.
- Facilitated the establishment of working groups to improve policy dialogue and coordination among stakeholders and development partners:
    - Working Group on Preparation of New Health Financing System led by MoH;
    - Regular interagency coordination meetings on Health Communication led by National Center for Public Health and Reform;
    - TB Interagency Working Group led by NTP; and
    - Working groups for development of specific CPGs.
- Helped to draft or improve a number of policies, strategies, and documents, including:
    - The Program of Implementation of the New Health Care Finance System and Mandatory Health Insurance (includes Concept of PHC Financing Reform);
    - Concept for Unified HIS;
    - Essential Drug List;
    - National Drug Formulary;
    - National Health Communication Concept;
    - National TB Strategy;
    - MDR-TB Program Implementation Plan;
    - HiT for Azerbaijan;
    - Health financing indicators for Health System Performance Assessment Framework; and
    - Health communication newsletters.

In January 2009, the MoH established the HPPU to help strengthen its capacity for stewardship in the health sector. The MoH hired two public health specialists, a policy analyst, and an

economist to work in the HPPU. It is expected that the HPPU will be responsible for providing overall input and guidance on health policies. The HPPU staff also will monitor the impact of health reforms on the health status of the population and develop advice and recommendations to the leadership of the MoH on priority health areas. PHCS worked closely with WHO and HSRP to develop a "capacity building" plan for the Unit that includes among other things a series of in-country and overseas trainings. In accordance with this plan, PHCS team members conducted the following trainings for HPPU staff:

- Main directions of health reform;
- Monitoring and evaluation systems in health care; and
- Health system performance assessment.

The project also assisted the MoH in developing a Scope of Work and Annual Work Plan for HPPU. In addition to capacity building efforts, the project provides technical assistance to this Unit in their day-to-day activities through ongoing provision of advice and frequent consultations.

National Drug Policy Development

In Year 2, PHCS continued to work closely with MoH, Analytical Expertise Center for Medicines (AECM), NCPHR, HSRP, and WHO to assist in the development of a NDP and related policies designed to improve rational drug use. PHCS continued to provide assistance in the development of a national formulary system. PHCS helped to facilitate development of the national formulary system through ongoing technical assistance, facilitation of working groups, and consultations with stakeholders, and helped to incorporate recommendations of WHO and the International Network for Rational Use of Drugs into a proposed formulary system for Azerbaijan. Formulary systems, when properly designed and implemented, can promote rational, clinically appropriate, safe, and cost-effective drug therapy. Formularies are ongoing processes whereby physicians, pharmacists, and other health care professionals establish policies on the use of drug products and therapies and identify drug products and therapies that are the most medically appropriate and cost-effective to best serve the health interests of a given patient population. The formulary is intended for use by prescribers, pharmacists and other healthcare professionals. It represents a rapid reference for authoritative, impartial and, where available, evidence-based advice on prescribing, dispensing, and administering medicines.

In Year 2, PHCS also agreed to continue strengthening RDU-related activities with an emphasis on rational use of antibiotics and needs in this area were identified and prioritized. AECM approached the project team to assist and coordinate the following steps: identifying prescribing practices in different health care facilities, developing a CPG on Rational Antibiotic Use (RAU), and developing a draft strategy on the use of antibiotics in Azerbaijan.

To assess prescribing practices in health care facilities, PHCS and AECM formed a small working group. The working group selected a number of basic indicators, which are referred to as core indicators, to evaluate the pharmaceutical prescribing practices of health providers. The core indicators are highly standardized, do not require national adaptation, and are commonly recommended for inclusion in any drug use study. They do not measure all aspects of drug utilization; instead, the core drug use indicators provide a simple tool for quick and

reliable assessment of certain critical aspects of pharmaceutical use at PHC level. In addition to the core indicators, the working group identified some complementary indicators – those indicators that are no less important in understanding prescribing practices, but are often more difficult to measure and cannot be collected reliably in some settings.

The study was retrospective examining sample cases selected randomly from around 500 medical records in 10 facilities including eight polyclinics in Baku and two polyclinics in Sheki. In addition, to catch differences between prescribers within the facility, patient cards were randomly selected in a way to represent all catchments areas of a polyclinic. Findings revealed significant issues with prescribing practices including unjustified use of antibiotics and injections, low use of generic names in prescriptions, frequent use of drugs with similar therapeutic effect simultaneously, and other issues. The study also showed that prescribing practices against CPGs for bronchial asthma and hypertension in adults also require improvement. Study findings are available in a report developed by AECM and are being used by AECM to plan future efforts to continue to improve RDU throughout Azerbaijan.

Based on the study findings, PHCS is providing technical assistance to AECM and others that are developing a MoH strategy for combating antibiotic resistance. The group came up with a set of recommendations drawn largely from the WHO global strategy for combating antibiotic resistance as well as other international experience in this field. The strategy calls for an inter-sectoral approach involving all relevant parties including the agricultural sector. The recommendations are grouped in the following areas: i) patients and the general community; ii) physicians and pharmacy workers; iii) hospitals; iv) government and health system; and v) pharmaceutical promotion. The strategy is currently under review and PHCS and WHO will continue to work with the MoH in Year 3 to finalize the strategy and make it operational.

Support Institutionalization of EBM

The introduction of EBM principles is an important step in improving the quality of preventive medicine and clinical care. PHCS continued to provide extensive technical assistance to NPHRC in supporting EBM in the country. PHCS and NCPHR conducted a second round of formal, five-day EBM training in May 2009 to expand the group of medical professionals involved in EBM/CPG development in the country. Twenty-eight specialists from different institutional structures under the MoH were trained. The participants came from different professional backgrounds including medicine, public health, TB, pharmacy, and laboratory services. The training was successful in meeting its goals and objectives and participants expressed their satisfaction about the quality of the training and the right balance between theory and practice. The participants also appreciated the value of being given practical examples to review/evaluate based on CPGs that are under development in Azerbaijan.

In Year 2, PHCS provided technical assistance in the CPG development process and was directly involved in preparation of nine CPGs or clinical protocols:

- Peptic ulcer (initiated in Year 1);
- Acute upper respiratory diseases (initiated in Year 1);
- Community-acquired pneumonia;
- Chronic obstructive pulmonary disease;

- Bleeding during pregnancy;
- Depression;
- Iron deficiency anemia;
- Hypertension; and
- Rational Antibiotic Use.

Along with EBM/CPG training and CPG development, PHCS and NCPHR also have initiated negotiations regarding integration of approved CPGs into postgraduate medical education curricula.

Family Medicine Development

PHCS team continued collaboration with NCPHR and HSRP regarding FM development in Azerbaijan. To assess the interests of various parties involved in or affected by the MoH's intention to reform the country's PHC system, NCPHR and PHCS initiated the second phase of a stakeholder analysis at the national level in order to map current roles and relationships of key players in the health system (particularly as they relate to PHC), determine the likely changes in roles and relationships due to PHC restructuring and other broad policy changes, and identify barriers to reform. The study was conducted in collaboration with NCPHR and was based on guidelines provided in the "Policy Toolkit for Strengthening Health Sector Reform" developed by the USAID Partnerships for Health Reform (PHR) Project.

Following the Toolkit guidelines, 35 key stakeholders were identified based on stakeholder information or characteristics. Stakeholders involved and interviewed included: 4 Parliament, 3 Ministry (MoH, Ministry of Education, Ministry of Social Protection), 4 NCPHR, Medical University, 2 Postgraduate Medical Institute, 2 Health Insurance Agencies, 2 National Committee on Family, Women and Child, National Institute on Pediatrician, National Institute on Obstetric Gynecology, 2 Civil Society-NAYORA, and a number of international and donor organizations (USAID, 3 UNICEF, 3 WB, WHO, Vishnevskaya-Rostropovich Foundation).

The study findings confirm the prevailing view about the existing PHC delivery system in Azerbaijan. The majority of the stakeholders agree that it is ineffective in terms of trained personnel, physical infrastructure, referral system and access to care. The MoH sees the introduction of FM along with the changes in health financing mechanisms and increasing provider autonomy as ways to improve the situation. The study revealed that there is strong support for those plans at the local level. The policy on capitation payment of providers was strongly supported, with the FM concept supported in second place, and increased provider autonomy supported the least. However, the local stakeholders overall have poor knowledge about these plans.

Component 3: Improve Quality of PHC Services

PHCS made significant progress against its work plan for Component 3. The Project continued to help the MoH, district health authorities, and pilot facilities to take steps to improve the quality of PHC services. Progress in Year 2 is reported below in two sections focusing on: i) integrating EBM into clinical practice and development of CPGs; and ii) supporting continuous quality improvement in PHC facilities. Some preliminary results of quality improvement efforts in pilot PHC facilities are highlighted as a success story in that section of the report.

Integration of EBM into Clinical Practice and Development of CPGs

Integration of clinical protocols in day-to-day clinical practice ensures higher quality and more efficient health care services. PHCS continued discussions with key stakeholders such as NCPHR and HSRP in order to keep the process of CPG development and implementation operational. In Year 2, PHCS continued to provide extensive technical assistance to develop and institutionalize a process to integrate new CPGs into clinical practice. The MoH issued a series of orders regarding development, introduction, and dissemination of CPGs in clinical settings (MoH Orders: #28 from 28.11.2008; #3 from 03.02.2009; #10 from 04.04.2009; #66 from 04.06.2009). Approved protocols were disseminated by NCPHR in 15 regions of Azerbaijan. The dissemination process in Baku clinical facilities was carried out by the Baku Health Care Department. CPGs also were distributed to the national scientific-research institutes, private facilities and medical facilities of other ministries, medical and central libraries, and international organizations working in the health sector in Azerbaijan.

PHCS conducted extensive work in pilot districts to build capacity of PHC providers to provide clinical care according to approved CPGs. PHCS also built capacity of DMTs to routinely work with the PHC facilities to monitor the quality of care against the CPGs. In Year 2, PHCS trained the PHC providers on a number of approved CPGs, including:

- 264 health providers on ARI
- 250 health providers on Arterial Hypertension
- 170 health providers on Peptic Ulcer
- 289 health providers on Iron Deficiency anemia

Trainings results demonstrated relatively low level of initial knowledge among PHC providers regarding diagnosing and treating of common PHC sensitive conditions and substantial increases in knowledge after training (see table below). Both local health authorities as well as trainees acknowledged the high quality of the trainings.

	Pre-test	**Post-test**
Peptic Ulcer		
Sheki	60%	82%
Qakh	49%	79%
Ismayilli	55%	87%
Agdash	58%	86%
Average	**55%**	**84%**

ARI		
Sheki	68%	87%
Qakh	56%	88%
Ismayilli	58%	95%
Agdash	54%	81%
Average	**59%**	**88%**
Hypertension		
Sheki	39%	58%
Qakh	44%	67%
Ismayilli	48%	74%
Agdash	37%	47%
Average	**42%**	**62%**
Anemia		
Sheki	66%	93%
Qakh	76%	89%
Ismayilli	54%	91%
Agdash	56%	81%
Average	**63%**	**89%**

PHCS also collaborated with NCPHR and HSRP to scale up training on developed and approved CPGs throughout Azerbaijan. A training plan was developed and submitted to MoH for approval.

Support Continuous Quality Improvement in PHC Facilities

PHCS, in collaboration with the NCPHR, held a series of meetings to discuss the development of EBM, CPGs and linkage with quality improvement (QI) strategies. PHCS reviewed various QI tools developed for PHC and inpatient care and selected a set of indicators that are mostly applicable to the current PHC settings in Azerbaijan. PHCS helped to establish District Monitoring Teams (DMTs) in all five pilot districts (3 districts in Year 1 – Sheki, Qakh, and Ismayilli; and 2 more in Year 2 – Agdash and Absheron). Then a QI tool was developed and reviewed with the participation of DMT in each district.

Together with DMTs, PHCS selected the following indicators to monitor initially:

- Percentage of patient records sampled that were completed accurately;
- Percentage of use of 2 or more drugs with similar therapeutic effect for ARI;
- Percent of adults over 18 years old who visited the PHC facility and who had their blood pressure checked; and
- Irrational use of antibiotic drugs during ARI.

Supportive monitoring visits were conducted in 10 selected PHC facilities in pilot districts. Key findings were analyzed and presented to each facility and at the district level. Findings from DMT monitoring visits for six facilities are highlighted in the success stories section of this report.

Component 4: Promote Personal Responsibility for Health among Individuals and Families

In Year 2, PHCS continued to leverage and build on excellent relationships with national and international partners active in health communication. With the ultimate purpose to promote health and equip individuals and families with information on the benefits of healthy lifestyle, the Project structured its activities around the following topics: i) setting a national agenda in health communication; ii) building health communication capacity of NCPHR; iii) supporting national health communication specialists; iv) responding to health emergencies; and v) coordinating health communication activities with PHCS activities under other components.

Helping to Establish a National Agenda for Health Communication

In Year 2, PHCS continued to provide technical assistance and capacity building to partners working in health communication. Because health communication is a somewhat new discipline for Azerbaijan, the country lacks a strategic framework for organizing health communication activities. PHCS suggested that Azerbaijan develop a National Health Communication Concept to embrace all the country's communication priorities and coordinate the activities of major stakeholders in health.

A National Communication Concept Development workshop was held on March 16-17 and brought together 30 representatives involved in health communication activities in the country including from government (from ministries of health, education, justice, as well as the State Committee for Family, Women and Children, NCPHR), international donor organizations (USAID, UNICEF, Vishnevskaya-Rostropovich Foundation), and local and international NGOs (ACQUIRE, World Vision, Azerbaijan Red Crescent Society, HAYAT, etc.).

Workshop participants were invited to discuss the main health priorities for Azerbaijan, define a list of communication interventions, and develop objectives for the Concept. The NCPHR was nominated to coordinate development of the Concept and further submit it to the relevant government structure for its approval. A first draft of the Concept has already been distributed among stakeholders and comments were received and incorporated. Counterparts will review and approve the Concept document in the beginning of Year 3.

Building Health Communication Capacity of NCPHR

The good working relationships established by the project and NCPHR's Department of Mass Media and Public Relations were further strengthened in Year 2. The Department reformulated its scope of work towards greater involvement in communication activities which resulted in the Department being renamed to the Department of Health Communication and Public Relations (DHCPR).

The project continued to build the professional capacity of the DHCPR's staff and facilitated the organization of the Leadership in Strategic Communication workshop supported by USAID's FORECAST project and led by a guest speaker from the Johns Hopkins University's Center for

Communication Programs. Participants from NCPHR, MoH's PR Department, and other partner organizations recommended by the project benefited from this two-week training event.

The Project also continued to support NCPHR's health communication specialists' network. Regular meetings with local and international organizations active in health communication were held throughout Year 2 to exchange information and to facilitate coordination of activities.

The NCPHR's monthly newsletter, initiated by the Project in Year 1 to outline the activities of partners working in the health sector, was regularly produced during Year 2, and can be found at the following web address: http://www.health.gov.az/article.php?isimbulleten.

Supporting National Health Communication Specialists

During Year 2, the Project established a partnership with the Azerbaijan Health Communication Association (AHCA). AHCA brings together national specialists in communication, PR and social marketing and provides professional development training, technical expertise in strategic communication, and social research. PHCS supported open workshops on Social Marketing, Media Relations, Press Release Writing, and Advocacy and Lobbying organized by AHCA for participants from various international (WHO, UNICEF), government (State Committee for Family, Women and Children, MoH, ombudsman's office), NGOs (Azerbaijan Red Crescent Society, Children Village, Hayat), private companies (Nestle, Janssen-Cilag), and mass media.

The Project has continued to help improve the availability of reference materials for health communication specialists available in Azerbaijani. PHCS translated the Johns Hopkins University/Center for Communication Program's "A Field Guide to Designing a Health Communication Strategy" manual together with DHCPR and submitted it to the NPHRC who printed over 1,000 copies of the book. During a presentation ceremony, the manual was distributed to all members of the health communication network.

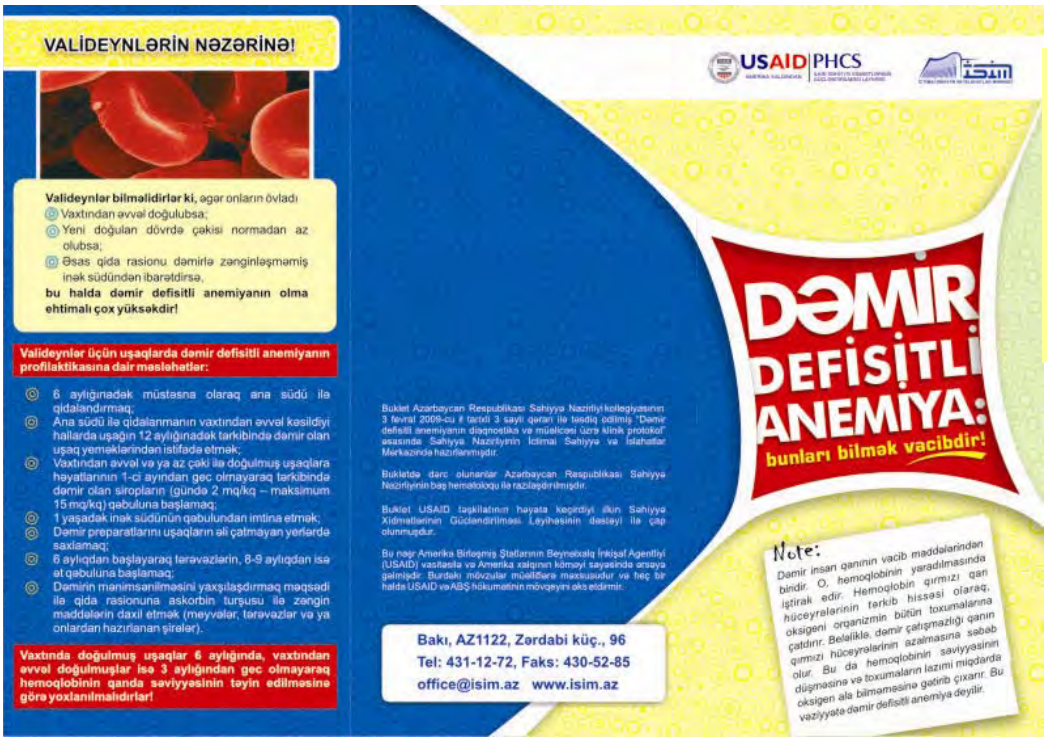
Responding to Health Emergencies

In response to the potential H1N1 pandemic, PHCS jointly with WHO and the NCPHR's DHCPR held a seminar on H1N1 for more than 20 journalists from 17 print, broadcast and electronic media. During the event, participants were updated about the global H1N1 situation and were provided information regarding preparation for possible outbreaks in Azerbaijan. Speakers from WHO/Baku and the MoH answered the participants' questions. The event resulted in two National TV channels (ANS TV and Khazar TV) and 12 print and electronic media outlets reporting on the event, effectively disseminating key H1N1 prevention messages to the broader population.

Collaborating with Other Project Components

PHCS continued to support activities in patient education to support the Project's quality improvement efforts in pilot PHC facilities. A number of leaflets for patients complementary to

approved CPGs that have been developed with support by the project (ARI, iron deficiency anemia, angina pectoris, ulcer, pancreatitis, flu, etc.) were developed and prepared for printing. 4,000 leaflets on ARI were printed for distribution in the Project's pilot sites.



Patient brochure on iron deficiency anemia developed by NCPHR and PHCS

Component 5: Improve TB Care and Treatment through Health Reform and Health System Strengthening

In early 2009, PHCS began to participate in policy dialogue at the national level on TB issues and helped the NTP to improve the coordination and collaboration among national partners and international organizations working on TB in Azerbaijan. PHCS made excellent progress in initiating TB activities according to its work plan. Progress is reported below in three sections focusing on: i) introducing international standards of TB control via legal and policy reform; ii) revising clinical guidelines/protocols based on international evidence; and iii) integrating TB services into PHC and improving clinical practice at facility level. Attachment I provides a summary of progress against work plan objectives for this component.

Introduce International Standards of TB Control via Legal and Policy Reform

To improve collaboration and cooperation on TB issues, an Interagency TB Working Group (IWG) was established in March 2009 under the Global Fund's Country Coordinating Mechanism (CCM). The IWG provides a forum for sharing information and coordinating TB activities. The goals and objectives of the TB IWG as well as a list of IWG members were discussed at the first meeting in March 2009. It was agreed that NTP will take responsibility for managing the IWG with assistance and operational support from PHCS. The IWG includes representatives from the MoH, Ministry of Justice (MoJ), NTP, GF, USAID, WHO, GOPA Worldwide Consultants, International Committee of the Red Cross (ICRC), and PHCS. During the year, the IWG met on a monthly basis to discuss progress, barriers, and critical steps to improve implementation of NTP in Azerbaijan. Meeting notes were developed to record decisions made by the group and to monitor follow-up steps between meetings.

PHCS also collaborated with NTP on development of the National TB Strategy for Azerbaijan. The NTP developed the draft Strategy in January 2009. PHCS reviewed the draft and made suggestions to strengthen the following sections:

- Addressing drug resistance: early diagnosing, prevention, treatment and elimination strategies to mitigate extremely high drug resistance prevalence in Azerbaijan;
- Improving TB case finding: actions to develop and implement a more effective TB case finding system; and
- Improving TB treatment: propose effective approaches to improve treatment results given poor treatment effectiveness in the past.

The final draft Strategy was reviewed by WHO experts and submitted to the MoH for approval. The Strategy was agreed with the Minister of Health and will be submitted for further Government approval in late 2009. PHCS and the TB IWG also reviewed a five-year national strategic plan on MDR-TB that was developed by the MoH and WHO international experts following a ministerial meeting among high MDR/XDR-TB burden countries held in Beijing in April 2009. The MDR-TB strategic plan will be incorporated into the final National TB Strategy.

In June 2009, NTP requested PHCS provide technical assistance in three areas to strengthen TB programs in Azerbaijan consistent with the Project's scope of work and work plan:

- Review of the five-year MDR-TB strategic plan and other programs/strategies developed by NTP, MoH, WHO, and GF, support in assessing progress made in implementing these programs, and provision of recommendations to improve implementation of national TB strategies and programs;
- Support in developing evidence-based clinical guidelines for TB detection and treatment and their implementation at facility level and in medical re-training programs; and
- Support in implementing MDR-TB interventions under GF Rounds 7 and 8 grants in the civilian sector through:
    - Clinical review/case management for MDR-TB at hospital and PHC level for patients receiving second-line drugs under GF grants (patients enrolled at current stage and for the next year);
    - Assessment of existing capacity of TB and overall health delivery structure in rural and urban areas to affirm the feasibility for expanding MDR-TB treatment under GF from 20 to 480 patients in 2009-2010; and
    - Defining a process and system to improve regular TB treatment and provide MDR-TB treatment at outpatient level.

Based on these agreed objectives, PHCS continued its intensive technical assistance collaborating with the NTP team on a daily basis and building their capacity through formal trainings and a "learning-by-doing" approach.

PHCS further collaborated with MoH to ensure TB care and treatment were integrated into specific national policies related to PHC and pharmaceuticals that the MoH is developing. As mentioned in Component 2, PHCS worked closely with AECM of the MoH and WHO in developing a National Pharmaceutical Policy including the National Formulary System and Essential Drug List (EDL). TB drugs are included in both the EDL and the proposed National Formulary System.

Revise Clinical Guidelines/Protocols based on International Evidence

PHCS initiated policy dialogue at the national level on evidence-based approaches for TB care and treatment. The Project worked closely with NTP, MoH, and NCPHR to establish an appropriate process to revise CPGs and protocols for TB based on international standards and evidence. A preliminary list of CPGs for TB services to be revised was prepared by PHCS and reviewed and agreed upon with NTP. Five CPGs on case finding, treatment, prevention and monitoring were selected by NTP as priorities and proposed for inclusion into the MoH's general list of CPGs to be developed in 2009-2010. NTP requested intensive technical assistance from PHCS to develop and implement these CPGs.

PHCS and NTP agreed to select two CPGs – TB Detection: Active and Passive and TB Treatment: Regular TB and MDR-TB – from the list to initiate the development process. A working group was established to develop the first CPG on TB detection which will include passive case finding, active case finding, and active case finding through screening of risk groups. The working group includes specialists from the National Institute of Lung Diseases, Medical Post-Graduate Institute, Medical University, MoH, Sanitary Epidemiological Station (SES), NCPHR, MoJ Medical Department, WHO, GF, and PHCS. PHCS has provided intensive

technical assistance to the working group by facilitating weekly meetings, providing technical leadership in CPG development, conducting trainings on EBM principles and approaches, and presenting international standards and best practices to working group members.

In June 2009, PHCS conducted a formal, five-day training on EBM/CPG development for 15 TB specialists and seven other specialists from different health areas. Major areas of evidence-based clinical guidelines development such as the principles of EBM, international standards of care, basic epidemiology, and evaluation of evidence were covered during the training. The training was successful in meeting its objectives and participants were able to immediately apply their newly acquired knowledge and skills to development of the CPG on TB detection.

Integrate TB Services into PHC and Improve Clinical Practice at Facility Level

In order to better understand the situation regarding TB diagnosis and treatment in Azerbaijan, PHCS and NTP conducted a visit to the Salyan district in February 2009 to learn more about the general health care delivery system, TB care delivery structures, and institutional capacities. PHCS took part in a further internal assessment of TB facilities and services provided at inpatient and outpatient levels in Baku and a few surrounding districts. Preliminary results of the assessment confirmed that the TB situation in Azerbaijan is critical and indicated increases in TB incidence, prevalence, and mortality in 2009. In comparison with 2008, the number of re-treated patients increased and the treatment effectiveness of new patients decreased. Based on these alarming findings, PHCS will help NTP finalize the assessment and develop a strategy and concrete steps for intensive improvement of the system.

In addition, PHCS provided support to NTP to engage in policy dialogue with GF, Green Light Committee (GLC), WHO, and others to expand the MDR-TB program supported by GF in 2009-10. Currently, only 20 of the 3,916 diagnosed MDR-TB patients in Azerbaijan receive appropriate treatment. PHCS helped the NTP to develop a process to implement GLC's recommendations and action points resulting from their April mission and to document the progress that had been achieved by August 2009. NTP requested an additional 480 courses of treatment for MDR-TB patients from GLC to be provided at outpatient level (health facilities/DOT points and National Reference Laboratory in Baku city). The GLC committee, satisfied that Azerbaijan was sufficiently prepared to expand their MDR-TB program, decided in August to allow Azerbaijan to provide MDR-TB treatment to an additional 240 patients in 2009-10. GLC will provide full courses of treatment for these patients. PHCS is now working with NTP to develop criteria to select patients and to define a structure of DOT points to be opened to treat these new patients. These issues will be discussed during the next GLC mission in October 2009.

MONITORING & EVALUATION REPORT

In Year 2, PHCS made significant progress in achieving its main objectives under each project component, which is tracked through the Project's monitoring and evaluation process. Attachment 2 provides an update on specific progress against indicators and Year 2 targets in the Project's Performance Monitoring Plan.

Under **Component 1**, PHCS continued to enhance legal and policy dialogue to improve the health financing reform process in Year 2 by significantly contributing to the development of 2 policies or programs: i) Program of Implementation of the new Health Care Financing Systems and Mandatory health Insurance in the Republic of Azerbaijan; and ii) National Health Information System Concept (Draft). PHCS also conducted 5 capacity building events on health financing, including a two-day training for national stakeholders on health financing, a seminar on DRGs for the MoH and HPPU, 2 workshops on DRG and HIS for hospitals in Baku city, and a workshop on cost accounting for MoH and 10 hospitals in Baku city. The Project also supported development of new provider payment options including revising the DRG system and developing a detailed concept for per capita payment of PHC facilities. In health information systems, PHCS significantly increased the number of facilities using the computerized database to track patient discharge forms, with the total number of forms entered increasing from 15,000 at the end of Year 1 to 30,000 at the end of Year 2.[1]

[1] This indicator has been revised in our PMP. Previously it sought to measure the % of forms entered into the database, but was difficult to calculate because there was no clear denominator. The indicator has been revised to report both the number of facilities implementing the computer database as well as the total number of forms entered.

Due to delays in making SAMHI operational, PHCS has not been able to enhance the capacity of SAMHI to act as a single payer for health care. PHCS also has not been able to further orient government officials to NHA methodologies and uses, as implementation of NHA has been postponed until 2010 at the Government's request.

Under **Component 2**, PHCS substantially contributed to the development of 3 policy-related documents, including National Health Reform Strategy (developed with support from PHCS in Year 1 but remains unapproved), National Drug Formulary, and Essential Drug List. PHCS contributed to improving policy analysis by conducting phase 2 of a stakeholder analysis on PHC and FM and by conducting a national RDU survey. Findings of the RDU survey were shared with the MoH and will be used by MoH to develop a number of concrete next steps to improve RDU, with guidance and support from PHCS and WHO. The findings of phase 2 of the stakeholder analysis will be combined with phase 1 findings and presented to the MoH for review and discussion in early Year 3. In Year 2, PHCS supported a National Round Table on PHC. The Project also supported the National Respiratory Association to participate in development and implementation of a CPG on asthma.

To improve quality of PHC services under **Component 3**, PHCS trained 32 people in EBM and the development of evidence-based CPGs in Year 2. Seven CPGs on PHC-sensitive conditions were developed by working groups under NCPHR with PHCS support. PHCS exceeded its targets for training PHC providers in Year 2:

- 264 PHC providers were trained on ARI according to an approved CPG;
- 250 PHC providers were trained on hypertension according to an approved CPG;
- 170 PHC providers were trained on peptic ulcer according to an approved CPG; and
- 289 PHC providers were training on iron deficient anemia according to an approved CPG.

Two additional DMTs were organized in Absheron and Agdash districts and trained on quality improvement approaches. The number of PHC facilities participating in quality improvement activities in pilot districts increased to 6 in Year 2.

In **Component 4**, PHCS helped to draft a National Health Communication Concept that is currently being circulated for review and approval. The Project conducted 4 trainings on health communication on topics including Advocacy and Lobbying, Writing Press Releases, Social Marketing, and Media Relations. PHCS supported NCPHR to hold 6 bi-monthly meetings on health communication and to develop and disseminate a Health Communication Strategy Guidebook, its monthly newsletter on health communication activities, and patient education materials on anemia and ARI.

Despite the fact that PHCS TB activities only began mid-way through the year in February 2009, PHCS was able to meet or exceed the majority of its targets for Year 2 under **Component 5**. An Interagency TB Working Group was established in March 2009 and met 7 times between March and August. PHCS reviewed the draft National TB Strategy and the MDR-TB program implementation plan and provide recommendations to NTP for their revision and improvement. PHCS met with MoJ twice to discuss coordination and integration of TB interventions between prison and civilian sectors and met twice with NTP and NCPHR to specifically discuss health communication strategies related to TB. The Project also agreed with

MoH and NTP on a list of TB CPGs to be developed/revised and helped form working groups to begin to develop CPGs on TB detection and treatment (including treatment of MDR-TB). PHCS trained 15 people in EBM concepts and CPG development. Finally, the Project jointly with NTP conducted a national assessment of TB indicators and services to inform strategies aimed to improve the effectiveness of TB services in the near future.

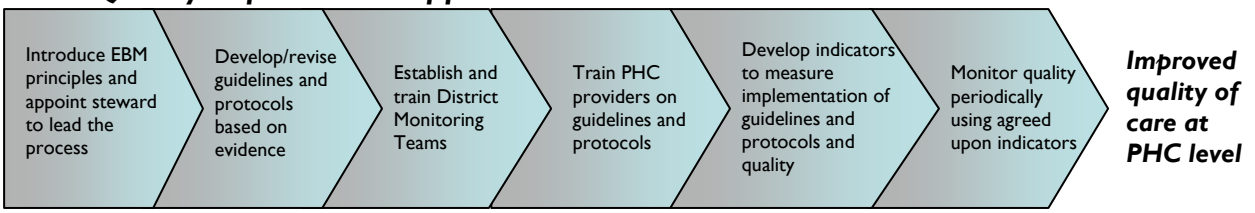
HIGHLIGHTS AND SUCCESS STORIES

District Monitoring Teams Note Improvements in Key PHC Indicators in Pilot Facilities

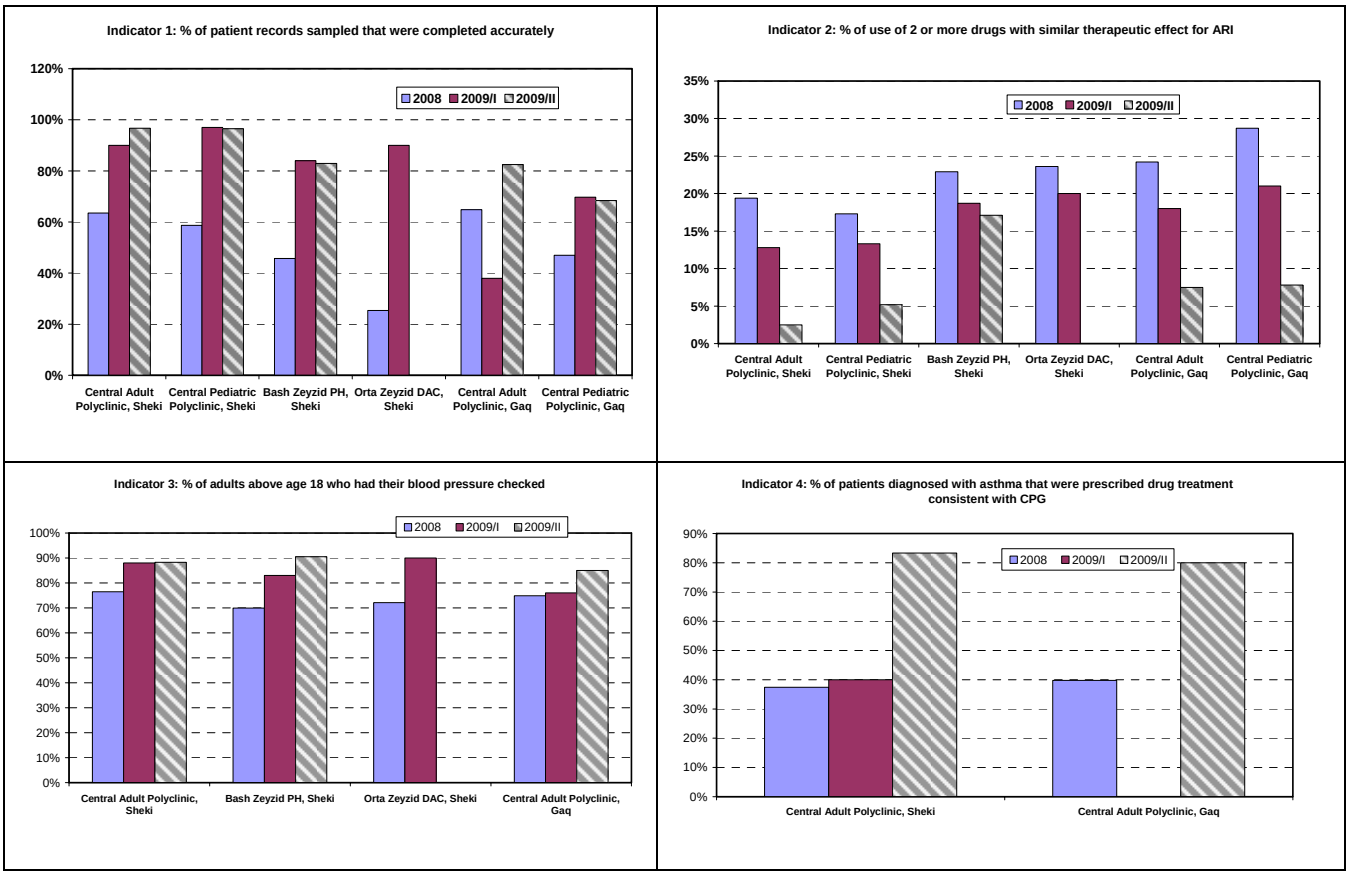
Many international development projects have used facility-based approaches to quickly improve the quality of care at the PHC level, typically focusing on one or two priority interventions, such as IMCI or prenatal care. While results may be achieved quickly, they may not necessarily be long-lasting or have an impact on the quality of all services provided by PHC providers. The PHCS Project in Azerbaijan has taken a different approach to improving quality of PHC – a systemic approach that it hopes will institutionalize quality improvement approaches and methodologies at central, district, and facility levels and make improvements in quality more sustainable and lasting.

As shown in the attached figure, the quality improvement approach starts with the introduction of EBM principles into the culture and practice of medicine. Clinical practice guidelines and protocols for PHC conditions are revised by expert working groups based on international evidence and best practices and approved by the MoH. District Monitoring Teams (DMTs) are formed to support facilities in monitoring their quality of care and trained in EBM and quality improvement approaches. Guidelines and protocols are disseminated to facilities through training for DMTs and PHC providers. Indicators are then selected for monitoring how well guidelines and protocols are implemented by PHC providers. Progress against these indicators over time reflects the quality of care provided by PHC facilities.

PHCS Quality Improvement Approach



As demonstrated in the graphs below, the PHCS quality improvement approach has yielded results in pilot PHC facilities in Sheki and Qakh districts. Through the sample size and number of indicators is limited, quality of care across all pilot facilities shows steady signs of improvement. The quality of patient records (ambulatory cards) is improving and becoming a more reliable source of information on clinical practices. The percentage of cases where two or more antibiotics with similar therapeutic effect were prescribed during episodes of acute respiratory infection (ARI) has decreased dramatically. A key process indicator in the fight against hypertension – the percentage of adults over 18 years old who visited a PHC facility and had their blood pressure checked – also increased significantly. Finally, the percentage of adults diagnosed with asthma that were prescribed drugs in line with the protocol also increased in the adult polyclinics in PHCS pilot districts.



Sadagat Osmanova, chief pediatrician and a DMT member in Sheki district has been impressed with the Project's quality improvement approach. She recently stated that "Establishment of the

DMT in Sheki has been an effective way to achieve our health targets. As a result of monitoring, we can observe how quality of health care services in target facilities is improving and internal control mechanisms are strengthened. Through recommendations given at the time of monitoring visits we try to refresh knowledge and skills [of health providers] received during trainings."

PHCS Supports National Health Communication Concept Development Workshop

On March 16, nearly 30 people were sitting around a long U-shaped table in the conference room of the National Center of Public Health and Reform (NCPHR) of the Ministry of Health. These representatives of government and non-government organizations, international and private institutions were brought together by the USAID-funded Primary Health Care Strengthening (PHCS) Project and NCPHR in an ambitious but visionary attempt to improve health communication in Azerbaijan. "Today, we are here to take the very first steps in developing a National Health Communication Concept; a Concept that we need to unite efforts of our partners in health and to improve the well-being of all Azerbaijanis," stated Nurlan Aliyev, head of the Health Communication and Public Relations Department of the NCPHR.



The one-and-a-half day workshop was facilitated by PHCS. The event was structured in a way that allowed participants not only to learn the status of health care problems and the corresponding situation with health communication in the country, but also to express their own opinions and suggest areas for improvement.

"Health communication is still quite a new subject for Azerbaijan, and we need to work together to find gaps in current activities in order to avoid them in the future," said Gulnara Akhundova, representative of the Azerbaijan Health Communication Association (AHCA).

At the workshop Ms. Akhundova was presenting the AHCA's achievements in the field of health communication. Other speakers – Lena Kolyada, a PHCS consultant, and Isa Aliyev from the Health Policy Unit of the Ministry of Health – outlined the strategy development framework and the country's current priorities for health interventions. These presentations served as a

basis for deciding on health communication "hot spots" and defining objectives for the future document.

The participants then talked about health communication efforts made by their organizations, and working in groups, they suggested areas that should by prioritized for interventions in the Concept document. It was agreed that the results of the workshop would be summarized by the PHCS consultant and further presented to the Ministry of Health for review.

"We will suggest that the Ministry establish a working group to finalize the Concept document and we will lobby for its approval and implementation," said Mr. N. Aliyev. "During this workshop we saw that our counterparts in health are willing to support and follow the Concept, the Concept we developed together."

LESSONS LEARNED

During Year 2, PHCS continued to achieve its objectives through complementary activities that provide technical support to policy development processes and simultaneously build capacity of policymakers, health care managers, health care providers, and health communicators. The Project continued to cultivate excellent working relationships with counterparts and stakeholders and planned and implemented Year 2 activities jointly with both government institutions and other development partners. This approach has helped increase the capacity of policymakers to engage in effective policy dialogue, increased ownership for reform efforts, and institutionalized key health system functions, such as CPG development and coordination of health communication activities, in appropriate local institutions.

One of the main lessons learned during the first and second years of the project was that delays in reaching project objectives due to the absence of certain political decisions should not hinder Project activities in that area. For instance, despite the formal approval of a Health Financing Concept and the decision to establish a single payer for health care in December 2007, the government has been slow to implement these new policies. Nevertheless, the Project continued its work in health financing by focusing on priority needs that are less dependent on political decisions. For instance, in Year 2, PHCS continued to help strengthen health information systems to prepare the MoH and health providers for the introduction of new financing mechanisms and to build their capacity in collection and analysis of clinical and financial data. PHCS also continued to work with the MoH and HSRP to develop proposals for a case-based hospital system and a per capita PHC payment system and to help plan pilot testing of

new systems. The MoH has agreed to move forward with these activities even in the absence of an operational SAMHI.

Another key lesson learned in Year 2 was that by starting with small, concrete deliverables, PHCS has been able to gain trust and garner interest among MoH and key stakeholders in more substantial changes in health policy. Policy dialogue focusing on the types of health information systems required to support provider payment systems, in particular automating Form #66 to prepare for introducing case-based payment in hospitals, led the MoH to request that PHCS provide assistance in developing a more comprehensive concept for health information systems. The resulting concept provides an organizing framework for all institutions that manage health information systems and health statistics and the end users of the health information. It offers an approach that takes account of the information systems that currently exist, allows for additional modules to be added that meet current and future information needs of users, and defines mechanisms for coordination and integration of information and software. The modular approach inherent in the concept makes changes and improvements in Azerbaijani health information systems feasible in the short term and sustainable over the long term.

LOOKING FORWARD

In Year 3 – the Project's final year – PHCS will solidify and continue to institutionalize the progress that it has achieved across all components in Years 1 and 2. Key areas of focus for Year 3 will include:

- Continuing to build the capacity of policymakers in evidence-based health policy, health reform, and health financing;
- Supporting further development and pilot testing of hospital and PHC provider payment systems with MoH and HSRP;
- Supporting implementation of the discharged patient database in 31 facilities to provide information to develop and refine the case-based hospital payment system;
- Continuing to support NCPHR to develop/revise CPGs on PHC-sensitive conditions and to implement them in PHC facilities in pilot districts through training, quality improvement approaches, and monitoring;
- Providing technical assistance to FM Department of the postgraduate medical institute, in collaboration with HSRP, to develop FM retraining program for pilot sites;
- Helping to support efforts to improve rational drug use through implementation of evidence-based CPGs and training of providers on rational drug use, including rational prescribing of antibiotics;
- Further increasing capacity of NCPHR's DHCPR and AHCA to coordinate and implement health communication activities on priority health topics in line with an approved National Health Communication Concept; and
- Working with NTP to improve delivery of TB and MDR-TB services by revising TB CPGs based on international evidence and best practices, and implementing approved CPGs

through provider training and monitoring in facilities where outpatient TB services are offered.

In August 2009, USAID allocated an additional $743,995 to PHCS and added a sixth component to the Project designed to integrate MNCH services and interventions into PHC. This sixth project component is designed to:

- Support the restructuring and strengthening of the PHC sector by advocating for the inclusion of MNCH integration into PHC reform efforts;
- Build the capacity of the MoH's NCPHR to develop additional MNCH clinical practice guidelines and protocols;
- Build the capacity of NCPHR and MoH to utilize MNCH data for better planning; and
- Engage in policy dialogue with key stakeholders to ensure that suitable MNCH strategies and policies are in place and being implemented effectively.

PHCS has included these additional MNCH activities into its Year 3 work plan and is actively recruiting to identify qualified international and local expertise to implement these planned activities.

LIST OF ACRONYMS

AECM	Analytical Expertise Center for Medicine
AHCA	Azerbaijan Health Communication Association
ARI	Acute respiratory infection
CCM	Country Coordinating Mechanism
CIS	Commonwealth of Independent States
CPG	Clinical practice guideline
DHCPR	Department of Health Communication and Public Relations
DHIS	Department of Health Information and Statistics
DMT	District Monitoring Team
DRG	Diagnostic related group
EBM	Evidence-based medicine
EDL	Essential drug list
FM	Family medicine
GF	Global Fund
GLC	Green Light Committee
GP	General Practitioner
HIS	Health information systems
HiT	Health Care Systems in Transition
HPPU	Health Policy and Planning Unit
HSPA	Health Systems Performance Assessment
HSRP	Health Sector Reform Project
ICRC	International Committee of the Red Cross
IWG	Interagency Working Group
MHI	Mandatory health insurance
MoF	Ministry of Finance
MoH	Ministry of Health
MoJ	Ministry of Justice
NCPHR	National Center for Public Health and Reform
NDP	National Drug Policy
NHA	National Health Accounts
NGO	Non-governmental organization
NTP	National TB Program
PHC	Primary health care
PHCS	Primary Health Care Strengthening Project
PHR	Partnerships for Health Reform

PR	Public relations
QI	Quality improvement
RAU	Rational antibiotic use
RDU	Rational drug use
SAMHI	State Agency for Mandatory Health Insurance
SES	Sanitary Epidemiological Station
TOT	Training of trainers
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

ATTACHMENT 1: PROGRESS REPORT ON TB ACTIVITIES

Expected Outcomes in PHCS TB Proposal	Progress Made by PHCS in Project Year 2
1. INTRODUCE INTERNATIONAL STANDARDS OF TB CARE VIA ONGOING LEGAL AND POLICY REFORM	
1.1 Introduce revised regulations and legislation that reflect ISTC	
Regulations and legislation for TB control that reflect ISTC drafted	Reviewed and provided comments on National TB Strategy and five-year implementation plan on MDR-TB component. PHCS and WHO's review of the Strategy and implementation plan ensured that they reflected international standards for TB care. The draft Strategy was presented at a ministerial meeting for high burden TB countries held in Beijing in April 2009. It is expected that the Government of Azerbaijan will approve the Strategy by November 2009 and present it at the next ministerial meeting to be held in Berlin.
Existence of policies supporting case detection in PHC settings and policies supporting directly observed treatment of TB cases in PHC settings	A CPG on TB case detection is in the process of being developed by a working group. Part of this development process is to define roles and responsibilities for case detection in DOT points and PHC facilities.
Legislation to ban the sale of first-line TB drugs without a prescription monitored	PHCS conducted monitoring in April and September. Two drug stores in Baku that were sampled reported that they continue to have one of five first-line TB drugs available (ethambutol and refampicin, respectively). Results of monitoring efforts were shared with the TB Interagency Working Group (IWG) in April so they might take follow-up action.
Existence of policy dialogue processes including active working groups on National TB Strategy and TB/PHC integration	TB IWG established in March 2009 with leadership by NTP and technical and operational support from PHCS. The IWG includes representatives from the MoH, MoJ, NTP, GF, USAID, WHO, GOPA Worldwide Consultants, ICRC, and PHCS. During the year, the IWG met on a monthly basis to discuss progress, barriers, and critical steps to improve implementation of NTP in Azerbaijan. Meeting notes were developed to record decisions made by the group and to monitor follow-up steps between meetings.
1.2 Increase managerial capacity of district health offices, SES and NTP	
Revised management charter for NTP and its decentralized regional units	Discussions with NTP revealed that there are no further plans for official establishment of decentralized regional units so PHCS will no longer report against this expected outcome. Roles and responsibilities for NTP and other organizations involved in TB control in Azerbaijan will be defined as TB strategies and guidelines are developed.

Improved capacity of district health offices, SES and NTP to plan and integrate TB/DOTS at PHC level	These stakeholders were included in EBM trainings and processes to develop CPGs on TB detection and treatment. PHCS is working with NTP to define where outpatient care for TB detection and treatment (including DOTS) will be delivered. Roles and responsibilities of SES will be defined during CPG development.
Improved reporting of TB outcomes	PHCS plans to bring a consultant in Project Year 3 to help NTP improve reporting of TB outcomes. The MoJ decided to implement the TB e-manager system (developed by MSH) for TB and MDR-TB cases in prisons and NTP decided to use the system for MDR-TB cases in the civilian sector. PHCS began to coordinate with MSH, MoJ, and NTP as they test and implement the system. NTP has raised concerns that the e-manager system is web-based rather than PC-based, and may not be used where access to internet is limited.
1.3 Ensure sufficient funding for TB control	
TB control services included in BBP	The MoH has delayed all discussions of the BBP until State Agency for Mandatory Health Insurance (SAMHI) becomes operational. If this should occur in Project Year 3, PHCS is ready to discuss inclusion of TB control services into the BBP with MoH and MoF.
Estimates of funds needed for TB control at the PHC level	PHCS has initiated discussions with NTP and GF to provide incentives for TB providers and patients for treatment. If there is interest from stakeholders, PHCS may help to develop an approach for estimating appropriate incentives for providers and patients.
Payment for TB services in line with PHC health financing reforms	Delays in the establishment of SAMHI have postponed discussions of provider payment systems for hospitals and PHC facilities. PHCS continues to participate in discussions with the MoH on development of provider payment systems for hospitals and PHC facilities. Discussing new payment systems for TB services would be premature before these more basic provider payment systems are in place. It is doubtful that payment systems for TB services can be further discussed or developed before the end of the Project.
1.4 Support WHO, MOH, and Pulmonologist Association in conducting national events and workshops	
Support provided to World TB Day and other national events and workshops	MoH, NTP, NCPHR, PHCS, and WHO conducted a National Round Table on TB in March 2009 to commemorate World TB Day. PHCS will help NTP to conduct a National TB Conference in collaboration with GF and a GLC mission in October 2009.
2. REVISE CLINICAL GUIDELINES/PROTOCOLS BASED ON INTERNATIONAL EVIDENCE	
2.1 Develop a process and methodology for development of CPGs/CPs for TB control, building on broader EBM processes	
Existence of policy dialogue processes including active working groups on case detection in PHC	PHCS worked closely with NTP, MoH, and NCPHR to establish an appropriate process to revise CPGs and protocols for TB based on international standards and evidence. A

settings and DOT(S) in PHC settings	preliminary list of CPGs for TB services to be revised was prepared by PHCS and reviewed and agreed upon with NTP. Five CPGs on case finding, treatment, prevention and monitoring were selected by NTP as priorities and proposed for inclusion into the MoH's general list of CPGs to be developed in 2009-2010. PHCS conducted a five-day formal training on EBM principles and CPG development for all specialists that will be involved in development of TB CPGs. PHCS and NTP agreed to select two CPGs – TB Detection: Active and Passive and TB Treatment: Regular TB and MDR-TB – from the list to initiate the development process. A working group was established to develop the first CPG on TB detection which will include passive case finding, active case finding, and active case finding through screening of risk groups. The working group includes specialists from the National Institute of Lung Diseases, Medical Post-Graduate Institute, Medical University, MoH, Sanitary Epidemiological Station (SES), NCPHR, MoJ Medical Department, WHO, GF, and PHCS. PHCS has provided intensive technical assistance to the working group by facilitating weekly meetings, providing technical leadership in CPG development, conducting trainings on EBM principles and approaches, and presenting international standards and best practices to working group members.
2.2 Collaborate to develop, adapt, and translate programmatic and clinical guidelines and protocols for TB control based on international evidence and best practices	
Translation of relevant documents, including International Standards of Tuberculosis Care, into Azerbaijani	Key articles and documents containing international evidence on TB care and treatment have been translated for review by the NTP, IWG, and CPG working groups.
CPGs/CPs on TB control (in PHC) developed	The first CPG on TB Detection has been drafted and will be submitted for review in October 2009. A working group has been established to develop a second CPG on TB treatment (regular TB and MDR-TB) and the group has begun to review international best practices and WHO recommendations that could be adopted in Azerbaijan.
3. INTEGRATE TB SERVICES INTO PHC AND IMPROVING CLINICAL PRACTICE	
3.1 Rapid baseline and endline studies to monitor clinical indicators	
Conduct baseline assessment	In June-July 2009, PHCS and NTP conducted an assessment of TB facilities and TB service provided at inpatient and outpatient level. The assessment focused on the Baku TB delivery structure and also included data from a few districts and attempted to analyze data across a four-year period. Preliminary results of the assessment show that the TB situation in Azerbaijan is critical, indicating a significant increase in TB incidence (by 15%), prevalence (by 22.6%), and mortality (by 7%) in 2009. In comparison with 2008, the

	number of re-treated patients increased by 28.6% and the treatment effectiveness among new patients decreased by 60%. PHCS and NTP presented the results to the MoH who requested that NTP and donors working in TB develop specific recommendations to improve the TB program based on the findings. One strategy that was explored with the MoH was to transfer TB and MDR-TB treatment from an inpatient to an outpatient basis to improve effectiveness and decrease cross-infection. The Minister asked that the assessment findings remain internal for the time being.
Conduct endline assessment	Endline study is planned to be conducted near the end of Project Year 3.
3.2 Establish a pilot integrating DOTS into PHC	
Pilot program integrating DOTS into PHC initiated and closely monitored	A program to strengthen DOTS services at the PHC/outpatient level is planned for Project Year 3. This will be closely coordinated with GF and GLC programs to strengthen DOT points to improve detection, care and treatment for both TB and MDR-TB patients. Also in Year 3, PHCS will help NTP to implement expanded MDR-TB component (additional 240 courses of treatment) by helping to develop criteria to select patients and by defining a structure of DOT points to be opened to treat these new patients.
3.3. Provide in-service training to PHC providers on DOTS	
300 PHC doctors and 500 PHC nurses trained in DOTS	Training of PHC providers is planned for Project Year 3 after CPGs have been developed and approved.
300 PHC doctors trained in Management of TB patients with most common concomitant conditions	Training of PHC providers is planned for Project Year 3. This training may be combined with the DOTS training planned above.
300 PHC doctors and 500 PHC nurses trained in interpersonal communication skills	Training of PHC providers is planned for Project Year 3.
Patient education materials on treatment adherence developed, printed and distributed	Patient education materials to be developed and distributed in Project Year 3. The IWG met to exchange information regarding which organizations are already conducting health communication activities and to discuss developing a health communication strategy for TB for health providers, patients, and the general population. A one-page strategy has been shared with all IWG members for review and comments.
3.4 Develop monitoring and supervision systems to encourage/ensure adherence to evidence-based programmatic and clinical guidelines and protocols	
300 PHC doctors and 500 PHC nurses trained in	Training of PHC providers is planned for Project Year 3.

monitoring and continuous quality improvement (CQI)	
3.5 Work with medical academy to introduce WHO DOTS training into undergraduate and postgraduate medical curriculum	
Curricular component for DOTS developed for undergraduate and postgraduate medical academies	This activity is planned for Project Year 3 after CPGs on TB detection and treatment have been developed and approved. The Head of NTP is also the Head of the TB Department at the Postgraduate Medical Institute and PHCS has already initiated discussion with him on inclusion of DOTS training into the postgraduate curriculum.

ATTACHMENT 2:
PERFORMANCE MONITORING PLAN INDICATORS

PHCS PMP indicators

Component 1: Increase Public Expenditures for Health and Improve Allocation for PHC

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Improved resources allocations to PHC	% of total public health expenditures in pilot districts/country spent on PHC (in 2007 – 16.4% according to the Law on State Budget)	n/a				16.4%	15.7%		n/a
Enhanced legal and policy dialogue to improve health financing reform process	# of health-finance-related laws, regulations, policies developed with the significant contribution of the project	4 (50%)	2 (25%)	2 (25%)	8 (100%)	4 (50%): 1. National Health Financing Concept; 2. Action Plan for implementation of HFC; 3. Draft Statute on State Agency for Mandatory Health Insurance (SAMHI);	2 (25%) 1. Program of Implementation of the new Healthcare Financing System and Mandatory Health Insurance in the Republic of Azerbaijan 2. Draft National Health		6 (75%)
Enhanced capacity of health authorities and providers to implement new health financing policies	# of capacity building events (training, workshops, seminars, study tours etc) conducted	2 (20%)	4 (40%)	4 (40%)	100% (10)	2 (20%)	5 (50%) 1. Two-day health financing and health systems training 2. DRG seminar for MOH and HPPU 3. Workshops (2) on DRG and HIS for hospitals in Baku city 4. Cost accounting for MoH and 10 hospitals in Baku city		7 (70%)

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Enhanced capacity of SAMHI to act as a single payer for health care	# of capacity building events (training, workshops, seminars, study tours etc) conducted	4 (33%)	4 (33%)	4 (33%)	12 (100%)	4 (33%)	N/A, SAMHI is not operational yet		4 (33%)
Supported development of new provider payment options and their piloting in the selected sites	# of HF or funds flow products/systems developed: - Case-based hospital payment system - Per capita payment for PHC services	1 (50%)	1 (50%)	0 (0%)	2 (100%)	1 (50%): case-based hospital payment system	1 (50%) Revision of DRG (50%) Concept for PC system for PHC (50%)		2 (100%)
	% of health facilities in pilot districts paid under new payment system	0%	50%	50%	100%	0%	N/A, SAMHI is not operational yet		0%
Strengthened health information systems to support the transition to new provider payment system	% of facilities using computerized database for patient discharge forms (of the planned facilities); and total number of forms entered	2 (5%)	5 (13.5%)	31 (84%)	37 (100%)	5%: 2 facilities in Sheki and Ismayilli districts (total number of forms entered = 15,000)	13.5%: 4 facilities in pilots and 1 republican hospital (total number of forms entered = 23,000)		16%
Supported GoAZ in institutionalization of National Health Accounts (NHA)	# of government officials oriented to NHA methodologies and uses	1 (20%)	2 (40%)	2 (40%)	5 (100%)	1 (20%)	NHA implementation postponed by Government		1 (20%)

PHCS PMP indicators

Component 2: Create a Policy and Legal Framework that Defines PHC and the PHC Delivery System

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Enhanced legal and policy dialogue to improve health policy reform process	# of health-related laws, regulations and policies developed to which PHCS substantially contributed	3 (37.5%)	3 (37.5%)	2 (25%)	8 (100%)	3 (37.5%): 1. Statue on Family Physicians and Family Nurse (2); 2. Statue on CPG development process	3 (37.5%) 1. National Health Reform Strategy drafted; 2. National Drug Formulary; 3. Essential Drug List		6 (75%)
Improved policy analysis	# of policy analyses and/or research studies to support health reform policy process developed with the substantial assistance of PHCS	3 (60%)	2 (40%)		5 (100%)	3 (60%): 1. Stakeholder analysis (1); 2. Rational Drug Use surveys (1); 3. Drug availability and price survey (1)	2 (40%) 1.Stakeholder Analysis/PhaseII; 2. Rational Drug Survey (national level)		5 (100%):
Improved capacity of MoH related to PHC	- # of persons trained on adult teaching techniques (TOT)	15 (100%)			15 (100%)	15 (100%)			15 (100%)
	- # of persons trained on RDU TOT	10 (100%)			10 (100%)	10 (100%)			10 (100%)
	- # of national workshops conducted by PHCS	1 (33%)	1 (33%)	1 (33%)	3 (100%)	1 (33%) National Health Reform Strategy round table	1 33%) National PHC round table		2 (67%)
Improved capacity of health sector non-governmental organizations (NGOs) and professional associations	# of health NGOs and associations supported by PHCS	2 (66%)	1 (33%)		3 (100%)	2 (66%): 1. Azerbaijan Medical Association; 2. Azerbaijan Health Communication Association	1 (33%) National Respiratory Association		3 (100%):

PHCS PMP indicators

Component 3: Improve Quality of PHC Services

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Improved research and analytical skills and knowledge required for the development of evidence-based CPGs	- # of persons (or person-days) trained and applying new skills and knowledge	16 (100%)			16 (100%)	16 (100%)	32		48 (300%)
Supported CPG development process	- # of CPGs and other meaningful products developed for which PHCS contributed significantly	2 (50%)	2 (50%)		4 (100%)	2 (50%)	7		9(225%)
	- EBM glossary translated	1 (100%)			1 (100%)	1 (100%)			1 (100%)
	- AGREE instrument	1 (100%)			1 (100%)	1 (100%)			1 (100%)
Improved clinical skills and knowledge in evidence-based medicine	- # and % of providers trained in approved Bronchial Asthma CPG for which PHCS supported the clinical training in pilot sites	60 (23%)	100 (38.5%)	100 (38.5%)	260 (100%)	296 (114%)			296 (114%)
	- # and % of providers trained in approved Acute Respiratory Infections CPG for which PHCS supported the clinical training in pilot sites		200 (67%)	100 (33%)	300 (100%)	0 (0%)	264 (88.4%)		264 (88.4%)
	- # and % of providers trained in approved Hypertension CPG for which PHCS supported the clinical training in pilot sites		250 (100%)		250 (100%)	0 (0%)	250 (100%)		250 (10%)
	- # and % of providers trained in approved Peptic Ulcer CPG for which PHCS supported the clinical training in pilot sites		150 (60%)	100 (40%)	250 (100%)	0 (0%)	170 (68%)		170 (68%)
	- # and % of providers trained on RDU in pilot sites	500 (100%)			500 (100%)	590 (118%)			590 (118%)
	- # and % of providers trained in approved Iron deficiency Anemia CPG for which PHCS supported the clinical training in pilot sites				No target defined		289		289
Improved capacity of District Health Authorities in CQI	- # of DMTs established/reestablished and trained on QI in pilot districts	3 (60%)	2 (40%)		5 (100%)	3 (60%)	2 (40%)		5 (100%)
	- # of PHC facilities participating in QI program		4 (40%)	6 (60%)	10 (100%)	0 (0%)	6 (60%)		6 (60%)

PHCS PMP indicators

Component 4: Promote Personal Responsibility for the Individual and Family

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Enhanced policy dialogue for establishing legal base and institutionalizing health communication structure within the MOH	# of regulations and policies developed to which PHCS substantially contributed: - Statute for the Department of Mass Media and Public Relations of NCPHR - National Health Communication Strategy	1 (50%)	1 (50%)		2 (100%)	1 (50%)	25% (NHCS drafted)		1.5 (75%)
Increased capacities of the dedicated CPHR body in regards of health communication	- # of workshops/training on health communication for NCPHR staff and representatives of partner organizations conducted with support from PHCS	2 (50%)	1 (25%)	1 (25%)	4 (100%)	2 (50%),(Basics of Health Communication), (How to Develop Health Communication Campaigns)	4 (100%), (Advocacy and Lobbying, Press-release Writing,Social Marketing, Media Relations)		6 (150%)
	- English-Azerbaijani glossary of health communication terminology developed	100%			100%	100%			100%
	- Health Communication Strategy Guide book	20%	80%		100%	20%	80%		100%
	- Monthly news bulletin outlining activities of NCPHR and partner organizations	5 (33%)	5 (33%)	5 (33%)	15 (100%)	5 (33%)	5(33%)		10 (66%)
	- Training module on patient-provider communication for HCW	100%			100%	100%			100%
	- # of patient education materials on health topics	2 (33%)	2 (33%)	2 (33%	6 (100%)	2 (33%), RDU, Injectibles	2(33%), Anemia, ARI		4 (66%)
Improved collaboration with other organizations active in health communication both locally and at the international level	# of regular meetings with local and international organizations active in health communication held at the NCPHR	4 (25%)	6 (37.5%)	6 (37.5%)	16 (100%)	4 (25%)	6(37.5%)		10 (62.5%)
	- # of persons went to an international study tour to health communication	2 (100%)			2 (100%)	2 (100%)			2 (100%)

Increased exposure to health communication materials for pilot regions population and health-care workers	- # of HCWs trained in patient-provider communication	500 (100%)			500 (100%)	590 (118%)			590 (118%)
	- # of communication materials on selected health topics developed, printed and distributed (RDU, Injectables, Hypertension, Bronchial Asthma, etc.)	10,000 (50%)	10,000 (50%)		20,000 (100%)	10,000 (50%)	4,000(20%), ARI		14,000 (70%)
	- # of products on selected health reform topics (patient rights, BBP, etc.)	0 (0%)	3 (50%)	3 (50%)	6 (100%)	0 (0%)	1(%), Child Rights round		15 (0%)

PHCS PMP indicators

Component 5: Improving TB Care and Treatment through Health Reform and System Strengthening

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Enhanced legal and policy dialogue to improve TB program	Interagency TB Working Group (IWG) at national level established		1		1 (100%)		1		1 (100%)
	# of IWG meeting conducted		6 (33%)	12 (67%)	18 (100%)		7 (39%)		7 (39%)
	# of TB-related regulations and policies revised/developed to which PHCS substantially support		1 (50%)	1 (50%)	2 (100%)		1 (National TB Strategy)		1 (50%)
	# of national level events (conferences, workshops, seminars, etc) conducted to inform on TB program progress		0	2 (100%)	2 (100%)		0		0 (%)
Improved policy dialogue with Ministry of Justice (MoJ)	# of meetings conducted with MOJ to discuss ways of better coordination and integration within TB interventions in prison and civil sector		2 (33%)	4 (67%)	6 (100%)		2 (Round 9 GF grant)		2 (33%)
Supported TB CPG development process and improved clinical skills	List of TB CPG to be developed agreed with MOH		1 (100%)		1 (100%)		1		1 (100%)
	# of people trained in EBM concept and CPG development		15 (100%)		15 (100%)		15		15 (100%)
	# of technical working groups created to develop CPG		1 (33%)	2 (67%)	3 (100%)		2 (67%)		2 (67%)
	# of CPGs developed:		1	2	3		1 (25%)		1 (25%)
	TB Detection		1				1 (in progress)		
	TB Treatment			1			1 (started)		
	TB Prevention			1					
	# of health providers trained in new CPGs			800 (100%)	800 (100%)				
Improved TB policy analysis	# of policy analyses and/or studies to support improvement of TB program developed with the substantial assistance of PHCS		1 (50%)	1 (50%)	2 (100%)		1 (TB Assessment)		1 (50%)
Increased exposure to TB-related communication materials for population/patients/ health care workers	# of meetings with NTP, NCPHR and international organizations active in health communication held		2 (33%)	4 (67%)	6 (100%)		2 (33%)		2 (33%)
	# of communication activities on selected TB topics developed and conducted			4 (100%)	4 (100%)		0		0%

PHCS PMP indicators

Component 6: Integrate MNCH Services and Interventions into PHC Reform Efforts

Expected Results	Performance Indicator	Project Targets				Achieved			
		Y1	Y2	Y3	Final	Y1	Y2	Y3	Cumulative
Enhanced legal and policy dialogue to improve MNCH process	MNCH Working Group at national level established			1	1 (100%)				
	# of MNCH WG meeting conducted			4	4 (100%)				
	# of MNCH-related regulations developed with the significant contribution of the project			2	2 (100%)				
	# of medical workers oriented to MNCH and RH strategies and dercees			100	100 (100%)				
Supported CPG development process and improved clinical skills	# of new CPGs on MNCH developed			2	2 (100%)				
	# of gynecologists, neonatalogists, midwives and PHC providers trained in new MNCH CPGs			300	300 (100%)				
Improved capacity of health providers in CQI	# of facilities implemented CQI activities with focus on MNCH			4	4 (100%)				
	# of CQI trainings conducted			4	4 (100%)				
	# of monitoring visits conducted in selected facilities			8	8 (100%)				
Enhanced capacity of health authorities and health providers in MNCH, monitoring, evaluation and using data for decissionmaking process	# of capacity building events (training, workshops, seminars, etc) conducted			6	6 (100%)				